STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

AMENDMENT # 1
RFP # 318.65-219

April 11, 2006

The subject RFP is hereby amended as follows.

The following RFP Schedule of Events updates or confirms scheduled RFP dates.

EVENT		TIME	DATE	UPDATED/ CONFIRMED
1.	State Issues RFP		April 7, 2006	CONFIRMED
2.	Disability Accommodation Request Deadline		April 17, 2006	CONFIRMED
3.	Pre-proposal Conference	10:00 a.m.	April 19, 2006	TIME UPDATED
4.	Notice of Intent to Propose Deadline		April 21, 2006	CONFIRMED
5.	Written Comments Deadline		April 26, 2006	CONFIRMED
6.	State Responds to Written Comments		May 9, 2006	CONFIRMED
7.	Proposal Deadline	2:00 p.m.	May 19, 2006	CONFIRMED
8.	State Completes Technical Proposal Evaluations		June 12, 2006	CONFIRMED
9.	State Opens Cost Proposals & Calculates Scores	9:00 a.m.	June 13, 2006	CONFIRMED
10.	State Issues Evaluation Notice & Opens RFP Files for Public Inspection	9:00 a.m.	June 14, 2006	CONFIRMED
11.	Contract Signing		June 26, 2006	CONFIRMED
12.	Contract Signature Deadline		July 3, 2006	CONFIRMED
13.	Contract Start Date (Readiness Review/Transition Begins; Actual Delivery of Services begins on January 1, 2007)		July 5, 2006	CONFIRMED
14.	Delivery of Services		January 1, 2007	CONFIRMED

STATE OF TENNESSEE

DEPARTMENT OF FINANCE AND ADMINISTRATION

BUREAU OF TENNCARE

REQUEST FOR PROPOSALS
FOR
MANAGED CARE ORGANIZATIONS FOR MIDDLE TENNESSEE

RFP NUMBER: 318.65-219

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1 INTRODUCTION

1.1 Statement of Purpose

The State of Tennessee, Department of Finance and Administration (F&A), Bureau of TennCare (the Bureau or TennCare), hereinafter referred to as the State, has issued this Request for Proposals (RFP) with the intent of securing two (2) contracts/Agreements for the provision of managed care services for TennCare enrollees and other populations in the Middle Grand Region of Tennessee. This RFP defines the State's minimum service requirements; solicits proposals; details proposal requirements; and, outlines the State's process for evaluating proposals and selecting the contractors.

Through this RFP, the State seeks to buy the best services at the most favorable, competitive prices and to give ALL qualified businesses, including those that are owned by minorities, women, and persons with a disability, and small business enterprises, opportunity to do business with the State as contractors and subcontractors.

These services, which are more fully described in Attachment 6.1, *Pro Forma* Contract, include the provision of covered physical health and behavioral health services, establishing and managing a provider network, credentialing and contracting with providers, utilization management, disease management, quality management, customer service, financial management, claims management, and maintaining sufficient information systems. The Middle Grand Region is comprised of four community service areas (CSAs), and each CSA is one or more counties. Information on the CSAs and counties in the Middle Grand Region are specified in Attachment 6.1, *Pro Forma* Contract, Section 1.

<u>Background Information</u>

History of TennCare

The TennCare program began January 1, 1994 to replace the existing Medicaid program in Tennessee. It was implemented as a five-year demonstration project approved by the Federal government pursuant to Section 1115 of the Social Security Act. Tennessee received several extensions after the initial expiration date of December 30, 1999. In July 2002 Tennessee received approval for another five (5) year period. Through the

TennCare program, the State was able to extend health insurance coverage to hundreds of thousands of Tennesseans who would otherwise have lacked such access.

The original managed care organization (MCO) contractors provided both physical and behavioral health services in one contract. However, in 1996, mental health and substance abuse services were “carved-out” into a separate contract and TennCare contracted with two behavioral health organizations (BHOs), beginning the TennCare Partners Program. There are currently three risk-based BHO contracts covering enrollees statewide.

In the 2002 proposal to the federal government the TennCare population was divided into two major eligibility groups: TennCare Medicaid, which is for persons who are eligible for Medicaid under the Medicaid State Plan, and TennCare Standard, which is for persons who are not Medicaid eligible but who have been determined to meet the State’s criteria as being either “uninsured” or “uninsurable”. One purpose of having TennCare Medicaid and TennCare Standard was to offer a different benefit package to each group; however, due to Court action, this plan was not implemented. TennCare Standard enrollees with family incomes at or above poverty were required to pay premiums and copayments while TennCare Medicaid enrollees were not required to pay premiums or copayments. Since that time there have been additional changes to eligibility, benefits, and cost sharing. Current information is included in Attachment 6.1, *Pro Forma* Contract.

The State has never used a competitive bidding process to procure MCOs for the delivery of physical health benefits, although such a process has been used to procure other managed care contractors. Initially, TennCare contracted with any qualified MCO that had a provider network by the implementation date, agreed to comply with the contract requirements, and accepted the capitation rates established by the State. TennCare MCOs originally operated under a full-risk capitation. However, in 1999 and early 2000, the TennCare program experienced several setbacks with some MCOs losing financial stability and exiting the program. In an effort to stabilize the program, by July 2002 all TennCare MCOs were operating under a Stabilization Plan. Under the Stabilization Plan MCOs were paid an administrative fee based on an enrollee’s eligibility category and were not at risk for the cost of medical services. In addition, the State developed a plan, called TennCare Select, whose risk is backed by the State. TennCare Select was created to serve as a backup if other MCOs failed or there was inadequate MCO capacity in any area of the state. In addition, TennCare select serves as the MCO for certain populations

statewide, including children in state custody and children eligible for SSI. TennCare Select is administered by Volunteer State Health Plan, a wholly-owned subsidiary of BlueCross BlueShield of Tennessee.

Litigation

Both before and after the creation of TennCare, several lawsuits were filed against the State related to its Medicaid program. These lawsuits resulted in consent decrees that in many instances imposed additional obligations for the State above and beyond what is required by federal law or by the Federal government in the TennCare demonstration project. One key case is *Grier v. Goetz*, which deals with the procedural protections to be afforded enrollees when TennCare services are denied, reduced, delayed, suspended, or terminated. On June 15, 2005, the State filed a motion to modify the consent decree in a number of respects that would enable effective implementation of reforms to the TennCare program, consistent with recent waiver amendments approved by the Federal government. In a series of orders the Court granted in part and denied in part the State's motion. Among other things, the Court's ruling reduces the State's obligation to provide an interim supply of non-preferred drugs when prescribed without prior authorization; confirmed the State's ability to impose and enforce numerical limits on certain benefits; recognized the State's right to dismiss without a hearing enrollee appeals that fail to raise a valid factual dispute; and restored the State's ability to appeal from adverse decisions of administrative law judges.

Program Reform

In 2003, newly elected Governor Phil Bredesen secured private funding for an independent analysis of the long term financial viability of the TennCare program. The international business consulting firm McKinsey and Company spent several months examining the program. Its conclusion was that if left unchecked, TennCare would consume 91% of all new state revenue growth by 2008, essentially eliminating the State's ability to fund other state departments and priorities. Knowing the TennCare program threatened to bankrupt the state, Governor Bredesen and the TennCare Bureau developed an initial plan to reform the program. The plan would have preserved full enrollment and placed certain service limits on some enrollees, thus returning the benefit package to one the state could afford to fund in the coming years. Despite near unanimous support by the General Assembly for what was widely regarded as a reasonable approach to rein in the program, the advocacy

community blocked the initial reform plan. Ultimately, the State was able to move forward with a modified reform plan and has achieved financial stability in the program.

Governor Bredesen and his team continue to work with the General Assembly and the courts and have substantially brought the program under control. An aggressive legal strategy has resulted in a series of legal victories resulting in relief from some of the most onerous provisions of the various consent decrees. Eligibility and membership in the program has stabilized. The stabilization period has resulted in better cost and utilization information that the State has used to set actuarially sound rates, and the MCOs that continue to operate in the State are back in a risk-sharing arrangement that has resulted in more federal support for the program. These accomplishments have allowed the TennCare Bureau to refocus efforts on improving the quality of care delivered through the program such as disease management and coordination of care.

Additional Information

Additional information related to the TennCare program can be found on the TennCare website at http://www.tn.gov/tenncare/.

1.2 Scope of Service, Contract Period, and Required Terms and Conditions

The RFP Attachment 6.1, *Pro Forma* Contract details the State's required:

- Program Requirements;
- Payment Terms;
- Terms and Conditions.

The *pro forma* contract substantially represents the contract document/Agreement that the Proposers selected by the State MUST agree to and sign.

1.3 Nondiscrimination

No person shall be excluded from participation in, be denied benefits of, be discriminated against in the admission or access to, or be discriminated against in treatment or employment in the State's contracted programs or activities on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by federal or Tennessee State Constitutional or statutory law; nor shall they be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of contracts/Agreements with the State or in the employment practices of the State's contractors. Accordingly, all Proposers entering into contracts/Agreements with the State shall, upon request, be required to show proof of such nondiscrimination and to post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

The State has designated the following person to coordinate compliance with the nondiscrimination requirements of the State of Tennessee, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and applicable federal regulations:

Helen Moore
Director of Non-Discrimination Compliance and Health Care Disparities
310 Great Circle Road
Nashville, TN 37243
(615) 507-6474

1.4 Assistance to Proposers With a Disability

A Proposer with a disability may receive accommodation regarding the means of communicating this RFP and participating in this RFP process. A Proposer with a disability should contact the RFP Coordinator to request reasonable accommodation no later than the Disability Accommodation Request Deadline detailed in the RFP Section 2, Schedule of Events.

1.5 RFP Communications

1.5.1 **Unauthorized contact regarding this RFP with employees or officials of the State of Tennessee other than the RFP Coordinator detailed below may result in disqualification from this procurement process.**

1.5.1.1 Interested Parties must direct all communications regarding this RFP to the following RFP Coordinator, who is the state of Tennessee's only official point of contact for this RFP:

Alma Chilton
Contract Coordinator
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
(615) 507-6384 (Phone)
(615) 532-3479 (Fax)
alma.chilton@state.tn.us

1.5.1.2 Notwithstanding the foregoing, Interested Parties may contact the staff of the Governor's Office of Diversity Business Enterprise for general, public information regarding this RFP, assistance available from the Governor's Office of Diversity Business Enterprise, or potential future state procurements.

1.5.2 The State has assigned the following RFP identification number that must be referenced in all communications regarding the RFP:

RFP-318.65-219

1.5.3 Any oral communications shall be considered unofficial and non-binding with regard to this RFP.

1.5.4 Each Proposer shall assume the risk of the method of dispatching any communication or proposal to the State. The State assumes no responsibility for delays or delivery failures resulting from the method of dispatch. Actual or electronic "postmarking" of a communication or proposal to the State by a deadline date shall not substitute for actual receipt of a communication or proposal by the State.

1.5.5 The RFP Coordinator must receive all written comments, including questions and requests for clarification, no later than the Written Comments Deadline detailed in the RFP Section 2, Schedule of Events. The Proposer must provide an electronic copy of the comments in an MS Excel table in the format specified below:

Proposer Name	Document Reference (e.g. RFP, *Pro Forma* Contract, RFP Attachment #, or Data Book)	Section Number	Section Heading	Page Number in Referenced Document	Question

1.5.6 The State reserves the right to determine, at its sole discretion, the appropriate and adequate responses to written comments, questions, and requests for clarification. The State's official responses and other official communications pursuant to this RFP shall constitute an amendment of this RFP.

1.5.7 The State will convey all official responses and communications pursuant to this RFP to the potential proposers from whom the State has received a Notice of Intent to Propose.

1.5.8 Only the State's official, written responses and communications shall be considered binding with regard to this RFP.

1.5.9 The State reserves the right to determine, at its sole discretion, the method of conveying official responses and communications pursuant to this RFP (*e.g.*, written, facsimile, electronic mail, or Internet posting).

1.5.10 Any data or factual information provided by the State, in this RFP or an official response or communication, shall be deemed for informational purposes only, and if a Proposer relies on such data or factual information, the Proposer should either: (1) independently verify the information; or, (2) obtain the State's written consent to rely thereon.

1.6 Notice of Intent to Propose

Each potential proposer should submit a Notice of Intent to Propose to the RFP Coordinator by the deadline detailed in the RFP Section 2, Schedule of Events. The notice should include:

- Proposer's name
- name and title of a contact person
- address, telephone number, and facsimile number of the contact person

NOTICE: A Notice of Intent to Propose creates no obligation and is not a prerequisite for making a proposal, however, it is necessary to ensure receipt of RFP amendments and other communications regarding the RFP (refer to RFP Sections 1.5, *et seq.*, above).

1.7 Proposal Deadline

Proposals must be submitted no later than the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events. A proposal must respond to the written RFP and any RFP exhibits, attachments, or amendments. A late proposal shall not be accepted, and a Proposer's failure to submit a proposal before the deadline shall cause the proposal to be disqualified.

1.8 Pre-Proposal Conference

A Pre-Proposal Conference will be held at the time and date detailed in the RFP Section 2, Schedule of Events. The purpose of the conference is to discuss the RFP scope of services. While questions will be entertained, the response to any question at the Pre-Proposal Conference shall be considered tentative and non-binding with regard to this RFP. Questions concerning the RFP should be submitted in writing prior to the Written Comments Deadline date detailed in the RFP Section 2, Schedule of Events. To ensure accurate, consistent responses to all known potential Proposers, the official response to questions will be issued by the State as described in RFP Sections 1.5, *et seq.*, above and on the date detailed in the RFP Section 2, Schedule of Events.

Pre-Proposal Conference attendance is not mandatory, and each potential Proposer may be limited to a maximum number of attendees depending upon overall attendance and space limitations. The conference will be held at:

Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

2 RFP SCHEDULE OF EVENTS

The following Schedule of Events represents the State's best estimate of the schedule that will be followed. Unless otherwise specified, the time of day for the following events will be between 8:00 a.m. and 4:30 p.m., Central Time.

RFP SCHEDULE OF EVENTS **NOTICE: The State reserves the right, at its sole discretion, to adjust this schedule as it deems necessary. The State will communicate any adjustment to the Schedule of Events to the potential proposers from whom the State has received a Notice of Intent to Propose.**		
EVENT	**TIME**	**DATE** **(all dates are state business days)**
1. State Issues RFP		**April 7, 2006**
2. Disability Accommodation Request Deadline		**April 17, 2006**
3. Pre-proposal Conference	**2:00 p.m.**	**April 19, 2006**
4. Notice of Intent to Propose Deadline		**April 21, 2006**
5. Written Comments Deadline		**April 26, 2006**
6. State Responds to Written Comments		**May 9, 2006**
7. Proposal Deadline	**2:00 p.m.**	**May 19, 2006**
8. State Completes Technical Proposal Evaluations		**June 12, 2006**
9. State Opens Cost Proposals and Calculates Scores	**9:00 a.m.**	**June 13, 2006**
10. State Issues Evaluation Notice and Opens RFP Files for Public Inspection	**9:00 a.m.**	**June 14, 2006**
11. Contract/Agreement Signing		**June 26, 2006**
12. Contract/Agreement Signature Deadline		**July 3, 2006**
13. Contract/Agreement Start Date (Readiness Review/Transition Begins; Actual Delivery of Services begins on January 1, 2007)		**July 5, 2006**
14. Delivery of Services		**January 1, 2007**

3 PROPOSAL REQUIREMENTS

Each Proposer must submit a proposal in response to this RFP with the most favorable terms that the Proposer can offer. There will be no best and final offer procedure.

3.1 Proposal Form and Delivery

3.1.1 Each response to this RFP must consist of a Technical Proposal and a Cost Proposal (as described below).

3.1.2 Technical Proposal (includes Mandatory Requirements, Qualifications and Experience and Technical Approach)

3.1.2.1 Each Proposer must submit one (1) original and eight (8) hard copies of the Technical Proposal to the State in a sealed package that is clearly marked:

"Technical Proposal in Response to RFP- 318.65-219 -- Do Not Open"

3.1.2.2 Each Proposer must include an electronic copy of the Technical Proposal on CD or disk in the sealed package with the hard copies of the Technical Proposal. The electronic copy of the Technical Proposal shall include one PDF file of the entire Technical Proposal as well as an MS Word version of the narrative. Attachments must be included in the MS Word file or provided in another file format that is commercially available, preferably an MS Office program.

3.1.3 Cost Proposal

3.1.3.1 Each Proposer must submit one (1) hard copy Cost Proposal to the State in a separate, sealed package that is clearly marked:

"Cost Proposal in Response to RFP- 318.65-219 -- Do Not Open"

3.1.3.2 Each Proposer must include an electronic copy of the Cost Proposal on CD or disk in the sealed package with the hard copy of the Cost Proposal. The electronic copy of the Cost Proposal must be in MS Excel.

3.1.4 If a Proposer encloses the separately sealed proposals (as detailed above) in a larger package for mailing, the Proposer must clearly mark the outermost package:

"Contains Separately Sealed Technical and Cost Proposals for RFP- 318.65-219"

3.1.5 The State must receive all proposals in response to this RFP, at the following address, no later than the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events.

Alma Chilton
Contract Coordinator
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
(615) 507-6384 (Phone)

3.1.6 A Proposer may not deliver a proposal orally or by any means of electronic transmission except as required in 3.1.2.2 and 3.1.3.2.

3.2 Technical Proposal

3.2.1 The RFP Attachment 6.3, Technical Proposal and Evaluation Guide details specific requirements for making a Technical Proposal in response to this RFP. This guide includes mandatory and general requirements as well as technical queries requiring a written response.

NOTICE: The Proposer shall submit the Summary of Key Utilization Assumptions (see RFP Attachments 6.3 and 6.6) as part of the Technical Proposal. No pricing information shall be included in any part of the Technical Proposal, including the Summary of Key Utilization Assumptions. Inclusion of Cost Proposal amounts in the Technical Proposal shall make the proposal non-responsive and the State shall reject it.

3.2.2 Each Proposer must use the Technical Proposal and Evaluation Guide to organize, reference, and draft the Technical Proposal. Each Proposer should duplicate the Technical Proposal and Evaluation Guide and use it as a table of contents covering the Technical Proposal (adding proposal page numbers as appropriate).

3.2.3 Each proposal should be economically prepared, with emphasis on completeness and clarity of content. A proposal, as well as any reference material presented, must be written in English and must be typed on standard 8 1/2" x 11" paper, single spaced, single sided, and with text no smaller than 11-point font. The pages must have at least one-inch margins. All proposal pages must be numbered and identified with the Proposer's name. Attachments must be clearly labeled.

3.2.4 All information included in a Technical Proposal should be relevant to a specific requirement detailed in the Technical Proposal and Evaluation Guide. All information must be incorporated into a response to a specific requirement and clearly referenced, including providing both the number of the requirement and text of the requirement from the Technical Proposal and Evaluation Guide. Attachments shall only be provided as requested in the Technical Proposal and Evaluation Guide. Any information not meeting these criteria will be deemed extraneous and will in no way contribute to the evaluation process.

3.2.5 The Technical Proposal shall comply with the page limits provided in the Technical Proposal and Evaluation Guide. Attachments shall not be counted towards the page limits.

3.2.6 The State may determine a proposal to be non-responsive and reject it if the Proposer fails to organize and properly reference the Technical Proposal as required by this RFP and the Technical Proposal and Evaluation Guide.

3.2.7 The State may determine a proposal to be non-responsive and reject it if the Technical Proposal document fails to appropriately address/meet all of the requirements detailed in the Technical Proposal and Evaluation Guide.

3.3 Cost Proposal

3.3.1 The Cost Proposal must be submitted to the State in a sealed package separate from the Technical Proposal.

3.3.2 All Cost Proposals must be submitted using RFP Attachment 6.7 Cost Scoring and Cost Proposal Forms. In order to be considered a complete Cost Proposal eligible for evaluation, the Proposer's Cost Proposal must include the following:

3.3.2.1 Proposed base capitation rates for each Category of Aid and Age/Sex Category combination for which a bid is required (see "Base Capitation Rates" below), accompanied by assumed utilization rates and expenditures per unit by service category. The State shall not consider awarding a contract/Agreement to a Proposer unless a base capitation rate is proposed for every Category of Aid and Age/Sex combination required. In addition, the State shall not consider awarding a bid to a Proposer that bids above the published maximum or below the published minimum for any rate cell (See 3.3.4.2);

3.3.2.2 An actuarial certification for each rate cell as indicated by signature of an actuary who is a member of the American Academy of Actuaries;

3.3.2.3 Acceptance of the rates specified in RFP Attachment 6.7 for the Behavioral Health Priority Add-On payment (see "Priority Add-On Rate" below) as well as the State Onlys and Judicials capitation rate (see "State Onlys and Judicials" below). The Proposer shall indicate acceptance of these rates by signature of the applicable Base Capitation Rate Calculation Sheet;

3.3.2.4 The proposed level of risk, which shall be indicated on the Scoring Summary worksheet and the Proposed Level of Risk worksheet included in RFP Attachment 6.7. TennCare provides three options of varied levels as described in RFP Attachment 6.1, Section 3.11; and

3.3.2.5 Acceptance of the process to be used to adjust the Proposer's base capitation rates as indicated by signature of the Health Status Risk Adjustment worksheet included in RFP Attachment 6.7 (see "Health Status Risk Adjustment" below). The Proposer's acceptance indicates agreement from the Proposer that the health status risk adjustment methodology

is acceptable and may result in a change in reimbursement, higher or lower, to the Proposer's base capitation rates.

3.3.3 Failure to submit the Cost Proposal in the format provided in the RFP Attachment 6.7 Cost Scoring and Cost Proposal Forms and in accordance with the requirements specified above will result in the disqualification of the Proposer's entire proposal.

3.3.4 Base Capitation Rates

3.3.4.1 Base capitation rates represent compensation for the provision of all covered services except for behavioral services for Priority enrollees (defined below under "Priority Add-On Rate").

3.3.4.2 The Proposer shall propose a base capitation rate equal to or within the published minimum and maximum rate range located in RFP Attachment 6.8, Data Book, Exhibit 18 for each of the following Category of Aid and Age/Sex Category combinations:

Aid Category	Age Group
Medicaid (TANF & Related)	Age Under 1
Medicaid (TANF & Related)	Age 1 – 13
Medicaid (TANF & Related)	Age 14 - 20 Female
Medicaid (TANF & Related)	Age 14 - 20 Male
Medicaid (TANF & Related)	Age 21 - 44 Female
Medicaid (TANF & Related)	Age 21 - 44 Male
Medicaid (TANF & Related)	Age 45 – 64
Medicaid (TANF & Related)	Age 65+
Uninsured/Uninsurable	Age Under 1
Uninsured/Uninsurable	Age 1 – 13
Uninsured/Uninsurable	Age 14 - 19 Female
Uninsured/Uninsurable	Age 14 - 19 Male
Disabled	Age <21
Disabled	Age 21+

Aid Category	Age Group
Duals	All Ages
Waiver Duals	All Ages

3.3.4.3 The proposed base capitation rate for each rate cell must fall within the published ranges specified in RFP Attachment 6.8, Data Book, Exhibit 18. The maximum rate is based on projected TennCare costs of physical health and behavioral health services for non-Priority enrollees for Middle Tennessee. The minimum rate is based on actuarial expectations of the impact of moving the utilization to a moderately well Medicaid managed care level. There is no companion assumption that provider cost per service will be impacted. Any Proposer that bids above the maximum or below the minimum in any rate cell will be disqualified and ineligible for contract/Agreement award.

3.3.5 Priority Add-On Rate

3.3.5.1 In addition to the base capitation rate, the MCOs that are awarded a contract/Agreement as a result of this procurement will be paid a Priority Add-On capitation rate for the provision of behavioral health services to all Priority enrollees except State Onlys and Judicials.

3.3.5.2 A Priority enrollee is a TennCare enrollee who has been assessed within the past twelve (12) months as belonging in Clinically Related Groups (CRGs) 1, 2, or 3 if he/she is eighteen (18) years old or older, or Target Population Group (TPG) 2 if he/she is under the age of eighteen (18) years. This assessment as a Priority enrollee expires twelve (12) months after the assessment has been completed. In order for an individual to remain a Priority enrollee after the twelve (12) month period ends, he/she must be reassessed as continuing to meet the criteria to belong in CRGs 1, 2, or 3 or TPG 2 categories. The reassessment, like the initial assessment, expires after twelve (12) months unless another assessment is done.

3.3.5.3 The CONTRACTOR will be paid the Priority Add-On capitation rate for all Priority enrollees, except State Onlys and Judicials, who have (a) received behavioral health services within the preceding twelve (12) months from the date of the calculation of the

monthly payment, and (b) had a valid CRG/TPG assessment within the preceding twelve (12) months from the date of the calculation of the monthly payment.

3.3.5.4 The Priority Add-On rate is based on TennCare experience over the last twelve (12) months and is calculated separately for Priority enrollees under age twenty-one (21) and Priority enrollees age twenty-one (21) and over. Details of the major components can be found in the Data Book (RFP Attachment 6.8).

3.3.5.5 The Priority Add-On rates per member per month (PMPM) are:

Under Age 21	$351.48 PMPM
21 and Over	$434.95 PMPM

3.3.6 State Onlys and Judicials

3.3.6.1 The MCOs that are awarded a contract/Agreement as a result of this procurement will be paid $408.49 per member per month for State Onlys and Judicials. This rate includes behavioral health services only. There is no separate Priority Add-On rate for State Onlys and Judicials.

3.3.7 Health Status Risk Adjustment

3.3.7.1 TennCare will analyze the risk profile of members enrolled in each MCO using the Medicaid-Ambulatory Care Group (ACG) Risk Classification System developed by Johns Hopkins University. Each member will be assigned an ACG, which has a calculated risk factor that reflects anticipated utilization of future services. These factors were developed using specific TennCare data over the last two fiscal years. If the risk profile for any MCO deviates from the regional profile by more than three percent (3%), each MCO's proposed base capitation rates will be proportionally adjusted. The overall risk adjustment will have no financial impact on TennCare in aggregate. After initial enrollment, this will be completed within thirty (30) days of data receipt and be retroactive to the start of the contract/Agreement period. A rolling twelve (12) months of claims data will be utilized to produce an individual’s ACG.

3.3.7.2 There is no health status risk adjustment to the behavioral health Priority Add-On rate or the State Onlys and Judicials rate.

3.3.8 Each Proposer shall ONLY record the proposed cost exactly as required by RFP Attachment 6.7, Cost Scoring and Cost Proposal Forms and shall not record any other rates, amounts or information.

3.3.9 The proposed cost shall incorporate all costs for services under the contract/Agreement for the period specified RFP Attachment 6.7.

3.3.10 The Proposer must sign and date the Cost Proposal.

3.3.11 If a Proposer fails to submit a Cost Proposal as required, the State shall determine the proposal to be non-responsive and reject it.

4 GENERAL REQUIREMENTS & CONTRACTING INFORMATION

4.1 Proposer Required Review and Waiver of Objections

Each Proposer must carefully review this RFP and all attachments, including but not limited to the *pro forma* contract, for comments, questions, defects, objections, or any other matter requiring clarification or correction (collectively called "comments"). Comments concerning RFP objections must be made in writing and received by the State no later than the Written Comments Deadline detailed in the RFP Section 2, Schedule of Events. This will allow issuance of any necessary amendments and help prevent the opening of defective proposals upon which contract award could not be made.

Protests based on any objection shall be considered waived and invalid if these comments/objections have not been brought to the attention of the State, in writing, by the Written Comments Deadline.

4.2 RFP Amendment and Cancellation

The State reserves the unilateral right to amend this RFP in writing at any time. If an RFP amendment is issued, the State will convey such amendment to the potential proposers who submitted a Notice of Intent to Propose. Each proposal must respond to the final written RFP and any exhibits, attachments, and amendments.

The State of Tennessee reserves the right, at its sole discretion, to cancel and reissue this RFP or to cancel this RFP in its entirety in accordance with applicable laws and regulations.

4.3 Proposal Prohibitions and Right of Rejection

4.3.1 The State of Tennessee reserves the right, at its sole discretion, to reject any and all proposals in accordance with applicable laws and regulations.

4.3.2 Each proposal must comply with all of the terms of this RFP and all applicable State laws and regulations. The State may reject any proposal that does not comply with all of the terms, conditions, and performance requirements of this RFP. The State may consider

any proposal that does not meet the requirements of this RFP to be non-responsive, and the State may reject such a proposal.

4.3.3 A proposal of alternate services (*i.e*., a proposal that offers services different from those requested by this RFP) shall be considered non-responsive and rejected.

4.3.4 A Proposer may not restrict the rights of the State or otherwise qualify a proposal. The State may determine such a proposal to be a non-responsive counteroffer, and the proposal may be rejected.

4.3.5 A Proposer may not submit the Proposer's own contract terms and conditions or other requirements in a response to this RFP. If a proposal contains such terms and conditions or requirements, the State may determine, at its sole discretion, the proposal to be a non-responsive counteroffer, and the proposal may be rejected.

4.3.6 A Proposer shall not submit more than one proposal. Submitting more than one proposal shall result in the disqualification of the Proposer.

4.3.7 A Proposer shall not submit multiple proposals in different forms. This prohibited action shall be defined as a Proposer submitting one proposal as a prime contractor and permitting a second Proposer to submit another proposal with the first Proposer offered as a subcontractor. This restriction does not prohibit different Proposers from offering the same subcontractor as a part of their proposals, provided that the subcontractor does not also submit a proposal as a prime contractor and the subcontractor has the capacity to provide services as a subcontractor to two prime contractors. Submitting multiple proposals in different forms may result in the disqualification of all Proposers knowingly involved.

4.3.8 The State shall reject a proposal if the Cost Proposal was not arrived at independently without collusion, consultation, communication, or agreement as to any matter relating to such prices with any other Proposer. Regardless of the time of detection, the State shall consider any of the foregoing prohibited actions to be grounds for proposal rejection or contract/Agreement termination.

4.3.9 The State shall not contract with or consider a proposal from:

4.3.9.1 an individual who is, or within the past six (6) months has been, an employee or official of the State of Tennessee;

4.3.9.2 a company, corporation, or any other contracting entity in which an ownership of two percent (2%) or more is held by an individual who is, or within the past six (6) months has been, an employee or official of the State of Tennessee (this shall not apply either to financial interests that have been placed into a "blind trust" arrangement pursuant to which the employee does not have knowledge of the retention or disposition of such interests or to the ownership of publicly traded stocks or bonds where such ownership constitutes less than two percent (2%) of the total outstanding amount of the stocks or bonds of the issuing entity);

4.3.9.3 a company, corporation, or any other contracting entity which employs an individual who is, or within the past six (6) months has been, an employee or official of the State of Tennessee in a position that would allow the direct or indirect use or disclosure of information, which was obtained through or in connection with his or her employment and not made available to the general public, for the purpose of furthering the private interest or personal profit of any person; or,

4.3.9.4 any individual, company, or other entity involved in assisting the State in the development, formulation, or drafting of this RFP or its scope of services shall be considered to have been given information that would afford an unfair advantage over other Proposers, and such individual, company, or other entity may not submit a proposal in response to this RFP.

4.3.9.5 For the purposes of applying the requirements of RFP subsection 4.3.9, *et. seq.*, an individual shall be deemed an employee or official of the State of Tennessee until such time as all compensation for salary, termination pay, and annual leave has been paid.

4.3.10 The State reserves the right, at its sole discretion, to waive a proposal's variances from full compliance with this RFP. If the State waives minor variances in a proposal, such waiver shall not modify the RFP requirements or excuse the Proposer from full compliance with such. Notwithstanding any minor variance, the State may hold any Proposer to strict compliance with this RFP.

4.4 Incorrect Proposal Information

If the State determines that a Proposer has provided, for consideration in this RFP process or subsequent contract negotiations, incorrect information that the Proposer knew or should have known was materially incorrect, that proposal shall be determined non-responsive and shall be rejected.

4.5 Proposal of Additional Services

If a proposal offers services in addition to those required by and described in this RFP, the additional services may be added to the contract/Agreement before contract/Agreement signing at the sole discretion of the State. Notwithstanding the foregoing, a Proposer shall not propose any additional cost amount(s) or rate(s) for additional services.

NOTICE: The Proposer's Cost Proposal shall record only the proposed cost as required in this RFP and shall not record any other rates, amounts, or information. If a Proposer fails to submit a Cost Proposal as required, the State shall determine the proposal to be non-responsive and shall reject the proposal.

4.6 Assignment and Subcontracting

4.6.1 The Proposer awarded a contract/Agreement pursuant to this RFP may not subcontract, transfer, or assign any portion of the contract/Agreement without the State's prior, written approval.

4.6.2 A subcontractor may <u>only</u> be substituted for a proposed subcontractor at the discretion of the State and with the State's prior, written approval.

4.6.3 At its sole discretion, the State reserves the right to refuse approval of any subcontract, transfer, or assignment.

4.6.4 Notwithstanding State approval of each subcontractor, the Proposer, if awarded a contract/Agreement pursuant to this RFP, shall be the prime contractor and shall be responsible for all work performed.

4.7 Right to Refuse Personnel

At its sole discretion, the State reserves the right to refuse any personnel, of the prime contractor or a subcontractor, for use in the performance of a contract/Agreement pursuant to this RFP.

4.8 Insurance

The State may require the apparent successful Proposers to provide proof of adequate worker's compensation and public liability insurance coverage before entering into an contract/Agreement. Additionally, the State may require, at its sole discretion, the apparent successful Proposers to provide proof of adequate professional malpractice liability or other forms of insurance. Failure to provide evidence of such insurance coverage is a material breach and grounds for termination of the contract negotiations. Any insurance required by the State shall be in form and substance acceptable to the State.

4.9 Licensure

Before it submits a proposal in response to this RFP, the Proposer must submit an application to the Tennessee Department of Commerce and Insurance (TDCI) for a certificate of authority (COA) to establish and operate a health maintenance organization (HMO) in Tennessee. Before the start date of operations the apparent successful Proposers must hold all necessary, applicable business and professional licenses, including appropriate non-temporary licensure from TDCI.

4.10 Service Location and Work Space

The service pursuant to this RFP is to be performed, completed, managed, and delivered as detailed in the RFP Attachment 6.1, *Pro Forma* Contract.

4.11 Proposal Withdrawal

A Proposer may withdraw a submitted proposal at any time up to the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events. To do so, a Proposer must submit a written request to withdraw a proposal to the RFP Coordinator. This written request must be signed by the Proposer's authorized representative. After withdrawing a previously submitted proposal, a Proposer may submit another proposal at any time up to the Proposal Deadline.

4.12 Proposal Errors and Amendments

Each Proposer is liable for all proposal errors or omissions. A Proposer will not be allowed to alter or amend proposal documents after the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events unless such is formally requested, in writing, by the State.

4.13 Proposal Preparation Costs

The State will not pay any costs associated with the preparation, submittal, or presentation of any proposal.

4.14 Disclosure of Proposal Contents

Each proposal and all materials submitted to the State in response to this RFP shall become the property of the State of Tennessee. Selection or rejection of a proposal does not affect this right. All proposal information, including detailed price and cost information, shall be held in confidence during the evaluation process. Notwithstanding, a list of actual proposers submitting timely proposals may be available to the public, upon request, directly after technical proposals are opened by the state.

Upon the completion of the evaluation of proposals, indicated by public release of an Evaluation Notice, the proposals and associated materials shall be open for review by the public in accordance with *Tennessee Code Annotated*, Section 10-7-504(a)(7). By submitting a proposal, the Proposer acknowledges and accepts that the full proposal contents and associated documents shall become open to public inspection.

4.15 Contractor Registration

All service contractors with state of Tennessee contracts must be registered through the Department of Finance and Administration's Service Provider Registry prior to contract/Agreement approval. However, registration with the state is not required to make a proposal (any unregistered service provider must simply register as required prior to the final contract/Agreement approval). Refer to the following Internet URL for more information about the Service Provider Registry and to register "on-line."

www.state.tn.us/finance/rds/ocr/sprs.html

4.16 Contract Approval

The RFP and the contractor selection processes do not obligate the State and do not create rights, interests, or claims of entitlement in either the two Proposers with the apparent best-evaluated proposals or any other Proposer. Contract award and State obligations pursuant thereto shall commence only after a contract/Agreement is signed by the Contractor and the head of the procuring state agency and after the contract/Agreement is approved and signed by all other State officials as required by State laws and regulations.

4.17 Contract Payments

All contract/Agreement payments shall be made in accordance with the contract/Agreement's payment provisions (refer to RFP Attachment 6.1, *Pro Forma* Contract Section 3). No payment shall be made until the start of operations and the approval of the contract /Agreement as required by State laws and regulations. Under no conditions shall the State be liable for payment of any type associated with the contract/Agreement or responsible for any work done by the Contractor, even work done in good faith and even if the Contractor is orally directed to proceed with the delivery of services, if it occurs before contract/Agreement approval by State officials as required by applicable statutes and rules of the State of Tennessee or before the *pro forma* contract start date or after the *pro forma* contract end date specified by the contract/Agreement.

4.18 Contractor Performance

The Contractor shall be responsible for the completion of all work set out in the contract/Agreement. All work is subject to inspection, evaluation, and acceptance by the State. The State may employ all reasonable means to ensure that the work is progressing and being performed in compliance with the contract/Agreement. At reasonable times, the State may inspect those areas of the Contractor's place of business that are related to the performance of the contract/Agreement. If the State requires such an inspection, the Contractor shall provide reasonable access and assistance.

4.19 Contract Amendment

During the course of this contract/Agreement, the State may request the Contractor to perform additional work for which the Contractor would be compensated. That work shall be within the general scope of this RFP. In such instances, the State shall provide the Contractor a written description of the additional work, and the Contractor shall submit a time schedule for accomplishing the additional work and a price for the additional work based on the rates included in the Contractor’s proposal to this RFP. If the State and the Contractor reach an agreement regarding the work and associated compensation, such agreement shall be effected by means of a contract/Agreement amendment. Any such amendment requiring additional work must be mutually agreed upon by the parties and signed by the Contractor and the head of the procuring state agency and must be approved by other State officials as required by State laws and regulations. The Contractor shall not commence additional work until the State has issued a written contract/Agreement amendment and secured all required approvals.

4.20 Severability

If any provision of this RFP is declared by a court to be illegal or in conflict with any law, said decision shall not affect the validity of the remaining RFP terms and provisions, and the rights and obligations of the State and Proposers shall be construed and enforced as if the RFP did not contain the particular provision held to be invalid.

5 PROPOSAL EVALUATION & CONTRACT AWARD

5.1 Evaluation Categories and Maximum Points

The State will consider qualifications and experience, technical approach, and cost in the evaluation of proposals. The maximum points that shall be awarded for each of these categories are detailed below.

CATEGORY	MAXIMUM POINTS POSSIBLE
Qualifications and Experience	**200**
Technical Approach	**500**
Cost Proposal	**300**

5.2 Evaluation Process

The proposal evaluation process is designed to award a contract/Agreement not necessarily to the two (2) Proposers of least cost, but rather to the two (2) Proposers with the best combination of attributes based upon the evaluation criteria.

5.2.1 The RFP Coordinator will use the RFP Attachment 6.3, Technical Proposal and Evaluation Guide to manage the Technical Proposal Evaluation and maintain evaluation records.

5.2.1.1 The RFP Coordinator will review each Technical Proposal to determine compliance with mandatory requirements (refer to RFP Attachment 6.3, Technical Proposal and Evaluation Guide, Technical Proposal Section A). If the RFP Coordinator determines that a proposal may have failed to meet one or more of the mandatory requirements, the Proposal Evaluation Team will review the proposal and document its determination of whether: (1) the proposal meets requirements for further evaluation; (2) the State will request clarifications or corrections; or, (3) the State will determine the proposal non-responsive to the RFP and reject it.

5.2.1.2 Proposal Evaluation Teams, made up of three or more State employees per team, will evaluate each Technical Proposal that appears responsive to the RFP. These teams, comprised of subject matter experts, will review and evaluate specified sections of each Technical Proposal.

5.2.1.3 Each Proposal Evaluation Team member will independently, evaluate each proposal against the evaluation criteria in this RFP, rather than against other proposals, and will score each in accordance with the RFP Attachment 6.3, Technical Proposal and Evaluation Guide.

5.2.1.4 The State reserves the right, at its sole discretion, to request Proposer clarification of a Technical Proposal or to conduct clarification discussions with any or all Proposers. Any such clarification or discussion shall be limited to specific sections of the proposal identified by the State. The subject Proposer shall put any resulting clarification in writing as may be required by the State.

5.2.2 After Technical Proposal evaluations are completed by the Proposal Evaluation Team members, the RFP Coordinator will calculate the overall score for each proposal. Only Cost Proposals whose associated Technical Proposal received an overall score of four-hundred ninety (490) or more points shall be opened. A Cost Proposal shall not be opened if the associated Technical Proposal did not receive four-hundred ninety (490) or more points.

5.2.3 Once the RFP Coordinator has determined which Technical Proposals received four-hundred ninety (490) or more points, the RFP Coordinator will open the associated Cost Proposals and use the RFP Attachment 6.7, Cost Scoring and Cost Proposal Forms to calculate and document the Cost Proposal scores.

5.2.4 <u>Evaluation of Cost</u>

Cost Proposals will be scored based on their composite capitation rate (see below) and the proposed level of risk (see below). The composite capitation rate will be worth a maximum of three hundred (300) points. The number of points awarded for the composite capitation rate will be weighted based on the level of risk proposed (see below) to arrive at the final cost points awarded.

5.2.4.1 <u>Composite Capitation Rate</u>

5.2.4.1.1 Based on the membership data included in the Data Book (RFP Attachment 6.8), the resulting capitation rates will be used to produce a weighted average composite capitation rate across all Categories of Aid and Age/Sex Categories. This composite rate will be

compared to the maximum and minimum possible composite rates, which are calculated using the weighted averages of the maximum and minimum rates for each range. Zero (0) points will be awarded for composite bid rates that match the maximum possible composite rate. The full three hundred (300) points will be awarded only for composite bid rates that match the minimum possible composite rate. Points for composite bid rates between the minimum and maximums will be awarded using linear interpolation. Points will be awarded solely on the merits of each proposal, independent of other proposals.

5.2.4.1.2 Note that these calculations all assume that comparable risk profiles will be enrolled in each MCO. As provided earlier, if actual enrollment causes a significant deviation (greater than three percent (3%)) in the risk profile of any successful Proposer, the proposed base capitation payment rates of all successful Proposers will be adjusted as specified in Section 3 of RFP Attachment 6.1, *Pro Forma* Contract. This may result in the MCO being paid more or less than the proposed rates.

5.2.4.2 Level Of Risk

5.2.4.2.1 Ultimately, TennCare's goal is to contract with MCOs that accept full risk, but TennCare is willing to share in financial gains in losses as specified in Section 3 of the RFP Attachment 6.1, *Pro Forma* Contract in order to ensure MCO participation.

5.2.4.2.2 The Proposer must select one of three risk-sharing options structured so that TennCare is entitled to a higher percentage of any gains than TennCare agreed to cover in losses. Essentially, the Contractor agrees to give up more in gains in exchange for the protection on losses.

5.2.4.2.3 The Proposer's cost bid score will be adjusted by the weight associated with the selected risk-sharing option to arrive at a final cost proposal score. The weights are as follows:

Risk Option	Risk Sharing - Losses	Risk Sharing - Gains	Weight
Option 1	TennCare would cover 50%	TennCare would receive 75%	50%
Option 2	TennCare would cover 25%	TennCare would receive 50%	75%
Option 3	TennCare would cover 0%	TennCare would receive 0%	100%

5.2.4.2.4 Proposers must accept one of these three risk-sharing options to accompany their capitation rates.

5.2.5 For each responsive proposal that received an overall score of four-hundred ninety (490) or more points, the RFP Coordinator will add the average Technical Proposal score to the Cost Proposal score (refer to RFP Attachment 6.9, Proposal Score Summary Matrix).

5.3 Contract Award Process

5.3.1 The RFP Coordinator will forward the results of the proposal evaluation process to the head of the procuring agency who will consider the proposal evaluation process results and all pertinent information available to make a determination about the contract/Agreement award. The State reserves the right to make an award without further discussion of any proposal.

Notwithstanding the foregoing, to effect a contract/Agreement award to a proposer other than the two receiving the highest evaluation score, the head of the procuring agency must provide written justification for such an award and obtain the written approval of the Commissioner of Finance and Administration and the Comptroller of the Treasury.

5.3.2 After the procuring agency head's determination, the State will issue an Evaluation Notice to identify the two (2) apparent best-evaluated proposals on the Evaluation Notice date detailed in the RFP Section 2, Schedule of Events.

NOTICE: The Evaluation Notice shall not create rights, interests, or claims of entitlement in either the Proposers with apparent best-evaluated proposals or any other Proposer.

5.3.3 The State will also make the RFP files available for public inspection on the Evaluation Notice date detailed in the RFP Section 2, Schedule of Events.

5.3.4 The two (2) Proposers with the apparent best-evaluated proposals <u>must</u> agree to and sign a *pro forma* contract with the State which shall be substantially the same as the RFP Attachment 6.1, *Pro Forma* Contract.

However, the State reserves the right, at its sole discretion, to add terms and conditions or to revise *pro forma* contract requirements in the State's best interests subsequent to this RFP process. No such terms and conditions or revision of contract/Agreement requirements shall materially affect the basis of proposal evaluations or negatively impact the competitive nature of the RFP process.

5.3.5 The two (2) Proposers with the apparent best-evaluated proposals must sign and return the contract/Agreement drawn by the State pursuant to this RFP no later than the Contract Signature Deadline date detailed in the RFP Section 2, Schedule of Events. If a Proposer fails to provide the signed contract/Agreement by the deadline, the State may determine that the Proposer is non-responsive to the terms of this RFP and reject the proposal.

ATTACHMENT 6.1

***PRO FORMA* CONTRACT**

The *pro forma* contract detailed in this attachment contains some "blanks" (signified by descriptions in capital letters) that will be completed with appropriate information in the final contract/Agreement resulting from this RFP.

CONTRACTOR RISK AGREEMENT BETWEEN

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

AND

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

CONTRACT NUMBER: FA_____

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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" or "State" and (name of a CONTRACTOR), hereinafter referred to as "the CONTRACTOR".

WHEREAS, the purpose of this Agreement is to assure the provision of quality physical health and behavioral health services while controlling the costs of such services;

WHEREAS, consistent with waivers granted by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, the State of Tennessee has been granted the authority to pay a monthly prepaid capitated payment amount to Health Maintenance Organizations (HMOs), referred to as Managed Care Organizations or MCOs, for rendering or arranging necessary physical health and behavioral health services to persons who are enrolled in Tennessee's TennCare program;

WHEREAS, the Tennessee Department of Finance and Administration is the state agency responsible for administration of the TennCare program and is authorized to contract with MCOs for the purpose of providing the services specified herein for the benefit of persons who are eligible for and are enrolled in the TennCare program, State Onlys and Judicials; and

WHEREAS, the CONTRACTOR is a Managed Care Organization as described in the 42 CFR Part 438, is licensed to operate as an HMO in the State of Tennessee, has met additional qualifications established by the State, is capable of providing or arranging for the provision of covered services to persons who are enrolled in the TennCare program and covered behavioral health services to State Onlys and Judicials for whom it has received prepayment, is engaged in said business, and is willing to do so upon and subject to the terms and conditions hereof;

NOW, THEREFORE, in consideration of the mutual promises contained herein the parties have agreed and do hereby enter into this Agreement according to the provisions set forth herein:

SECTION 1 - DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

The terms used in this Agreement shall be given the meaning used in TennCare rules and regulations. However, the following terms when used in this Agreement, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, and other Sections of this Agreement, the specific language in Sections 2 through 4 of this Agreement shall govern.

Administrative Cost – All costs to the CONTRACTOR related to the administration of this Agreement that are non-medical in nature including, but not limited to:

1. Meeting general requirements in Section 2.2;
2. Enrollment and disenrollment in accordance with Section 2.4 and 2.5;
3. Additional services and use of incentives in Section 2.6.6;
4. Health education and outreach in Section 2.7.3;
5. Meeting requirements for coordination of services specified in Section 2.9;
6. Establishing and maintaining a provider network in accordance with the requirements specified in Section 2.11, Attachments III, IV and V;
7. Utilization Management as specified in Section 2.14;
8. Quality Management and Quality Improvement activities as specified in Section 2.15;
9. Production and distribution of Member Materials as specified in Section 2.17;
10. Customer service requirements in Section 2.18;
11. Appeals processing and resolution in accordance with Section 2.19;
12. Determination of recoveries from third party liability resources in accordance with Section 2.21.4;
13. Claims Processing in accordance with Section 2.22;
14. Maintenance and operation of Information Systems in accordance with Section 2.23;
15. Personnel requirements in Section 2.29;
16. Production and submission of required reports as specified in Section 2.30;
17. Administration of this Agreement in accordance with policies and procedures;
18. All other Administration and Management responsibilities as specified in Attachments II through IX and Sections 2.20, 2.21, 2.24, 2.25, 2.26, 2.27, and 2.28;
19. Premium tax; and

20. Costs of subcontractors engaged solely to perform a non-medical administrative function for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing) are considered to be an "administrative cost".

Adverse Action – Any action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits.

Appeal Procedure – The process to resolve an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by TennCare rules and regulations and any and all applicable court orders and consent decrees.

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

Behavioral Health Assessment – Procedures used to diagnose mental health or substance abuse conditions and determine treatment plans.

Behavioral Health Services – Mental health and substance abuse services.

Benefits – The package of health care services, including behavioral health services, that define the covered services available to TennCare enrollees enrolled in the CONTRACTOR's MCO pursuant to this Agreement.

Bureau of TennCare – The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers the TennCare program. For the purposes of this Agreement, Bureau of TennCare shall mean the State of Tennessee and its representatives.

Business Day – Monday through Friday, except for State of Tennessee holidays.

CAHPS (Consumer Assessment of Healthcare Providers and Systems) – A comprehensive and evolving family of surveys that ask consumers and patients to evaluate various aspects of health care.

Capitation Payment – The fee that is paid by TENNCARE to the CONTRACTOR for each member covered by this Agreement, whether or not the member utilizes services during the payment period. The CONTRACTOR is at financial risk as specified in Section 3 of this Agreement for the payment of services incurred in excess of the amount of the capitation payment. "Capitation Payment" includes Base Capitation Rate payments and Priority Add-on rate payments unless otherwise specified.

Capitation Rate – The amount established by TENNCARE pursuant to the methodology described in Section 3 of this Agreement, including the base capitation rate and priority add-on rate.

Centers of Excellence (COE) for AIDS – Integrated networks designated by the State as able to provide a standardized and coordinated delivery system encompassing a range of services needed by TennCare enrollees with HIV or AIDS.

Centers of Excellence (COE) for Behavioral Health **–** COEs that provide a limited range of direct services to children in and at risk for state custody (i.e., not just DCS children/youth). These services are to augment the existing service system. Therefore, COEs for Behavioral Health typically only provide services where there is sufficient complexity in the case to warrant the COE for Behavioral Health resources and/or all other means to provide the service in the TennCare network have been exhausted.

CFR – Code of Federal Regulations.

Clean claim – A claim received by the CONTRACTOR for adjudication that requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the CONTRACTOR.

Clinical Practice Guidelines – Systematically developed tools or standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances. Such guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

Clinically Related Group 1: Severely and/or Persistently Mentally Ill (SPMI) – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. They are recently severely impaired and the duration of their severe impairment totals six months or longer of the past year.

Clinically Related Group 2: Persons with Severe Mental Illness (SMI) – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are recently severely impaired and the duration of their severe impairment totals less than six months of the past year.

Clinically Related Group 3: Persons who are Formerly Severely Impaired – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are not recently severely impaired but have been severely impaired in the past and need services to prevent relapse.

Clinically Related Group 4: Persons with Mild or Moderate Mental Disorders – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are not recently severely impaired and are *either* not formerly severely impaired *or* are formerly severely impaired but do not need services to prevent relapse.

Clinically Related Group 5: Persons who are not in clinically related groups 1-4 as a result of their diagnosis – Persons in this group are 18 years or older diagnosed with DSM-IV-TR (and subsequent revisions) substance use disorders, developmental disorders or V-codes only.

CMS – Centers for Medicare & Medicaid Services.

Community Service Area (CSA) – One or more counties in a defined geographical area in which the CONTRACTOR is authorized to enroll and serve TennCare enrollees in exchange for a monthly capitation fee.

The following counties shall constitute the identified Community Service Areas in Tennessee:

Northwest CSA	-	Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll and Benton Counties
Southwest CSA	-	Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester and McNairy Counties
Shelby CSA	-	Shelby County
Mid-Cumberland CSA	-	Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson and Rutherford Counties
Davidson CSA	-	Davidson County
South Central CSA	-	Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore Counties
Upper Cumberland CSA	-	Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, Dekalb, Putnam, Cumberland, White, Cannon, Warren and Van Buren Counties
Southeast CSA	-	Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley and Marion Counties
Hamilton CSA	-	Hamilton County
East Tennessee CSA	-	Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon and Roane Counties
Knox CSA	-	Knox County
First Tennessee CSA	-	Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter and Johnson Counties

Complaint – A written or verbal statement from an enrollee that contests an action taken by the CONTRACTOR or service provider other than an adverse action. The CONTRACTOR shall not treat anything as a complaint that falls within the definition of adverse action.

Contract Provider – A provider that is employed by or has signed a provider agreement with the CONTRACTOR to provide covered services.

Covered Services – See Benefits.

Consumer – An individual who uses a mental health or substance abuse service.

CRA – Contractor Risk Agreement; also referred to as "Agreement."

CRG (Clinically Related Group) – Defining and classifying consumers 18 years or older into clinically related groups involves diagnosis, the severity of functional impairment, the duration of severe functional impairment, and the need for services to prevent relapse. Based on these criteria, there are five clinically related groups:

Group 1 - Persons with Severe and Persistent Mental Illness (SPMI)

Group 2 - Persons with Severe Mental Illness (SMI)

Group 3 - Persons who were Formerly Severely Impaired and need services to prevent relapse

Group 4 - Persons with Mild or Moderate Mental Disorder

Group 5 - Persons who are not in Clinically Related Groups 1 – 4 as a result of their diagnosis being substance use disorder, developmental disorder, or V-codes

Days – Calendar days unless otherwise specified.

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

DHHS – United States Department of Health and Human Services.

Disenrollment – The removal of an enrollee from participation in the CONTRACTOR's MCO and deletion from the enrollment file furnished by TENNCARE to the CONTRACTOR.

Eligible – Any person certified by TENNCARE as eligible to receive services and benefits under the TennCare program.

Emergency Medical Condition – A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition.

Enrollee – A person who has been determined eligible for TennCare and who has been enrolled in the TennCare program (see Member, also).

Enrollment – The process by which a TennCare enrollee becomes a member of the CONTRACTOR's MCO.

EPSDT – The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The federal regulations for EPSDT are in 42 CFR Part 441, Subpart B.

Essential Hospital Services – Tertiary care hospital services to which it is essential for the CONTRACTOR to provide access. Essential hospital services include, but are not limited to, neonatal, perinatal, pediatric, trauma and burn services.

Evidence-Based Practice – A clinical intervention that has demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness; specifically, the evidence-based practices recognized by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS).

Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the CONTRACTOR or its affiliates for purposes related to this Agreement; or (b) maintained by a subcontractor or provider to provide services on behalf of the CONTRACTOR.

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

FQHC – Federally Qualified Health Center.

Grand Region – A defined geographical region that includes specified Community Service Areas in which the CONTRACTOR is authorized to enroll and serve TennCare enrollees in exchange for a monthly capitation fee. The CONTRACTOR shall serve an entire Grand Region. The following Community Service Areas constitute the Grand Regions in Tennessee:

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

Health Maintenance Organization (HMO) – An entity certified by TDCI under applicable provisions of TCA Title 56, Chapter 32.

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

HIPAA – Health Insurance Portability and Accountability Act.

Hospice – Services as described in TennCare rules and regulations and 42 CFR Part 418, which are provided to terminally ill individuals who elect to receive hospice services provided by a certified hospice agency.

Information System(s) (Systems) – A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

Institutionalized Medicaid – Individuals who are receiving (as described in TennCare rules and regulations) long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver covered services provided through a Home and Community Based Services (HCBS) waiver as an alternative for these institutional services.

Judicial – An individual who requires judicial services as specified in Section 2.7.2.10 of this Agreement but (1) does not meet eligibility requirements for enrollment in the TennCare program or has a TennCare application pending; and (2) has not been determined to be a State Only participant by TDMHDD. A Judicial is not a TennCare enrollee nor a member of the CONTRACTOR's MCO and is only entitled to coverage of those behavioral health evaluation and treatment services required by state law or by the court order under which the individual was referred. Eligibility criteria for judicial coverage must be met as determined by TDMHDD.

Law – Statutes, codes, rules, regulations, and/or court rulings.

Legally Appointed Representative – Any person appointed by a court of competent jurisdiction or authorized by legal process (e.g., power of attorney for health care treatment, declaration for mental health treatment) to determine the legal and/or health care interests of an individual and/or his/her estate.

Long-Term Care – The services of one of the following: a nursing facility (NF); an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a Home and Community Based Services (HCBS) waiver program. (Services provided under a HCBS waiver program are considered to be alternatives to long-term care.)

Managed Care Organization (MCO) – An HMO that participates in the TennCare program.

Mandatory Outpatient Treatment (MOT) – Process whereby a person who was hospitalized for psychiatric reasons and who requires outpatient treatment can be required by a court to participate in that behavioral health outpatient treatment to prevent deterioration in his/her mental condition.

Marketing – Any communication, from the CONTRACTOR to a TennCare enrollee who is not enrolled in the CONTRACTOR's MCO, that can reasonably be interpreted as intended to influence the person to enroll in the CONTRACTOR's MCO, or either to not enroll in, or to disenroll from, another MCO's TennCare product.

Medical Expenses – Shall be determined as follows:

1. Medical Expenses include the amount paid to providers for the provision of covered physical health and behavioral health services to members pursuant to the following listed Sections of the Agreement:

    a. Section 2.6.1, CONTRACTOR Covered Benefits;

    b. Section 2.6.4, Second Opinions;

    c. Section 2.6.5, Use of Cost Effective Alternative Services;

    d. Section 2.7, Specialized Services except TENNderCare member and provider outreach and education, health education and outreach and advance directives;

    e. Capitated payment to licensed providers;

    f. Medical services directed by TENNCARE or an Administrative Law Judge; and

    g. Net impact of reinsurance coverage purchased by the CONTRACTOR.

2. Medical Expenses do not include:

    a. 2.6.2 TennCare Benefits Provided by TENNCARE;

    b. 2.6.7 Cost sharing for services;

    c. 2.10 Services Not Covered;

    d. Services eligible for reimbursement by Medicare; or

    e. The activities described in or required to be conducted in Attachments II through IX, which are administrative costs.

3. Medical expenses will be net of any TPL recoveries or subrogation activities.

4. This definition does not apply to NAIC filings.

Medical Loss Ratio (MLR) – The percentage of capitation payment received from TENNCARE that is used to pay medical expenses.

Medical Records – All medical and behavioral health histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical and behavioral health documentation in written or electronic format; and analyses of such information.

Member – A TennCare enrollee who enrolls in the CONTRACTOR's MCO under the provisions of this Agreement (see Enrollee, also).

Member Month – A month of coverage for a TennCare enrollee enrolled in the CONTRACTOR's MCO.

Mental Health Services – The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

NAIC – National Association of Insurance Commissioners.

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

Non-Contract Provider – Any provider that is not directly or indirectly employed by or does not have a provider agreement with the CONTRACTOR or any of its subcontractors pursuant to the Agreement between the CONTRACTOR and TENNCARE.

Office of Inspector General (OIG) – The State of Tennessee agency that investigates and may prosecute civil and criminal fraud and abuse of the TennCare program or any other violations of state law related to the operation of the TennCare program administratively, civilly or criminally.

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

Post-stabilization Care Services – Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e), to improve or resolve the member's condition.

Prepaid Limited Health Service Organization (PLHSO) – An entity certified by TDCI under applicable provisions of TCA Title 56, Chapter 51.

Presumptive Eligibility – An established period of time (45 days) during which certain pregnant women are eligible for TennCare Medicaid. During this period of time the presumptively eligible enrollee must complete an application for Medicaid in order to stay on the program.

Primary Care Physician – A physician responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is generally a physician who has limited his practice of medicine to general practice or who is an Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner. However, as provided in Section 2.11.2.4 of this Agreement, in certain circumstances other physicians may be primary care physicians if they are willing and able to carry out all PCP responsibilities in accordance with this Agreement.

Primary Care Provider (PCP) – A primary care physician or other licensed health practitioner practicing in accordance with state law who is responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A PCP may practice in various settings such as local health departments, FQHCs or community mental health agencies (CMHAs) provided that the PCP is willing and able to carry out all PCP responsibilities in accordance with this Agreement.

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

Priority Add-on Rate – The amount established by TENNCARE pursuant to the methodology described in Section 3 of this Agreement as compensation for the provision of behavioral health services for Priority enrollees.

Priority Enrollee – A TennCare enrollee who has been assessed within the past twelve (12) months as belonging in Clinically Related Groups (CRGs) 1, 2, or 3 if he/she is 18 years old or older, or Target Population Group (TPG) 2 if he/she is under the age of 18 years. This assessment as a Priority enrollee expires twelve (12) months after the assessment as been completed. In order for an individual to remain a Priority enrollee after the twelve (12) month period ends, he/she must be reassessed as continuing to meet the criteria to belong in CRGs 1, 2, or 3 or TPG 2 categories. The reassessment, like the initial assessment, expires after twelve (12) months unless another assessment is done. Also referred to as Priority member once the enrollee is enrolled in the CONTRACTOR's MCO.

Privacy Rule – Standards for the Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164.

Protected Health Information (PHI) – Identifiable health information as defined in 45 CFR Part 160 and Part 164.

Provider – An institution, facility, physician, or other health care practitioner that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished.

Provider Agreement – An agreement, using the provider agreement template approved by TDCI, between the CONTRACTOR and a provider or between the CONTRACTOR's subcontractor and a provider that describes the conditions under which the provider agrees to furnish covered services to the CONTRACTOR's members.

Quality Improvement (QI) – The effort to assess and improve the performance of a program or organization. Quality improvement includes quality assessment and implementation of corrective actions to address any deficiencies identified.

Quality Management (QM) – The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.

Recovery – A consumer driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite a disability.

Resilience – A dynamic developmental process for children and adolescents that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Routine Care – Non-urgent and non-emergency medical or behavioral health care such as screenings, immunizations, or health assessments.

Security Incident – The attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with the system operations in an information system.

Security Rule – The Final Rule adopting Security Standards for the Protection of Electronic Health Information at 45 CFR Parts 160 and 164.

Seriously Emotionally Disturbed (SED) – Seriously Emotionally Disturbed shall mean persons who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the criteria provided below:

1. Person under the age of 18; and

2. Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association with the exception of DSM-IV-TR (and subsequent revisions) V- codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable mental, behavioral, or emotional disturbance other than above exclusions. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects; and

3. The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, and community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and is evidenced by a Global Assessment of Functioning (GAF) score of 50 or less in accordance with the DSM-IV-TR (and subsequent revisions). Children and adolescents who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

Severely and/or Persistently Mentally Ill (SPMI) – Severely and/or Persistently Mentally Ill shall mean individuals who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the following criteria. These persons will be identified as belonging in one of the Clinically Related Groups that follow the criteria:

1. Age 18 and over; and

2. Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association, with the exception of DSM-IV-TR (and subsequent revisions) V-codes, substance use disorders, and developmental disorders, unless these disorders co-occur with another diagnosable serious mental illness other than above exclusions. All of these disorders have episodic, recurrent, or persistent features, however, they vary in terms of severity and disabling effects; and

3. The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in major life activities including basic living skills (e.g., eating, bathing, dressing); instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. This definition includes adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services.

Shall – Indicates a mandatory requirement or a condition to be met.

Span of Control – Information systems and telecommunications capabilities that the CONTRACTOR itself operates or for which it is otherwise legally responsible according to this Agreement. The CONTRACTOR's span of control also includes Systems and telecommunications capabilities outsourced by the CONTRACTOR.

Specialty Services – Includes Essential Hospital Services and specialty physician services.

SSI – Supplemental Security Income.

Start Date of Operations – The date, as determined by TENNCARE, when the CONTRACTOR will begin providing services to members.

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

State Onlys – Uninsured individuals who (1) are not eligible for the TennCare program or have a TennCare application pending; and (2) are determined by TDMHDD, or its designee, to be severely and/or persistently mentally ill (SPMI) or seriously emotionally disturbed (SED) and in need of behavioral health services on an inpatient or outpatient basis. Individuals must meet eligibility criteria specified by TDMHDD.

State Representative – Any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this Agreement. Such entity(s) may include, but are not limited to, contractors and federal agencies.

Subcontract – An agreement entered into by the CONTRACTOR with any other organization or person who agrees to perform any administrative function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, disease management) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Agreement. This shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement. Agreements to provide covered services as described in Section 2.6 of this Agreement shall be considered provider agreements and governed by Section 2.12 of this Agreement.

Subcontractor – Any organization or person who provides any function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement.

Substance Abuse Services – The assessment, diagnosis, treatment, detoxification, residential care, rehabilitation, education, training, counseling, referral or supervision of individuals who are abusing or have abused substances.

System Unavailability – As measured within the CONTRACTOR's information systems span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "Enter" or other function key.

Target Population Group (TPG) – An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and severity of impairment due to a mental illness. Based on these criteria, there are three target population groups.

1. Target Population Group 2: Seriously Emotionally Disturbed (SED)
   Children and adolescents under 18 years of age with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children are currently severely impaired as evidenced by 50 or less Global Assessment of Functioning (GAF).

2. Target Population Group 3: At Risk of a (SED)
   Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children may or may not be currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have psychosocial issues that can potentially place them at risk of a SED.

3. Target Population Group 4: Persons who do not meet criteria TPG Group 2 or 3
   Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis and are not currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have no psychosocial issues that can potentially place them at risk of a SED.

TCA – Tennessee Code Annotated.

TENNCARE – TENNCARE shall have the same meaning as "State."

TennCare or TennCare Program **–** The program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare Medicaid Enrollee – An enrollee who qualifies and has been determined eligible for benefits in the TennCare program through Medicaid eligibility criteria as described in TennCare rules and regulations.

TennCare Select – TennCare Select is a statewide MCO whose risk is backed by the State of Tennessee. TennCare Select was created to serve as a backup if other MCOs failed or there was inadequate MCO capacity and to be the MCO for certain populations, including children in state custody and children eligible for SSI. Children eligible for SSI may opt out of TennCare Select and enroll in another MCO.

TennCare Standard Enrollee – An enrollee who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as "TennCare Standard" as described in the approved TennCare waiver and the TennCare rules and regulations.

TENNderCare – Tennessee's EPSDT program; see EPSDT.

Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The Tennessee Bureau of Investigation's Medicaid Fraud Control Unit has the authority to investigate and prosecute (or refer for prosecution) violations of all applicable state and federal laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, the activities of providers of medical assistance in the state Medicaid program (TennCare), allegations of abuse or neglect of patients in health care facilities receiving payments under the state Medicaid program, misappropriation of patients' private funds in such facilities, and allegations of fraud and abuse in board and care facilities.

Tennessee Department of Children's Services (DCS) – The state agency responsible for child protective services, foster care, adoption, programs for delinquent youth, probation, aftercare, treatment and rehabilitation programs for identified youth, and licensing for all child-welfare agencies, except for child (day) care agencies and child support.

Tennessee Department of Commerce and Insurance (TDCI) – The state agency having the statutory authority to regulate, among other entities, insurance companies and health maintenance organizations.

Tennessee Department of Finance and Administration (F&A) – The state agency that oversees all state spending and acts as the chief corporate office of the state. It is the single state Medicaid agency. The Bureau of TennCare is a division of the Tennessee Department of Finance and Administration.

Tennessee Department of Health (DOH) – The state agency having the statutory authority to provide for health care needs in Tennessee.

Tennessee Department of Human Services (DHS) – The state agency having the statutory authority to provide human services to meet the needs of Tennesseans and enable them to achieve self-sufficiency. DHS is responsible for TennCare eligibility determinations (other than presumptive eligibility and SSI).

Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) – The state agency having the statutory authority to provide care for persons with mental illness and persons with developmental disabilities. For the purposes of this Agreement, TDMHDD shall mean the State of Tennessee and its representatives.

Third Party Liability (TPL) – Any amount due for all or part of the cost of medical or behavioral health care from a third party.

Third Party Resource – Any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or part of the cost of health care of the enrollee.

USC – United States Code

Vital MCO Documents – Consent forms and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents must be available in Spanish.

SECTION 2 – PROGRAM REQUIREMENTS

2.1 REQUIREMENTS PRIOR TO OPERATIONS

2.1.1 Licensure

2.1.1.1 Prior to the start date of operations (as defined in Section 1 of this Agreement) and prior to accepting TennCare enrollees, the CONTRACTOR shall obtain a standard certificate of authority (COA) from TDCI to operate as an HMO in Tennessee in the service area covered by this Agreement (see Section 2.4.2).

2.1.1.2 Prior to the start date of operations and prior to accepting TennCare enrollees, the CONTRACTOR shall ensure that any subcontractor(s) accepting risk under this Agreement shall be licensed, as necessary, by TDCI. In particular, if the CONTRACTOR subcontracts for the provision of behavioral health services, and that subcontractor accepts risk, TDCI may require that the subcontractor be licensed as a Prepaid Limited Health Service Organization (PLHSO).

2.1.1.3 Prior to the start date of operations, the CONTRACTOR shall ensure that its staff, all subcontractors and providers, and their staff are appropriately licensed.

2.1.1.4 The CONTRACTOR shall ensure that the CONTRACTOR and its staff, all subcontractors and staff, and all providers and staff retain at all times during the period of this Agreement a valid license, as appropriate, and comply with all applicable licensure requirements.

2.1.2 Readiness Review

2.1.2.1 Prior to the start date of operations, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that it is able to meet the requirements of this Agreement.

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

2.1.2.3 Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR. TennCare enrollees may not be enrolled with the CONTRACTOR until TENNCARE has determined that the CONTRACTOR is able to meet the requirements of this Agreement.

2.1.2.4 If the CONTRACTOR is unable to demonstrate its ability to meet the requirements of this Agreement, as determined by TENNCARE, within the time frames specified by TENNCARE, TENNCARE may terminate this Agreement in accordance with Section 4.4 of this Agreement and shall have no liability for payment to the CONTRACTOR.

2.2 GENERAL REQUIREMENTS

2.2.1 The CONTRACTOR shall comply with all the provisions of this Agreement and any amendments thereto and shall act in good faith in the performance of these provisions. The CONTRACTOR shall respect the legal rights (including rights conferred by the Agreement) of every enrollee, regardless of the enrollee's family status as head of household, dependent, or otherwise. Nothing in this Agreement may be construed to limit the rights or remedies of enrollees under state or federal law. The CONTRACTOR acknowledges that failure to comply with provisions of this Agreement may result in the assessment of liquidated damages and/or termination of the Agreement in whole or in part, and/or imposition of other sanctions as set forth in this Agreement.

2.2.2 The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement including all subcontractors, providers, employees, agents, and anyone acting for or on behalf of the CONTRACTOR.

2.3 ELIGIBILITY

2.3.1 Overview

TennCare is Tennessee's Medicaid program operating under the authority of a research and demonstration project approved by the federal government pursuant to section 1115 of the Social Security Act. Eligibility for TennCare is determined by the State in accordance with federal requirements and state law and policy.

2.3.2 Eligibility Categories

TennCare currently consists of traditional Medicaid coverage groups (TennCare Medicaid) and an expanded population of children (TennCare Standard).

2.3.2.1 <u>TennCare Medicaid</u>

As provided in state rules and regulations, TennCare Medicaid covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged, and individuals with disabilities. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

2.3.2.2 <u>TennCare Standard</u>

TennCare Standard includes children in the following eligibility categories:

2.3.2.2.1 Uninsured children under age nineteen (19) with family incomes up to two-hundred percent (200%) of the federal poverty level (FPL) who were eligible for TennCare as of April 29, 2005;

2.3.2.2.2 Uninsured children under age nineteen (19) who meet the "medically eligible" criteria (has a health condition that makes the child uninsurable) and who were eligible for TennCare as of April 29, 2005; and

2.3.2.2.3 Children under age nineteen (19) who are no longer eligible for TennCare Medicaid and who are either uninsured or medically eligible.

2.3.3 **TennCare Applications**

The CONTRACTOR shall not cause applications for TennCare to be submitted.

2.3.4 **Eligibility Determination and Determination of Cost Sharing**

The State shall have sole responsibility for determining the eligibility of an individual for TennCare. The State shall have sole responsibility for determining the applicability of TennCare cost sharing amounts and for the collection of applicable premiums.

2.3.5 **Eligibility for Enrollment in an MCO**

Except for TennCare enrollees enrolled in the Program of All-Inclusive Care for the Elderly (PACE) and enrollees who are only receiving assistance with Medicare cost-sharing, all TennCare enrollees will be enrolled in an MCO, including TennCare Select (see definition in Section 1 of this Agreement).

2.4 ENROLLMENT

2.4.1 **General**

TENNCARE is solely responsible for enrollment of TennCare enrollees in an MCO.

2.4.2 **Authorized Service Area**

2.4.2.1 Grand Region

Enrollees will be enrolled in MCOs by Grand Region(s) of the state. The Community Service Areas (CSAs) in each Grand Region and the specific counties in each CSA are listed in Section 1 of this Agreement.

2.4.2.2 CONTRACTOR's Authorized Service Area

The CONTRACTOR is authorized under this Agreement to serve enrollees who reside in the Grand Region(s) specified below:

__East Grand Region **X Middle Grand Region** __West Grand Region

2.4.3 **Maximum Enrollment**

2.4.3.1 The CONTRACTOR agrees to accept enrollment in the CONTRACTOR's MCO of up to seventy percent (70%) of the eligible population in the applicable Grand Region. TENNCARE shall determine and notify the CONTRACTOR of the number of eligibles in the applicable Grand Region and the CONTRACTOR's maximum enrollment limit, which shall be approximately seventy percent (70%) of the eligible population in the applicable Grand Region.

2.4.3.2 TENNCARE shall establish an enrollment threshold for the CONTRACTOR that will equal approximately ninety percent (90%) of the maximum enrollment limit established in Section 2.4.3.1 above. This enrollment threshold may be adjusted by TENNCARE at its discretion.

2.4.3.3 Once the CONTRACTOR's enrollment threshold is met, TENNCARE may discontinue default assignment of enrollees to the CONTRACTOR's MCO. Enrollees who select the CONTRACTOR or whose family members are enrolled in the CONTRACTOR's MCO shall continue to be enrolled in the CONTRACTOR's MCO until the maximum enrollment limit established in Section 2.4.3.1 above is met.

2.4.3.4 Both TENNCARE and the CONTRACTOR recognize that management of the CONTRACTOR's maximum enrollment limit and enrollment threshold within exact limits may not be possible. In the event enrollment in the CONTRACTOR's MCO exceeds the maximum enrollment limit, TENNCARE may reduce enrollment in the CONTRACTOR's MCO based on a plan established by TENNCARE that provides appropriate notice to the CONTRACTOR, allows appropriate choice of MCOs for enrollees, and meets the objectives of the TennCare program.

2.4.3.5 The establishment of a maximum enrollment limit and/or of an enrollment threshold does not obligate the State to enroll a certain number of TennCare enrollees in the CONTRACTOR's MCO and does not create in the CONTRACTOR any rights, interests or claims of entitlement to enrollment. The CONTRACTOR's actual enrollment level will be determined through the MCO selection and assignment process described in Section 2.4.4 below.

2.4.3.6 The CONTRACTOR shall demonstrate to the satisfaction of TENNCARE it has the capacity to serve the number of enrollees in the maximum enrollment limit prior to the assignment of any enrollees.

2.4.4 MCO Selection and Assignment

2.4.4.1 General

TENNCARE shall enroll individuals determined eligible for TennCare and eligible for enrollment in an MCO that is available in the Grand Region in which the enrollee resides. Enrollment in an MCO may be the result of an enrollee's selection of a particular MCO or assignment by TENNCARE. Enrollment in the CONTRACTOR's MCO is subject to the CONTRACTOR's maximum enrollment limit and threshold (see Section 2.4.3) and capacity to accept additional members.

2.4.4.2 Current TennCare Enrollees

TennCare enrollees who are known to be eligible for enrollment with the CONTRACTOR as of the start date of operations (defined in Section 1 of this Agreement) and residing in the Grand Region served by the CONTRACTOR shall be assigned by TENNCARE to the MCOs serving the Grand Region in accordance with the process described in Section 2.4.4.6 below. Except as otherwise provided in Section 2.4.4, this includes individuals currently enrolled in another MCO, including TennCare Select.

2.4.4.3 New TennCare Enrollees

2.4.4.3.1 Except as otherwise provided in this Agreement, all non-SSI applicants shall be required at the time of their application to select an MCO other than TennCare Select from those MCOs available in the Grand Region where the applicant resides. If the applicant does not select an MCO, the person will be assigned to an MCO by the State in accordance with Section 2.4.4.6.

2.4.4.3.2 Adults eligible for TennCare as a result of being eligible for SSI benefits will be assigned to an MCO (other than TennCare Select) by the State.

2.4.4.3.3 Children eligible for TennCare as a result of being eligible for SSI will be assigned to TennCare Select (defined in Section 1 of this Agreement) but may opt-out of TennCare Select and choose another MCO.

2.4.4.3.4 TennCare may allow enrollment of new TennCare enrollees in TennCare Select if there is insufficient capacity in other MCOs.

2.4.4.4 Children in State Custody

TennCare enrollees who are children in the custody of the Department of Children's Services (DCS) will be enrolled in TennCare Select. When these enrollees exit state custody, they remain enrolled in TennCare Select for a specified period of time and then are disenrolled from TennCare Select. After disenrollment from TennCare Select, if the enrollee has a family member in an MCO (other than TennCare Select) he/she will be enrolled in that MCO. Otherwise, the enrollee will be given the opportunity to select another MCO. If the enrollee does not select another MCO, he/she will be assigned to an MCO (other than TennCare Select) using the default logic in the auto assignment process (see Section 2.4.4.6 below).

2.4.4.5 Enrollment in MCO Other than the MCO Selected

In certain circumstances, if an enrollee requests enrollment in a particular MCO, the enrollee may be assigned by the State to an MCO other than the one that he/she requested. Examples of circumstances when an enrollee would not be enrolled in the requested MCO include, but are not limited to, such factors as the enrollee does not reside in the Grand Region covered by the requested MCO, the enrollee has other family members already enrolled in a different MCO, the MCO is closed to new TennCare enrollment, or the enrollee is a member of a population that is to be enrolled in a specified MCO as defined by TENNCARE (e.g., children in the custody of the Department of Children's Services are enrolled in TennCare Select).

2.4.4.6 Auto Assignment

2.4.4.6.1 TENNCARE will auto assign an enrollee to an MCO, in specified circumstances, including but not limited to, the enrollee does not request enrollment in a specified MCO, cannot be enrolled in the requested MCO, or is an adult eligible as a result of receiving SSI benefits**.**

2.4.4.6.2 The current auto assignment process does not apply to children eligible for TennCare as a result of being eligible for SSI or children in the state's custody.

2.4.4.6.3 There are four different levels to the current auto assignment process:

2.4.4.6.3.1 If the enrollee was previously enrolled with an MCO and lost TennCare eligibility for a period of two (2) months or less, the enrollee will be re-enrolled with that MCO.

2.4.4.6.3.2 If the enrollee has family members in an MCO (other than TennCare Select), the enrollee will be enrolled in that MCO.

2.4.4.6.3.3 If the enrollee is a newborn, the enrollee will be assigned to his/her mother's MCO.

2.4.4.6.3.4 If none of the above applies, the enrollee will be assigned using default logic that randomly assigns enrollees to MCOs (other than TennCare Select).

2.4.4.6.4 TENNCARE may modify the auto assignment algorithm to change or add criteria including but not limited to quality measures.

2.4.4.7 Non-Discrimination

2.4.4.7.1 The CONTRACTOR shall accept enrollees in the order in which applications are approved and enrollees are assigned to the CONTRACTOR (whether by selection or assignment).

2.4.4.7.2 The CONTRACTOR shall accept an enrollee in the health condition the enrollee is in at the time of enrollment and shall not discriminate against individuals on the basis of health status or need for health care services.

2.4.4.8 Family Unit

If an individual is determined eligible for TennCare and has another family member already enrolled in an MCO, that individual shall be enrolled in the same MCO. This does not apply when the individual or family member is assigned to TennCare Select. If the newly enrolled family member opts to change MCOs during the 45-day change period (see Section 2.4.7.2.1), all family members in the case will be transferred to the new MCO.

2.4.5 Effective Date of Enrollment

2.4.5.1 Initial Enrollment of Current TennCare Enrollees

The effective date of initial enrollment in an MCO for TennCare enrollees who are enrolled in accordance with Section 2.4.4.2 shall be the date provided on the enrollment file from TENNCARE. In general, the effective date of enrollment for these enrollees will be the start date of operations.

2.4.5.2 Ongoing Enrollment

In general, a member's effective date of enrollment in the CONTRACTOR's MCO will be the member's effective date of eligibility for TennCare. For SSI enrollees the effective date of eligibility/enrollment is determined by the Social Security Administration in approving SSI coverage for the individual. The effective date of eligibility for other TennCare enrollees is the date of application or the date of the qualifying event (e.g., the date the spend down obligation is met for medically needy enrollees). The effective date on the enrollment file provided by TENNCARE to the CONTRACTOR shall govern regardless of the other provisions of this Section 2.4.5.2.

2.4.5.3 In the event the effective date of eligibility provided by TENNCARE to the CONTRACTOR for either the initial enrollment of current TennCare enrollees or ongoing enrollment precedes the start date of operations, the CONTRACTOR shall treat the enrollee as a member of the CONTRACTOR's MCO effective on the start date of operations. Although the enrollee is not a member of the CONTRACTOR's MCO prior to the start date of operations, the CONTRACTOR shall be responsible for the payment of claims incurred by the enrollee during the period of eligibility prior to the start date of operations as specified in Section 3.7.1.2.1.

2.4.5.4 Enrollment Prior to Notification

2.4.5.4.1 Because individuals can be retroactively eligible for TennCare, and the effective date of initial enrollment in an MCO is the effective date of eligibility or start date of operations, whichever is sooner, the effective date of enrollment may occur prior to the CONTRACTOR being notified of the person's enrollment. Therefore, enrollment of individuals in the CONTRACTOR's MCO may occur without prior notice to the CONTRACTOR or enrollee.

2.4.5.4.2 The CONTRACTOR shall not be liable for the cost of any covered services prior to the effective date of enrollment/eligibility but shall be responsible for the costs of covered services obtained on or after 12:01 a.m. on the effective date of enrollment/eligibility.

2.4.5.4.3 TENNCARE shall make payments to the CONTRACTOR from the effective date of an enrollee's date of enrollment/eligibility. If the effective date of enrollment/eligibility precedes the start date of operations, payment shall be made in accordance with Section 3.7.1.2.1.

2.4.5.4.4 Except for applicable TennCare cost sharing, the CONTRACTOR shall ensure that members are held harmless for the cost of covered services provided as of the effective date of enrollment with the CONTRACTOR.

2.4.6 **Eligibility and Enrollment Data**

2.4.6.1 The CONTRACTOR shall receive, process, and update enrollment files from TENNCARE. Enrollment data shall be updated or uploaded to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE.

2.4.6.2 The CONTRACTOR shall provide an electronic eligibility file to TENNCARE as specified and in conformance to data exchange format and method standards outlined in Section 2.23.5.

2.4.7 **Enrollment Period**

2.4.7.1 General

2.4.7.1.1 The CONTRACTOR shall be responsible for the provision and costs of all covered services provided to enrollees during their period of enrollment with the CONTRACTOR.

2.4.7.1.2 Enrollment shall begin at 12:01 a.m. on the effective date of enrollment in the CONTRACTOR's MCO and shall end at 12:00 midnight on the date that the enrollee is disenrolled from the CONTRACTOR's MCO (see Section 2.5).

2.4.7.1.3 Once enrolled in the CONTRACTOR's MCO, the member shall remain enrolled in the CONTRACTOR's MCO until or unless the enrollee is disenrolled pursuant to Section 2.5 of this Agreement.

2.4.7.2 Changing MCOs

2.4.7.2.1 *45-Day Change Period*

After becoming eligible for TennCare and enrolling in the CONTRACTOR's MCO (whether the result of selection by the enrollee or assignment by TENNCARE), enrollees shall have one (1) opportunity, anytime during the forty-five (45) day period immediately following the date of enrollment with the CONTRACTOR's MCO or the date TENNCARE sends the member notice of enrollment in an MCO, whichever is later, to request to change MCOs. Children eligible for TennCare as a result or being eligible for SSI may request to enroll in another MCO or re-enroll with TennCare Select.

2.4.7.2.2 *Annual Choice Period*

2.4.7.2.2.1 TENNCARE shall provide an opportunity for members to change MCOs (excluding TennCare Select) every twelve (12) months. Children eligible for TennCare as a result or being eligible for SSI may request to enroll in another MCO or re-enroll with TennCare Select.

2.4.7.2.2.2 Members who do not select another MCO will be deemed to have chosen to remain with their current MCO.

2.4.7.2.2.3 Enrollees who select a new MCO shall have one (1) opportunity anytime during the forty-five (45) day period immediately following the specified enrollment effective date in the newly selected MCO to request to change MCOs.

2.4.7.2.3 *Appeal Based on Hardship Criteria*

As provided in TennCare rules and regulations, members may appeal to TENNCARE to change MCOs based on hardship criteria.

2.4.7.2.4 *Additional Reasons for Disenrollment*

As provided in Section 2.5.2, a member may be disenrolled from the CONTRACTOR's MCO for the reasons specified therein.

2.4.7.3 Member Moving out of Grand Region

The CONTRACTOR shall be responsible for the provision and cost of all covered services for any member moving outside the CONTRACTOR's Grand Region until the member is disenrolled by TENNCARE. TENNCARE shall continue to make payments to the CONTRACTOR on behalf of the enrollee until such time as the enrollee is enrolled in another MCO or otherwise disenrolled by TENNCARE (e.g., enrollee is terminated from the TennCare program). TENNCARE shall notify the CONTRACTOR promptly upon enrollment of the enrollee in another MCO.

2.4.8 **Transfers from Other MCOs**

2.4.8.1 The CONTRACTOR shall accept enrollees (enrolled or pending enrollment) from any MCO in the CONTRACTOR's service area as authorized by TENNCARE. The transfer of membership may occur at any time during the year. No enrollee from another MCO shall be transferred retroactively to the CONTRACTOR except as specified in Section 2.4.9. Except as provided in Section 2.4.9, the CONTRACTOR shall not be responsible for payment of any covered services incurred by enrollees transferred to the CONTRACTOR prior to the effective date of transfer to the CONTRACTOR.

2.4.8.2 Transfers from other MCOs shall be in consideration of the maximum enrollment levels established in Section 2.4.3.

2.4.8.3 To the extent possible and practical, TENNCARE shall provide advance notice to all MCOs serving a Grand Region of the impending failure of one of the MCOs serving the Grand Region; however, failure by TENNCARE to provide advance notice shall not limit in any manner the responsibility of each MCO to accept enrollees from failed MCOs.

2.4.9 **Enrollment of Newborns**

2.4.9.1 TennCare-eligible newborns and their mothers, to the extent that the mother is eligible for TennCare, should be enrolled in the same MCO with the exception of newborns that are SSI eligible at birth. Newborns that are SSI eligible at birth shall be assigned to TennCare Select but may opt out and enroll in another MCO.

2.4.9.2 A newborn may be inadvertently enrolled in an MCO different than its mother. When such cases are identified by the CONTRACTOR, the CONTRACTOR shall immediately report to TENNCARE, in accordance with written procedures provided by TENNCARE, that a newborn has been incorrectly enrolled in an MCO different than its mother.

2.4.9.3 Upon receipt of notice from the CONTRACTOR or discovery by TENNCARE that a newborn has been incorrectly enrolled in an MCO different than its mother, TENNCARE shall immediately:

2.4.9.3.1 Disenroll the newborn from the incorrect MCO;

2.4.9.3.2 Enroll the newborn in the same MCO as its mother with the same effective date as when the newborn was enrolled in the incorrect MCO;

2.4.9.3.3 Recoup any payments made to the incorrect MCO for the newborn; and

2.4.9.3.4 Make payments only to the correct MCO for the period of coverage.

2.4.9.4 The MCO in which the newborn is correctly enrolled shall be responsible for the coverage and payment of covered services provided to the newborn for the full period of eligibility. Except as provided below, the MCO in which the newborn was incorrectly enrolled shall have no liability for the coverage or payment of any services during the period of incorrect MCO assignment. TENNCARE shall only be liable for the capitation payment to the correct MCO.

2.4.9.5 There are circumstances in which a newborn's mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborns within the time frames specified in Section 2.22.4 of this Agreement. A CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn, during any period of enrollment in the CONTRACTOR's MCO, because the newborn's mother is not a member of the CONTRACTOR's MCO. However, it is recognized that in complying with the claims processing time frames specified in 2.22.4 of this Agreement, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn enrolled in the CONTRACTOR's MCO at the time of payment but the newborn's eligibility may subsequently be moved to another MCO. In such event, the MCO in which the newborn is first enrolled (first MCO) may submit supporting documentation to the MCO in which the newborn is moved (second MCO) and the second MCO shall reimburse the first MCO within thirty (30) calendar days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the newborn prior to the newborn's eligibility having been moved to the second MCO. Such reimbursement shall be the actual amount expended by the first MCO. The second MCO agrees that should the second MCO fail to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second MCO and to reimburse the first MCO. Should it become necessary for TENNCARE to intervene in such cases, both the second MCO and the first MCO agree that TENNCARE shall be held harmless by both MCOs for actions taken by TENNCARE to resolve the dispute.

2.4.10 **Information Requirements Upon Enrollment**

As described in Section 2.17 of this Agreement, the CONTRACTOR shall provide the following information to new members: a member handbook, a provider directory and an identification card.

2.5 DISENROLLMENT FROM AN MCO

2.5.1 **General**

A member may be disenrolled from the CONTRACTOR's MCO only when authorized by TENNCARE.

2.5.2 **Acceptable Reasons for Disenrollment from an MCO**

A member may request disenrollment or be disenrolled from the CONTRACTOR's MCO if:

2.5.2.1 The member selects another MCO during the forty-five (45) day change period after enrollment with the CONTRACTOR's MCO and is enrolled in another MCO;

2.5.2.2 The member selects another MCO during the annual choice period and is enrolled in another MCO;

2.5.2.3 An appeal by the member to change MCOs based on hardship criteria (pursuant to TennCare rules and regulations) is decided by TENNCARE in favor of the member, and the member is enrolled in another MCO;

2.5.2.4 The member is assigned incorrectly to the CONTRACTOR's MCO by TENNCARE and enrolled in another MCO;

2.5.2.5 The member moves outside the MCO's service area and is enrolled in another MCO;

2.5.2.6 During the appeal process, if TENNCARE determines it is in the best interest of the enrollee and TENNCARE (see Section 2.19.2.9);

2.5.2.7 The member loses eligibility for TennCare;

2.5.2.8 TENNCARE grants members the right to terminate enrollment pursuant to Section 4.20.1, and the member is enrolled in another MCO;

2.5.2.9 The CONTRACTOR no longer participates in TennCare; or

2.5.2.10 This Agreement expires or is terminated.

2.5.3 **Unacceptable Reasons for Disenrollment from an MCO**

The CONTRACTOR shall not request disenrollment of an enrollee for any reason. TENNCARE shall not disenroll members for any of the following reasons:

2.5.3.1 Adverse changes in the enrollee's health;

2.5.3.2 Pre-existing medical or behavioral health conditions;

2.5.3.3 High cost medical or behavioral health bills;

2.5.3.4 Failure or refusal to pay applicable TennCare cost sharing responsibilities, except when this results in loss of eligibility for TennCare;

2.5.3.5 Enrollee's utilization of medical or behavioral health services;

2.5.3.6 Enrollee's diminished mental capacity; or

2.5.3.7 Enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

2.5.4 Informing TENNCARE of Potential Ineligibility

Although the CONTRACTOR may not request disenrollment of a member, the CONTRACTOR shall inform TENNCARE promptly when the CONTRACTOR knows or has reason to believe that an enrollee may satisfy any of the conditions for termination from the TennCare program as described in TennCare rules and regulations.

2.5.5 Effective Date of Disenrollment

2.5.5.1 Member Requested Disenrollment

All TENNCARE approved disenrollment requests from enrollees shall be effective on or before the first calendar day of the second month following the month of an enrollee's request to disenroll from an MCO. The effective date shall be indicated on the termination record sent by TENNCARE.

2.5.5.2 Other Disenrollments

The effective date of disenrollments other than at the request of the member shall be determined by TENNCARE and indicated on the termination record.

2.6 BENEFITS/SERVICE REQUIREMENTS AND LIMITS

2.6.1 CONTRACTOR Covered Benefits

2.6.1.1 The CONTRACTOR shall cover the physical health and behavioral health services/benefits outlined below. Additional requirements for behavioral health services are included in Section 2.7.2 and Attachment I.

2.6.1.2 The CONTRACTOR shall pay for medically necessary covered services regardless of the existence or absence of a specific diagnosis of the member. The CONTRACTOR shall provide all medically necessary covered services as delineated in this Agreement or as required by state or federal law.

2.6.1.3 CONTRACTOR Physical Health Benefits Chart

SERVICE		BENEFIT LIMIT
Inpatient Hospital Services		**Non-Institutionalized Medicaid Eligible, Age 21 and older:** As medically necessary. **Institutionalized Medicaid:** As medically necessary. **NOTE: Age 21 and older:** Inpatient rehabilitation hospital facility services are not covered unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5). **Medicaid/Standard Eligible, Under age 21:** As medically necessary, including rehabilitation hospital facility.
Outpatient Hospital Services		As medically necessary.
Physician Inpatient Services		As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services		As medically necessary.
TENNderCare Services		**Medicaid Eligibles, Age 21 and older:** Not covered. **Medicaid/Standard Eligibles, Under age 21:** Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. See Section 2.7.5.
Preventive Care Services		As described in Section 2.7.4.
Lab and X-ray Services		As medically necessary.
Hospice Care		As medically necessary. Must be provided by a Medicare-certified hospice.

SERVICE		BENEFIT LIMIT
Dental Services		**Dental Services shall be provided by the Dental Benefits Manager.** However, the provision of transportation to and from said services as well as the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM. This requirement only applies to Medicaid/Standard Eligibles Under age 21.
Vision Services		**Medicaid Eligible, Age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery. **Medicaid/Standard Eligible, Under age 21:** Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TENNderCare requirements.
Home Health Care		As medically necessary in accordance with Newberry.
Pharmacy Services		**Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.** The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid. Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section 2.6.2.2).
Durable Medical Equipment		As medically necessary. Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations.

SERVICE		BENEFIT LIMIT
Medical Supplies		As medically necessary.
Emergency Air And Ground Ambulance Transportation		As medically necessary.
Non-emergency Transportation (including Non-Emergency Ambulance Transportation)		As necessary to get a member to and from covered services, dental services (provided by the DBM), and pharmacy services (provided through the PBM) for enrollees not having access to transportation. If the CONTRACTOR is unable to meet the access standards included in this Agreement (see Section 2.11) for a member, transportation must be provided regardless of whether or not the member has access to transportation. If the member is a child, transportation must be provided in accordance with TENNderCare requirements (see Section 2.7.5.4.6). As with any denial, all notices and actions must be in accordance with the requirements of this Agreement (see Section 2.14.2.2 and Section 2.19). The CONTRACTOR may require advance notice of the need for transportation in order to timely arrange transportation. The CONTRACTOR shall contract with the transportation vendor selected by the State and shall pay the vendor the rate determined by TENNCARE.
Renal Dialysis Services		As medically necessary.
Private Duty Nursing		As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Speech Therapy		**Medicaid Eligible, Age 21 and older:** Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.

SERVICE		BENEFIT LIMIT
Occupational Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.
Physical Therapy		**Medicaid Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.
Organ and Tissue Transplant And Donor Organ Procurement		**Medicaid Eligible, Age 21 and older:** All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements. Experimental or investigational transplants are not covered.
Reconstructive Breast Surgery		Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.

SERVICE		BENEFIT LIMIT
Chiropractic Services		**Medicaid Eligible, Age 21 and older:** Not covered unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.

2.6.1.4 Soft Limits/Service Thresholds for Certain Physical Health Services

2.6.1.4.1 TENNCARE has established thresholds that apply to certain covered physical health services for non-institutionalized Medicaid adults. The CONTRACTOR shall track, in a manner prescribed by TENNCARE, and report on accumulated benefit information for each service that has a threshold. Depending on the service, once a member reaches a threshold, the CONTRACTOR shall enroll the member in MCO case management or a disease management program or shall determine whether the person should be enrolled in MCO case management or a disease management program.

2.6.1.4.2 The service thresholds and the CONTRACTOR's responsibility once a non-institutionalized adult has met the threshold are as follows:

Service	Threshold for Non-Institutionalized Medicaid Eligibles, Age 21 and Older	CONTRACTOR Responsibility Once Member Has Reached Threshold
Inpatient Hospital Services	20 days per SFY	Enroll member in MCO case management or disease management program, whichever is more appropriate
Outpatient Hospital Services	8 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	12 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate
Lab and X-ray Services	10 visits per SFY year	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate

2.6.1.4.3 As provided in Section 2.30.3, the CONTRACTOR shall report on the number of members who reach each threshold, were assessed, and/or were enrolled in MCO case management or a disease management program, and the reasons for failure to enroll in MCO case management or disease management.

2.6.1.5 CONTRACTOR Behavioral Health Benefits Chart

SERVICE		BENEFIT LIMIT
Psychiatric Inpatient Hospital Services (including physician services)		As medically necessary.
24-hour Psychiatric Residential Treatment		**Medicaid Eligible, Age 21 and older:** As medically necessary. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Outpatient Mental Health Services (including physician services)		As medically necessary.
Inpatient, Residential & Outpatient Substance Abuse Benefits[1]		**Medicaid Eligible, Age 21 and older:** Limited to ten (10) days detox, $30,000 in medically necessary lifetime benefits. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Mental Health Case Management		As medically necessary.
Psychiatric-Rehabilitation Services		As medically necessary.
Behavioral Health Crisis Services		As necessary.
Lab and X-ray Services		As medically necessary.
Non-emergency Transportation (including Non-Emergency Ambulance Transportation)		Same as for physical health (see Section 2.6.1.3 above).

[1]When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.

2.6.2 **TennCare Benefits Provided by TENNCARE**

TennCare shall be responsible for the payment of the following benefits:

2.6.2.1 Dental Services

Except as provided in Section 2.6.1.3 of this Agreement, dental services shall not be provided by the CONTRACTOR but shall be provided by a dental benefits manager (DBM) under contract with TennCare. Coverage of dental services is described in TennCare rules and regulations.

2.6.2.2 Pharmacy Services

Except as provided in Section 2.6.1.3 of this Agreement, pharmacy services shall not be provided by the CONTRACTOR but shall be provided by a pharmacy benefits manager (PBM) under contract with TennCare. Coverage of pharmacy services is described in TennCare rules and regulations. TENNCARE does not cover pharmacy services for enrollees who are dually eligible for TennCare and Medicare.

2.6.2.3 Institutional Services and Alternatives to Institutional Services

For qualified enrollees in accordance with TennCare policies and/or TennCare rules and regulations, TENNCARE covers the costs of long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or alternatives to institutional services provided through the Home and Community Based Services (HCBS) waivers.

2.6.3 **Medical Necessity Determination**

2.6.3.1 The CONTRACTOR may establish procedures for the determination of medical necessity. The determination of medical necessity shall be made on a case by case basis and in accordance with the definition of medical necessity defined in TCA 71-5-144 and any regulations promulgated thereto. However, this requirement shall not limit the CONTRACTOR's ability to use medically appropriate cost effective alternatives in accordance with Section 2.6.5.

2.6.3.2 The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The CONTRACTOR shall have the ability to place tentative limits on a service; however, such tentative limits placed by the CONTRACTOR shall be exceeded (up to the applicable hard limit on detoxification provided in Section 2.6.1.5 above) when medically necessary based on a member's individual characteristics.

2.6.3.3 The CONTRACTOR shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

2.6.3.4 The CONTRACTOR may deny services that are non-covered except as otherwise required by TENNderCare or unless otherwise directed to provide by TENNCARE and/or an administrative law judge.

2.6.3.5 All medically necessary services shall be covered for enrollees under twenty-one (21) years of age in accordance with TENNderCare requirements (see Section 2.7.5).

2.6.4 **Second Opinions**

The CONTRACTOR shall provide for a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition when requested by a member, parent and/or legally appointed representative. The second opinion must be provided by a contracted qualified health care professional or the CONTRACTOR shall arrange for a member to obtain one from a non-contract provider. The second opinion shall be provided at no cost to the member.

2.6.5 **Use of Cost Effective Alternative Services**

The CONTRACTOR shall be allowed to use cost effective alternative services, whether listed as covered or non-covered or omitted in Section 2.6.1 of this Agreement, when the use of such alternative services is medically appropriate and is cost effective. This may include, for example, use of nursing facilities as step down alternatives to acute care hospitalization or hotel accommodations for persons on outpatient radiation therapy to avoid the rigors of daily transportation. The CONTRACTOR shall comply with TennCare policies and procedures. As provided in the applicable TennCare policies and procedures, services not listed in the TennCare policies and procedures must be prior approved in writing by TENNCARE.

2.6.6 **Additional Services and Use of Incentives**

The CONTRACTOR shall not advertise, offer or provide any services that are not required by this Agreement other than those permitted pursuant to Section 2.6.1 of this Agreement. However, the CONTRACTOR may provide incentives that have been specifically prior approved in writing by TENNCARE. For example, TENNCARE may approve the use of incentives given to enrollees to encourage participation in disease management programs.

2.6.7 **Cost Sharing for Services**

2.6.7.1 General

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations, including but not limited to, holding enrollees liable for debt due to insolvency of the CONTRACTOR or non-payment by the State to the CONTRACTOR. Further, the CONTRACTOR and all providers and subcontractors may not charge enrollees for missed appointments.

2.6.7.2 Preventive Services

TennCare cost sharing responsibilities shall apply to covered services other than the preventive services described in TennCare rules and regulations.

2.6.7.3 Cost Sharing Schedule

The current TennCare cost sharing schedule is included in this Agreement as Attachment II. The CONTRACTOR shall not waive or use any alternative cost sharing schedules, unless required by TENNCARE.

2.6.7.4 Provider Requirements

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

2.6.7.4.1.1 If the services are not covered services and, prior to providing the services, the provider informed the enrollee that the services were not covered. The provider must inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee.

2.6.7.4.1.2 If the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee.

2.6.7.4.1.3 If the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost sharing amounts must be refunded when a claim is submitted to an MCO because the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim).

2.6.7.4.1.4 If the services are not covered because they are in excess of an enrollee's hard benefit limit, and the provider complies with applicable TennCare rules and regulations.

2.6.7.4.2 The CONTRACTOR shall require, as a condition of payment, that the provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for

the service. Except in the circumstances described above, if the CONTRACTOR is aware that a provider, or a collection agency acting on the provider's behalf, bills an enrollee for amounts other than the applicable amount of TennCare cost sharing responsibilities due from the enrollee, the CONTRACTOR shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. If a provider continues to bill an enrollee after notification by the CONTRACTOR, the CONTRACTOR shall refer the provider to the Tennessee Bureau of Investigation.

2.7 SPECIALIZED SERVICES

2.7.1 Emergency Services

2.7.1.1 Emergency services (as defined in Section 1 of this Agreement) shall be available twenty-four (24) hours a day, seven (7) days a week.

2.7.1.2 The CONTRACTOR shall review and approve or disapprove claims for emergency services based on the definition of emergency medical condition specified in Section 1 of this Agreement. The CONTRACTOR shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The CONTRACTOR shall not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard.

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

2.7.1.4 If an emergency screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition exists, the CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the member. The CONTRACTOR shall be required to pay for all emergency services which are medically necessary until the clinical emergency is stabilized. This includes all medical and behavioral health services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the member's condition is likely to result from, or occur during, discharge of the member or transfer of the member to another facility. If there is a disagreement between the hospital and the CONTRACTOR concerning whether the member is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending provider(s) actually caring for the member at the treating facility prevails and is binding on the CONTRACTOR. The CONTRACTOR, however, may establish arrangements with a hospital whereby the CONTRACTOR may send one of

its own providers with appropriate emergency room privileges to assume the attending provider's responsibilities to stabilize, treat, and transfer the member, provided that such arrangement does not delay the provision of emergency services.

2.7.1.5 The CONTRACTOR shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition does not exist, then the determining factor for payment liability shall be whether the member had acute symptoms of sufficient severity at the time of presentation. In such cases, the CONTRACTOR shall review the presenting symptoms of the member and shall pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard regardless of final diagnosis.

2.7.1.6 When the member's PCP or the CONTRACTOR instructs the member to seek emergency services, the CONTRACTOR shall be responsible for payment for the medical screening examination and for other medically necessary emergency services, without regard to whether the member's condition meets the prudent layperson standard.

2.7.1.7 Once the member's condition is stabilized, the CONTRACTOR may require prior authorization for hospital admission or follow-up care.

2.7.2 **Behavioral Health Services**

2.7.2.1 <u>General Provisions</u>

2.7.2.1.1 The CONTRACTOR shall provide all behavioral health services as described in this Section, Section 2.6.1 and Attachment I.

2.7.2.1.2 The CONTRACTOR shall provide behavioral health services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by the State.

2.7.2.1.3 The CONTRACTOR shall ensure that all members receiving behavioral health services from providers whose primary focus is to render behavioral health services have individualized treatment plans. Providers included in this requirement are:

2.7.2.1.3.1 Community mental health agencies;

2.7.2.1.3.2 Case management agencies;

2.7.2.1.3.3 Psychiatric rehabilitation agencies;

2.7.2.1.3.4 Psychiatric and substance abuse residential treatment facilities; and

2.7.2.1.3.5 Psychiatric and substance abuse inpatient facilities.

2.7.2.1.4 Individualized treatment plans shall be completed within thirty (30) calendar days of the start date of service and updated every six (6) months, or more frequently as clinically appropriate. The treatment plans shall be developed, negotiated and agreed upon by the members and/or their support systems in face-to-face encounters and shall be used to identify the treatment needs necessary to meet the members' stated goals. The duration and intensity of treatment shall promote the recovery and resilience of members and shall be documented in the treatment plans.

2.7.2.2 Psychiatric Inpatient Hospital Services

2.7.2.2.1 The CONTRACTOR shall ensure that all psychiatric inpatient hospitals serving children, youth, and adults separate members by age and render developmental age appropriate services.

2.7.2.2.2 The CONTRACTOR shall require that all psychiatric inpatient facilities are JCAHO accredited and accept voluntary and involuntary admissions.

2.7.2.3 24-Hour Psychiatric Residential Treatment

2.7.2.3.1 The CONTRACTOR shall ensure that 24-hour psychiatric residential treatment facilities (RTFs) serving children, youth, and adults separate members by age and render developmental age appropriate services.

2.7.2.3.2 The CONTRACTOR shall ensure RTFs have the capacity to render short term crisis stabilization and long-term treatment and rehabilitation.

2.7.2.3.3 The CONTRACTOR shall ensure all RTFs meet local housing codes.

2.7.2.3.4 The CONTRACTOR shall ensure all RTFs are accredited by a State-recognized accreditation organization as required by 42 CFR 441.151.

2.7.2.4 Outpatient Mental Health Services

2.7.2.4.1 The CONTRACTOR shall ensure that outpatient mental health providers (including providers of intensive outpatient and providers of partial hospitalization services) serving children, youth and adults separate members by age and render developmental age appropriate services.

2.7.2.4.2 The CONTRACTOR shall ensure outpatient mental health providers are capable of rendering services both on and off site, as appropriate, depending on the services being rendered. On site services include, but are not limited to intensive outpatient services, partial hospitalization and many types of therapy. Off site services include but are not limited to intensive in home service for children and youth and home and community treatment for adults.

2.7.2.5 Inpatient, Residential & Outpatient Substance Abuse Services

2.7.2.5.1 The CONTRACTOR shall provide substance abuse treatment through inpatient, residential and outpatient services.

2.7.2.5.2 Detoxification services may be rendered as part of inpatient, residential or outpatient services, as clinically appropriate. The CONTRACTOR shall ensure all member detoxifications are supervised by Tennessee licensed physicians with a minimum daily re-evaluations by a physician or a registered nurse.

2.7.2.6 Mental Health Case Management

2.7.2.6.1 The CONTRACTOR shall provide mental health case management services only through providers licensed by the State to provide mental health outpatient services.

2.7.2.6.2 The CONTRACTOR shall provide mental health case management services according to mental health case management standards set by the State and outlined in Attachment I. Mental health case management services will consist of two (2) levels of service as specified in Attachment I.

2.7.2.6.3 The CONTRACTOR shall require its providers to collect and submit individual encounter records for each mental health case management visit, regardless of the method of payment by the CONTRACTOR. The CONTRACTOR shall identify and separately report "level 1" and "level 2" mental health case management encounters outlined in Attachment I.

2.7.2.6.4 The CONTRACTOR shall require mental health case managers to involve the member, the member's family or parent(s), or legally appointed representative, PCP and other agency representatives, if appropriate and authorized by the member as required, in mental health case management activities.

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2.7.2.6.5 The CONTRACTOR shall ensure the continuing provision of mental health case management services to members under the conditions and time frames indicated below:

2.7.2.6.5.1 Members receiving mental health case management services at the start date of operations shall be maintained in mental health case management until such time as the member no longer qualifies on the basis of medical necessity or refuses treatment;

2.7.2.6.5.2 Members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities shall be evaluated for mental health case management services and provided with appropriate behavioral health follow-up services; and

2.7.2.6.5.3 The CONTRACTOR shall review the cases of members referred by PCPs or otherwise identified to the CONTRACTOR as potentially in need of mental health case management services and shall contact and offer such services to all members who meet medical necessity criteria.

2.7.2.7 Psychiatric Rehabilitation Services

The CONTRACTOR shall provide psychiatric rehabilitation services in accordance with the requirements in Attachment I. As described in Attachment I, the covered array of services available under psychiatric rehabilitation are psychosocial rehabilitation, supported employment, peer support, illness management and

recovery, and supported housing. An individual may receive one or more of these services and may receive different services from different providers.

2.7.2.8 Behavioral Health Crisis Services

2.7.2.8.1 *Entry into the Behavioral Health Crisis Services System*

2.7.2.8.1.1 The State shall maintain a statewide toll free telephone number for entry into the behavioral health crisis system. This line shall be for any individual in the general population for the purposes of providing immediate phone intervention by trained crisis specialists and dispatch of mobile crisis teams.

2.7.2.8.1.2 The CONTRACTOR shall ensure that the crisis telephone line is linked to an appropriate crisis service team staffed by qualified crisis service providers in order to provide crisis intervention services to members.

2.7.2.8.1.3 As required in Section 2.11.5.3, the CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by the State.

2.7.2.8.1.4 The CONTRACTOR shall require the crisis service teams to provide telephone and walk-in triage screening services, telephone and face-to-face crisis intervention/assessment services, and follow-up telephone or face-to-face assessments to ensure the safety of the member until the member's treatment begins and/or the crisis is alleviated and/or stabilized.

2.7.2.8.1.5 Prior to admission to a psychiatric inpatient hospital on an involuntary basis, the CONTRACTOR shall ensure that the member has been evaluated by a crisis team. In addition, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a face-to-face evaluation by a mandatory pre-screening agent (MPA), is conducted to assess eligibility for emergency involuntary admission to an RMHI and determine whether all available less drastic alternatives services and supports are unsuitable.

2.7.2.8.2 *Behavioral Health Crisis Respite and Crisis Stabilization Services*

2.7.2.8.2.1 The CONTRACTOR shall ensure access to behavioral health crisis respite and crisis stabilization services.

2.7.2.8.2.2 Behavioral health crisis respite services provide immediate shelter to members with emotional/behavioral problems who are in need of emergency respite. The CONTRACTOR shall ensure that behavioral health crisis respite services are provided in a CONTRACTOR approved community location.

2.7.2.8.2.3 The CONTRACTOR shall ensure behavioral health crisis stabilization services are rendered at sites licensed by the State. These services are more intensive than regular behavioral health crisis services in that they require more secure environments, highly trained staff, and typically have longer stays.

2.7.2.8.3 The CONTRACTOR shall monitor behavioral health crisis services and report information to TENNCARE on a quarterly basis as described in Section 2.30.4.4.

2.7.2.9 Clinically Related Group (CRG) and Target Population Group (TPG) Assessments

2.7.2.9.1 The CONTRACTOR shall provide CRG/TPG assessments in response to requests from members or legally appointed representatives or, in the case of minors, the members' parents or legally appointed representatives, behavioral health providers, PCPs, or the State.

2.7.2.9.2 The CONTRACTOR shall complete CRG/TPG assessments within fourteen (14) calendar days of the requests. The CONTRACTOR shall not require prior authorization in order for a member to receive a CRG/TPG assessment.

2.7.2.9.3 The CONTRACTOR shall ensure that its contract providers are trained and that there is sufficient capacity to perform CRG/TPG assessments. The CONTRACTOR shall require providers to use the CRG/TPG assessment form(s) as appropriate, prescribed by and in accordance with the policies of the state. The CRG/TPG assessments shall be subject to review and approval by the State.

2.7.2.9.4 The CONTRACTOR shall identify persons in need of CRG/TPG assessments. The CONTRACTOR shall use the CRG/TPG assessments to identify persons who are SPMI or SED for reporting and tracking purposes, in accordance with the definitions contained in Section 1.

2.7.2.9.5 The CONTRACTOR shall ensure that providers who perform CRG/TPG assessments have been trained and authorized by the State to perform CRG/TPG assessments. Certified trainers will be responsible for providing rater training within their agencies.

2.7.2.9.6 The CONTRACTOR shall reject all CRG/TPG assessments completed by unapproved raters. The CONTRACTOR shall report on rejected assessments as required in Section 2.30.4.6.

2.7.2.9.7 The CONTRACTOR shall conduct audits of CRG/TPG assessments for accuracy and conformity to state policies and procedures. The CONTRACTOR shall audit all providers conducting these assessments on at least an annual basis. The methodology for these audits and the results of these audits shall be reported as required in Sections 2.30.4.7 and 2.30.4.8.

2.7.2.10 Judicial Services

2.7.2.10.1 The CONTRACTOR shall provide covered court ordered behavioral health services to its members pursuant to court order(s). The CONTRACTOR shall furnish these services in the same manner as services furnished to other members.

2.7.2.10.2 The CONTRACTOR shall provide for behavioral health services to its members in accordance with state law. Specific laws employed include the following:

2.7.2.10.2.1 Psychiatric treatment for persons found by the court to require judicial psychiatric hospitalization (TCA 33-6 part 4 and part 5). The CONTRACTOR may apply medical necessity criteria to the situation after seventy-two (72) hours of emergency services, unless there is a court order prohibiting release;

2.7.2.10.2.2 Judicial review of discharge for persons hospitalized by a circuit, criminal or juvenile court (TCA 33-6-708);

2.7.2.10.2.3 Access to and provision of mandatory outpatient psychiatric treatment and services to persons who are discharged from psychiatric hospitals after being hospitalized (TCA 33-6, Part 6);

2.7.2.10.2.4 Inpatient psychiatric examination for up to forty-eight (48) hours for persons whom the court has ordered to be detained for examination but who have been unwilling to be evaluated for hospital admission (TCA 33-3-607);

2.7.2.10.2.5 Voluntary psychiatric hospitalization for persons when determined to be medically necessary, subject to the availability of suitable accommodations (TCA 33-6, Part 2); and

2.7.2.10.2.6 Voluntary psychiatric hospitalization for persons with a severe impairment when determined to be medically necessary but who do not meet the criteria for emergency involuntary hospitalization, subject to the availability of suitable accommodations (TCA 33-6, Part 3).

2.7.2.11 Mandatory Outpatient Treatment

2.7.2.11.1 The CONTRACTOR shall provide mandatory outpatient treatment for individuals found not guilty by reason of insanity following a sixty (60) to ninety (90) calendar day inpatient evaluation. Treatment can be terminated only by the court pursuant to TCA 33-7-303(b).

2.7.2.11.2 The State will assume responsibility for all forensic services other than the mandatory outpatient treatment service identified in Section 2.7.2.11.1 (TCA 33-7-301(a), 33-7-301(b), 33-7-303(a) and 33-7-303(c)).

2.7.3 **Health Education and Outreach**

2.7.3.1 The CONTRACTOR shall develop programs and participate in activities to enhance the general health and well-being of members. Health education and outreach programs and activities may include the following:

2.7.3.1.1 General physical and behavioral health education classes;

2.7.3.1.2 Mental illness awareness programs and education campaigns with special emphasis on events such as National Mental Health Month and National Depression Screening Day;

2.7.3.1.3 Smoking cessation programs with targeted outreach for adolescents and pregnant women;

2.7.3.1.4 Nutrition counseling;

2.7.3.1.5 Early intervention and risk reduction strategies to avoid complications of disability and chronic illness;

2.7.3.1.6 Prevention and treatment of alcohol and substance abuse;

2.7.3.1.7 Self care training, including self-examination;

2.7.3.1.8 Need for clear understanding of how to take medications and the importance of coordinating all medications;

2.7.3.1.9 Understanding the difference between emergent, urgent and routine health conditions;

2.7.3.1.10 Telephone calls, mailings and home visits to current members for the sole purpose of educating current members about services offered by or available through the CONTRACTOR's MCO; and

2.7.3.1.11 General activities that benefit the entire community (e.g., health fairs and school activity sponsorships).

2.7.3.2 The CONTRACTOR shall report on these activities as required in Section 2.30.4.9.

2.7.4 **Preventive Services**

2.7.4.1 The CONTRACTOR shall provide preventive services which includes, but is not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services and immunizations in accordance with TennCare rules and regulations. These services shall be exempt from TennCare cost sharing responsibilities described in Section 2.6.7 of this Agreement (see TennCare rules and regulations for service codes).

2.7.4.2 <u>Prenatal Care</u>

2.7.4.2.1 The CONTRACTOR is required to provide or arrange for the provision of medically necessary prenatal care to members beginning on the date of their enrollment in the CONTRACTOR's MCO. This requirement includes pregnant women who are presumptively eligible for TennCare, enrollees who become pregnant, as well as enrollees who are pregnant on the effective date of enrollment in the CONTRACTOR's MCO. The requirement to provide or arrange for the provision of medically necessary prenatal care shall include assistance in making a timely appointment for a woman who is presumptively eligible and shall be provided as soon as the CONTRACTOR becomes aware of the enrollment. For a woman in her second or third trimester, the appointment shall occur as required in Section 2.11.4.2. In the event a member enrolling in the CONTRACTOR's MCO is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall comply with the requirements in Sections 2.9.2.2 and 2.9.2.3 regarding prior authorization of prenatal care.

2.7.4.2.2 Failure of the CONTRACTOR to respond to a member's request for prenatal care by failing to identify a prenatal care provider to honor a request from a member, including a presumptively eligible member, (or from an PCP or patient advocate acting on behalf of a member) for a prenatal care appointment shall be considered a material breach of this Agreement.

2.7.4.2.3 The CONTRACTOR shall notify all contract providers that any unreasonable delay in providing care to a pregnant member seeking prenatal care will be considered a material breach of the provider's agreement with the CONTRACTOR. Unreasonable delay in care for pregnant members shall mean failure of the prenatal care provider to meet the accessibility requirements required in Section 2.11.4 of this Agreement.

2.7.5 **TENNderCare**

2.7.5.1 General Provisions

2.7.5.1.1 The CONTRACTOR shall provide TENNderCare services to members under age twenty-one (21) in accordance with TennCare and federal requirements including TennCare rules and regulations, TennCare policies and procedures, 42 USC 1396a(a)(43), 1396d(a) and (r), 42 CFR Part 441, Subpart B, the Omnibus Budget Reconciliation Act of 1989, and the State Medicaid Manual. TENNderCare services means early and periodic screening, diagnosis and treatment of members under age twenty-one (21) to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and providing treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, regardless of whether the required service is a covered benefit as described in Section 2.6.1.

2.7.5.1.2 The CONTRACTOR shall use the name "TENNderCare" in describing or naming the State's EPSDT program or services. This requirement is applicable for all policies, procedures and other material, regardless of the format or media. No other names or labels shall be used.

2.7.5.1.3 The CONTRACTOR shall have written policies and procedures for the TENNderCare program that include coordinating services with child-serving agencies and providers, providing all medically necessary TENNderCare services to all eligible members under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, and conducting outreach and education. The CONTRACTOR shall ensure the availability and accessibility of required health care resources and shall help members and their parents or legally appointed representatives use these resources effectively.

2.7.5.1.4 The CONTRACTOR shall be responsible for and comply with all provisions related to screening, vision, dental, and hearing services (including making arrangements for necessary follow-up if all components of a screen cannot be completed in a single visit).

2.7.5.1.5 The CONTRACTOR shall:

2.7.5.1.5.1 Require that providers provide TENNderCare services;

2.7.5.1.5.2 Require that providers make appropriate referrals and document said referrals in the member's medical record;

2.7.5.1.5.3 Educate contract providers about proper coding and encourage them to submit the appropriate diagnosis codes identified by TENNCARE in conjunction with evaluation and management procedure codes for TENNderCare services;

2.7.5.1.5.4 Educate contract providers about how to submit claims with appropriate codes and modifiers as described in standardized billing requirements (e.g., CPT, HCPCS, etc.) and require that they adjust billing methodology according to described components of said procedure codes/modifiers; and

2.7.5.1.5.5 Monitor provider compliance with required TENNderCare activities including compliance with proper coding.

2.7.5.1.6 The CONTRACTOR shall require that its contract providers notify the CONTRACTOR in the event a screening reveals the need for other health care services and the provider is unable to make an appropriate referral for those services. Upon notification of the inability to make an appropriate referral, the CONTRACTOR shall secure an appropriate referral and contact the member to offer scheduling assistance and transportation for members lacking access to transportation. In the event the failed referral is for dental services, the CONTRACTOR shall coordinate with the DBM to arrange for services.

2.7.5.1.7 The CONTRACTOR shall not require prior authorization for periodic and interperiodic screens conducted by PCPs. The CONTRACTOR shall provide all medically necessary covered services regardless of whether the need for such services was identified by a provider who had received prior authorization from the CONTRACTOR or from a contract provider.

2.7.5.1.8 The CONTRACTOR shall have a tracking system to monitor each TENNderCare eligible member's receipt of the required screening, diagnosis, and treatment services as well as all referrals made as a result of a TENNderCare screen. The tracking system shall have the ability to generate immediate reports on each member's TENNderCare status, reflecting all encounters reported more than sixty (60) days prior to the date of the report.

2.7.5.1.9 In the event that a member under sixteen (16) years of age is seeking behavioral health TENNderCare services and the member's parent(s), or legally appointed representative is unable to accompany the member to the examination, the CONTRACTOR shall require that its providers either contact the member's parent(s), or legally appointed representative to discuss the findings and inform the family of any other necessary health care, diagnostic services, treatment or other measures recommended for the member or notify the MCO to contact the parent(s), or legally appointed representative with the results.

2.7.5.2 <u>Member Education and Outreach</u>

2.7.5.2.1 The CONTRACTOR shall be responsible for outreach activities and for informing members who are under the age of twenty-one (21), or their parent or legally appointed representative, of the availability of TENNderCare services. All TENNderCare member materials shall be submitted to TENNCARE for approval prior to distribution in accordance with Section 2.17.1 and shall be made available in accordance with the requirements specified in Section 2.17.2.

2.7.5.2.2 The CONTRACTOR shall have a minimum of six (6) "outreach contacts" per member per calendar year in which it provides information about TENNderCare to members. The minimum "outreach contacts" include: one (1) member handbook as described in Section 2.17.4, four (4) quarterly member newsletters as described in Section 2.17.5, and one (1) reminder notice issued before a screening is due. The reminder notice shall include an offer of transportation and scheduling assistance.

2.7.5.2.3 The CONTRACTOR shall have a mechanism for systematically notifying families when TENNderCare screens are due.

2.7.5.2.4 As part of its TENNderCare policies and procedures, the CONTRACTOR shall have a process for following up with members who do not get their screenings timely. This process for follow up must include provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. The CONTRACTOR shall make at least one (1) effort per quarter in excess of the six (6) "outreach contacts" to get the member in for a screening. The efforts, whether written or oral, shall be different each quarter. The CONTRACTOR is prohibited from simply sending the same letter four (4) times.

2.7.5.2.5 The CONTRACTOR shall have a process for determining if a member who is eligible for TENNderCare has used no services within a year and shall make two (2) reasonable attempts to re-notify such members about TENNderCare. One (1) of these attempts can be a referral to DOH. (These two (2) attempts are in addition to the one (1) attempt per quarter mentioned in Section 2.7.5.2.4 above.)

2.7.5.2.6 The CONTRACTOR shall require that providers have a process for documenting services declined by a parent or legally appointed representative or mature competent child, specifying the particular service was declined. This process must meet all requirements outlined in Section 5320.2.A of the State Medicaid Manual.

2.7.5.2.7 The CONTRACTOR shall make and document a minimum of two (2) reasonable attempts to find a member when mail is returned as undeliverable. At least one (1) of these attempts must be oral.

2.7.5.2.8 The CONTRACTOR shall make available to members and families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare members as described in Section 2.17.7 of this Agreement.

2.7.5.2.9 The CONTRACTOR shall target specific informing activities to pregnant women and families with newborns. Provided that the CONTRACTOR is aware of the pregnancy, the CONTRACTOR shall inform all pregnant women prior to the estimated delivery date about the availability of TENNderCare services for their children. The CONTRACTOR shall offer TENNderCare services for the child when it is born.

2.7.5.3 Screening

2.7.5.3.1 The CONTRACTOR shall provide periodic comprehensive child health assessments meaning, "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth."

2.7.5.3.2 At a minimum, these screens shall include periodic and interperiodic screens and be provided at intervals which meet reasonable standards of medical, behavioral and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care. The State has determined that "reasonable standards of medical and dental practice" are those standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Tools used for screening shall be consistent with the screening guidelines recommended by the State which are available on the TennCare web site. These include, but are not limited to recommended screening guidelines for developmental/behavioral surveillance and screening, hearing screenings, and vision screenings.

2.7.5.3.3 The screens shall include, but not be limited to:

2.7.5.3.3.1 Comprehensive health and developmental history (including assessment of physical and mental health development and dietary practices);

2.7.5.3.3.2 Comprehensive unclothed physical examination, including measurements (the child's growth shall be compared against that considered normal for the child's age and gender);

2.7.5.3.3.3 Appropriate immunizations scheduled according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history;

2.7.5.3.3.4 Appropriate vision and hearing testing provided at intervals which meet reasonable standards of medical practice and at other intervals as medically necessary to determine the existence of suspected illness or condition;

2.7.5.3.3.5 Appropriate laboratory tests (including lead toxicity screening appropriate for age and risk factors). All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at twelve (12) and twenty-four (24) months of age. Children between the ages of thirty-six (36) months and seventy-two (72) months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test equal to or greater than ten (10) ug/dL obtained by capillary specimen (finger stick) must be confirmed by using a venous blood sample; and

2.7.5.3.3.6 Health education which includes anticipatory guidance based on the findings of all screening. Health education should include counseling to both members and members' parents or to the legally appointed representative to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

2.7.5.3.4 The CONTRACTOR shall encourage providers to refer children to dentists for periodic dental screens beginning no later than three (3) years of age and earlier as needed (as early as six (6) to twelve (12) months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate.

2.7.5.3.5 The CONTRACTOR shall establish a procedure for PCPs or other providers completing TENNderCare screenings to refer TENNderCare eligible members requiring behavioral health services to appropriate providers.

2.7.5.4 Services

2.7.5.4.1 Should screenings indicate a need, the CONTRACTOR must provide all necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) (Section 1905 (a) of the Social Security Act) to correct or ameliorate or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan (see Section 2.7.5.4.8). This includes, but is not limited to, the services detailed below.

2.7.5.4.2 The CONTRACTOR shall provide treatment for defects in vision and hearing, including eyeglasses and hearing aids.

2.7.5.4.3 The CONTRACTOR shall coordinate with the DBM to ensure that TENNderCare eligible members receive dental care services furnished by direct referral to a dentist, at as early an age as necessary, and at intervals which meet reasonable standards of dental practice as determined by the State and at other intervals as medically necessary to determine the existence of a suspected illness or condition.

2.7.5.4.4 The CONTRACTOR shall not require prior authorization or written PCP referral in order for a member to obtain a mental health or substance abuse assessment, whether the assessment is requested as follow-up to a TENNderCare screening or an interperiodic screening. This requirement shall not preclude the CONTRACTOR from requiring notification for a referral for an assessment. Furthermore, the CONTRACTOR shall establish a procedure for PCPs, or other providers, completing TENNderCare screenings, to refer members under the age of twenty-one (21) for a mental health or substance abuse assessment.

2.7.5.4.5 For services not covered by Section 1905(a) of the Social Security Act, but found to be needed as a result of conditions disclosed during screening and diagnosis, the CONTRACTOR shall provide referral assistance as required by 42 CFR 441.61, including referral to providers and State health agencies.

2.7.5.4.6 *Transportation Services*

2.7.5.4.6.1 The CONTRACTOR shall provide transportation assistance for a child. This includes related travel expenses, cost of meals, and lodging in route to and from care, and the cost of an attendant to accompany a child if necessary.

2.7.5.4.6.2 The CONTRACTOR shall not impose blanket restrictions when determining coverage for transportation services. Each determination shall be based on individualized circumstances for each case by the CONTRACTOR and/or the transportation vendor. Each request for transportation services is to be reviewed individually and documented by the CONTRACTOR and/or the transportation vendor.

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

2.7.5.4.6.4 The CONTRACTOR shall offer transportation and scheduling assistance to all members under age twenty-one (21) who do not have access to transportation in order to access covered services. This may be accomplished through various means of communication to members, including but not limited to, member handbooks, TENNderCare outreach notifications, etc.

2.7.5.4.6.5 Circumstances that may permit the CONTRACTOR and/or its transportation vendor to refuse the transportation request would be when the member or attendant according to a reasonable person's standards is noticeably indisposed (disorderly conduct, intoxicated, armed (firearms), is in possession of illegal drugs, knives and/or other weapons) or is in any other condition that may affect the safety of the driver or persons being transported.

2.7.5.4.7 *Services for Elevated Blood Lead Levels*

2.7.5.4.7.1 The CONTRACTOR shall provide follow up for elevated blood lead levels in accordance with the State Medicaid Manual, Part 5. The Manual currently says that children with blood lead levels equal to or greater than ten (10) ug/dL should be followed according to CDC guidelines. These guidelines include follow up blood tests and investigations to determine the source of lead, when indicated.

2.7.5.4.7.2 The CONTRACTOR shall provide for any follow up service within the scope of the federal Medicaid statute, including diagnostic or treatment services determined to be medically necessary when elevated blood lead levels are identified in children. Such services would include both MCO case management services and a one (1) time investigation to determine the source of lead.

2.7.5.4.7.3 The CONTRACTOR is responsible for the primary environmental lead investigation—commonly called a "lead inspection"—for children when elevated blood levels suggest a need for such an investigation.

2.7.5.4.7.4 If the lead inspection does not reveal the presence of lead paint in the home, there may be a need for other testing, such as risk assessments involving water and soil sampling or inspections of sites other than the primary residence if the child spends a substantial amount of time in another location. The CONTRACTOR is not responsible for either the risk assessments or the lead inspection at the secondary site. However, the CONTRACTOR shall contact the DOH when these services are indicated as this agency is responsible for these services.

2.7.5.4.7.5 CONTRACTOR reimbursement for the primary environmental investigations is limited to the items specified in Part 5 of the State Medicaid Manual. These items include the health professional's time and activities during the on-site investigation of the child's primary residence. They do not include testing of environmental substances such as water, paint, or soil.

2.7.5.4.8 *Services Chart*

Pursuant to federal and state requirements, TennCare enrollees under the age of 21 are eligible for all services listed in Section 1905(a) of the Social Security Act. These services, and the entity responsible for providing them to TennCare enrollees under the age of 21, are listed below. Notwithstanding any other provision of this Agreement, the CONTRACTOR shall provide all services for which "MCO" is identified as the responsible entity to members under the age of 21. All services, other than TENNderCare screens and interperiodic screens, must be medically necessary in order to be covered by the CONTRACTOR.

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(1) Inpatient hospital services (other than services in an institution for mental diseases)		MCO	
(2)(A) Outpatient hospital services		MCO	
(2)(B) Rural health clinic services (RHCs)		MCO	MCOs are not required to contract with RHCs if the services are available through other contract providers.
(2)(C) Federally-qualified health center services (FQHCs)		MCO	MCOs are not required to contract with FQHCs if they can demonstrate adequate provider capacity without them.
(3) Other laboratory and X-ray services		MCO	

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(4)(A) Nursing facility services for individuals age 21 and older			Not applicable for TENNderCare
(4)(B) EPSDT services		MCO for physical health and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services as described except as in Section 2.6.1.3	
(4)(C) Family planning services and supplies		MCO; PBM for pharmacy services except as described in Section 2.6.1.3	
(5)(A) Physicians' services furnished by a physician, whether furnished in the office, the patient's home, a hospital, or a nursing facility		MCO	
(5)(B) Medical and surgical services furnished by a dentist		DBM except as described in Section 2.6.1.3	
(6) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law		MCO	See Item (13)
(7) Home health care services		MCO	
(8) Private duty nursing services		MCO	
(9) Clinic services		MCO	
(10) Dental services		DBM except as described in Section 2.6.1.3	
(11) Physical therapy and related services		MCO	

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(12) Prescribed drugs, dentures, and prosthetic devices, and eyeglasses		MCO; PBM for pharmacy services except as described in Section 2.6.1.3; DBM for dentures	
(13) Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level		MCO for physical health and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services except as described in Section 2.6.1.3	The following are considered practitioners of the healing arts in Tennessee law:[1] • Alcohol and drug abuse counselor • Athletic trainer • Audiologist • Certified acupuncturist • Certified master social worker • Certified nurse practitioner • Certified professional counselor • Certified psychological assistant • Chiropractic physician • Chiropractic therapy assistant • Clinical pastoral therapist • Dentist • Dental assistant • Dental hygienist • Dietitian/nutritionist • Dispensing optician • Electrologist • Emergency medical personnel • First responder • Hearing instrument specialist • Laboratory personnel

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

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
			• Licensed clinical perfusionist • Licensed clinical social worker • Licensed practical nurse • Licensed professional counselor • Marital and family therapist, certified • Marital and family therapist, licensed • Massage therapist • Medical doctor • Medical doctor (special training) • Midwives and nurse midwives • Nurse aide • Occupational therapist • Occupational therapy assistant • Optometrist • Osteopathic physician • Pharmacist • Physical therapist • Physical therapist assistant • Physician assistant • Podiatrist • Psychological examiner • Psychologist • Registered nurse • Registered certified reflexologist • Respiratory care assistant • Respiratory care technician • Respiratory care therapist

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
			• Senior psychological examiner • Speech pathologist • Speech pathology aide • X-ray op in chiropractic physician's office • X-ray op in MD office • X-ray op in osteopathic office • X-ray op in podiatrist's office
(14) Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases			Not applicable for TENNderCare
(15) Services in an intermediate care facility for the mentally retarded		TENNCARE	
(16) Inpatient psychiatric services for individuals under age 21		MCO	
(17) Services furnished by a nurse-midwife		MCO	The MCOs are not required to contract with nurse-midwives if the services are available through other contract providers.
(18) Hospice care		MCO	
(19) Case management services		MCO	
(20) Respiratory care services		MCO	
(21) Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner		MCO	The MCOs are not required to contract with PNPs or CFNPs if the services are available through other contract providers.

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(22) Home and community care for functionally disabled elderly individuals			Not applicable for TENNderCare
(23) Community supported living arrangements services			Not applicable for TENNderCare
(24) Personal care services		MCO	
(25) Primary care case management services			Not applicable
(26) Services furnished under a PACE program			Not applicable for TENNderCare
(27) Any other medical care, and any other type of remedial care recognized under state law.		MCO for physical and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services except as described in Section 2.6.1.3	See Item (13)

2.7.5.4.8.1 **Note 1:** "Targeted case management services," which are listed under section 1915(g)(1), are **not TENNderCare services** except to the extent that the definition in section 1915(g)(2) is used with Item (19) above.

2.7.5.4.8.2 **Note 2:** "Psychiatric residential treatment facility" is not listed in Social Security Act section 1905(a). It is, however, defined in 42 CFR 483.352 as "a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age twenty-one (21), in an inpatient setting."

2.7.5.4.8.3 **Note 3:** "Rehabilitative" services are differentiated from "habilitative" services in federal law. "Rehabilitative" services, which are TENNderCare services, are defined in 42 CFR 440.130(d) as services designed "for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." "Habilitative" services, which are **not TENNderCare services**, are defined in section 1915(c)(5) as services designed "to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings."

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

2.7.5.4.8.5 **Note 5:** Certain services are not coverable even under a Home and Community Based waiver and are **not TENNderCare services**. These services include room and board, and special education and related services which are otherwise available through a Local Education Agency. (See Section 1915(c)(5).)

2.7.5.5 Children with Special Health Care Needs

Children with special health care needs are those children who are in the custody of DCS. As provided in Section 2.4.4.4, TennCare enrollees who are in the custody of DCS will be enrolled in TennCare Select.

2.7.6 **Advance Directives**

2.7.6.1 The CONTRACTOR shall maintain written policies and procedures for advance directives that comply with all federal and state requirements concerning advance directives, including but not limited to 42 CFR 422.128, 438.6 and 489 Subpart I; TCA 32-11-101 *et seq.*, 34-6-201 *et seq.*, and 68-11-201 through 68-11-224; and any requirements as stipulated by the member. Any written information provided by the CONTRACTOR must reflect changes in state law by the effective date specified in the law, if not specified then within thirty (30) calendar days after the effective date of the change.

2.7.6.2 The CONTRACTOR shall provide its policies and procedures to all members eighteen (18) years of age and older and shall educate members about their ability to direct their care using this mechanism and shall specifically designate which staff members and/or contract providers are responsible for providing this education.

2.7.6.3 The CONTRACTOR shall educate its staff about its policies and procedures on advance directives, situations in which advance directives may be of benefit to members, and their responsibility to educate members about this tool and assist them to make use of it.

2.7.6.4 The CONTRACTOR, for behavioral health services, shall provide its policies and procedures to all members sixteen (16) years of age and older and shall educate members about their ability to direct their care using advance directives including the use of Declarations for Mental Health Treatment under TCA Title 33, Chapter 6, Part 10. The CONTRACTOR shall specifically designate staff members and/or providers responsible for providing this education.

2.7.7 **Sterilizations, Hysterectomies and Abortions**

2.7.7.1 The CONTRACTOR shall cover sterilizations, hysterectomies and abortions pursuant to applicable federal and state law. The CONTRACTOR shall ensure that when coverage requires the completion of a specific form, the form is properly completed as described in the instructions with the original form maintained in the member's medical records and a copy submitted to the CONTRACTOR for retention in the event of audit.

2.7.7.2 Sterilizations

Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing. The CONTRACTOR shall cover sterilizations only if the following requirements are met:

2.7.7.2.1 The member has given informed consent not less than thirty (30) full calendar days (or not less than seventy-two (72) hours in the case of premature delivery or emergency abdominal surgery) but not more than one-hundred eighty (180) calendar days before the date of the sterilization;

2.7.7.2.2 The member is at least twenty-one (21) years old at the time consent is obtained;

2.7.7.2.3 The member is mentally competent;

2.7.7.2.4 The member is not institutionalized; i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed; and

2.7.7.2.5 The member has voluntarily given informed consent on the approved "STERILIZATION CONSENT FORM" which is available on TENNCARE's web site. The form shall be available in English and Spanish, and the CONTRACTOR shall provide assistance in completing the form when an alternative form of communication is necessary.

2.7.7.3 Hysterectomies

2.7.7.3.1 The CONTRACTOR shall cover hysterectomies only if the following requirements are met:

2.7.7.3.1.1 The hysterectomy is medically necessary;

2.7.7.3.1.2 The member or her authorized representative, if any, has been informed orally and in writing that the hysterectomy will render the member permanently incapable of reproducing; and

2.7.7.3.1.3 The member or her authorized representative, if any, has signed and dated a "STATEMENT OF RECEIPT OF INFORMATION CONCERNING HYSTERECTOMY" form which is available on TENNCARE's web site, prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age in accordance with federal requirements. The form shall be available in English and Spanish, and assistance must be provided in completing the form when an alternative form of communication is necessary.

2.7.7.3.2 The CONTRACTOR shall not cover hysterectomies under the following circumstances:

2.7.7.3.2.1 If it is performed solely for the purpose of rendering an individual permanently incapable of reproducing;

2.7.7.3.2.2 If there is more than one purpose for performing the hysterectomy, but the primary purpose is to render the individual permanently incapable of reproducing; or

2.7.7.3.2.3 It is performed for the purpose of cancer prophylaxis.

2.7.7.4 Abortions

2.7.7.4.1 The CONTRACTOR shall cover abortions and services associated with the abortion procedure only if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

2.7.7.4.2 The CONTRACTOR shall ensure that a "CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION" form, which is available on TENNCARE's web site, is completed.

2.8 DISEASE MANAGEMENT

2.8.1 General

2.8.1.1 The CONTRACTOR shall establish and operate a disease management (DM) program for each of the following conditions:

2.8.1.1.1 Maternity care management, in particular high-risk obstetrics;

2.8.1.1.2 Diabetes;

2.8.1.1.3 Congestive heart failure;

2.8.1.1.4 Asthma;

2.8.1.1.5 Coronary artery disease;

2.8.1.1.6 Chronic-obstructive pulmonary disease;

2.8.1.1.7 Bipolar disorder;

2.8.1.1.8 Major depression; and

2.8.1.1.9 Schizophrenia.

2.8.1.2 Each DM program must utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the CONTRACTOR's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee and patient empowerment strategies to support the provider-patient relationship and the plan of care. For the conditions listed in 2.8.1.1 through 2.8.1.6, the guidelines shall include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia shall include the use of the evidence-based practice for co-occurring disorders.

2.8.1.3 The DM programs must emphasize the prevention of exacerbation and complications of the conditions as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.

2.8.1.4 The CONTRACTOR shall develop and maintain DM program policies and procedures. These policies and procedures must include, for each of the conditions listed above, the following:

2.8.1.4.1 The definition of the target population;

2.8.1.4.2 Member identification strategies;

2.8.1.4.3 The guidelines;

2.8.1.4.4 Written description of the stratification levels for each of the conditions, including member criteria and associated interventions;

2.8.1.4.5 Program content;

2.8.1.4.6 Methods for informing and educating members;

2.8.1.4.7 Methods for informing and educating providers; and

2.8.1.4.8 Program evaluation.

2.8.1.5 As part of its DM program policies and procedures, the CONTRACTOR shall also address how the DM programs will coordinate with MCO case management activities, in particular for members who would benefit from both.

2.8.2 Member Identification Strategies

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

2.8.2.1.1 Members who have reached the service threshold for inpatient hospital services (see Section 2.6.1.4); and

2.8.2.1.2 Members who have reached the service threshold for other (non-inpatient hospital services (see Section 2.6.1.4) and could potentially benefit from enrollment in a disease management program.

2.8.2.1.3 Members who have reached the service threshold for inpatient hospital services shall be enrolled in either a disease management program or MCO case management, whichever the CONTRACTOR determines is more appropriate.

2.8.2.2 The CONTRACTOR shall operate its disease management programs using an "opt out" methodology, meaning that disease management services will be provided to eligible members unless they specifically ask to be excluded.

2.8.3 **Stratification**

As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member-provided information. The DM programs shall tailor the program content, education activities, and benchmarks and goals for each risk level.

2.8.4 **Program Content**

Each DM program shall include the development of treatment plans that serve as the outline for all of the activities and interventions in the program. At a minimum the activities and interventions associated with the treatment plan must address condition monitoring, patient adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues.

2.8.5 **Informing and Educating Members**

The DM programs shall educate members and/or their caregivers regarding their particular condition(s) and needs. This information shall be provided upon enrollment in the DM program. The DM programs shall educate members to increase their understanding of their condition(s), the factors that impact their health status (e.g., diet and nutrition, lifestyle, exercise, medication compliance), and to empower members to be more effective in self-care and management of their health so they:

2.8.5.1 Are proactive and effective partners in their care;

2.8.5.2 Understand the appropriate use of resources needed for their care;

2.8.5.3 Identify precipitating factors and appropriate responses before they require more acute intervention; and

2.8.5.4 Are compliant and cooperative with the recommended treatment plan.

2.8.6 **Informing and Educating Providers**

As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning

how the program(s) works. The DM's provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions.

2.8.7 **Program Evaluation**

2.8.7.1 The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. These benchmarks and goals shall be specific to each condition but should include:

2.8.7.1.1 Performance measured against at least two important clinical aspects of the guidelines associated with each DM program;

2.8.7.1.2 The rate of emergency department utilization and inpatient hospitalization;

2.8.7.1.3 Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the maternity care management program;

2.8.7.1.4 Appropriate HEDIS measures;

2.8.7.1.5 The active participation rates (as defined by NCQA) and the number of individuals participating in each level of each of the DM programs;

2.8.7.1.6 Cost savings;

2.8.7.1.7 Member adherence to treatment plans; and

2.8.7.1.8 Provider adherence to the guidelines.

2.8.7.2 The CONTRACTOR shall report on DM activities as required in Section 2.30.5.

2.8.8 **Obesity Disease Management**

In addition to the aforementioned DM program requirements, the CONTRACTOR shall have a DM program for obesity that is provided as a cost effective alternative service (see Section 2.6.5). This DM program shall, at a minimum, fulfill all requirements related to the TennCare Partnership with Weight Watchers program. This means that, at a minimum, the CONTRACTOR shall have provider agreements with the appropriate Weight Watchers regional center(s); educate its contract providers about the program to ensure they make appropriate referrals for members; and process claims according to the requirements in Section 2.22. The CONTRACTOR is encouraged to undertake additional obesity disease management activities as cost effective alternative services pursuant to Section 2.6.5.

2.9 SERVICE COORDINATION

2.9.1 **General**

2.9.1.1 The CONTRACTOR shall be responsible for the management, coordination, and continuity of care for all its TennCare members and shall develop and maintain policies and procedures to address this responsibility.

2.9.1.2 The CONTRACTOR shall:

2.9.1.2.1 Coordinate care between PCPs and specialists;

2.9.1.2.2 Perform reasonable preventive health case management services, have mechanisms to assess the quality and appropriateness of services furnished, and provide appropriate referral and scheduling assistance;

2.9.1.2.3 Document authorized referrals in its utilization management system;

2.9.1.2.4 Monitor members with ongoing medical or behavioral health conditions;

2.9.1.2.5 Identify members using emergency department services inappropriately to assist in scheduling follow-up care with PCPs and/or appropriate specialists to improve continuity of care and establish a medical home;

2.9.1.2.6 Maintain and operate a formalized hospital and/or institutional discharge planning program;

2.9.1.2.7 Coordinate hospital and/or institutional discharge planning that includes post-discharge care, as appropriate;

2.9.1.2.8 Maintain an internal tracking system that identifies the current preventive services screening status and pending preventive services screening due dates for each member; and

2.9.1.2.9 Authorize services provided by non-contract providers, as required in this Agreement (see, e.g., Section 2.13).

2.9.2 **Transition of New Members**

2.9.2.1 In the event an enrollee entering the CONTRACTOR's MCO is receiving medically necessary covered services in addition to or other than prenatal services (see below for enrollees receiving only prenatal services) the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The CONTRACTOR must provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The CONTRACTOR may require prior authorization for continuation of the services beyond thirty (30) calendar days however the CONTRACTOR is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

2.9.2.2 In the event an enrollee entering the CONTRACTOR's MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal care, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the CONTRACTOR can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

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

2.9.2.4 The CONTRACTOR shall ensure that the member is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing amounts described in Section 2.6.7 and in Attachment II of this Agreement.

2.9.2.5 The CONTRACTOR shall develop and maintain policies and procedures regarding the transition of new members.

2.9.3 **Transition of Care**

2.9.3.1 The CONTRACTOR shall actively assist members with chronic or acute medical or behavioral health conditions in transitioning to another provider when their current provider has terminated participation with the CONTRACTOR. The CONTRACTOR must provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption of care, whichever is less. The CONTRACTOR shall allow continued access to the provider through the postpartum period for members in their second or third trimester of pregnancy.

2.9.3.2 The CONTRACTOR shall actively assist members in transitioning to another provider when there are changes in providers. The CONTRACTOR shall have transition policies that, at a minimum, include the following:

2.9.3.2.1 A schedule which ensures transfer does not create a lapse in service;

2.9.3.2.2 A mechanism for timely information exchange (including transfer of the member record);

2.9.3.2.3 A mechanism for assuring confidentiality;

2.9.3.2.4 A mechanism for allowing a member to request and be granted a change of provider;

2.9.3.2.5 An appropriate schedule as approved by the State for transitioning members from one (1) provider to another when there is medical necessity for ongoing care.

2.9.3.2.6 Specific transition language on the following special populations:

2.9.3.2.6.1 Children who are SED;

2.9.3.2.6.2 Adults who are SPMI;

2.9.3.2.6.3 Persons who have addictive disorders;

2.9.3.2.6.4 Persons who have co-occurring disorders of both mental health and alcohol and/or drug abuse disorders; and

2.9.3.2.6.5 Persons with behavioral health conditions who also have a developmental disorder (dually diagnosed). These members shall be allowed to remain with their providers of the services listed below for the minimum time frames set out below as long as the services continue to be medically necessary. The CONTRACTOR may shorten these transition time frames only when the provider of services is no longer available to serve the member or when a change in providers is agreed to in writing by the member.

2.9.3.2.6.5.1 Mental health case management: three (3) months;

2.9.3.2.6.5.2 Psychiatrist: three (3) months;

2.9.3.2.6.6 Outpatient behavioral health therapy: three (3) months;

2.9.3.2.6.7 Psychosocial rehabilitation and supported employment: three (3) months; and

2.9.3.2.6.8 Psychiatric inpatient or residential treatment and supportive housing: six (6) months.

2.9.4 **MCO Case Management**

2.9.4.1 The CONTRACTOR shall maintain an MCO case management program that includes the following components:

2.9.4.1.1 A systematic approach to identify eligible members;

2.9.4.1.2 Assessment of member needs;

2.9.4.1.3 Development of an individualized plan of care;

2.9.4.1.4 Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and

2.9.4.1.5 Monitoring of outcomes.

2.9.4.2 The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to:

2.9.4.2.1 Members who have reached the service threshold for inpatient hospital services (see Section 2.6.1.4);

2.9.4.2.2 Members who have reached the service threshold for other (non-inpatient hospital) services and could potentially benefit from enrollment in MCO case management; and

2.9.4.2.3 Members with co-occurring mental illness and substance abuse, and/or co-morbid physical health and behavioral health conditions.

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

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

2.9.4.5 The CONTRACTOR shall develop a process to inform members and providers about the availability of MCO case management and to inform the member's PCP when a member has been assigned to the MCO case management program.

2.9.4.6 The CONTRACTOR shall use utilization data, including pharmacy data provided by TENNCARE or its PBM (see Section 2.9.6), to identify members for MCO case management services as appropriate. In particular, the CONTRACTOR shall track utilization data to determine when a member has reached a service threshold (see Section 2.6.1.4).

2.9.5 Coordination and Collaboration Between Physical Health and Behavioral Health

2.9.5.1 General

As provided in Section 2.6.1 of this Agreement, the CONTRACTOR shall be responsible for providing a full continuum of physical health and behavioral health services. The CONTRACTOR shall ensure communication and coordination between PCPs and medical specialists. The CONTRACTOR shall also be responsible for ensuring continuity and coordination between covered physical and behavioral health services and ensuring collaboration between physical health and behavioral health providers. The CONTRACTOR shall develop policies and procedures that address key elements in meeting this requirement. These elements include, but are not limited to, screening for behavioral health needs (including the screening tool), referral to physical and behavioral health providers, exchange of information, confidentiality, assessment, treatment plan development, collaboration, MCO case management and disease management, provider training, and monitoring implementation and outcomes.

2.9.5.2 Subcontracting for Behavioral Health Services

If the CONTRACTOR subcontracts for the provision of behavioral health services, the CONTRACTOR shall develop and implement a written agreement with the subcontractor regarding the coordination of services provided by the CONTRACTOR and those provided by the subcontractor. The agreement shall address the responsibilities of the CONTRACTOR and the subcontractor regarding,

at a minimum, the items identified in Section 2.9.5.1 as well as prior authorization, claims payment, claims resolution, contract disputes, and reporting. The subcontract shall comply with all of the requirements regarding subcontracts included in Section 2.26 of this Agreement.

2.9.5.3 Screening for Behavioral Health Needs

2.9.5.3.1 The CONTRACTOR shall ensure that the need for behavioral health services is systematically identified by and addressed by the member's PCP at the earliest possible time following initial enrollment of the member in the CONTRACTOR's MCO or after the onset of a condition requiring mental health and/or substance abuse treatment.

2.9.5.3.2 The CONTRACTOR shall encourage PCPs and other providers to use a screening tool prior approved by the State as well as other mechanisms to facilitate early identification of behavioral health needs.

2.9.5.4 Referrals to Behavioral Health Providers

The CONTRACTOR shall ensure through screening that members with a need for behavioral health services, particularly members with SED/SPMI are appropriately referred to behavioral health providers. The CONTRACTOR shall develop provider education and training materials to ensure that physical health providers know when and how to refer members who need specialty behavioral health services. This shall include education about behavioral health services, including the recovery process and resilience for children. The CONTRACTOR shall develop a referral process to be used by its providers, including what information must be exchanged and when to share this information.

2.9.5.5 Referrals to PCPs

The CONTRACTOR shall ensure that members with both physical health and behavioral health needs are appropriately referred to their PCPs for treatment of their physical health needs. The CONTRACTOR shall develop provider education and training materials to ensure that behavioral health providers know when and how to refer members who need physical health services. The CONTRACTOR shall develop a referral process to be used by its providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health provider.

2.9.5.6 Behavioral Health Assessment and Treatment Plan

The CONTRACTOR's policies and procedures shall identify the role of physical health and behavioral health providers in assessing a member's behavioral health needs and developing an individualized treatment plan. For members with chronic physical conditions that require ongoing treatment who also have behavioral health needs, the CONTRACTOR shall encourage participation of both the member's physical health provider (PCP or specialist) and behavioral health provider in the assessment and individualized treatment plan development process as well as the ongoing provision of services.

2.9.5.7 MCO Case Management and Disease Management

The CONTRACTOR shall use its MCO case management and disease management programs (see Sections 2.9.4 and 2.8) to support the continuity and coordination of covered physical and behavioral health services and the collaboration between physical health and behavioral health providers.

2.9.5.8 Monitoring

The CONTRACTOR shall evaluate and monitor the effectiveness of its policies and procedures regarding the continuity and coordination of covered physical and behavioral health services and collaboration between physical and behavioral health providers. This shall include, but not be limited to, an assessment of the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs; an evaluation of the appropriateness of psychopharmacological medication; and analysis of data regarding access to appropriate services. Based on these monitoring activities, the CONTRACTOR shall develop and implement interventions to improve continuity, coordination, and collaboration for physical and behavioral health services.

2.9.6 **Coordination and Collaboration Among Behavioral Health Providers**

2.9.6.1 The CONTRACTOR shall ensure communication and coordination between mental health providers and substance abuse providers, including:

2.9.6.1.1 Assignment of a responsible party to ensure communication and coordination occur;

2.9.6.1.2 Determination of the method of mental health screening to be completed by substance abuse service providers;

2.9.6.1.3 Determination of the method of substance abuse screening to be completed by mental health service providers;

2.9.6.1.4 Description of how treatment plans will be coordinated between behavioral health service providers; and

2.9.6.1.5 Assessment of cross training of behavioral health providers: mental health providers being trained on substance abuse issues and substance abuse providers being trained on mental health issues.

2.9.6.2 The CONTRACTOR shall ensure coordination between the children and adolescent service delivery system as they transition into the adult mental health service delivery system, through such activities as communicating treatment plans and exchange of information.

2.9.6.3 The CONTRACTOR shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:

2.9.6.3.1 The outpatient provider must be involved in the admissions process when possible; if the outpatient provider is not involved, the outpatient provider must be notified promptly of the member’s hospital admission;

2.9.6.3.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan in which the member has participated (an outpatient visit must be scheduled before discharge, which ensures access to proper provider/medication follow-up; also, an appropriate placement or housing site must be secured prior to discharge);

2.9.6.3.3 An evaluation must be performed prior to discharge to determine if mental health case management services are medically necessary. Once deemed medically necessary, the mental health case manager must be involved in discharge planning; if there is no mental health case manager, then the outpatient provider must be involved; and

2.9.6.3.4 A procedure to ensure continuity of care regarding medication must be developed and implemented.

2.9.6.4 The CONTRACTOR shall identify and develop community alternatives to inpatient hospitalization for those members who are receiving inpatient psychiatric facility services who could leave the facility if appropriate community or residential care alternatives were available in the community. In the event the CONTRACTOR does not provide appropriate community alternatives, the CONTRACTOR shall remain financially responsible for the continued inpatient care of these individuals.

2.9.6.5 The CONTRACTOR is responsible for providing a discharge plan as outlined in Section 2.9.6.3.2.

2.9.7 **Coordination of Pharmacy Services**

2.9.7.1 The CONTRACTOR is not responsible for the provision and payment of pharmacy benefits; TENNCARE contracts with a pharmacy benefits manager (PBM) to provide these services. However, the CONTRACTOR shall coordinate with the PBM as necessary to ensure that members receive appropriate pharmacy services without interruption. The CONTRACTOR shall monitor and manage its contract providers as it relates to prescribing patterns and its members as it relates to utilization of prescription drugs. The CONTRACTOR shall participate in regularly scheduled meetings with the PBM and TENNCARE to discuss operational and programmatic issues.

2.9.7.2 The CONTRACTOR shall accept and maintain prescription drug data from TENNCARE or its PBM.

2.9.7.3 The CONTRACTOR shall monitor and manage members by, at a minimum, conducting the activities as described below:

2.9.7.3.1 Analyzing prescription drug data and/or reports provided by the PBM to identify high-utilizers and other members who inappropriately use pharmacy services and assign them to the MCO case management and/or disease management programs as appropriate;

2.9.7.3.2 Analyzing prescription drug data and/or reports provided by the PBM to identify potential pharmacy lock-in candidates and referring them to TENNCARE; and

2.9.7.3.3 Regularly providing information to members about appropriate prescription drug usage. At a minimum, this information shall be included in the Member Handbook and in at least two (2) quarterly member newsletters within a twelve (12) month period.

2.9.7.4 The CONTRACTOR shall monitor and manage providers' prescription patterns by, at a minimum, conducting the activities described below:

2.9.7.4.1 Collaborating with the PBM to educate the MCO's contract providers regarding compliance with the State's preferred drug list (PDL) and appropriate prescribing practices; and

2.9.7.4.2 Intervening with contract providers whose prescribing practices appear to be operating outside industry or peer norms as defined by TENNCARE, are non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns, and/or who are failing to follow required prior authorization processes and procedures. The goal of these interventions will be to improve prescribing practices among the identified contract providers, as appropriate. Interventions shall be personal and one-on-one.

2.9.7.5 At any time, upon request from TENNCARE, the CONTRACTOR shall provide assistance in educating, monitoring and intervening with providers. For example, TENNCARE may require assistance in monitoring and intervening with providers regarding prescribing patterns for narcotics.

2.9.8 **Coordination of Dental Benefits**

2.9.8.1 General

2.9.8.1.1 The CONTRACTOR is not responsible for the provision and payment of dental benefits; TENNCARE contracts with a dental benefits manager (DBM) to provide these services.

2.9.8.1.2 As provided in Section 2.6.1.3, the CONTRACTOR is responsible for transportation to and from dental services as well as the facility, medical and anesthesia services related to medically necessary and approved dental services that are not provided by a dentist or in a dentist's office.

2.9.8.1.3 The CONTRACTOR may require prior authorization for transportation, facility, anesthesia, and/or medical services related to the dental service; however, the CONTRACTOR may waive authorization of said services based on authorization of the dental services by the dental benefits manager.

2.9.8.2 Services and Responsibilities

The CONTRACTOR shall coordinate with the DBM for dental services. Coordination of dental services, at a minimum, includes establishing processes for:

2.9.8.2.1 Means for referral that ensures immediate access for emergency care and provision of urgent and routine care according to TennCare guidelines for specialty care (see Attachment III);

2.9.8.2.2 Means for the transfer of information (to include items before and after the visit);

2.9.8.2.3 Maintenance of confidentiality;

2.9.8.2.4 Resolving disputes related to prior authorizations and claims and payment issues; and

2.9.8.2.5 Cooperation with the DBM regarding training activities provided by the DBM.

2.9.8.3 Operating Principles

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

2.9.8.4 Resolution of Requests for Prior Authorization

2.9.8.4.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, that any dispute concerning which party should respond to a request for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a TennCare enrollee. The CONTRACTOR shall require that its care coordinators will, in addition to their responsibilities for care coordination, deal with issues related to requests for prior authorization that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR shall provide the DBM with a list of its care coordinators and telephone number(s) at which each care coordinator may be contacted. When the CONTRACTOR receives a request for prior authorization from a provider for a member and the CONTRACTOR believes the service is the responsibility of the DBM, the CONTRACTOR's care coordinator shall contact the DBM's care coordinator by the next business day after receiving the request for prior authorization. The care coordinator shall also contact the member and or member's provider. For routine requests contact to the member or member's provider shall be made within fourteen (14) days or less of the provider's request for prior authorization and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations. For urgent requests, contact shall be made immediately after receiving the request for prior authorization.

2.9.8.4.2 The CONTRACTOR shall assign staff members to serve on a coordination committee with DBM staff members. This committee shall be responsible for addressing all issues of dental care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the

terms of this Agreement. The CONTRACTOR and the DBM will attempt in good faith to resolve any dispute and communicate the decision to the provider requesting prior authorization of a service. In the event the CONTRACTOR and the DBM cannot agree within ten (10) calendar days of the provider's request for prior authorization, the party who first received the request from the provider will be responsible for prior authorization and payment to the contract provider within the time frames designated by TENNCARE. The CONTRACTOR and the DBM are responsible for enforcing hold harmless protection for the member. The CONTRACTOR shall ensure that any response to a request for authorization shall not exceed fourteen (14) calendar days and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations.

2.9.8.5 Claim Resolution Processes

2.9.8.5.1 The CONTRACTOR shall designate one or more claims coordinators to deal with issues related to claims and payment issues that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR agrees and recognizes that the DBM has agreed through its contractual arrangement with the State, to also designate one or more claims coordinators to deal with issues related to claims and payment issues that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR shall provide the DBM and TennCare, with a list of its claims coordinators and telephone number(s) at which each claims coordinator may be contacted.

2.9.8.5.2 When the CONTRACTOR receives a disputed claim for payment from a provider for a member and believes care is the responsibility of the DBM, the CONTRACTOR's claims coordinators shall contact the DBM's claims coordinators within four (4) calendar days of receiving such claim for payment. If the CONTRACTOR's claims coordinators are unable to reach agreement with the DBM's claims coordinators on which party is responsible for payment of the claim, the claim shall be referred to the Claims Coordination Committee (described below) for review.

2.9.8.5.3 The CONTRACTOR shall assign claims coordinators and other representatives, as needed, to a joint CONTRACTOR/DBM Claims Coordination Committee. The number of members serving on the Claims Coordination Committee shall be determined within ten (10) calendar days of the execution of this Agreement by the mutual agreement of the DBM and MCO. The CONTRACTOR shall, at a minimum, assign two (2) representatives to the committee. The make-up of the committee may be revisited from time to time during the term of this Agreement, the Claims Coordination Committee shall review any disputes and negotiate responsibility between the CONTRACTOR and the DBM. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party shall reimburse and abide by the prior decisions of that party. Reimbursement shall be made within ten (10) calendar days of the Claims Coordination Committee's decision.

2.9.8.5.4 If the Claims Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) calendar days of the initial referral to the Claims Coordination Committee, said claim shall be referred to the both the

CONTRACTOR's and the DBM's CEO or the CEO's designee, for resolution immediately. A meeting shall be held among the CEOs or their designee(s), as soon as possible, but not longer than ten (10) calendar days after the meeting of the Claims Coordination Committee.

2.9.8.5.5 If the meeting between the CEOs, or their designee(s), of the DBM and MCO does not successfully resolve the dispute within ten (10) calendar days, the parties shall, within fourteen (14) calendar days of the meeting, submit a Request for Resolution of the dispute to the State or the State's designee for a decision on responsibility.

2.9.8.5.6 The process before the submission of a Request for Resolution as described above, shall be completed within thirty (30) calendar days of receiving the claim for payment. In the event the parties cannot agree within thirty (30) calendar days of receiving the claim for payment, the MCO and the DBM will be responsible for enforcing hold harmless protections for the member and the party who first received the request or claim from the provider will be responsible for authorization and payment to the provider in accordance with the requirements of the MCO's and DBM's respective Agreement/contract with the State of Tennessee. Moreover, the party that first received the request or claim from the provider must also make written request of all requisite documentation for payment and must provide written reasons for any denial.

2.9.8.5.7 The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable Agreement/contract provisions, and the position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party. The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of the Request for Resolution. The Response shall contain the same information required of the Request for Resolution. Failure to timely file a Response or obtain an extension from the State shall be deemed a waiver of any objections to the Request for Resolution.

2.9.8.5.8 The State, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) calendar days of the receipt of the required information ("Decision"). The "Decision" may reflect a split payment responsibility that designates specific proportions to be paid by the MCO and the DBM. The "Decision" shall be determined solely by the State, or its designee based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the State, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars ($1,000) for each Request for Resolution. The amount of the DBM's or MCO's payment responsibility shall be contained in the State's Decision. These payments may be made with reservation of rights regarding any judicial resolution. If a party fails to pay the State for the party's payment responsibility as described in this Section, Section 2.9.8.5.8, within thirty (30) calendar days of the date of the State's Decision, the State may deduct amounts of the payment responsibility from any current or future amount owed the party by the State.

2.9.8.6 Denial, Delay, Reduction, Termination or Suspension

The CONTRACTOR agrees that any claims payment dispute or request for authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate services to a TennCare member. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim must be approved or disapproved based on the definition of emergency services specified in this Agreement.

2.9.8.7 Emergencies

Prior authorization shall not be required for emergency services prior to stabilization.

2.9.8.8 Claims Processing Requirements

All claims must be processed in accordance with the requirements of the MCO's and DBM's respective Agreements/contracts with the State of Tennessee.

2.9.8.9 Appeal of Decision

Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, TCA 4-5-201 *et seq*. Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section, Section 2.9.8.9.

2.9.8.10 Duties and Obligations

The existence of any dispute under this Agreement shall in no way affect the duty of the CONTRACTOR and the DBM to continue to perform their respective obligations, including their obligations established in their respective Agreements/contracts with the State pending resolution of the dispute under this Section, Section 2.9.8.10. In accordance with TCA 56-32-226(b), a provider may elect to resolve the claims payment dispute through independent review.

2.9.8.11 Confidentiality

2.9.8.11.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, to cooperate with the State to develop confidentiality guidelines that (1) meet state, federal, and other regulatory requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both DBM and MCO standards. These standards shall apply to both DBM's and MCO's providers and staff. If the CONTRACTOR believes that the standards require updating, or operational changes are needed to enforce the standards, the CONTRACTOR shall meet with the DBM to resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

2.9.8.11.2 The DBM and MCO shall ensure all materials and information directly or indirectly identifying any current or former member which is provided to or obtained by or through the MCO's or DBM's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of TCA 33-4-22 of this Agreement, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, unless required by applicable law, shall not be disclosed except in accordance with those statutes or to the TennCare Bureau, and CMS, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former member or potential member.

2.9.8.12 Access to Service

The MCO agrees and recognizes that the DBM has agreed through its contractual arrangement with the State, to establish methods of referral which ensure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

2.9.9 **Coordination with Medicare**

2.9.9.1 The CONTRACTOR is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare.

2.9.9.2 The CONTRACTOR shall ensure that services covered and provided pursuant to this Agreement are delivered without charge to members who are dually eligible for Medicare and Medicaid services.

2.9.9.3 The CONTRACTOR shall coordinate with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.

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2.9.10 **Institutional Services and Alternatives to Institutional Services**

2.9.10.1 For members enrolled in the long-term care program, the CONTRACTOR is not responsible for long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or for services provided through Home and Community Based Services (HCBS) waivers as an alternative to these institutional services. These services shall be provided to qualified members as described in TennCare rules and regulations through contracts between TENNCARE and appropriate providers.

2.9.10.2 The CONTRACTOR is responsible for covered services for members residing in long-term care institutions or enrolled in a HCBS waiver. The CONTRACTOR is responsible for those TennCare covered benefits that are not included in the per diem reimbursement for institutional services (e.g., prosthetics, some items of durable medical equipment, non–emergency ambulance transportation, and non-emergency transportation) or are not provided through the HCBS waiver. Covered benefits that are not provided by TENNCARE through the long-term care institution or HCBS waiver shall be the responsibility of the CONTRACTOR.

2.9.10.3 The CONTRACTOR shall coordinate the provision of covered services with institutional and HCBS waiver providers to minimize disruption and duplication of services.

2.9.10.4 The CONTRACTOR shall use its best efforts to increase the use of HCBS waivers as an alternative to long-term care institutions. This should include educating members entering or recently admitted to a long-term care institution, as well as their providers, about available HCBS waivers and coordinating with the Commission on Aging and Disability and TennCare Bureau, Long Term Care Division, as needed and as requested by TENNCARE.

2.9.11 **Inter-Agency Coordination**

The CONTRACTOR shall coordinate with other state and local departments and agencies to ensure that coordinated care is provided to members. This includes, but is not limited to, coordination with:

2.9.11.1 Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) and Tennessee Department of Children's Services (DCS) for the purpose of interfacing with and assuring continuity of care;

2.9.11.2 Tennessee Department of Health (DOH), for the purposes of establishing and maintaining relationships with member groups and health service providers;

2.9.11.3 Tennessee Department of Human Services (DHS) and DCS Protective Services Section, for the purposes of reporting and cooperating in the investigation of abuse and neglect;

2.9.11.4 The Division of Mental Retardation Services (DMRS), for the purposes of interfacing with and assuring continuity of care;

2.9.11.5 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;

2.9.11.6 Commission on Aging and Disability and TennCare Bureau, Long Term Care Division for the purposes of coordinating care for members requiring long-term care services; and

2.9.11.7 Local law enforcement agencies and hospital emergency rooms for the purposes of crisis service provider relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.

2.10 SERVICES NOT COVERED

Except as authorized pursuant to Section 2.6.5 of this Agreement, the CONTRACTOR shall not pay for non-covered services as described in TennCare rules and regulations.

2.11 PROVIDER NETWORK

2.11.1 General Provisions

2.11.1.1 The CONTRACTOR shall provide or ensure the provision of all covered services specified in Section 2.6.1 of this Agreement. Accessibility of covered services, including geographic access and appointments and wait times shall be in accordance with the Terms and Conditions for Access which is part of the TennCare waiver and is contained herein as Attachment III, the Specialty Network Standards in Attachment IV, the Access and Availability for Behavioral Health Services in Attachment V and the requirements herein. These minimum requirements are not intended to release the CONTRACTOR from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members, whether specified above or not.

2.11.1.2 The CONTRACTOR may provide covered services directly or may enter into written agreements with providers and provider subcontracting entities or organizations that will provide covered services to the members in exchange for payment by the CONTRACTOR for services rendered.

2.11.1.3 Should the CONTRACTOR elect to contract with providers (as opposed to using staff providers) and develop a network for the provision of covered services, the CONTRACTOR shall:

2.11.1.3.1 Not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program;

2.11.1.3.2 Consider: the anticipated TennCare enrollment; the expected utilization of services, taking into consideration the characteristics of specific TennCare populations included in this Agreement; the number and types of providers required to furnish TennCare services; the number of contract providers who are not accepting new members; and the geographic location of providers and TennCare members, considering distance, travel time, the means of transportation ordinarily used by TennCare members, and whether the location provides physical access for members with disabilities;

2.11.1.3.3 Have in place, written policies and procedures for the selection and retention of providers. These policies and procedures must not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment;

2.11.1.3.4 Not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. The CONTRACTOR's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination;

2.11.1.3.5 Give affected providers written notice if it declines to include individual or groups of providers in its network; and

2.11.1.3.6 Maintain all provider agreements in accordance with the provisions specified in 42 CFR 438.12, 438.214 and Section 2.12 of this Agreement.

2.11.1.4 Section 2.11.1.3 shall not be construed to:

2.11.1.4.1 Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its members and the access standards of this Agreement;

2.11.1.4.2 Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different providers in the same specialty; or

2.11.1.4.3 Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

2.11.1.5 The CONTRACTOR may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

2.11.1.5.1 The member's health status, medical or behavioral health care, or treatment options, including any alternative treatment that may be self administered;

2.11.1.5.2 Any information the member needs in order to decide among all relevant treatment options;

2.11.1.5.3 The risks, benefits, and consequences of treatment or non-treatment; or

2.11.1.5.4 The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2.11.1.6 Prior to including a provider on the *Provider Enrollment File* (see Section 2.30.7.1) and/or paying a provider's claim, the CONTRACTOR shall ensure that the provider has obtained a Medicaid provider number from TENNCARE.

2.11.1.7 If a member requests a provider located outside the access standards, and the CONTRACTOR has an appropriate provider within the access requirements who accepts new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall not be responsible for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider.

2.11.1.8 If the CONTRACTOR is unable to meet the access standards for a member, the CONTRACTOR shall provide transportation regardless of whether the member has access to transportation.

2.11.1.9 If the CONTRACTOR is unable to provide medically necessary covered services to a particular member using contract providers, the CONTRACTOR shall adequately and timely cover these services for that member using non-contract providers, for as long as the CONTRACTOR's provider network is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the member can be safely transferred, the CONTRACTOR may transfer the member to an appropriate contract provider as specified in Section 2.9.2.

2.11.1.10 The CONTRACTOR shall monitor provider compliance with applicable access requirements, including but not limited to appointment and wait times and take corrective action for failure to comply. The CONTRACTOR shall conduct surveys and office visits to monitor compliance with appointment waiting time standards and shall report findings and corrective actions to TENNCARE in accordance with Section 2.30.7.2.

2.11.1.11 The CONTRACTOR shall use its best efforts to contract with providers to whom the CONTRACTOR routinely refers members.

2.11.1.12 To demonstrate sufficient accessibility and availability of covered services, the CONTRACTOR shall comply with all reporting requirements specified in Section 2.30.7.

2.11.2 **Primary Care Providers (PCPs)**

2.11.2.1 With the exception of members dually eligible for Medicare and TennCare, the CONTRACTOR shall ensure that each member has an identified PCP, as defined in Section 1, who is responsible for coordinating the covered services provided to the member.

2.11.2.2 The CONTRACTOR shall ensure that there are PCPs willing and able to provide the level of care and range of services necessary to meet the medical and behavioral health needs of its members, including those with chronic conditions. There shall be a sufficient number of PCPs who accept new TennCare members within the CONTRACTOR's service area so that the CONTRACTOR meets the Terms and Conditions for Access provided in Attachment III.

2.11.2.3 To the extent feasible and appropriate, the CONTRACTOR shall offer each member (other than members who are dually eligible for Medicare and TennCare) the opportunity to select a PCP.

2.11.2.4 The CONTRACTOR may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities, acute, or chronic conditions, as determined by the CONTRACTOR) to select their attending specialists as their PCP so long as the specialist is willing to perform responsibilities of a PCP as defined in Section 1.

2.11.2.5 If a member who is not dually eligible for Medicare and TennCare fails or refuses to select a PCP from those offered within thirty (30) calendar days of enrollment, the CONTRACTOR shall assign a PCP. The CONTRACTOR may assign a PCP in less than thirty (30) calendar days if the CONTRACTOR provides the enrollee an opportunity to change PCPs upon receipt of notice of PCP assignment.

2.11.2.6 The CONTRACTOR shall establish policies and procedures to enable members reasonable opportunities to change PCPs. Such policies and procedures may not specify a length of time greater than twelve (12) months between PCP changes under normal circumstances. If the ability to change PCPs is limited, the CONTRACTOR must include provisions for more frequent PCP changes with good cause. The policies and procedures shall include a definition of good cause as well as the procedures to request a change.

2.11.2.7 If a member requests assignment to a PCP located outside the distance/time requirements in Attachment III and the CONTRACTOR has PCPs available within the distance/time requirements who accept new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall have no responsibility for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider. In these cases, the CONTRACTOR must allow the member to change assignment to a PCP within the distance/time requirements at any time if the member requests such a change.

2.11.3 **Specialty Service Providers**

2.11.3.1 Essential Hospital Services and Centers of Excellence

2.11.3.1.1 The CONTRACTOR shall demonstrate sufficient access to essential hospital services which means that, at a minimum, in each Grand Region served by the CONTRACTOR, the CONTRACTOR shall demonstrate a contractual arrangement with at least one (1) tertiary care center for each of the following:

2.11.3.1.1.1 Neonatal services;

2.11.3.1.1.2 Perinatal services;

2.11.3.1.1.3 Pediatric services;

2.11.3.1.1.4 Trauma services; and

2.11.3.1.1.5 Burn services.

2.11.3.1.2 The CONTRACTOR shall demonstrate sufficient access to comprehensive care for people with HIV/AIDS which means that, at a minimum, in each Grand Region in which the CONTRACTOR operates, the CONTRACTOR shall demonstrate a contractual arrangement with at least two (2) HIV/AIDS Centers of Excellence located within the CONTRACTOR's approved Grand Region(s). HIV/AIDS centers of Excellence are designated by the DOH.

2.11.3.1.3 The CONTRACTOR shall demonstrate a contractual arrangement with all Centers of Excellence for Behavioral Health located within the Grand Region(s) served by the CONTRACTOR.

2.11.3.2 Physician Specialists

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

2.11.3.2.1.1 The CONTRACTOR has signed provider agreements with providers of the specialty types listed in Attachment IV who accept new TennCare enrollees and are available on at least a referral basis; and

2.11.3.2.1.2 The CONTRACTOR is in compliance with the access and availability requirements in Attachments III, IV, and V

2.11.3.3 TENNCARE Monitoring

2.11.3.3.1 TENNCARE will monitor CONTRACTOR compliance with specialty network standards on an ongoing basis. TENNCARE will use data from the monthly *Provider Enrollment File* required in Section 2.30.7.1, to verify compliance with the specialty network requirements. TENNCARE will use these files to confirm the CONTRACTOR has a sufficient number and distribution of physician specialists and in conjunction with MCO enrollment data to calculate member to provider ratios. TENNCARE will also periodically phone providers listed on these reports to confirm that the provider is a contract provider as reported by the CONTRACTOR. TENNCARE shall also monitor appeals data for indications that problems exist with access to specialty providers.

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

2.11.3.3.2.1 Twenty-five percent (25%) or more of non-dual members do not have access to one or more of the physician specialties listed in Attachment IV within sixty (60) miles;

2.11.3.3.2.2 Any non-dual member does not have access to one or more of the physician specialties listed in Attachment IV within ninety (90) miles; or

2.11.3.3.2.3 The member to provider ratio exceeds that listed in Attachment IV.

2.11.3.3.3 TENNCARE will review all corrective action plans and determine, based on the actions proposed by the CONTRACTOR, appeals data, and the supply of specialty providers available to non-TennCare members, whether the corrective action plan will be accepted. Corrective action plans shall include, at a minimum, the following:

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

2.11.3.3.3.2 A list of providers with name, location, and expected date of provider agreement execution with whom the CONTRACTOR is currently negotiating a provider agreement and, if the provider becomes a contract provider would resolve the specialty network deficiency;

2.11.3.3.3.3 For those deficiencies that are not resolved, a detailed account of attempts to secure an agreement with each provider that would resolve the deficiency. This shall include the provider name(s), address(es), date(s) contacted, and a detailed explanation as to why the CONTRACTOR is unable to secure an agreement, e.g., lack of provider willingness to participate in the TennCare program, provider prefers to limit access to practice, or rate requests are inconsistent with TennCare actuarial assumptions;

2.11.3.3.3.4 A listing of non-contract providers, including name and location, who are being used to provide the deficient specialty provider services and the rates the CONTRACTOR is currently paying these non-contract providers;

2.11.3.3.3.5 Affirmation that transportation will be provided for members to obtain services from providers who are willing to provide services to members but do not meet the specialty network standards;

2.11.3.3.3.6 Documentation of how these arrangements are communicated to the member; and

2.11.3.3.3.7 Documentation of how these arrangements are communicated to the PCPs.

2.11.3.4 Weight Watchers

The CONTRACTOR shall include in its network the Weight Watchers regional center in the Grand Region(s) in which the CONTRACTOR operates.

2.11.4 **Special Conditions for Prenatal Care Providers**

2.11.4.1 The CONTRACTOR shall have a sufficient number of contract providers who accept members in accordance with TennCare access standards in Attachment III so that prenatal or other medically necessary covered services are not delayed or denied to pregnant women at any time, including during their presumptive eligibility period. Additionally, the CONTRACTOR shall make services available from non-contract providers, if necessary, to provide medically necessary covered services to a woman enrolled in the CONTRACTOR's MCO.

2.11.4.2 Regardless of whether prenatal care is provided by a PCP, physician extender or an obstetrician who is not the member's PCP, the access standards for PCP services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible for TennCare. For women who are past their first trimester of pregnancy on the day they are determined to be eligible, a first prenatal care appointment shall occur within fifteen (15) calendar days of the day they are determined to be eligible. Failure to do so shall be considered a material breach of the provider's provider agreement with the CONTRACTOR (see Sections 2.7.4.2. and 2.11.4).

2.11.5 **Special Conditions for Behavioral Health Services**

2.11.5.1 At the direction of the State, the CONTRACTOR shall divert new admissions to other inpatient facilities to ensure that the Regional Mental Health Institutes do not operate above their licensed capacity.

2.11.5.2 The CONTRACTOR shall identify, develop or enhance existing mental health and/or substance abuse inpatient and residential treatment capacity for adults and adolescents with a co-occurring mental health and substance abuse disorder.

2.11.5.3 The CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by TENNCARE unless the State approves the use of other crisis service providers.

2.11.6 **Safety Net Providers**

2.11.6.1 Federally Qualified Health Centers (FQHCs)

2.11.6.1.1 The CONTRACTOR is encouraged to contract with FQHCs and other safety net providers (e.g., rural health clinics) in the CONTRACTOR's service area to the extent possible and practical. Where FQHCs are not utilized, the CONTRACTOR must demonstrate to DHHS, the Tennessee DHS and TENNCARE that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in the CONTRACTOR's service area without contracting with FQHCs.

2.11.6.1.2 FQHC reporting information shall be submitted to TENNCARE as described in Section 2.30.7.6 of this Agreement.

2.11.6.2 Community Mental Health Agencies (CMHAs)

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

2.11.6.3 Local Health Departments

The CONTRACTOR shall contract with each local health department in the Grand Region(s) served by the CONTRACTOR for the provision of TENNderCare screening services until such time as the CONTRACTOR achieves an adjusted periodic screening percentage of eighty percent (80%) or greater. Payment to local health departments shall be in accordance with Section 2.13.4.

2.11.7 Credentialing and Other Certification

2.11.7.1 Credentialing of Contract Providers

The CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentailing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

2.11.7.2 Credentialing of Non-Contract Providers

The CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the CONTRACTOR selects and directs its members to see a specific provider or group of providers.

2.11.7.3 Credentialing of Behavioral Health Entities

2.11.7.3.1 The CONTRACTOR shall ensure each behavioral health provider's service delivery site meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approval per state requirements.

2.11.7.3.2 When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the CONTRACTOR to ensure, based on applicable state licensure rules and/or programs standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

2.11.7.4 Compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988

The CONTRACTOR shall require that all laboratory testing sites providing services under this Agreement have either a current CLIA certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificate of registration may perform a full range of laboratory tests. The CONTRACTOR shall comply with the provisions of CLIA 1988.

2.11.7.5 Weight Watchers Centers

The CONTRACTOR is not required to credential the Weight Watchers centers(s) referenced in Section 2.11.3.4 of this Agreement.

2.11.8 Network Notice Requirements

2.11.8.1 Member Notification

All member notices required shall be written using the notice template provided by TENNCARE and shall include all notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.

2.11.8.1.1 *Change in PCP*

The CONTRACTOR shall immediately provide written notice to a member when the CONTRACTOR changes the member's PCP. The notice shall be issued in advance of the PCP change when possible or as soon as the CONTRACTOR becomes aware of the circumstances necessitating a PCP change.

2.11.8.1.2 *PCP Termination*

If a PCP ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who has chosen or been assigned to that provider as their PCP. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2.11.8.1.3 *Providers Providing Ongoing Treatment Termination*

If a member is in a prior authorized ongoing course of treatment with any other contract provider who becomes unavailable to continue to provide services to such member and the CONTRACTOR is aware of such ongoing course of treatment, the CONTRACTOR shall provide written notice to each member as soon as possible but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2.11.8.1.4 *Non-PCP Provider Termination*

If a non-PCP provider, including but not limited to a specialist or hospital, ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice to members who have been patients of the non-PCP provider. Notice shall be issued no less than thirty (30) days prior to the effective date of the termination of the non-PCP provider when possible or immediately upon the CONTRACTOR becoming aware of the termination.

2.11.8.1.5 *Network Deficiency*

Upon notification from TENNCARE that a corrective action plan designed to remedy a network deficiency has not been accepted, the CONTRACTOR shall immediately provide written notice to members living in the affected area of a provider shortage in the CONTRACTOR's network.

2.11.8.2 TENNCARE Notification

2.11.8.2.1 *Subcontractor Termination*

When a subcontract that relates to the provision of services to members or claims processing is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCI. Said notices shall include, at a minimum: a CONTRACTOR's intent to change to a new subcontractor for the provision of said services; an effective date for termination and/or change; and any other pertinent information that may be needed to access services. In addition to prior written notice, the CONTRACTOR shall also provide a transition plan to TENNCARE within fifteen (15) calendar days, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition and how continuity of care will be maintained for the members.

2.11.8.2.2 *Hospital Termination*

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

2.11.8.2.3 *Other Provider Terminations*

2.11.8.2.3.1 The CONTRACTOR shall notify TENNCARE of any provider termination and shall submit a copy of one of the member notices sent as well as an electronic listing identifying each member to whom a notice was sent within five (5) business days of the date the member notice was sent as required in Section 2.11.8.1. The CONTRACTOR shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TENNCARE. If the termination was initiated by the provider, the notice to TENNCARE shall include a copy of the provider's notification to the CONTRACTOR.

2.11.8.2.3.2 If termination of the CONTRACTOR's provider agreement with any PCP or physician group or clinic, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Section 2.11 and Attachments III, IV and V, such termination shall be reported by the CONTRACTOR in writing to TENNCARE, in the standard format provided by TENNCARE to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

2.12 PROVIDER AGREEMENTS

2.12.1 Provider agreements, as defined in Section 1 of this Agreement, shall be administered in accordance with this Agreement and must contain all of the items listed in this Section 2.12.

2.12.2 All template provider agreements and revisions thereto must be approved in advance by TDCI in accordance with statutes regarding the approval of a certificate of authority (COA) and any material modifications thereof.

2.12.3 The CONTRACTOR shall revise provider agreements as directed by TENNCARE.

2.12.4 All single case agreements shall be reported to TENNCARE in accordance with Section 2.30.8; however, prior approval will not be required unless TENNCARE determines, upon review of said reports, that it appears single case agreements are being used to circumvent the provider agreement review and approval process.

2.12.5 No provider agreement terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Agreement are carried out. It shall be the responsibility of the CONTRACTOR to provide all necessary training and information to providers to ensure satisfaction of all CONTRACTOR responsibilities as specified in this Agreement.

2.12.6 The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program.

2.12.7 All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, shall, at a minimum, meet the following requirements:

2.12.7.1 Be in writing. All new provider agreements and existing provider agreements as they are renewed, must include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties;

2.12.7.2 Specify the effective dates of the provider agreement;

2.12.7.3 Specify that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;

2.12.7.4 Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without the prior approval of the CONTRACTOR;

2.12.7.5 Identify the population covered by the provider agreement;

2.12.7.6 Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

2.12.7.7 Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;

2.12.7.8 Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section 2.10 of this Agreement and the TennCare rules and regulations;

2.12.7.9 Provide that emergency services be rendered without the requirement of prior authorization of any kind;

2.12.7.10 Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care will be considered a material breach of the provider's agreement with the CONTRACTOR and include definition of unreasonable delay as described in Section 2.7.4.2.3 of this Agreement;

2.12.7.11 If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

2.12.7.12 Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the provider agreement (behavioral health records must be maintained at the provider level for ten (10) years after the termination of the provider agreement pursuant to TCA 33-3-101) or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions);

2.12.7.13 Include a statement that as a condition of participation in TennCare, enrollees shall give TENNCARE, the Office of the Comptroller, and any health oversight agency, such as OIG, MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic

monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Comptroller personnel, including, but not limited to, the OIG, the MFCU, the DHHS OIG and the DOJ;

2.12.7.14 Include medical records requirements found in Section 2.24.4 of this Agreement ;

2.12.7.15 Contain the language described in Section 2.25.6 of this Agreement regarding Audit Requirements and Section 2.25.5 of this Agreement regarding Availability of Records;

2.12.7.16 Provide that TENNCARE, DHHS OIG, Comptroller, OIG, MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, MFCU, DHHS OIG, DOJ, Office of the Comptroller, may use these records and information for administrative, civil or criminal investigations and prosecutions;

2.12.7.17 Provide for monitoring, whether announced or unannounced, of services rendered to members;

2.12.7.18 Provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE;

2.12.7.19 Specify CONTRACTOR's responsibilities under this Agreement and its agreement with the provider, including but not limited to, provision of a copy of the member handbook and provider handbook whether via web site or otherwise and requirement that the CONTRACTOR notice a provider of denied authorizations;

2.12.7.20 Specify that the CONTRACTOR shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical or behavioral health care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;

2.12.7.21 Require that the provider comply with corrective action plans initiated by the CONTRACTOR;

2.12.7.22 Provide for the timely submission of all reports and clinical information required by the CONTRACTOR;

2.12.7.23 Provide the name and address of the official payee to whom payment shall be made;

2.12.7.24 Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR;

2.12.7.25 Provide for prompt submission of information needed to make payment. Specify that a provider shall have one hundred twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the MCO with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment;

2.12.7.26 Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in TCA 56-32-226 and Section 2.22.4 of this Agreement;

2.12.7.27 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus the amount of any applicable TennCare cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable TennCare cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the enrollee being served;

2.12.7.28 Specify that in the event that TENNCARE deems the CONTRACTOR unable to timely process and reimburse claims and requires the CONTRACTOR to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the CONTRACTOR's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;

2.12.7.29 Specify the provider's responsibilities and prohibited activities regarding cost sharing as provided in Section 2.6.7 of this Agreement;

2.12.7.30 Specify the provider's responsibilities regarding third party liability (TPL);

2.12.7.31 For those agreements where the provider is compensated via a capitation arrangement, language which requires:

2.12.7.31.1 That if a provider becomes aware for any reason that he or she is not entitled to a capitation payment for a particular enrollee (a patient dies, for example), the provider shall immediately notify both the CONTRACTOR and TENNCARE by certified mail, return receipt requested; and

2.12.7.31.2 The provider shall submit utilization or encounter data as specified by the CONTRACTOR so as to ensure the CONTRACTOR's ability to submit encounter data to TENNCARE that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims;

2.12.7.32 Require the provider to comply with fraud and abuse requirements described in Section 2.20 of this Agreement;

2.12.7.33 Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CONTRACTOR's members and the CONTRACTOR under the provider agreement. The provider shall maintain such insurance coverage at all times during the provider agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;

2.12.7.34 Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the CONTRACTOR and the provider. Provide that the agreement incorporates by reference all applicable federal law and state laws, TennCare rules and regulations, consent decrees or court orders, and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the provider agreement, as they become effective;

2.12.7.35 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the provider agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, then the terms must include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc);

2.12.7.36 Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 4.4 of this Agreement, the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the CONTRACTOR/provider agreement. The provision of such records shall be at no expense to TENNCARE;

2.12.7.37 Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the CONTRACTOR as provided at TCA 56-32-226(b);

2.12.7.38 Include a conflict of interest clause as stated in Section 4.19 of this Agreement, Gratuities clause as stated in Section 4.23 of this Agreement, and Lobbying clause as stated in Section 4.24 of this Agreement between the CONTRACTOR and TENNCARE;

2.12.7.39 Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the CONTRACTOR. This indemnification may be accomplished by incorporating Section 4.30 of the TENNCARE/CONTRACTOR Agreement in its entirety in the provider agreement or by use of other language developed by the CONTRACTOR and approved by TENNCARE;

2.12.7.40 Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Sections 2.27 and 4.32 of this Agreement;

2.12.7.41 Specify provider actions to improve patient safety and quality;

2.12.7.42 Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider will comply with the appeal process, including but not limited to the following:

2.12.7.42.1 Assist an enrollee by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review; and

2.12.7.42.2 Require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization or change or cancel the prescription when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).

2.12.7.43 Require the provider to coordinate with the TennCare PBM regarding authorization and payment for pharmacy services;

2.12.7.44 Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CONTRACTOR's request for information, the request to provide medical records, credentialing information, etc.; at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial consequences against the provider as appropriate;

2.12.7.45 Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. The CONTRACTOR shall ensure that providers have a correct and adequate supply of public notices;

2.12.7.46 Include language which informs providers of the package of benefits that TENNderCare offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. TENNderCare requirements are contained in Section 2.7.5 of this Agreement. All provider agreements must contain language that references the TENNderCare requirements in this Agreement between TENNCARE and the CONTRACTOR, and the provider agreement shall either physically incorporate these sections of the Agreement or include language to require that these sections be furnished to the provider upon request;

2.12.7.47 Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TENNCARE;

2.12.7.48 Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees;

2.12.7.49 Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;

2.12.7.50 Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B; and

2.12.7.51 Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the CONTRACTOR, such requirement shall be null and void and all other provisions shall remain in full force and effect.

2.12.8 No other terms or conditions agreed to by the CONTRACTOR and the provider shall negate or supersede the requirements listed in 2.12.7 above.

2.12.9 The provider agreement with a local health department (see Section 2.11.6.3) must meet the minimum requirements specified above and must also specify for the purpose of TENNderCare screening services: (1) that the local health department agrees to submit encounter data timely to the CONTRACTOR; (2) that the CONTRACTOR agrees to timely process claims for services in accordance with Section 2.22.4; (3) that the local health department may terminate the agreement for cause with thirty (30) days advance notice; and (4) that the CONTRACTOR agrees prior authorization shall not be required for the provision of TENNderCare screening services.

2.12.10 The provider agreement for CRG/TPG assessments shall meet the minimum requirements specified above and shall also specify that all CRG/TRG assessments detailed in Section 2.7.2.9 are completed by State-certified raters and that the assessments are completed within the specified time frames. The rater certification process shall include completing the CRG/TPG assessments training and passing the State rater competency examination, scored only by State-certified trainers.

2.13 PROVIDER AND SUBCONTRACTOR PAYMENTS

2.13.1 General

2.13.1.1 The CONTRACTOR must agree to reasonable reimbursement standards to providers for covered services, to be determined in conjunction with actuarially sound rate setting. All reimbursement paid by CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State.

2.13.1.2 The CONTRACTOR shall require, as a condition of payment, that the provider (contract or non-contract provider) accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service.

2.13.1.3 If the CONTRACTOR is required to reimburse a non-contract provider pursuant to this Agreement, and the CONTRACTOR's payment to a non-contract provider is less than it would have been for a contract provider, and the provider contests the payment amount, the CONTRACTOR shall notify the non-contract provider that the provider may initiate the independent review procedures in accordance with TCA 56-32-226, including but not limited to reconsideration by the CONTRACTOR.

2.13.1.4 The CONTRACTOR shall ensure that the member is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing amounts described in Section 2.6.7 and in Attachment II of this Agreement.

2.13.2 Hospice

If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR must pay an amount equal to at least ninety-five percent (95%) of the prevailing NF room and board rate to the hospice provider.

2.13.3 Behavioral Health Crisis Service Teams

2.13.3.1 The CONTRACTOR shall reimburse crisis mobile teams for their intervention services on a monthly basis at a rate to be determined and set by the State. The rate shall be factored into the CONTRACTOR's capitation payments.

2.13.3.2 The CONTRACTOR shall assume financial liability for crisis respite and crisis stabilization services.

2.13.4 Local Health Departments

2.13.4.1 The CONTRACTOR shall reimburse contracted local health departments (see Sections 2.11.6.3 and 2.12.9) for TENNderCare screenings to members under age twenty-one (21) at no less than the following rates, unless specified otherwise by TENNCARE. Although the codes include preventive visits for individuals twenty-one (21) and older, this Section only requires the CONTRACTOR to pay local health departments for the specified visits for members under age twenty-one (21).

Preventive Visits	85% of 2001 Medicare
99381 New pt. Up to 1 yr.	$80.33
99382 New pt. 1- 4 yrs.	$88.06
99383 New pt. 5 - 11yrs.	$86.60
99384 New pt. 12 - 17yrs.	$95.39
99385 New pt. 18 - 39 yrs.	$93.93
99391 Estab. pt. Up to 1 yr.	$63.04
99392 Estab. pt. 1 - 4 yrs.	$71.55
99393 Estab. pt. 5 - 11yrs.	$70.96
99394 Estab. pt. 12 - 17yrs.	$79.57
99395 Estab. pt. 18 - 39 yrs.	$78.99

2.13.4.2 TENNCARE may conduct an audit of the CONTRACTOR's reimbursement methodology and related processes on an annual basis to verify compliance with this requirement. In addition, the Local Health Department may initiate the independent review procedure at any time it believes the CONTRACTOR's payment is less than the required minimum reimbursement rate.

2.13.5 **Physician Incentive Plan (PIP)**

2.13.5.1 The CONTRACTOR shall notify and make TENNCARE and TDCI aware of any operations or plans to operate a physician incentive plan (PIP). Prior to implementation of any such plans, the CONTRACTOR shall submit to TDCI any provider agreement templates or subcontracts that involve a PIP for review as a material modification.

2.13.5.2 The CONTRACTOR shall not implement a PIP in the absence of TDCI TennCare Division review and approval.

2.13.5.3 If the CONTRACTOR operates a PIP, the CONTRACTOR shall ensure that no specific payment be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

2.13.5.4 If the CONTRACTOR operates a PIP, upon TENNCARE's request, the CONTRACTOR must report descriptive information about its incentive plan in sufficient detail to enable TENNCARE to adequately monitor the CONTRACTOR. The information that may be requested shall include, but not be limited to, the following:

2.13.5.4.1 Whether services not furnished by the physician or physician group are covered by the incentive plan;

2.13.5.4.2 The type or types of incentive arrangements, such as, withholds, bonus, capitation;

2.13.5.4.3 The percent of any withhold or bonus the plan uses;

2.13.5.4.4 Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection;

2.13.5.4.5 The patient panel size and, if the plan uses pooling, the pooling method; and

2.13.5.4.6 If the CONTRACTOR is required to conduct enrollee surveys, a summary of the survey results.

2.13.6 **Emergency Services Obtained from Non-Contract Providers**

2.13.6.1 Payments to non-contract providers for emergency services may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care services, as described in Section 1. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TennCare rules and regulations for emergency services provided by non-contract providers.

2.13.6.2 Payment by the CONTRACTOR for properly documented claims for emergency services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

2.13.6.3 The CONTRACTOR must review and approve or disapprove claims for emergency services based on the definition of emergency services specified in Section 1 of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency services does not meet the definition as specified in Section 1 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and time frames for reconsideration and subsequent steps regarding an informal review by TENNCARE. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency services, the provider may pursue the independent review process for disputed claims as provided by TCA 56-32-226, including but not limited to reconsideration by the CONTRACTOR.

2.13.7 **Medically Necessary Services Obtained from Non-Contract Provider when MCO Assignment is Unknown**

2.13.7.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a non-contract provider when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service. Examples of when this may occur include, but are not limited to, (i) when an enrollee receives services during a retroactive eligibility period (see Section 2.4.5) and the enrollee did not select an MCO and is assigned to an MCO by TENNCARE, or (ii) the enrollee was assigned to an MCO other than the one that he/she requested (see Section 2.4.4.5). In these cases, the effective date of enrollment may occur prior to the CONTRACTOR or the enrollee being notified of the enrollee becoming a member of the CONTRACTOR's MCO.

2.13.7.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services provided during this period of eligibility for lack of prior authorization or lack of referral; likewise, the CONTRACTOR shall not deny a claim

on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.8 **Medically Necessary Services Obtained from Contract Provider without Prior Authorization when MCO Assignment is Unknown**

2.13.8.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a contract provider without prior authorization or referral when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service.

2.13.8.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services for lack of prior authorization or lack of referral; likewise, a CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.9 **Medically Necessary Services Obtained from Non-Contract Provider Referred by Contract Provider**

The CONTRACTOR shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider. The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the CONTRACTOR if the member had received the services from a contract provider.

2.13.10 **Medically Necessary Services Obtained from Non-Contract Provider Not Authorized by the CONTRACTOR**

2.13.10.1 With the exception of circumstances described in Section 2.13.9, when an enrollee has utilized medically necessary non-emergency covered services from a non-contract provider, and the CONTRACTOR has not authorized such use in advance, the CONTRACTOR shall not be required to pay for the service(s) received unless payment is required pursuant to a directive from TENNCARE or an Administrative Law Judge.

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

2.13.11 **Covered Services Ordered by Medicare Providers for Dual Eligibles**

2.13.11.1 When a TennCare enrollee is dually eligible for Medicare and TennCare and requires services that are covered under this Agreement but are not covered by Medicare, and the services are ordered by a Medicare provider who is a non-contract provider, the CONTRACTOR must pay for the ordered, medically necessary service if it is provided by a contract provider.

2.13.11.2 Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider.

2.13.11.3 The CONTRACTOR shall not pay for non-covered services, services that are not medically necessary, or services ordered and obtained from non-contract providers.

2.13.12 **Transition of New Members**

Pursuant to the requirements in Section 2.9.2.1 regarding transition of new members, the CONTRACTOR shall not deny payment for the costs of continuation of medically necessary covered services provided by contract or non-contract providers for lack of prior authorization or lack of referral during the required time period for continuation of services. However, if, pursuant to Section 2.9.2.1, the CONTRACTOR requires prior authorization for continuation of services beyond thirty (30) calendar days, the CONTRACTOR may deny payment for care rendered beyond the initial thirty (30) days for lack of prior authorization but may not do so solely on the basis that the provider is a non-contract provider.

2.13.13 **Transition of Care**

In accordance with the requirements in Section 2.9.3.1 of this Agreement, if a provider has terminated participation with the CONTRACTOR, the CONTRACTOR shall pay the non-contract provider for the continuation of treatment through the applicable period provided in Section 2.9.3.1.

2.13.14 **Limits on Payments to Providers and Subcontractors Related to the CONTRACTOR**

2.13.14.1 The CONTRACTOR shall not pay more for similar services rendered by any provider or subcontractor that has an indirect ownership interest or an ownership or control interest in the CONTRACTOR or the CONTRACTOR's affiliates or the CONTRACTOR's management company than the CONTRACTOR pays to providers and subcontractors that do not have an indirect ownership interest or an ownership or control interest in the CONTRACTOR, the CONTRACTOR's affiliates or the CONTRACTOR's management company for similar services. The standards and criteria for determining whether a provider or a subcontractor has an indirect ownership interest, an ownership interest or a control interest are set out at 42 CFR Part 455, Subpart B.

2.13.14.2 Any payments made by the CONTRACTOR that exceed the limitations set forth in this section shall be considered non-allowable payments for covered services and shall be reduced from total expenditures prior to the State sharing in any losses pursuant to Section 3.11. Likewise, this excess payment will be excluded from medical expenses reported in the MLR report required in Section 2.30.14.2.1.

2.13.14.3 As provided in Section 2.30.9 of this Agreement, the CONTRACTOR shall submit information on payments to related providers and subcontractors.

2.13.15 **1099 Preparation**

In accordance with federal requirements, the CONTRACTOR shall prepare and submit Internal Revenue Service (IRS) Form 1099s for all providers who are not employees of the CONTRACTOR to whom payment is made

2.14 UTILIZATION MANAGEMENT (UM)

2.14.1 General

2.14.1.1 The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.

2.14.1.2 The CONTRACTOR shall notify all network providers of and enforce compliance with all provisions relating to UM procedures.

2.14.1.3 The UM program shall have criteria that:

2.14.1.3.1 Are objective and based on medical and/or behavioral health evidence;

2.14.1.3.2 Are applied based on individual needs;

2.14.1.3.3 Are applied based on an assessment of the local delivery system;

2.14.1.3.4 Involve appropriate practitioners in developing, adopting and reviewing them; and

2.14.1.3.5 Are annually reviewed and up-dated as appropriate.

2.14.1.4 The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease.

2.14.1.5 Except as provided in Section 2.6.1.5, the CONTRACTOR shall not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history. The CONTRACTOR shall consider individual member characteristics in the determination of readiness for discharge. This requirement is not intended to limit the

ability of the CONTRACTOR to use clinical guidelines or criteria in placing tentative limits on the length of a prior authorization or pre-admission certification.

2.14.1.6 The CONTRACTOR shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition.

2.14.1.7 The CONTRACTOR shall assure, consistent with 42 CFR 438.6(h), 42 CFR 422.208 and 422.210, that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

2.14.1.8 As part of the provider survey required by Section 2.18.7.2, the CONTRACTOR shall assess provider/office staff satisfaction with UM processes to identify areas for improvement.

2.14.1.9 The UM program policies and procedures, the annual evaluation (which includes an analysis of findings and actions taken) and the work plan shall be approved by the CONTRACTOR's oversight committee. These three (3) items shall be submitted to TENNCARE for approval in accordance with Section 2.30.10.1.

2.14.1.10 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 UM policies and procedures and, at a minimum, shall include the items specified in subparagraphs 2.14.1.10.1 through 2.14.1.10.5 below:

2.14.1.10.1 Pre-admission certification upon notification for all non-emergency admissions;

2.14.1.10.2 A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CONTRACTOR shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a member can be transferred to a contract facility in the network, if presently in a non-contract facility;

2.14.1.10.3 Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;

2.14.1.10.4 Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and

2.14.1.10.5 Prospective review procedures for pre-admission testing criteria and criteria for same day surgery procedures.

2.14.1.11 Emergency Department (ED) Utilization

The CONTRACTOR shall utilize the following guidelines in identifying and managing care for members who are determined to have excessive and/or inappropriate ED utilization:

2.14.1.11.1 Review ED utilization data, at a minimum, every six (6) months (in January and July) to identify members with utilization exceeding the threshold defined by TENNCARE in the preceding six (6) month period. The January review shall cover ED utilization during the preceding April through September; the July review shall cover ED utilization during the preceding October through March;

2.14.1.11.2 Enroll members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period in MCO case management if appropriate;

2.14.1.11.3 As appropriate, make contact with members whose utilization exceeded the threshold of ED visits defined by TENNCARE in the previous six (6) month period and their primary care providers for the purpose of providing education on appropriate ED utilization; and

2.14.1.11.4 Assess the most likely cause of high utilization and develop an MCO case management plan based on results of the assessment for each member.

2.14.1.12 Hospitalizations and Surgeries

The CONTRACTOR shall comply with any applicable federal and state laws or rules related to length of hospital stay. TENNCARE will closely monitor encounter data related to length of stay and re-admissions to identify potential problems. If indicated, TENNCARE may conduct special studies to assess the appropriateness of hospital discharges.

2.14.2 **Prior Authorization for Covered Services**

2.14.2.1 General

2.14.2.1.1 The CONTRACTOR shall have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The policies and procedures shall provide for consultation with the requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR, payment for the prior authorized service shall not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted.

2.14.2.1.2 Prior authorization requests shall be reviewed subject to the guidelines described in TennCare rules and regulations which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request.

2.14.2.2 Notice of Adverse Action Requirements

2.14.2.2.1 The CONTRACTOR shall clearly document and communicate the reasons for each denial of a prior authorization request in a manner sufficient for the provider and member to understand the denial and decide about requesting reconsideration of or appealing the decision.

2.14.2.2.2 The CONTRACTOR shall comply with all member notice provisions in TennCare rules and regulations.

2.14.2.3 Medical History Information Requirements

2.14.2.3.1 The CONTRACTOR is responsible for eliciting pertinent medical history information from the treating health care provider(s), as needed, for purposes of making medical necessity determinations. The CONTRACTOR shall take action (e.g., sending a CONTRACTOR representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem if a treating health care provider is uncooperative in supplying needed information. The CONTRACTOR shall make documentation of such action available to TENNCARE, upon request. Providers who do not provide requested medical information for purposes of making a medical necessity determination for a particular item or service shall not be entitled to payment for the provision of such item or service.

2.14.2.3.2 Upon request by TENNCARE, the CONTRACTOR shall provide TENNCARE with individualized medical record information from the treating health care provider(s). The CONTRACTOR shall take whatever action necessary to fulfill this responsibility within the required appeal time lines as specified by TENNCARE and/or applicable TennCare rules and regulations, up to and including going to the provider's office to obtain the medical record information. Should a provider fail or refuse to respond to the CONTRACTOR's efforts to obtain medical information, and the appeal is decided in favor of the member, at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

2.14.3 **Referrals**

2.14.3.1 Except as provided in Section 2.14.4, the CONTRACTOR may require members to seek a referral from their PCP prior to accessing non-emergency specialty physical health services**.**

2.14.3.2 If the CONTRACTOR requires members to obtain PCP referral, the CONTRACTOR may exempt certain services, identified by the CONTRACTOR in the member handbook, from PCP referral.

2.14.3.3 For members determined to need a course of treatment or regular care monitoring, the CONTRACTOR shall have a mechanism in place to allow members to directly access a specialist as appropriate for the members' condition and identified needs.

2.14.3.4 The CONTRACTOR shall not require that a woman go in for an office visit with her PCP in order to obtain the referral for prenatal care.

2.14.3.5 Referral Provider Listing

2.14.3.5.1 The CONTRACTOR shall provide all PCPs with a current hard copy listing of referral providers, including behavioral health providers at least thirty (30) calendar days prior to the start date of operations. Thereafter the CONTRACTOR shall mail PCPs an updated version of the listing on a quarterly basis. The CONTRACTOR shall also maintain an updated electronic, web-accessible version of the referral provider listing.

2.14.3.5.2 The referral provider listing shall be in the format specified by TENNCARE for the provider directory in Section 2.17.7.

2.14.3.5.3 As required in Section 2.30.10.7, the CONTRACTOR shall submit to TENNCARE a copy of the referral provider listing, a data file of the provider information in a media and format described by TENNCARE, and documentation regarding mailing.

2.14.4 **Exceptions to Prior Authorization and/or Referrals**

2.14.4.1 Emergency and Post-Stabilization Care Services

The CONTRACTOR shall provide emergency services without requiring prior authorization or PCP referral, as described in Section 2.7.1, regardless of whether these services are provided by a contract or non-contract provider. The CONTRACTOR shall provide, without prior authorization or PCP referral, post-stabilization care services as defined in Section 1.

2.14.4.2 TENNderCare

The CONTRACTOR shall not require prior authorization or PCP referral for the provision of TENNderCare screening services.

2.14.4.3 Access to Women's Health Specialists

The CONTRACTOR shall allow female members direct access (without requiring a referral) to a women's health specialist who is a contract provider for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

2.14.4.4 Behavioral Health Services

The CONTRACTOR shall not require a PCP referral for members to access a behavioral health provider.

2.14.4.5 Transition of New Members

Pursuant to the requirements in Section 2.9.2.1 regarding transition of new members, the CONTRACTOR shall provide for the continuation of medically necessary covered services regardless of prior authorization or referral requirements. However, as provided in Section 2.9.2.1, in certain circumstances the CONTRACTOR may require prior authorization for continuation of services beyond the initial thirty (30) days.

2.14.5 **PCP Profiling**

The CONTRACTOR shall profile its PCPs. Further, the CONTRACTOR shall investigate the circumstances surrounding PCPs who appear to be operating outside peer norms and will intervene, as appropriate, when utilization or quality of care issues are identified. As part of these profiling activities, the CONTRACTOR shall analyze utilization data, including but not limited to, information provided to the CONTRACTOR by TENNCARE, and report back information as requested by TENNCARE. PCP profiling shall include, but not be limited to the following areas:

2.14.5.1 Utilization of Non-Contract Providers

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of services provided by non-contract providers by PCP panel.

2.14.5.2 Specialist Referrals

The CONTRACTOR shall maintain a procedure to identify and evaluate member specialty provider utilization by PCP panel.

2.14.5.3 Emergency Room Utilization

The CONTRACTOR shall maintain a procedure to identify and evaluate member emergency room utilization by PCP panel. As provided in Section 2.9.4, members who establish a pattern of accessing emergency room services shall be referred to MCO case management as appropriate for follow-up.

2.14.5.4 Inpatient Admissions

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of inpatient services by PCP panel.

2.14.5.5 Pharmacy Utilization

At a minimum, the CONTRACTOR shall profile PCP prescribing patterns for generic versus brand name and the number of narcotic prescriptions written. In addition, the CONTRACTOR shall comply with the requirements in Section 2.9.8 of this Agreement.

2.14.5.6 Advanced Imaging Procedures

The CONTRACTOR shall profile the utilization of advanced imaging procedures by PCP panel. Advanced imaging procedures include: PET Scans; CAT Scans and MRIs.

2.14.5.7 PCP Visits

The CONTRACTOR shall profile the average number of visits per member assigned to each PCP.

2.15 QUALITY MANAGEMENT/QUALITY IMPROVEMENT

2.15.1 Quality Management/Quality Improvement (QM/QI) Program

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

2.15.1.1.1 Specifically address behavioral health care;

2.15.1.1.2 Be accountable to the CONTRACTOR's board of directors and executive management team;

2.15.1.1.3 Have substantial involvement of a designated physician and designated behavioral health practitioner;

2.15.1.1.4 Have a QM/QI committee that oversees the QM/QI functions;

2.15.1.1.5 Have an annual work plan;

2.15.1.1.6 Have resources – staffing, data sources and analytical resources – devoted to it; and

2.15.1.1.7 Be evaluated annually and updated as appropriate.

2.15.1.2 The CONTRACTOR shall make all information about its QM/QI program available to providers and members.

2.15.1.3 As part of the QM/QI program, the CONTRACTOR shall collect information on providers' actions to improve patient safety and make performance data available to providers and members.

2.15.1.4 Any changes to the QM/QI program structure shall require prior written approval from TENNCARE. The QM/QI program description, associated work plan, and annual evaluation of the QM/QI Program shall be submitted to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.

2.15.2 **QM/QI Committee**

2.15.2.1 The CONTRACTOR shall have a QM/QI committee which shall include staff and contract providers. Medical and behavioral health staff and contract providers shall be represented on the QM/QI committee. This committee shall recommend policy decisions, analyze and evaluate the results of QM/QI activities, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description and associated work plan prior to submission to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.

2.15.2.2 The QM/QI committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA accreditation review.

2.15.2.3 The CONTRACTOR shall provide the Chief Medical Officer of TENNCARE with ten (10) calendar days advance notice of all regularly scheduled meetings of the QM/QI committee. To the extent allowed by law, the Chief Medical Officer of TENNCARE, or his/her designee, may attend the QM/QI committee meetings at his/her option.

2.15.3 **Performance Improvement Projects (PIPs)**

2.15.3.1 The CONTRACTOR shall perform three (3) clinical PIPs, one (1) in the area of diabetes management, one (1) in the area of maternity management and one (1) in the area of behavioral health. The behavioral health PIP shall be relevant to one of the behavioral health disease management programs for bipolar disorder, major depression, or schizophrenia.

2.15.3.2 The CONTRACTOR shall ensure that CMS protocols for PIPs are followed and that the following are documented for each activity:

2.15.3.2.1 Rationale for selection as a quality improvement activity;

2.15.3.2.2 Specific population targeted, include sampling methodology if relevant;

2.15.3.2.3 Metrics to determine meaningful improvement and baseline measurement;

2.15.3.2.4 Specific interventions (enrollee and provider);

2.15.3.2.5 Relevant clinical practice guidelines; and

2.15.3.2.6 Date of re-measurement.

2.15.3.3 The CONTRACTOR shall report on PIPs as required in Section 2.30.11.3, Reporting Requirements.

2.15.4 **Performance Indicators**

2.15.4.1 The CONTRACTOR's QM/QI program shall identify benchmarks and set achievable performance goals for the three (3) PIPs required in Section 2.15.3. The three (3) clinical performance indicators that must show meaningful improvement are diabetes management, maternity management and behavioral health. The CONTRACTOR shall identify a relevant HEDIS measure where there is an opportunity to show improvement. The source of the benchmark should be identified, e.g., NCQA's Quality Compass. The CONTRACTOR must demonstrate improvement against the baseline measure as indicated:

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

2.15.4.2 The CONTRACTOR shall report performance indicator results as required in Section 2.30.11.1, Reporting Requirements.

2.15.4.3 The CONTRACTOR's failure to demonstrate meaningful improvement toward benchmark levels of performance shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2.25.9.

2.15.5 **Clinical Practice Guidelines**

2.15.5.1 The CONTRACTOR shall select at least four (4) evidence-based clinical practice guidelines from recognized sources that are relevant to the enrollee population. Two (2) of these guidelines must be related to behavioral health conditions, one (1) of which may be a behavioral health component of a medical guideline; however, it must address a separate condition or an aspect of a behavioral health condition distinctively different from the behavioral health guideline. One (1) of the behavioral health guidelines should address the treatment of depression. At least two (2) of the CONTRACTOR's adopted clinical practice guidelines shall be the clinical basis for the DM programs described in Section 2.8. The CONTRACTOR shall measure performance against at least two (2) important aspects of each of the four (4) clinical practice guidelines annually. The guidelines must be reviewed and revised at least every two (2) years or whenever the guidelines change.

2.15.5.2 The CONTRACTOR shall distribute the guidelines to all appropriate providers upon signing of the provider agreement and when the guidelines are revised.

2.15.6 **NCQA Accreditation**

2.15.6.1 The CONTRACTOR shall obtain NCQA accreditation by September 30, 2008 and shall maintain it thereafter. In order to ensure that the CONTRACTOR is making forward progress, TENNCARE shall require that the following information and/or benchmarks be met:

EVENT	REQUIRED DEADLINE
CALENDAR YEAR 2007	
Purchase NCQA ISS Tool for 2008 MCO Accreditation Survey	August 15, 2007
Copy of signed contract with NCQA approved vendor to perform 2008 CAHPS surveys (Adult, Child and Children With Chronic Conditions to TENNCARE	October 15, 2007
Copy of signed contract with NCQA approved vendor to perform 2008 HEDIS Audit to TENNCARE (The CONTRACTOR must perform the complete Medicaid HEDIS Data Set with the exception of dental related measures)	October 15, 2007
NCQA Accreditation Survey Application Submitted and Pre Survey Fee paid	November 15, 2007
CALENDAR YEAR 2008	
HEDIS Baseline Assessment Tool completed and submitted to Contracted HEDIS Auditor, TENNCARE, and the EQRO	February 15, 2008
Submit copy of signed NCQA Survey contract to TENNCARE	February 15, 2008
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TENNCARE	June 13, 2008
Notify TENNCARE of date for ISS Submission and NCQA On-site review	June 13, 2008
Finalize preparations for NCQA Survey (Final payment must be submitted to NCQA sixty (60) calendar days prior to submission of ISS)	Notify TennCare of final payment within five (5) business days of submission to NCQA.
Submission of ISS to NCQA	Notify TennCare within five (5) business days of submission to NCQA.
NCQA Survey Completed and copy of NCQA Final Report to TENNCARE: • Excellent, Commendable, or Accredited • Provisional – Corrective Action required to achieve status of Excellent, Commendable, or Accredited; resurvey within twelve (12) months. • Accreditation Denied – Results in termination of this Agreement.	September 30, 2008

2.15.6.2 If the CONTRACTOR consistently fails to meet the timelines as described above, the CONTRACTOR shall be considered to be in breach of the terms of this Agreement and may be subject to termination in accordance with Section 4.4 of this Agreement.

2.15.6.3 Failure to obtain NCQA accreditation by September 30, 2008 and maintain accreditation thereafter shall be considered a breach of this Agreement and shall result in termination of this Agreement in accordance with the terms set forth in Section 4.4 of this Agreement. Achievement of provisional accreditation status shall require a corrective action plan within thirty (3) calendar days of receipt of Final Report from NCQA and may result in termination of this Agreement in accordance with Section 4.4 of this Agreement.

2.15.7 **HEDIS and CAHPS**

2.15.7.1 Annually, beginning with HEDIS 2008, the CONTRACTOR shall complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set shall be dental measures. The CONTRACTOR shall contract with an NCQA certified HEDIS auditor to validate the processes of the CONTRACTOR in accordance with NCQA requirements. Audited HEDIS results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year beginning in 2008.

2.15.7.2 Annually, beginning in 2008, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR's vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey. Survey results shall be reported to TENNCARE separately for each required CAHPS survey listed above. Survey results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year beginning in 2008.

2.16 MARKETING

The CONTRACTOR shall not conduct any marketing activities, as defined in Section 1 of this Agreement. This prohibition includes, but is not limited to the following information and activities:

2.16.1 Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers.

2.16.2 Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined, or similar techniques;

2.16.2.1 Offers of gifts or material or financial gain as incentives to enroll;

2.16.2.2 Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;

2.16.2.3 Direct solicitation of prospective enrollees;

2.16.2.4 Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;

2.16.2.5 Assertions or statements (whether oral or written) that the enrollee must enroll with the CONTRACTOR in order to obtain benefits or in order not to lose benefits;

2.16.2.6 Assertions or statements (whether written or oral) that the CONTRACTOR is endorsed by CMS, the federal or state government or similar entity;

2.16.2.7 Use of independent marketing agents in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions; and

2.16.2.8 Seeking to influence enrollment in conjunction with the sale or offering of any private insurance.

2.17 MEMBER MATERIALS

2.17.1 Prior Approval Process for All Member Materials

2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior approval all materials that will be distributed to members (referred to as member materials). This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, member education and outreach activities as described in this Section, Section 2.17 and Section 2.7.3, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.

2.17.1.2 All member materials shall be submitted to TENNCARE on paper and electronic file media, in the format prescribed by TENNCARE. The materials shall be accompanied by a plan that describes the CONTRACTOR's intent and procedure for the use of the materials. Materials developed by a recognized entity having no association with the CONTRACTOR that are related to management of specific types of diseases (e.g., heart, diabetes, asthma, etc.) or general health improvement must be submitted for approval; however, unless otherwise requested by TENNCARE, an electronic file for these materials is not required. The electronic files must be submitted in a format acceptable to TENNCARE. Electronic files submitted in any other format than those approved by TENNCARE will not be processed.

2.17.1.3 TENNCARE shall review the submitted member materials and either approve or deny them within fifteen (15) calendar days from the date of submission. In the event TENNCARE does not approve the materials TENNCARE may provide written comments, and the CONTRACTOR shall resubmit the materials.

2.17.1.4 Once member materials have been approved by TENNCARE, the CONTRACTOR shall submit to TENNCARE an electronic version of the final printed product and five (5) original prints of the final product, unless otherwise specified by TENNCARE, within thirty (30) calendar days from the print date. Photo copies may not be submitted as a final product. Upon request, the CONTRACTOR shall provide additional original prints of the final product to TENNCARE.

2.17.1.5 Prior to modifying any approved member material, the CONTRACTOR shall submit for approval by TENNCARE a detailed description of the proposed modification. Proposed modifications shall be submitted in accordance with the requirements herein.

2.17.1.6 TENNCARE reserves the right to notify the CONTRACTOR to discontinue or modify member materials after approval.

2.17.2 **Written Material Guidelines**

The CONTRACTOR shall comply with the following requirements as it relates to written member materials:

2.17.2.1 All member materials shall be worded at a sixth (6th) grade reading level, unless TENNCARE approves otherwise;

2.17.2.2 All written materials shall be clearly legible with a minimum font size of 12pt. with the exception of member I.D. cards, and unless otherwise approved by TENNCARE;

2.17.2.3 All written materials shall be printed with the assurance of non-discrimination as provided in Section 4.31;

2.17.2.4 The following shall not be used on any written materials, including but not limited to member materials, without the written approval of TENNCARE:

2.17.2.4.1 The Seal of the State of Tennessee;

2.17.2.4.2 The TennCare name unless the initials "SM" denoting a service mark, is superscripted to the right of the name (TennCare^{sm});

2.17.2.4.3 The word "free" unless the service is at no cost to all members. If members have cost sharing responsibilities, the service is not free. Any conditions of payments must be clearly and conspicuously disclosed in close proximity to the "free" good or service offer; and

2.17.2.4.4 The use of phrases to encourage enrollment such as "keep your doctor" implying that enrollees can keep all of their physicians. Enrollees in TennCare should not be led to think that they can continue to go to their current physician, unless that particular physician is a contract provider with the CONTRACTOR's MCO;

2.17.2.5 All vital CONTRACTOR documents must be translated and available in Spanish. Within ninety (90) calendar days of notification from TENNCARE, all vital CONTRACTOR documents must be translated and available to each Limited English Proficiency group identified by TENNCARE that constitutes five percent (5%) of the TennCare population or one-thousand (1,000) enrollees, whichever is less;

2.17.2.6 All written member materials shall notify enrollees that oral interpretation is available for any language at no expense to them and how to access those services;

2.17.2.7 All written member materials shall be made available in alternative formats for persons with special needs at no expense to the member; and

2.17.2.8 The CONTRACTOR shall provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. The CONTRACTOR shall provide written notice at least thirty (30) days before the effective date of the change.

2.17.3 **Distribution of Member Materials**

2.17.3.1 The CONTRACTOR shall distribute member materials as required by this Agreement. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters, and identification cards.

2.17.3.2 The CONTRACTOR may distribute additional materials and information, other than those required by this Section, Section 2.17, to members in order to promote health and/or educate enrollees.

2.17.4 **Member Handbooks**

2.17.4.1 The CONTRACTOR shall develop a member handbook based on a template provided by TENNCARE, and update it periodically (at least annually). Upon notice to TENNCARE of material changes to the member handbook, the CONTRACTOR shall make appropriate revisions and immediately distribute the revised handbook to members and providers.

2.17.4.2 The CONTRACTOR shall distribute member handbooks to members within thirty (30) calendar days of receipt of notice of enrollment in the CONTRACTOR's MCO or prior to enrollees' enrollment effective date as described in Section 2.4.5 and at least annually thereafter. In the event of material revisions to the member handbook, the CONTRACTOR shall distribute the new and revised handbook to all members immediately.

2.17.4.3 In situations where there is more than one member in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook to each address listed for the member's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to members. Should a single individual be enrolled and be added into an existing case, a member handbook (new or updated) must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to members in the existing case.

2.17.4.4 The CONTRACTOR shall distribute a member handbook to all contract providers upon initial credentialing, annually thereafter as handbooks are updated, and whenever there are material revisions. For purposes of providing member handbooks to providers, it shall be acceptable to provide handbooks in electronic format, including but not limited to CD or access via a web link.

2.17.4.5 Each member handbook shall, at a minimum, be in accordance with the following guidelines:

2.17.4.5.1 Must be in accordance with all applicable requirements as described in Section 2.17.2 of this Agreement;

2.17.4.5.2 Shall include a table of contents;

2.17.4.5.3 Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment;

2.17.4.5.4 Shall include a description of services provided including benefit limits and thresholds, including how reaching service thresholds may trigger enrollment in MCO case management or disease management, exclusions, and use of non-contract providers;

2.17.4.5.5 Shall include descriptions of both the Medicaid Benefits and the Standard Benefits;

2.17.4.5.6 Shall include a description of TennCare cost sharing responsibilities including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts. Further, the information shall indicate that the member may not be billed for covered services except for the amounts of the specified TennCare cost sharing responsibilities and of their right to appeal in the event that they are billed for amounts other than their TennCare cost sharing responsibilities;

2.17.4.5.7 Shall include information about preventive services for adults and children, including TENNderCare, a listing of covered preventive services, and notice that preventive services are at no cost and without cost sharing responsibilities;

2.17.4.5.8 Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract providers. The handbook shall advise members that if they need a service that is not available from a contract provider, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider;

2.17.4.5.9 Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the CONTRACTOR's service area, including but not limited to: an explanation of post-stabilization services, the use of 911, locations of emergency settings and locations for post-stabilization services;

2.17.4.5.10 Shall include information on how to access the primary care provider on a twenty-four (24) hour basis as well as the twenty-four (24) hour nurse hotline. The handbook may encourage members to contact the PCP or twenty-four (24) hour nurse hotline when they have questions as to whether they should go to the emergency room;

2.17.4.5.11 Shall include notice of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) and a complaint form on which to do so;

2.17.4.5.12 Shall include appeal procedures as described in Section 2.19 of this Agreement;

2.17.4.5.13 Shall include notice that in addition to the member's right to file an appeal directly to TENNCARE for actions taken by the CONTRACTOR, the member shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;

2.17.4.5.14 Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs;

2.17.4.5.15 Shall include written information concerning advance directives as described in 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128;

2.17.4.5.16 Shall include notice that enrollment in the CONTRACTOR's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the CONTRACTOR's MCO and notice of continuation of care when entering the CONTRACTOR's MCO as described in Section 2.9.2 of this Agreement;

2.17.4.5.17 Shall include notice to the member that it is the member's responsibility to notify the CONTRACTOR and the TENNCARE agency each and every time the member moves to a new address;

2.17.4.5.18 Shall include notice that a new member may request to change MCOs at anytime during the forty-five (45) calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;

2.17.4.5.19 Shall include notice that the member may change MCOs at the next choice period as described in Section 2.4.7.2.2 of this Agreement and shall have a forty-five (45) calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;

2.17.4.5.20 Shall include notice that the member has the right to appeal to TENNCARE to request to change MCOs based on hardship and how to do so;

2.17.4.5.21 Shall include notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TENNCARE for termination forms and additional information on termination;

2.17.4.5.22 Shall include the toll free telephone number for TENNCARE with a statement that the member may contact the CONTRACTOR or TENNCARE regarding questions about the TennCare program;

2.17.4.5.23 Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;

2.17.4.5.24 Shall include information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law;

2.17.4.5.25 Shall include directions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans" (see Section 2.13.5);

2.17.4.5.26 Shall include information that the member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

2.17.4.5.27 Shall include information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

2.17.4.5.28 Shall include information on appropriate prescription drug usage (see Section 2.9.7); and

2.17.4.5.29 Shall include any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

2.17.5 **Quarterly Member Newsletter**

2.17.5.1 The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.

2.17.5.2 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.2.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;

2.17.5.2.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;

2.17.5.2.3 A notice to members of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and a CONTRACTOR phone number for doing so. The notice shall be in English and Spanish;

2.17.5.2.4 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services;

2.17.5.2.5 Information about appropriate prescription drug usage; and

2.17.5.2.6 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to www.state.tn.us/tenncare and click on 'Report Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."

2.17.5.3 The quarterly member newsletter shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletter and the date that the information was mailed to members along with an invoice or other type of documentation to indicate the date and volume of the quarterly member newsletter mailing.

2.17.6 **Identification Card**

Each member shall be provided an identification card, which identifies the member as a participant in the TennCare program within thirty (30) calendar days of notification of enrollment into the CONTRACTOR's MCO or prior to the member's enrollment effective date. The identification card shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), must comply with all state and federal requirements and, at a minimum, shall include:

2.17.6.1 The CONTRACTOR's name and issuer identifier, with the company logo;

2.17.6.2 Phone numbers for information and/or authorizations, including for behavioral health services;

2.17.6.3 Descriptions of procedures to be followed for emergency or special services;

2.17.6.4 The member's identification number;

2.17.6.5 The member's name (First, Last and Middle Initial);

2.17.6.6 The member's date of birth;

2.17.6.7 The member's enrollment effective date;

2.17.6.8 Copayment information;

2.17.6.9 The Health Insurance Portability and Accountability Act (HIPAA) adopted identifier; and

2.17.6.10 The words "Medicaid" or "Standard" based on eligibility.

2.17.7 **Provider Directory**

2.17.7.1 The CONTRACTOR shall distribute provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the CONTRACTOR's MCO or prior the member's enrollment effective date. The

CONTRACTOR shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.

2.17.7.2 Provider directories, and any revisions thereto, shall be submitted to TENNCARE for approval prior to distribution to enrollees in accordance with Section 2.17.1 of this Agreement. The text of the directory shall be in the format prescribed by TENNCARE. In addition, the provider information used to populate the provider directory shall be submitted as a TXT file or such format as otherwise approved by TENNCARE and be produced using the same extract process as the actual provider directory.

2.17.7.3 Provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network PCPs and specialists, hospital listings including locations of emergency settings and post-stabilization services, identification of providers accepting new patients and whether or not a provider performs TENNderCare screens.

2.17.8 **Additional Information Available Upon Request**

The CONTRACTOR shall provide all other information to members as required by CMS, including but not limited to the following information to any enrollee who requests it:

2.17.8.1 Information regarding the structure and operation of the CONTRACTOR's MCO; and

2.17.8.2 Information regarding physician incentive plans, including but not limited to:

2.17.8.2.1 Whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services;

2.17.8.2.2 The type of incentive arrangement;

2.17.8.2.3 Whether stop-loss protection is provided; and

2.17.8.2.4 If the CONTRACTOR was required to conduct a survey, a summary of the survey results.

2.18 CUSTOMER SERVICE

2.18.1 Member Services Toll-Free Phone Line

2.18.1.1 The CONTRACTOR shall operate a toll-free telephone line (member services information line) to respond to member questions, comments, and inquiries from the member, the member's family, or the member's provider.

2.18.1.2 The CONTRACTOR shall develop member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

2.18.1.3 The member services information line shall handle calls from non-English speaking callers as well as calls from members who are hearing impaired.

2.18.1.4 The CONTRACTOR shall ensure that the member services information line is staffed adequately to respond to members' questions, at a minimum, from 8 a.m. to 5 p.m. Central Time Monday through Friday, except State of Tennessee holidays.

2.18.1.5 The member services information line shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified nurses to triage urgent care and emergency calls from members. The CONTRACTOR may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements of this Section, Section 2.18.1.

2.18.1.6 The member services information line shall be adequately staffed with staff trained to accurately respond to member questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, TENNderCare, and the CONTRACTOR's provider network.

2.18.1.7 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.1.8 The CONTRACTOR shall have an automated system available during non-business hours, including weekends and holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

2.18.1.9 <u>Performance Standards for Member Services Line/Queue</u>

2.18.1.9.1 The CONTRACTOR shall adequately staff the member services information line to ensure that the line, including the nurse triage/nurse advice line or queue, meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.

2.18.1.9.2 The CONTRACTOR shall submit the reports required in Section 2.30.12.1 of this Agreement.

2.18.2 **Interpreter and Translation Services**

2.18.2.1 The CONTRACTOR shall develop written polices and procedures for the provision of language interpreter and translation services to any member who needs such services, including but not limited to, members with Limited English Proficiency and members who are hearing impaired.

2.18.2.2 The CONTRACTOR shall provide interpreter and translation services free of charge to members.

2.18.2.3 Interpreter services should be available in the form of in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.

2.18.3 **Cultural Competency**

As required by 42 CFR 438.206, the CONTRACTOR shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds.

2.18.4 **Provider Services and Utilization Management Toll-Free Telephone Line**

2.18.4.1 The CONTRACTOR shall operate a toll-free telephone line (provider service line) to respond to provider questions, comments, and inquiries.

2.18.4.2 The CONTRACTOR shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

2.18.4.3 The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to providers' questions at a minimum from 8 a.m. to 5 p.m. Central Time, Monday through Friday, except State of Tennessee holidays.

2.18.4.4 The provider service line shall also be adequately staffed to provide appropriate and timely responses regarding prior authorization requests as described in Section 2.14.2 of this Agreement. The CONTRACTOR may meet this requirement by having a separate utilization management line.

2.18.4.5 The provider service line shall be adequately staffed with staff trained to accurately respond to questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, TENNderCare, prior authorization and referral requirements, and the CONTRACTOR's provider network.

2.18.4.6 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.4.7 The CONTRACTOR shall have an automated system available during non-business hours. This automated system shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

2.18.4.8 Performance Standards for UM Line/Queue

2.18.4.8.1 The CONTRACTOR shall adequately staff the provider service line to ensure that the utilization management line/queue meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.

2.18.4.8.2 The CONTRACTOR shall submit the reports required in Section 2.30.12.1 of this Agreement.

2.18.5 **Provider Handbook**

2.18.5.1 The CONTRACTOR shall issue a provider handbook to all contract providers. The CONTRACTOR may distribute the provider handbook electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider. At a minimum the provider handbook shall include the following information:

2.18.5.1.1 Description of the TennCare program;

2.18.5.1.2 Covered services;

2.18.5.1.3 Emergency service responsibilities;

2.18.5.1.4 TENNderCare services and standards;

2.18.5.1.5 Information on members' appeal rights;

2.18.5.1.6 Policies and procedures of the provider complaint system;

2.18.5.1.7 Medical necessity standards and clinical practice guidelines;

2.18.5.1.8 PCP responsibilities;

2.18.5.1.9 Coordination with other TennCare contractors or MCO subcontractors;

2.18.5.1.10 Prior authorization, referral and other utilization management requirements and procedures;

2.18.5.1.11 Protocol for encounter data element reporting/records;

2.18.5.1.12 Medical records standard;

2.18.5.1.13 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;

2.18.5.1.14 Payment policies; and

2.18.5.1.15 Member rights and responsibilities.

2.18.5.2 The CONTRACTOR shall disseminate bulletins as needed to incorporate any needed changes to the provider handbook.

2.18.6 **Provider Education and Training**

2.18.6.1 The CONTRACTOR shall develop an education and training plan and materials for contract providers and provide education and training to contract providers and their staff regarding key requirements of this Agreement.

2.18.6.2 The CONTRACTOR shall conduct initial education and training to contract providers at least thirty (30) calendar days prior to the start date of operations.

2.18.6.3 The CONTRACTOR shall also conduct ongoing provider education and training as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Agreement.

2.18.6.4 The CONTRACTOR shall distribute on a quarterly basis a newsletter to contract providers to update providers on CONTRACTOR initiatives and communicate pertinent information to contract providers.

2.18.7 **Provider Relations**

2.18.7.1 The CONTRACTOR shall establish and maintain a formal provider relations function to timely and adequately respond to inquiries, questions and concerns from contract providers. The CONTRACTOR shall implement policies to monitor and ensure compliance of providers with the requirements of this Agreement.

2.18.7.2 The CONTRACTOR shall conduct an annual survey to assess provider satisfaction, including satisfaction with provider enrollment, provider communication, provider complaints and appeals, claims processing, utilization management processes, including medical reviews, and audit and reimbursement. The CONTRACTOR shall submit an annual report on the survey to TENNCARE as required in Section 2.30.12.4. The CONTRACTOR shall take action to address opportunities for improvement identified through the survey. The survey shall be structured so that behavioral health provider satisfaction results and physical health provider satisfaction results can be separately stratified.

2.18.8 **Provider Complaint System**

2.18.8.1 The CONTRACTOR shall establish and maintain a provider complaint system for any provider (contract or non-contract) who is not satisfied with the CONTRACTOR's policies and procedures or a decision made by the contractor that does not impact the provision of services to members.

2.18.8.2 The procedures for resolution of any disputes regarding the payment of claims shall comply with TCA 56-32-226(b).

2.18.9 **Member Involvement with Behavioral Health Services**

2.18.9.1 The CONTRACTOR shall develop policies and procedures with respect to member, parent, or legally appointed representative involvement with behavioral health. These policies and procedures must include, at a minimum, the following elements:

2.18.9.1.1 The requirement that all behavioral health treatment plans document member involvement. Fulfilling this requirement means that each treatment plan has a member/family member signature or the signature of a legally appointed representative on the treatment plan and upon each subsequent treatment plan review, where appropriate, and a description of how this requirement will be met;

2.18.9.1.2 The requirement that member education materials include statements regarding the member's, parent's, or legally appointed representative's right to involvement in behavioral health treatment decisions, their ability to choose and change service providers, and a description of how this requirement will be met;

2.18.9.1.3 The requirement that provider education include materials regarding the rights of members, parent(s), or legally appointed representatives to be involved in behavioral health treatment decisions and a description of how this requirement will be met; and

2.18.9.1.4 A description of the quality monitoring activities to be used to measure provider compliance with the requirement for member, parent, or legally appointed representative involvement in behavioral health treatment planning.

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

2.18.9.3 The CONTRACTOR shall require providers to inform children and adolescents for whom residential treatment is being considered and their parent(s) or legally appointed representative, and adults for whom voluntary inpatient treatment is being considered, of all their options for residential and/or inpatient placement, and alternatives to residential and/or inpatient treatment and the benefits, risks and limitations of each in order that they can provide informed consent.

2.18.9.4 The CONTRACTOR shall require providers to inform all members being considered for prescription of psychotropic medications of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

2.19 COMPLAINTS AND APPEALS

2.19.1 General

2.19.1.1 Members shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including but not limited to, a provider with the member's written consent. Complaint shall mean a member's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall inform members of their complaint and appeal rights in the member handbook in compliance with the requirements in Section 2.17.4. The CONTRACTOR shall have internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.

2.19.1.2 The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section 2.15.2, to the review of member complaints and appeals that have been received.

2.19.1.3 The CONTRACTOR shall ensure that punitive action is not taken against a provider who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

2.19.2 Appeals

2.19.2.1 The CONTRACTOR's appeal process shall, at a minimum, meet the requirements outlined herein.

2.19.2.2 The CONTRACTOR shall have a contact person who is knowledgeable of appeal procedures and shall direct all appeals, whether the appeal is verbal or the member chooses to file in writing, to TENNCARE. Should a member choose to appeal in writing, the member will be instructed to file via mail or fax to the designated TENNCARE P. O. Box or fax number for medical appeals.

2.19.2.3 The CONTRACTOR shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The CONTRACTOR shall notify TENNCARE of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.

2.19.2.4 The CONTRACTOR shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action must be taken by the CONTRACTOR regarding the handling and disposition of an appeal.

2.19.2.5 The CONTRACTOR shall identify the appropriate individual or body within the CONTRACTOR's MCO having decision-making authority as part of the appeal procedure.

2.19.2.6 The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, members shall not be required to use a TENNCARE approved appeal form in order to file an appeal.

2.19.2.7 Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form(s).

2.19.2.8 The CONTRACTOR shall provide reasonable assistance to all appellants during the appeal process.

2.19.2.9 At any point in the appeal process, TENNCARE shall have the authority to remove a member from the CONTRACTOR's MCO when it is determined that such removal is in the best interest of the member and TENNCARE.

2.19.2.10 The CONTRACTOR shall require providers to display notices of members' right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The CONTRACTOR shall ensure that providers have correct and adequate supply of public notices.

2.19.2.11 Neither the CONTRACTOR nor TENNCARE shall prohibit or discourage any individual from testifying on behalf of a member.

2.19.2.12 The CONTRACTOR shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.

2.19.2.13 TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which shall be followed by the CONTRACTOR. However, the CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, the CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.

2.19.2.14 The CONTRACTOR shall provide general and targeted education to providers regarding expedited appeals (described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.

2.19.2.15 The CONTRACTOR shall require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the CONTRACTOR when requested by TENNCARE.

2.19.2.16 The CONTRACTOR shall provide for notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation as described in Section 2.24.4.

2.19.2.17 The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).

2.19.2.18 Members 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 TennCare rules and regulations. The CONTRACTOR shall be bound by the state level decision.

2.19.2.19 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.

2.20 FRAUD AND ABUSE

2.20.1 General

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

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

2.20.1.3 The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.

2.20.2 Reporting and Investigating Suspected Fraud and Abuse

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

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

2.20.2.1.2 All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU; and

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

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

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

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

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

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

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

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

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

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

2.20.2.8 The CONTRACTOR and providers, whether contract or non-contract, shall, upon request and as required by this Agreement or state and/or federal law, make available to the TBI MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are

expended. In addition, the TBI MFCU/OIG shall, as required by this Agreement or state and/or federal law, be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG.

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

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

2.20.3 **Compliance Plan**

2.20.3.1 The CONTRACTOR shall have a written fraud and abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare program Integrity Unit within ninety (90) calendar days of Agreement execution.

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

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

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

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

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

2.20.3.2.4.1 Claims edits;

2.20.3.2.4.2 Post-processing review of claims;

2.20.3.2.4.3 Provider profiling and credentialing;

2.20.3.2.4.4 Prior authorization;

2.20.3.2.4.5 Utilization management;

2.20.3.2.4.6 Relevant subcontractor and provider agreement provisions; and

2.20.3.2.4.7 Written provider and member material regarding fraud and abuse referrals.

2.20.3.2.5 Contain provisions for the confidential reporting of plan violations to the designated person;

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

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

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

2.20.3.2.9 Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to the OIG; and

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

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

2.20.3.4 The CONTRACTOR shall report fraud and abuse activities as required in Section 2.30.13, Reporting Requirements.

2.21 FINANCIAL MANAGEMENT

The CONTRACTOR shall be responsible for sound financial management of its MCO. The CONTRACTOR shall adhere to the minimum guidelines outlined below.

2.21.1 Capitation Payments

The CONTRACTOR shall accept capitation payments, remitted by TENNCARE in accordance with Section 3, incentive payments, if applicable, and any applicable risk-sharing settlement calculations (see Section 3.11) as payment in full for all services required pursuant to this Agreement.

2.21.2 Savings/Loss

2.21.2.1 The CONTRACTOR shall not be required to share with TENNCARE any financial gains realized under this Agreement, unless the CONTRACTOR has elected to participate in risk-sharing Option 1 or risk-sharing Option 2 described in Section 3.11.

2.21.2.2 TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement, unless the CONTRACTOR has elected to participate in risk-sharing Option 1 or risk-sharing Option 2 described in Section 3.11.

2.21.2.3 If the CONTRACTOR has elected to participate in risk-sharing Option 1 or risk-sharing Option 2:

2.21.2.3.1 The CONTRACTOR's financial gain or loss shall be calculated in accordance with the requirements and methodology specified in Section 3.11.

2.21.2.3.2 Any calculation of a financial gain or loss shall be approved by TENNCARE prior to remittance of any payment by TENNCARE or the CONTRACTOR.

2.21.2.3.3 TENNCARE shall only be liable to the CONTRACTOR for a portion of the financial loss in accordance with the applicable risk-sharing option specified in Section 3.11.

2.21.2.3.4 The CONTRACTOR shall only be liable to TENNCARE for a portion of the financial gain in accordance with the applicable risk-sharing option specified in Section 3.11.

2.21.2.3.5 The CONTRACTOR shall not record as an admitted asset on its NAIC financial statements a receivable from TENNCARE for TENNCARE's risk share of a financial loss until that receivable is approved by TENNCARE.

2.21.3 **Interest**

2.21.3.1 Interest generated from the deposit of funds paid to the CONTRACTOR pursuant to this Agreement shall be the property of the CONTRACTOR and available for use at the CONTRACTOR's discretion, unless the CONTRACTOR has elected to participate in risk-sharing Option 1 or risk-sharing Option 2 described in Section 3.11.

2.21.3.2 If the CONTRACTOR has elected to participate in risk-sharing Option 1 or risk-sharing Option 2 described in Section 3.11, interest generated from the deposit of funds paid to the CONTRACTOR pursuant to this Agreement shall be treated as TennCare Revenue for the purpose of settlement calculations as specified in Section 3.11.

2.21.4 **Third Party Liability Resources**

2.21.4.1 The TennCare program shall be the payer of last resort for all covered services in accordance with federal regulations. The CONTRACTOR shall exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrollees under this Agreement and cost avoid and/or recover any such liability from the third party.

2.21.4.1.1 If the CONTRACTOR has determined that third party liability (TPL) exists for part or all of the services provided directly by the CONTRACTOR to an enrollee, the CONTRACTOR shall make reasonable efforts to recover from TPL sources the value of services rendered.

2.21.4.1.2 If the CONTRACTOR has determined that TPL exists for part or all of the services provided to an enrollee by a subcontractor or a provider, and the third party will make payment within a reasonable time, the CONTRACTOR may pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount of TPL.

2.21.4.1.3 If the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR may reject the claim and return it to the provider for a determination of the amount of any TPL, unless the claim is for one of these services:

2.21.4.1.3.1 TENNderCare;

2.21.4.1.3.2 Prenatal or preventive pediatric care; or

2.21.4.1.3.3 All claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act.

2.21.4.1.4 The claims specified in Sections 2.21.4.1.3.1, 2.21.4.1.3.2, and 2.21.4.1.3.3 will be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party.

2.21.4.2 The CONTRACTOR shall deny payment on a claim that has been denied by a third party payer when the reason for denial is the provider or enrollee's failure to follow prescribed procedures, including but not limited to, failure to obtain prior authorization, timely filing, etc.

2.21.4.3 The CONTRACTOR shall treat funds recovered from third parties as offsets to claims payments. The CONTRACTOR shall report all cost avoidance values to TENNCARE in accordance with federal guidelines and as described in Section 2.21.4 of this Agreement

2.21.4.4 The CONTRACTOR shall post all third party payments to claim level detail by enrollee. Unless otherwise indicated below, claims for which the CONTRACTOR's files indicate TPL exists, but do not reflect third party payment shall not be treated as an allowable expense for the purpose of risk-sharing settlement calculations.

2.21.4.5 Third party resources shall include subrogation recoveries. The CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall be treated by the CONTRACTOR as offsets to medical expenses for the purposes of reporting and risk-sharing settlement calculations.

2.21.4.6 TennCare cost sharing responsibilities permitted pursuant to Section 2.6.7 of this Agreement shall not be considered TPL.

2.21.4.7 The CONTRACTOR shall provide TPL data to any provider having a claim denied by the CONTRACTOR based upon TPL.

2.21.4.8 The CONTRACTOR shall provide to TENNCARE any third party resource information necessary in a format and media described by TENNCARE and shall cooperate in any manner necessary, as requested by TENNCARE, with TENNCARE and/or a cost recovery vendor at such time that TENNCARE acquires said services.

2.21.4.9 TENNCARE may require a TennCare contracted TPL vendor to review paid claims that are over ninety (90) calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the CONTRACTOR's reported encounter data.

2.21.4.10 If the CONTRACTOR operates or administers any non-Medicaid HMO, health plan or other lines of business, the CONTRACTOR shall assist TENNCARE with the identification of enrollees with access to other insurance.

2.21.4.11 The CONTRACTOR shall demonstrate, upon request, to TENNCARE that reasonable effort has been made to seek, collect and/or report third party recoveries. TENNCARE shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

2.21.5 **Solvency Requirements**

2.21.5.1 Minimum Net Worth

2.21.5.1.1 Until the CONTRACTOR has provided services under this Agreement for a full calendar year, the CONTRACTOR shall establish and maintain a minimum net worth equal to the greater of:

2.21.5.1.1.1 One million five-hundred thousand dollars ($1,500,000); or

2.21.5.1.1.2 An amount totaling four percent (4%) of the first one-hundred fifty million dollars ($150,000,000) of the CONTRACTOR's TennCare revenue which shall be calculated by: totaling the weighted average capitation rate, as determined by TENNCARE using the base capitation rates originally proposed by the CONTRACTOR and the priority add-on and State Only and Judicial capitation rates effective on the start date of operations specified by the State, multiplied by the number of enrollees assigned to the CONTRACTOR as of December 1, 2006 (for enrollment effective on January 1, 2007).

2.21.5.1.2 In the event that actual enrollment as of sixty (60) days after the start date of operations increased or decreased by more than ten percent (10%) over enrollment as of thirty (30) calendar days prior to the start date of operations, the minimum net worth requirement specified in Section 2.21.5.1.1 shall be recalculated to reflect actual enrollment as of sixty (60) calendar days after the start date of operations.

2.21.5.1.3 After the CONTRACTOR has provided services under this Agreement for a full calendar year, the CONTRACTOR shall establish and maintain the minimum net worth requirements required by TDCI, including but not limited to TCA 56-32-212.

2.21.5.1.4 Any and all payments made by TENNCARE, including payments of the base capitation rate, priority add-on rate and any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1, as well as incentive payments (if applicable) and risk-sharing settlements to the CONTRACTOR shall be considered "Premium revenue" for the purpose of calculating the minimum net worth required by TCA 56-32-212.

2.21.5.1.5 The CONTRACTOR shall demonstrate evidence of its compliance with this provision to TDCI in the financial reports filed with TDCI by the CONTRACTOR. The CONTRACTOR agrees that failure to maintain any of the financial requirements in accordance with this Section 2.21.5.1 through 2.21.5.5, as determined by TDCI, shall constitute hazardous financial conditions as defined by TCA 56-32-212.

2.21.5.2 Statutory Net Worth for Enhanced Enrollment

In the event of a significant enrollment expansion as defined in TCA 56-32-203(c)(2):

2.21.5.2.1 The CONTRACTOR agrees that in order to maintain the minimum net worth requirements described in Section 2.21.5.1, the minimum net worth requirements are to be recalculated.

2.21.5.2.2 The calculation of minimum net worth shall be based upon annual projected premiums including the estimated premiums for the additional enrollment versus the prior year actual premium revenue. Estimated premiums will be based on the capitation payment rates in effect at the time of the calculation and projected future enrollment. The formula set forth in TCA 56-32-212(a)(2) shall then be applied to the annualized projected premiums to determine the enhanced minimum net worth requirement.

2.21.5.2.3 The CONTRACTOR must demonstrate to the satisfaction of TDCI that this enhanced minimum net worth balance has been established prior to the assignment of additional enrollees to the CONTRACTOR by TENNCARE.

2.21.5.2.4 The CONTRACTOR shall maintain the greater of the enhanced minimum net worth balance or the minimum net worth balance calculated pursuant to TCA 56-32-212, until the CONTRACTOR has completed a full calendar year with the significantly expanded enrollment.

2.21.5.3 Restricted Deposits

The CONTRACTOR shall achieve and maintain restricted deposits in an amount equal to net worth requirement specified in Section 2.21.5.1. TDCI shall calculate the amount of restricted deposits based on the CONTRACTOR's TennCare revenue only unless this calculation would result in restricted deposits below the statutory requirements set forth in TCA 56-32-212 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI. This contractual requirement shall in no way be construed as a way to circumvent, waive or modify the statutory requirement.

2.21.5.4 Restricted Deposits for Enhanced Enrollment

In the event of an increase in the CONTRACTOR's statutory net worth requirement as a result of a significant enrollment expansion as defined in TCA 56-32-203(c)(2), the CONTRACTOR shall increase its restricted deposit to equal its enhanced minimum net worth requirement required by Section 2.21.5.1. TDCI shall calculate the amount of the increased restricted deposits based on the CONTRACTOR's TennCare revenue only unless this calculation would result in restricted deposits

below the statutory requirements set forth in TCA 56-32-212 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI. This contractual requirement shall in no way be construed as a way to circumvent, waive or modify the statutory requirement. The CONTRACTOR must demonstrate to the satisfaction of TDCI that the CONTRACTOR has increased its restricted deposit in accordance with this Section prior to the assignment of additional enrollees to the CONTRACTOR by TENNCARE.

2.21.5.5 Liquidity Ratio Requirement

In addition to the positive working capital requirement described in TCA 56-32-212, the CONTRACTOR shall maintain a liquidity ratio where admitted assets consisting of cash, cash equivalents, short-term investments and bonds exceed total liabilities as reported on the NAIC financial statements.

2.21.5.6 If the CONTRACTOR fails to meet the applicable net worth and/or restricted deposit requirement, said failure shall constitute a hazardous financial condition and the CONTRACTOR shall be considered to be in breach of the terms of the Agreement.

2.21.6 **Accounting Requirements**

2.21.6.1 The CONTRACTOR shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this Agreement and any other costs and expenditures made under the Agreement.

2.21.6.2 Specific accounting records and procedures are subject to TENNCARE and federal approval. Accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the Agreement period and for five (5) years thereafter unless otherwise specified elsewhere in this Agreement.

2.21.7 **Insurance**

2.21.7.1 The CONTRACTOR shall obtain adequate worker's compensation and general liability insurance coverage prior to commencing any work in connection with this Agreement. Additionally, TENNCARE may require, at its sole discretion, the CONTRACTOR to obtain adequate professional malpractice liability or other forms of insurance. Any insurance required by TENNCARE shall be in the form and substance acceptable to TENNCARE.

2.21.7.2 The CONTRACTOR shall require that any subcontractors or contract providers obtain all similar insurance required of it prior to commencing work.

2.21.7.3 The CONTRACTOR shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to TENNCARE.

2.21.7.4 TENNCARE shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the CONTRACTOR, subcontractor and/or provider obtaining such insurance. The same holds true of any premiums paid on any insurance policy pursuant to this Agreement.

2.21.7.5 Failure to provide proof of adequate coverage within the specified time period may result in this Agreement being terminated.

2.21.8 **Ownership and Financial Disclosure**

The CONTRACTOR shall disclose, to TENNCARE, the Comptroller General or CMS, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379 of the Acts of 1999. This disclosure shall be made in accordance with the requirements in Section 2.30.14.2. The following information shall be disclosed:

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

2.21.8.2 The identity of any provider or subcontractor with whom the CONTRACTOR has had significant business transactions, defined as those totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the disclosure, and any significant business transactions between the CONTRACTOR, any wholly owned supplier, or between the CONTRACTOR and any provider or subcontractor, during the five (5) year period ending on the date of the disclosure;

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

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

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

2.21.8.5.1 The CONTRACTOR shall disclose the following transactions:

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

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

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

2.21.8.5.2 The information which must be disclosed in the transactions includes:

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

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

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

2.21.8.5.2.4 Justification of the reasonableness of each transaction.

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

2.21.8.5.4 A party in interest is:

2.21.8.5.4.1 Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

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

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

2.21.8.5.4.4 Any spouse, child, or parent of an individual described in Sections 2.21.8.5.4.1, 2.21.8.5.4.2, or 2.21.8.5.4.3

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

2.21.9 **Internal Audit Function**

The CONTRACTOR shall establish and maintain an internal audit function responsible for providing an independent review and evaluation of the CONTRACTOR's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The CONTRACTOR's internal audit function shall be responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. Further, the CONTRACTOR's internal audit department shall be responsible for performance of the claims payment accuracy tests as described in Section 2.22.6 of this Agreement.

2.21.10 **Audit of Business Transactions**

2.21.10.1 The CONTRACTOR shall cause an audit of its business transactions to be performed by a licensed certified public accountant, including but not limited to the financial transactions made under this Agreement. Such audit shall be performed in accordance with the requirements in Section 2.30.14.3.5 of this Agreement.

2.21.10.2 The agreement for such audits shall be subject to prior approval of the Comptroller of the Treasury and must be submitted on the standard "Contract to Audit Accounts". In the event that terms included in the standard contract to audit accounts differ from those contained in this Agreement, this Agreement takes precedent.

2.22 CLAIMS MANAGEMENT

2.22.1 **General**

To the extent that the CONTRACTOR compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the CONTRACTOR shall process, as described herein, the provider's claims for covered benefits provided to members consistent with applicable CONTRACTOR policies and procedures and the terms of this Agreement including but not limited to timely filing, and compliance with all applicable state and federal laws, rules and regulations.

2.22.2 **Claims Management System Capabilities**

2.22.2.1 The CONTRACTOR shall maintain a claims management system that can uniquely identify the provider of the service, date of receipt (the date the CONTRACTOR receives the claim as indicated by a date-stamp), real-time-accurate history of actions taken on each provider claim (i.e., paid, denied, suspended, appealed, etc.), date of payment (the date of the check or other form of payment) and all data elements as required by TENNCARE for encounter data submission (see Section 2.23), and can track service use against hard benefit limits and service thresholds in accordance with a methodology set by TENNCARE.

2.22.2.2 The CONTRACTOR shall have in place, an electronic claims management (ECM) capability that accepts and processes claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.).

2.22.2.3 The ECM capability shall function in accordance with information exchange and data management requirements specified in Section 2.23 of this Agreement.

2.22.2.4 As part of this ECM function, the CONTRACTOR shall also provide on-line and phone-based capabilities to obtain claims processing status information.

2.22.2.5 The CONTRACTOR shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

2.22.2.6 The CONTRACTOR shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the CONTRACTOR or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees/charges.

2.22.3 **Paper Based Claims Formats**

2.22.3.1 The CONTRACTOR shall comply at all times with standardized paper billing forms/formats (and all future updates) as follows:

Claim Type	Claim Form
Professional	CMS 1500
Institutional	CMS 1450
Dental	ADA

2.22.3.2 The CONTRACTOR shall not revise or modify the standardized forms or format.

2.22.3.3 For the forms identified in Section 2.22.3.1, the CONTRACTOR shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with TENNCARE. These shall include, but not be limited to, HIPAA-based standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, as well as TDCI rules for Uniform Claims Process for TennCare in accordance with TCA 71-5-191.

2.22.3.4 The CONTRACTOR agrees that at such time that TENNCARE in conjunction with appropriate work groups presents recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within ninety (90) calendar days from notice by TENNCARE.

2.22.4 **Prompt Payment**

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

2.22.4.2 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for services delivered to a TennCare enrollee are paid within thirty (30) calendar days of the receipt of such claims.

2.22.4.3 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for covered services delivered to a TennCare enrollee. The terms "processed and paid" are synonymous with terms "process and pay" of TCA 56-32-226(b)(1)(A) and (B).

2.22.4.4 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

2.22.4.5 To the extent that the provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the provider agreement/contract between the provider and the CONTRACTOR or subcontractor, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or (iii) if the CONTRACTOR is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting remittance advice information from TENNCARE.

2.22.4.6 The CONTRACTOR shall not deny provider claims on the basis of untimely filing in situations regarding coordination of benefits or subrogation, in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the CONTRACTOR's MCO with a retroactive eligibility date. In situations of third party benefits, the time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment.

2.22.4.7 As it relates to MCO Assignment Unknown (see Sections 2.13.7 and 2.13.8), the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the member was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.22.5 **Claims Dispute Management**

2.22.5.1 The CONTRACTOR shall have an internal claims dispute procedure that will be reviewed and approved by TENNCARE prior to its implementation.

2.22.5.2 The CONTRACTOR shall contract with independent reviewers to review disputed claims as provided by TCA 56-32-226.

2.22.5.3 The CONTRACTOR shall systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

2.22.6 **Claims Payment Accuracy – Minimum Audit Procedures**

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

2.22.6.2 The report shall be based on an audit conducted by the CONTRACTOR. The audit shall be conducted by an entity or staff independent of claims management. Requirements for the internal audit function are outlined in Section 2.21.9 of this Agreement.

2.22.6.3 The audit shall utilize a random sample of all "processed or paid" claims upon initial submission in each quarter (the terms "processed and paid" are synonymous with terms "process and pay" of TCA 56-32-226(b)(1)(A) and (B)). A minimum sample of three-hundred (300) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the quarter tested is required. The sample shall be further decomposed into minimum sub-samples of one-hundred (100) claims randomly selected from the entire population of claims processed and paid upon initial submission for each month in the quarter.

2.22.6.4 The minimum attributes to be tested for each claim selected shall include:

2.22.6.4.1 Claim data correctly entered into the claims processing system;

2.22.6.4.2 Claim is associated to the correct provider;

2.22.6.4.3 Service obtained the proper authorization;

2.22.6.4.4 Member eligibility at processing date correctly applied;

2.22.6.4.5 Allowed payment amount agrees with contracted rate;

2.22.6.4.6 Duplicate payment of the same claim has not occurred;

2.22.6.4.7 Denial reason applied appropriately;

2.22.6.4.8 Copayment application considered and applied;

2.22.6.4.9 Effect of modifier codes correctly applied;

2.22.6.4.10 Processing considered if service subject to hard benefit limits considered and applied;

2.22.6.4.11 Other insurance properly considered and applied;

2.22.6.4.12 Application of hard benefit limits; and

2.22.6.4.13 Proper coding including bundling/unbundling.

2.22.6.5 For audit and verification purposes, the population of claims should be maintained. Additionally, the results of testing at a minimum should be documented to include:

2.22.6.5.1 Results for each attribute tested for each claim selected;

2.22.6.5.2 Amount of overpayment or underpayment for claims processed or paid in error;

2.22.6.5.3 Explanation of the erroneous processing for each claim processed or paid in error;

2.22.6.5.4 Determination if the error is the result of keying errors or the result of errors in the configuration or table maintenance of the claims processing system; and

2.22.6.5.5 Claims processed or paid in error have been corrected.

2.22.7 **Claims Processing Methodology Requirements**

2.22.7.1 The CONTRACTOR shall perform front end system edits, including but not limited to:

2.22.7.1.1 Confirming eligibility on each enrollee as claims are submitted on the basis of the eligibility information provided by the State that applies to the period during which the charges were incurred;

2.22.7.1.2 Third party liability (TPL);

2.22.7.1.3 Medical necessity (e.g., appropriate age/sex for procedure);

2.22.7.1.4 Prior approval: the system shall determine whether a covered service required prior approval and, if so, whether the CONTRACTOR granted such approval;

2.22.7.1.5 Duplicate claims: the system shall in an automated manner flag a claim as being (1) exactly the same as a previously submitted claim or (2) a possible duplicate and either deny or pend the claim as needed;

2.22.7.1.6 Covered service: the system shall verify that a service is a covered service and is eligible for payment;

2.22.7.1.7 Provider validation: the system shall approve for payment only those claims received from providers eligible to render services for which the claim was submitted;

2.22.7.1.8 Quantity of service: the system shall evaluate claims for services provided to members to ensure that any applicable hard benefit limits are applied; and

2.22.7.1.9 Benefit limits: the system shall ensure that hard benefit limit rules set by TENNCARE are factored into the determination of whether a claim should be adjudicated and paid.

2.22.7.2 The CONTRACTOR shall perform system edits for valid dates of service: the system shall assure that dates of service are valid dates, e.g., not in the future or outside of a member's TennCare eligibility span.

2.22.7.3 The CONTRACTOR shall perform post-payment review on a sample of claims to ensure services provided were medically necessary.

2.22.7.4 The CONTRACTOR shall have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

2.22.8 **Explanation of Benefits (EOBs) and Related Functions**

2.22.8.1 The CONTRACTOR shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TENNCARE.

2.22.8.2 The CONTRACTOR shall omit any claims in the EOB file that are associated with sensitive services. The CONTRACTOR, with guidance from TENNCARE, shall develop "sensitive services" logic to be applied to the handling of said claims for EOB purposes.

2.22.8.3 At a minimum, EOBs shall be designed to address requirements found in 42 CFR 455.20 and 433.116 as well as requirements associated with a change in TennCare policy and shall include: claims for services with hard benefit limits, claims with enrollee cost sharing, denied claims with enrollee responsibility, and a sampling of paid claims (excluding ancillary and anesthesia services).

2.22.8.4 Regarding the paid claims sample referenced in Section 2.22.6.3, the CONTRACTOR shall stratify said sample to ensure that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the CONTRACTOR considers a particular specialty (or provider) to warrant closer scrutiny, the CONTRACTOR may over sample the group. The paid claims sample should be a minimum of twenty-five (25) claims per check run with a minimum of 100 claims per month.

2.22.8.5 Based on the EOBs sent to TennCare enrollees, the CONTRACTOR shall track any complaints received from enrollees and resolve the complaints according to its established policies and procedures. The resolution may be enrollee education, provider education, or referral to TBI/OIG. The CONTRACTOR shall use the feedback received to modify or enhance the EOB sampling methodology.

2.22.9 **Remittance Advices and Related Functions**

2.22.9.1 In concert with its claims payment cycle the CONTRACTOR shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as capitated payments generated and paid by the CONTRACTOR.

2.22.9.2 The status report shall contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to TPL data.

2.22.9.3 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice must specifically identify all such information and documentation.

2.22.9.4 In accordance with 42 CFR 455.18 and 455.19, the following statement must be included on each remittance advice sent to providers: ‘‘I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws.”

2.22.10 **Processing of Payment Errors**

The CONTRACTOR shall not employ off-system or gross adjustments when processing corrections to payment errors, unless it requests and receives prior written authorization from TENNCARE.

2.22.11 **Notification to Providers**

For purposes of network management, the CONTRACTOR shall, at a minimum, notify all contract providers to file claims associated with covered services directly with the CONTRACTOR, or its subcontractors, on behalf of TennCare enrollees.

2.22.12 **Payment Cycle**

At a minimum, the CONTRACTOR shall run one (1) provider payment cycle per week, on the same day each week, as determined by the CONTRACTOR and approved by TENNCARE.

2.22.13 **Excluded Providers**

2.22.13.1 The CONTRACTOR shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or is otherwise not in good standing with TENNCARE.

2.22.13.2 The CONTRACTOR shall not pay any claim submitted by a provider that is on payment hold under the authority of TENNCARE.

2.23 INFORMATION SYSTEMS

2.23.1 General Provisions

2.23.1.1 Systems Functions

The CONTRACTOR shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet TENNCARE and federal reporting requirements and other Agreement requirements and that are in compliance with this Agreement and all applicable state and federal laws, rules and regulations including HIPAA.

2.23.1.2 Systems Capacity

The CONTRACTOR's Systems shall possess capacity sufficient to handle the workload projected for the start date of operations and will be scaleable and flexible so they can be adapted as needed, within negotiated time frames, in response to changes in Agreement requirements, increases in enrollment estimates, etc.

2.23.1.3 Electronic Messaging

2.23.1.3.1 The CONTRACTOR shall provide a continuously available electronic mail communication link (e-mail system) with TENNCARE.

2.23.1.3.2 The e-mail system shall be capable of attaching and sending documents created using software products other than CONTRACTOR's Systems, including TENNCARE's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

2.23.1.3.3 As needed, the CONTRACTOR shall be able to communicate with TENNCARE using TENNCARE's e-mail system over a secure virtual private network (VPN).

2.23.1.3.4 As needed, based on the sensitivity of data contained in an electronic message, the CONTRACTOR shall support network-to-network encryption of said messages.

2.23.1.4 Participation in Information Systems Work Groups/Committees

The CONTRACTOR and TENNCARE shall establish an information systems work group/committee to coordinate activities and develop cohesive systems strategies among TENNCARE and the MCOs. The Work Group will meet on a designated schedule as agreed to by TENNCARE and the CONTRACTOR.

2.23.1.5 Connectivity to TENNCARE/State Network and Systems

The CONTRACTOR shall be responsible for establishing connectivity to TENNCARE's/the state's wide area data communications network, and the relevant information systems attached to this network, in accordance to all applicable TENNCARE and/or state policies, standards and guidelines.

2.23.1.6 Systems Refresh Plan

The CONTRACTOR shall provide to TENNCARE an annual Systems refresh plan (see Section 2.30.16). The plan shall outline how Systems within the CONTRACTOR's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The systems refresh plan will also indicate how the CONTRACTOR will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

2.23.2 **Data and Document Management Requirements**

2.23.2.1 Adherence to Data and Document Management Standards

2.23.2.1.1 The CONTRACTOR's Systems shall conform to the data and document management standards by information type/subtype detailed in the HIPAA Implementation and TennCare Companion guides, inclusive of the standard transaction code sets specified in the guides.

2.23.2.1.2 The CONTRACTOR's Systems shall conform to HIPAA standards for data and document management that are currently under development within one-hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or TENNCARE.

2.23.2.2 Data Model and Accessibility

The CONTRACTOR's Systems shall be SQL and/or ODBC compliant; alternatively, the CONTRACTOR's Systems shall employ a relational data model in the architecture of its databases in addition to a relational database management system (RDBMS) to operate and maintain said databases.

2.23.2.3 Data and Document Relationships

2.23.2.3.1 When the CONTRACTOR houses indexed images of documents used by members and providers to transact with the CONTRACTOR the CONTRACTOR shall ensure that these documents maintain logical relationships to certain key data such as member identification and provider identification number.

2.23.2.3.2 The CONTRACTOR shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, e.g., interactions with a particular member about a reported problem.

2.23.2.3.3 Upon TENNCARE request, the CONTRACTOR shall be able to generate a listing of all members and providers that were sent a particular document, the date and time

that the document was generated, and the date and time that it was sent to particular members or providers or groups thereof. The CONTRACTOR shall also be able to generate a sample of said document.

2.23.2.4 Information Retention

2.23.2.4.1 The CONTRACTOR shall provide and maintain a comprehensive information retention plan that is in compliance with state and federal requirements. The plan shall comply with the applicable requirements of the Tennessee Department of General Services, Records Management Division.

2.23.2.4.2 The CONTRACTOR shall maintain information on-line for a minimum of three (3) years, based on the last date of update activity, and update detailed and summary history data monthly for up to three (3) years to reflect adjustments.

2.23.2.4.3 The CONTRACTOR shall provide twenty-four (24) hour turnaround or better on requests for access to information that is between three (3) years and six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is between six (6) and ten (10) years old.

2.23.2.4.4 If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

2.23.2.5 Information Ownership

All information, whether data or documents, and reports that contain or make references to said information, involving or arising out of this Agreement is owned by TENNCARE. The CONTRACTOR is expressly prohibited from sharing or publishing TENNCARE information and reports without the prior written consent of TENNCARE.

2.23.3 **System and Data Integration Requirements**

2.23.3.1 Adherence to Standards for Data Exchange

2.23.3.1.1 The CONTRACTOR's Systems shall be able to transmit, receive and process data in HIPAA-compliant or TENNCARE-specific formats and methods, including but not limited to secure File Transfer Protocol (FTP) over a secure connection such as a VPN, that are in use at the start of Systems readiness review activities. These formats are detailed in the HIPAA Implementation and TennCare Companion guides.

2.23.3.1.2 The CONTRACTOR's Systems shall conform to future federal and/or TENNCARE specific standards for data exchange within one-hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or TENNCARE. The CONTRACTOR shall partner with TENNCARE in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the CONTRACTOR shall conform to these standards as stipulated in the plan to implement such standards.

2.23.3.2 HIPAA Compliance Checker

All HIPAA-conforming exchanges of data between TENNCARE and the CONTRACTOR shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.

2.23.3.3 TENNCARE/State Website/Portal Integration

Where deemed that the CONTRACTOR's Web presence will be incorporated to any degree to TENNCARE's or the state's web presence/portal, the CONTRACTOR shall conform to the applicable TENNCARE or state standards for website structure, coding and presentation.

2.23.3.4 Connectivity to and Compatibility/Interoperability with TENNCARE Systems and IS Infrastructure

2.23.3.4.1 The CONTRACTOR shall be responsible for establishing connectivity to TENNCARE's/the state's wide area data communications network, and the relevant information systems attached to this network, in accordance to all applicable TENNCARE and/or state policies, standards and guidelines.

2.23.3.4.2 All of the CONTRACTOR's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with TENNCARE and/or state systems and shall conform to applicable standards and specifications set by TENNCARE and/or the state agency that owns the system.

2.23.3.5 Data Exchange in Support of TENNCARE's Program Integrity and Compliance Functions

The CONTRACTOR's System(s) shall be capable of generating files in the prescribed formats for upload into TENNCARE Systems used specifically for program integrity and compliance purposes.

2.23.3.6 Address Standardization

The CONTRACTOR's System(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

2.23.4 **Encounter Data Provision Requirements (Encounter Submission and Processing)**

2.23.4.1 Adherence to HIPAA Standards

The CONTRACTOR's Systems are required to conform to HIPAA-standard transaction code sets as specified in the HIPAA Implementation and TennCare Companion guides.

2.23.4.2 Quality of Submission

2.23.4.2.1 The CONTRACTOR shall submit encounter data that meets established TENNCARE data quality standards. These standards are defined by TENNCARE to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. TENNCARE will revise and amend these standards as necessary to ensure continuous quality improvement. The CONTRACTOR shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with TENNCARE data quality standards as originally defined or subsequently amended. The CONTRACTOR shall comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim. In the event that the CONTRACTOR denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the CONTRACTOR shall submit all available claim data to TENNCARE without alteration or omission. Where the CONTRACTOR has entered into capitated reimbursement arrangements with providers, the CONTRACTOR must require submission of all utilization or encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims (see Section 2.12.7.31); the CONTRACTOR shall require this submission from providers as a condition of the capitation payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data. The CONTRACTOR shall be required to submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by TENNCARE, in order to support comprehensive financial reporting and utilization analysis. The CONTRACTOR must submit encounter data according to standards and formats as defined by TENNCARE, complying with standard code sets and maintaining integrity with all reference data sources including provider and member data. All encounter data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the CONTRACTOR for immediate correction. Due to the need for timely data and to maintain integrity of processing sequence, the CONTRACTOR shall address any issues that prevent processing of an encounter batch in accordance with procedures specified in Section 2.23.13.

2.23.4.2.2 TENNCARE will reject or report individual claims or encounters failing certain edits, as deemed appropriate and necessary by TENNCARE to ensure accurate processing or encounter data quality, and will return these transactions to the CONTRACTOR for research and resolution. TENNCARE will require expeditious action on the part of the CONTRACTOR to resolve errors or problems associated with said claims or the adjudication thereof, including any necessary changes or corrections to any systems, processes or data transmission formats, in accordance with the procedure specified in Section 2.23.13. Generally the CONTRACTOR shall, unless otherwise directed by TENNCARE, address ninety percent (90%) of reported errors within thirty (30) calendar days and address ninety-nine percent (99%) of reported errors within sixty (60) calendar days. Such errors will be considered acceptably addressed when the CONTRACTOR has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or

documentation that substantiates the dispute. TENNCARE may require resubmission of the transaction with reference to the original in order to document resolution. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan as required, may result in damages and sanctions as described in Section 2.23.13.

2.23.4.3 Provision of Encounter Data

2.23.4.3.1 Within forty-eight (48) hours of the end of a payment cycle the CONTRACTOR shall generate encounter data files for that payment cycle from its claims management system(s) and/or other sources.

2.23.4.3.2 Any encounter data from a subcontractor shall be included in the file from the CONTRACTOR. The CONTRACTOR shall not submit separate encounter files from subcontractors.

2.23.4.3.3 The files shall contain settled claims and claim adjustments, including but not limited to adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the CONTRACTOR has a capitation arrangement.

2.23.4.3.4 The level of detail associated with encounters from providers with whom the CONTRACTOR has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the CONTRACTOR received and settled a fee-for-service claim.

2.23.4.3.5 The CONTRACTOR shall adhere to federal and/or TENNCARE payment rules in the definition and treatment of certain data elements, e.g., units of service, that are standard fields in the encounter data submissions and will be treated similarly by TENNCARE across all MCOs.

2.23.4.3.6 The CONTRACTOR shall provide encounter data files electronically to TENNCARE in adherence to the procedure and format indicated in the HIPAA Implementation and TennCare Companion guides.

2.23.4.3.7 The CONTRACTOR shall institute processes to insure the validity and completeness of the data it submits to TENNCARE. At its discretion, TENNCARE will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: member ID, date of service, provider ID, category and sub category (if applicable) of service, diagnosis codes, procedure codes and modifiers, revenue codes, adherence to hard benefit limits, date of claim processing, and date of claim payment. Control totals shall also be reviewed and verified. Additionally, the CONTRACTOR shall reconcile all encounter data submitted to the State to control totals and to the CONTRACTOR's check register and/or invoices and supply the reconciliation to TENNCARE with the encounter data submission.

2.23.4.3.8 Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the CONTRACTOR's applicable reimbursement methodology for that service.

2.23.4.3.9 The CONTRACTOR shall be able to receive, maintain and utilize data extracts from TENNCARE and its contractors, e.g., pharmacy data from TENNCARE or its PBM.

2.23.5 **Eligibility and Enrollment Data Exchange Requirements**

2.23.5.1 The CONTRACTOR shall receive, process and update enrollment files sent daily by TENNCARE.

2.23.5.2 The CONTRACTOR shall update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files.

2.23.5.3 The CONTRACTOR shall transmit to TENNCARE, in the formats and methods specified in the HIPAA Implementation and TennCare Companion guides or as otherwise specified by TENNCARE: member address changes, telephone number changes, and PCP.

2.23.5.4 The CONTRACTOR shall be capable of uniquely identifying a distinct TennCare member across multiple populations and Systems within its span of control.

2.23.5.5 The CONTRACTOR shall be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by TENNCARE, and resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

2.23.6 **System and Information Security and Access Management Requirements**

2.23.6.1 The CONTRACTOR's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

2.23.6.1.1 Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;

2.23.6.1.2 Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions will be restricted to specified staff jointly agreed to by TENNCARE and the CONTRACTOR; and

2.23.6.1.3 Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

2.23.6.2 The CONTRACTOR shall make System information available to duly authorized representatives of TENNCARE and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

2.23.6.3 The CONTRACTOR's Systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the CONTRACTOR and TENNCARE.

2.23.6.4 Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

2.23.6.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

2.23.6.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;

2.23.6.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;

2.23.6.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs;

2.23.6.4.5 Facilitate auditing of individual records as well as batch audits; and

2.23.6.4.6 Be maintained online for no less than two (2) years; additional history shall be retained for no less than ten (10) years and shall be retrievable within 48 hours.

2.23.6.5 The CONTRACTOR's Systems shall have inherent functionality that prevents the alternation of finalized records.

2.23.6.6 The CONTRACTOR shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The CONTRACTOR shall provide TENNCARE with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Agreement.

2.23.6.7 The CONTRACTOR shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

2.23.6.8 The CONTRACTOR shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

2.23.6.9 The CONTRACTOR shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CONTRACTOR's span of control. This includes but is not limited to: no provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access.

2.23.6.10 The CONTRACTOR shall ensure that remote access users of its Systems can only access said Systems via a Virtual Private Network (VPN) and by two-factor user authentication before allowing access to said network and the IS resources accessible therein.

2.23.6.11 The CONTRACTOR shall comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. At a minimum, the CONTRACTOR shall conduct a security risk assessment and communicate the results in an information security plan provided prior to the start date of operations. The risk assessment shall also be made available to appropriate federal agencies.

2.23.7 **Systems Availability, Performance and Problem Management Requirements**

2.23.7.1 The CONTRACTOR shall ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to Confirmation of MCO Enrollment (CME), ECM, and self-service customer service functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled System unavailability agreed upon by TENNCARE and the CONTRACTOR. Unavailability caused by events outside of a CONTRACTOR's span of control is outside of the scope of this requirement.

2.23.7.2 The CONTRACTOR shall ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7 a.m. and 7 p.m. Central Time Monday through Friday.

2.23.7.3 The CONTRACTOR shall ensure that the systems and processes within its span of control associated with its data exchanges with TENNCARE are available and operational according to specifications and the data exchange schedule.

2.23.7.4 In the event of a declared major failure or disaster, the CONTRACTOR's core eligibility/enrollment and claims processing systems shall be back online within seventy-two (72) hours of the failure's or disaster's occurrence.

2.23.7.5 Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of critical systems functions and the availability of critical information as defined in this Section of the Agreement, including any problems impacting scheduled exchanges of data between the CONTRACTOR and TENNCARE, the CONTRACTOR shall notify the applicable TennCare staff via phone, fax and/or electronic mail within sixty (60) minutes of such discovery. In its notification the CONTRACTOR shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes.

2.23.7.6 Where the problem results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, the CONTRACTOR shall notify the applicable TENNCARE staff within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocols.

2.23.7.7 The CONTRACTOR shall provide to appropriate TENNCARE staff information on System unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

2.23.7.8 The CONTRACTOR shall resolve unscheduled System unavailability of CME and ECM functions, caused by the failure of systems and telecommunications technologies within the CONTRACTOR's span of control, and shall implement the restoration of services, within sixty (60) minutes of the official declaration of System unavailability. Unscheduled System unavailability to all other CONTRACTOR System functions caused by systems and telecommunications technologies within the CONTRACTOR's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability.

2.23.7.9 Cumulative System unavailability caused by systems and/or IS infrastructure technologies within the CONTRACTOR's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period.

2.23.7.10 The CONTRACTOR shall not be responsible for the availability and performance of systems and IS infrastructure technologies outside of the CONTRACTOR's span of control.

2.23.7.11 Within five (5) business days of the occurrence of a problem with system availability, the CONTRACTOR shall provide TENNCARE with full written documentation that includes a corrective action plan describing how the CONTRACTOR will prevent the problem from occurring again.

2.23.7.12 <u>Business Continuity and Disaster Recovery (BC-DR) Plan</u>

2.23.7.12.1 Regardless of the architecture of its Systems, the CONTRACTOR shall develop and be continually ready to invoke a BC-DR plan that is reviewed and prior approved by TENNCARE.

2.23.7.12.2 At a minimum the CONTRACTOR's BC-DR plan shall address the following scenarios: (a) the central computer installation and resident software are destroyed or damaged, (b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (c) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, and (d) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e., causes unscheduled System unavailability.

2.23.7.12.3 The CONTRACTOR's BC-DR plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

2.23.7.12.4 The CONTRACTOR shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to TENNCARE that it can restore System functions per the standards outlined elsewhere in this Section, Section 2.23 of the Agreement.

2.23.7.12.5 The CONTRACTOR shall submit a baseline BC-DR plan to TENNCARE and communicate proposed modifications as required in Section 2.30.16.

2.23.8 **System User and Technical Support Requirements**

2.23.8.1 The CONTRACTOR shall provide Systems Help Desk (SHD) services to all TENNCARE staff and the other agencies that may have direct access to CONTRACTOR systems.

2.23.8.2 The CONTRACTOR's SHD shall be available via local and toll free telephone service and via e-mail from 7 a.m. to 7 p.m. Central Time Monday through Friday, with the exception of State of Tennessee holidays. Upon TENNCARE request, the CONTRACTOR shall staff the SHD on a state holiday, Saturday, or Sunday.

2.23.8.3 The CONTRACTOR's SHD staff shall answer user questions regarding CONTRACTOR System functions and capabilities; report recurring programmatic and operational problems to appropriate CONTRACTOR or TENNCARE staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate TENNCARE login account administrator.

2.23.8.4 The CONTRACTOR shall ensure individuals who place calls to the SHD between the hours of 7 p.m. and 7 a.m. Central Time shall be able to leave a message. The CONTRACTOR's SHD shall respond to messages by noon the following business day.

2.23.8.5 The CONTRACTOR shall ensure recurring problems not specific to System unavailability identified by the SHD shall be documented and reported to CONTRACTOR management within one (1) business day of recognition so that deficiencies are promptly corrected.

2.23.8.6 The CONTRACTOR shall have an IS service management system that provides an automated method to record, track and report on all questions and/or problems reported to the SHD.

2.23.9 **System Testing and Change Management Requirements**

2.23.9.1 The CONTRACTOR shall notify the applicable TENNCARE staff person of the following changes to Systems within its span of control within at least ninety (90) calendar days of the projected date of the change.

2.23.9.1.1 Major changes, upgrades, modifications or updates to application or operating software associated with the following core production Systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, and encounter data management; and

2.23.9.1.2 Conversions of core transaction management Systems.

2.23.9.2 If so directed by TENNCARE, the CONTRACTOR shall discuss the proposed change in the Systems work group.

2.23.9.3 The CONTRACTOR shall respond to TENNCARE notification of System problems not resulting in System unavailability according to the following time frames:

2.23.9.3.1 Within five (5) calendar days of receiving notification from TENNCARE the CONTRACTOR shall respond in writing to notices of system problems.

2.23.9.3.2 Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.

2.23.9.3.3 The CONTRACTOR shall correct the deficiency by an effective date to be determined by TENNCARE.

2.23.9.3.4 The CONTRACTOR's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.

2.23.9.3.5 The CONTRACTOR shall put in place procedures and measures for safeguarding against unauthorized modifications to CONTRACTOR Systems.

2.23.9.4 Valid Window for Certain System Changes

Unless otherwise agreed to in advance by TENNCARE as part of the activities described in this Section 2.23.9, the CONTRACTOR shall not schedule System unavailability to perform System maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.

2.23.9.5 Testing

2.23.9.5.1 The CONTRACTOR shall work with TENNCARE pertaining to any testing initiative as required by TENNCARE.

2.23.9.5.2 The CONTRACTOR shall provide sufficient system access to allow testing by TENNCARE of the CONTRACTOR's systems during readiness review (see Section 2.1.2) and as required during the term of the Agreement.

2.23.10 **Information Systems Documentation Requirements**

2.23.10.1 The CONTRACTOR shall ensure that written System process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

2.23.10.2 The CONTRACTOR shall develop, prepare, print, maintain, produce, and distribute to TENNCARE distinct System design and management manuals, user manuals and quick/reference guides, and any updates.

2.23.10.3 The CONTRACTOR's System user manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system data.

2.23.10.4 When a System change is subject to TENNCARE prior approval, the CONTRACTOR shall submit revisions to the appropriate manuals for prior approval before implementing said System changes.

2.23.10.5 All of the aforementioned manuals and reference guides shall be available in printed form and/or on-line. If so prescribed, the manuals will be published in accordance to the appropriate TENNCARE and/or TENNCARE standard.

2.23.10.6 The CONTRACTOR shall update the electronic version of these manuals immediately; updates to the printed version of these manuals shall occur within ten (10) business days of the update taking effect.

2.23.11 **Reporting Requirements (Specific to Information Management and Systems Functions and Capabilities)**

2.23.11.1 The CONTRACTOR shall comply with all reporting requirements as described in Section 2.30.16 of this Agreement.

2.23.11.2 The CONTRACTOR shall provide systems-based capabilities for access by authorized TENNCARE personnel, on a secure and read-only basis, to data that can be used in ad hoc reports.

2.23.12 **Other Requirements**

2.23.12.1 Statewide Data Warehouse Requirements

The CONTRACTOR shall participate in a statewide effort to tie all hospitals, physicians, and other providers' information into a data warehouse that shall include, but will not be limited to, claims information, formulary information, medically necessary service information, cost sharing information and a listing of providers by specialty for each MCO.

2.23.12.2 Community Health Record for TennCare Enrollees (Electronic Medical Record)

2.23.12.2.1 At such time that TENNCARE requires, the CONTRACTOR shall participate and cooperate with TennCare to implement, within a reasonable time frame, a secure, Web-accessible community health record for TennCare enrollees.

2.23.12.2.2 The design of the Web site for accessing the community health record and the record format and design shall comply with HIPAA, other federal and all state privacy and confidentiality regulations.

2.23.12.2.3 The CONTRACTOR shall provide a Web-based access vehicle for contract providers to the System described in Section 2.23.12.2.1, and shall work with said providers to encourage adoption of this System.

2.23.13 **Corrective Actions, Liquidated Damages and Sanctions Related to Information Systems**

2.23.13.1 Within five (5) business days of receipt of notice from TENNCARE of the occurrence of a problem with the provision and/or intake of an encounter or enrollment file, the CONTRACTOR shall provide TENNCARE with full written documentation that includes acknowledgement of receipt of the notice, a corrective action plan describing how the CONTRACTOR has addressed or will address the immediate problem and how the CONTRACTOR shall prevent the problem from recurring. In the event that the CONTRACTOR fails to correct errors which prevent processing of encounter or enrollment data in a timely manner as required by TENNCARE, fails to submit a corrective action plan as requested or required, or fails to comply with an accepted corrective action plan, TENNCARE may assess liquidated damages as specified in Section 4.20.2. Continued or repeated failure to submit clean encounter data may result in the application of additional damages or sanctions, including possible forfeiture of the withhold (see Section 3.9), or be considered a breach of the Agreement.

2.23.13.2 Individual records submitted by the CONTRACTOR may be rejected; these records, once errors therein have been corrected, shall be resubmitted by the CONTRACTOR as stipulated by TENNCARE. In the event that the CONTRACTOR is unable to research or address reported errors in a timely manner as required by TENNCARE, the CONTRACTOR shall submit to TENNCARE a corrective action plan describing how the CONTRACTOR will research and address the errors and how the CONTRACTOR shall prevent the problem from recurring within five (5) business days of receipt of notice from TENNCARE that individual records submitted by the CONTRACTOR have been rejected. In the event that the CONTRACTOR fails to address or resolve problems with individual records in a timely manner as required by TENNCARE, which shall include failure to submit a corrective action plan as requested or required, or failure to comply with an accepted corrective action plan, TENNCARE may assess liquidated damages as specified in Section 4.20.2. Continued or repeated failure to address reported errors may result in additional damages or sanctions including possible forfeiture of the withhold (see Section 3.9) or be considered a breach of the Agreement.

2.23.13.3 In the event that the CONTRACTOR fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Agreement, the CONTRACTOR shall submit to TENNCARE a corrective action plan that describes how the failure will be resolved. The corrective action plan shall be delivered within five (5) business days of the conclusion of the test.

2.24 ADMINISTRATIVE REQUIREMENTS

2.24.1 **General Responsibilities**

2.24.1.1 TENNCARE shall be responsible for management of this Agreement. Management shall be conducted in good faith with the best interest of the State and the citizens it serves being the prime consideration. Management of TennCare shall be conducted in a manner consistent with simplicity of administration and the best interests of enrollees, as required by 42 USC 1396a(a)(19).

2.24.1.2 The CONTRACTOR shall be responsible for complying with the requirements of this Agreement and shall act in good faith in the performance of the requirements of this Agreement.

2.24.1.3 The CONTRACTOR shall develop policies and procedures that describe how the CONTRACTOR will comply with the requirements of this Agreement, and the CONTRACTOR shall administer this Agreement in accordance with those policies and procedures unless otherwise directed or approved by TENNCARE.

2.24.1.4 The CONTRACTOR shall submit policies and procedures and other deliverables specified by TENNCARE to TENNCARE for review and/or approval in the format and within the time frames specified by TENNCARE. The CONTRACTOR shall make any changes requested by TENNCARE to policies and procedures or other deliverables and in the time frames specified by TENNCARE.

2.24.1.5 As provided in Section 4.10 of this Agreement, should the CONTRACTOR have a question on policy determinations, benefits, or operating guidelines required for proper performance of the CONTRACTOR's responsibilities, the CONTRACTOR shall request a determination from TENNCARE in writing.

2.24.2 **Behavioral Health Advisory Committee**

The CONTRACTOR shall establish a behavioral health advisory committee that is accountable to the CONTRACTOR's governing body to provide input and advice regarding all aspects of the provision of behavioral health services according to the following requirements:

2.24.2.1 The CONTRACTOR's behavioral health advisory committee must be comprised of at least fifty-one percent (51%) consumer and family representatives, of which the majority must include families of adults with serious and/or persistent mental illness (SPMI) and families of children with serious emotional disturbance (SED);

2.24.2.2 There must be geographic diversity;

2.24.2.3 There must be cultural and racial diversity;

2.24.2.4 There must be representation by providers and consumers (or family members of consumers) of substance abuse services;

2.24.2.5 At a minimum, the CONTRACTOR's behavioral health advisory committee must have input into policy development, planning for services, service evaluation, and member, family member and provider education;

2.24.2.6 Meetings must be held at least quarterly;

2.24.2.7 Travel costs must be paid by the CONTRACTOR;

2.24.2.8 The CONTRACTOR shall report on the activities of the CONTRACTOR's behavioral health advisory committee as required in Section 2.30.17; and

2.24.2.9 The CONTRACTOR, as membership changes, must submit current membership lists to the State.

2.24.3 **Performance Standards**

The CONTRACTOR agrees TENNCARE may assess liquidated damages for failure to meet the performance standards specified in Attachment VII.

2.24.4 **Medical Records Requirements**

2.24.4.1 The CONTRACTOR shall maintain, and shall require contract providers and subcontractors to maintain, medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions.

2.24.4.2 The CONTRACTOR shall have medical record keeping policies and practices which are consistent with 42 CFR 456 and current NCQA standards for medical record documentation. The CONTRACTOR shall distribute these policies to practice sites. At a minimum, the policies and procedures shall address:

2.24.4.2.1 Confidentiality of medical records;

2.24.4.2.2 Medical record documentation standards; and

2.24.4.2.3 The medical record keeping system and standards for the availability of medical records. At a minimum the following shall apply:

2.24.4.2.3.1 Medical records shall be maintained or available at the site where covered services are rendered;

2.24.4.2.3.2 Enrollees (for purposes of behavioral health records, enrollee includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 *et seq.*, and, subject to reasonable charges, (except as provided in Section 2.24.4.2.3.3. below) be given copies thereof upon request;

2.24.4.2.3.3 Provisions for ensuring that, in the event a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care provider, the first provider does not charge the enrollee or the second provider for providing the medical records; and

2.24.4.2.3.4 Performance goals to assess the quality of medical record keeping.

2.24.4.2.4 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records in conformity with TCA 33-3-101 *et seq.* for persons with serious emotional disturbance or mental illness.

2.24.4.2.5 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent.

2.25 MONITORING

2.25.1 General

2.25.1.1 TENNCARE, in its daily activities, shall monitor the CONTRACTOR for compliance with the provisions of this Agreement.

2.25.1.2 TENNCARE, CMS, or their representatives shall at least annually monitor the operation of the CONTRACTOR for compliance with the provisions of this Agreement and applicable federal and state laws and regulations. Monitoring activities shall include, but not be limited to, inspection of the CONTRACTOR's facilities, auditing and/or review of all records developed under this Agreement including periodic medical audits, appeals, enrollments, disenrollments, termination of providers, utilization and financial records, reviewing management systems and procedures developed under this Agreement and review of any other areas or materials relevant to or pertaining to this Agreement. TENNCARE will emphasize case record validation because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes.

2.25.1.3 TENNCARE shall prepare a report of its findings and recommendations and require the CONTRACTOR to develop corrective action plans as appropriate.

2.25.2 Facility Inspection

TENNCARE, CMS, or their representatives may conduct on-site inspections of all health facilities and service delivery sites to be utilized by the CONTRACTOR in fulfilling the obligations under this Agreement. Inspections may be made at anytime during the Agreement period and without prior notice.

2.25.3 Inspection of Work Performed

TENNCARE, CMS, or their representatives shall, at all reasonable times, have the right to enter into the CONTRACTOR's premises, or such other places where duties of this Agreement are being performed, to inspect, monitor, or otherwise evaluate including periodic audits of the work being performed. The CONTRACTOR and all other subcontractors or providers must supply reasonable access to all facilities and assistance for TENNCARE's representatives. All inspections and evaluations shall be performed in such a manner as to minimize disruption of normal business.

2.25.4 Approval Process

2.25.4.1 As specified by TENNCARE, TENNCARE must approve various deliverables/items before they can be implemented by the CONTRACTOR.

2.25.4.2 At any time that approval of TENNCARE is required in this Agreement, such approval shall not be considered granted unless TENNCARE issues its approval in writing.

2.25.4.3 The CONTRACTOR and TENNCARE shall agree to the appropriate deliverables (see Attachment VIII), deliverable instructions, submission and approval time frames, and technical assistance as required.

2.25.4.4 Should TENNCARE not respond to a submission of a deliverable in the amount of time agreed to by TENNCARE and the CONTRACTOR, the CONTRACTOR shall not be penalized with either liquidated damages or a withhold as a result of implementing the item awaiting approval. However, failure by TENNCARE to assess liquidated damages or withholds shall not preclude TENNCARE from requiring the CONTRACTOR to rescind or modify the item if it is determined by TENNCARE to be in the best interest of the TennCare program.

2.25.5 **Availability of Records**

2.25.5.1 The CONTRACTOR shall ensure within its own organization and pursuant to any agreement the CONTRACTOR may have with any other providers of service, including, but not limited to providers, subcontractors or any person or entity receiving monies directly or indirectly by or through TennCare, that TENNCARE representatives and authorized federal, state and Comptroller of the Treasury personnel, including, but not limited to TENNCARE, the Office of the Inspector General (OIG), the Medicaid Fraud Control Unit (MFCU), the Department of Health and Human Services, Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to services provided to TennCare enrollees.

2.25.5.2 The CONTRACTOR and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through TennCare shall make all records (including but not limited to, financial and medical records) available at the CONTRACTOR's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Comptroller of Treasury personnel, including representatives from the OIG, the MFCU, DOJ and the DHHS OIG, TENNCARE or any duly authorized state or federal agency. Access will be either through on-site review of records or through the mail at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. The CONTRACTOR shall send all records to be sent by mail to TENNCARE within twenty (20) business days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE, authorized federal, state, and Comptroller of Treasury personnel, including representatives from the OIG, the MFCU, DOJ and the DHHS OIG, or any duly authorized state or federal agency. Records related to appeals shall be forwarded within the time frames specified in the appeal process portion of this Agreement. Such requests made by TENNCARE shall not be unreasonable.

2.25.5.3 The CONTRACTOR and any of its subcontractors, providers or any entity or person directly or indirectly receiving monies originating from TennCare, shall make all records, including, but not limited to, financial, administrative and medical records available to any duly authorized government agency, including but not limited to TENNCARE, OIG, MFCU, DHHS OIG and DOJ, upon any authorized government agency's request. Any authorized government agency, including but not limited to OIG, MFCU, DHHS OIG and DOJ, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.

2.25.5.4 The CONTRACTOR, any CONTRACTOR's management company and any CONTRACTOR's claims processing subcontractor shall cooperate with the State, or any of the State's contractors and agents, including, but not limited to TENNCARE, OIG, MFCU, DOJ and the DHHS OIG, and the Office of the Comptroller, and any duly authorized governmental agency, during the course of any claims processing, financial or operational examinations or during any administrative, civil or criminal investigation, hearing or prosecution. This cooperation shall include, but shall not be limited to the following:

2.25.5.4.1 Providing full cooperation and direct and unrestricted access to facilities, information, and staff, including facilities, information and staff of any management company or subcontractor, to the State or any of the State's contractors and agents, which includes, but is not limited to TENNCARE, OIG, MFCU, DOJ and the DHHS OIG, and the Office of the Comptroller and any duly authorized governmental agency, including federal agencies; and

2.25.5.4.2 Maintaining full cooperation and open authority for claims processing systems access and mailroom visits by TDCI or designated representatives or any authorized entity of the state or federal government, and to cooperate fully with detail claims testing for claims processing system compliance.

2.25.5.5 The CONTRACTOR shall cooperate fully with audits the State may conduct of medical management to include clinical processes and outcomes, internal audits, provider networks, and any other aspect of the program the State deems appropriate. The State may select any qualified person or organization to conduct the audits.

2.25.6 **Audit Requirements**

The CONTRACTOR and its providers, subcontractors and other entities receiving monies originating by or through TennCare shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section 2.20 of this Agreement. Records other than medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for any authorized federal, state, including, but not limited to TENNCARE, OIG, MFCU, DOJ and the DHHS OIG, and Comptroller personnel during the Agreement period and five (5) years thereafter, unless an audit, administrative, civil or criminal

investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the Agreement period, these records shall be available at the CONTRACTOR's chosen location in Tennessee subject to the approval of TENNCARE. If the records need to be sent to TENNCARE, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR, subcontractor or provider records must be requested and approved by TENNCARE.

2.25.7 Independent Review of the CONTRACTOR

2.25.7.1 The CONTRACTOR shall cooperate fully with TENNCARE's External Quality Review Organization (EQRO) which will conduct a periodic and/or an annual independent review of the CONTRACTOR.

2.25.7.2 The CONTRACTOR shall cooperate fully with any evaluation of the TennCare program conducted by CMS.

2.25.8 Accessibility for Monitoring

For purposes of monitoring under this Agreement, the CONTRACTOR shall make available to TENNCARE or its representative and other authorized state and federal personnel, all records, books, documents, and other evidence pertaining to this Agreement, as well as appropriate administrative and/or management personnel who administer the MCO. The monitoring shall occur periodically during the Agreement period and may include announced or unannounced visits, or both.

2.25.9 Corrective Action Requirements

2.25.9.1 If TENNCARE determines that the CONTRACTOR is not in compliance with one or more requirements of this Agreement, TENNCARE will issue a notice of deficiency identifying the deficiency(ies), follow-up recommendations/requirements (e.g., a request for a corrective action plan), and time frames for follow-up.

2.25.9.2 Upon receipt of a notice of deficiency(ies) from TENNCARE, the CONTRACTOR shall comply with all recommendations/requirements made in writing by TENNCARE within the time frames specified by TENNCARE.

2.25.9.3 The CONTRACTOR shall be responsible for ensuring corrective action when a subcontractor or provider is not in compliance with the Agreement.

2.26 SUBCONTRACTS

2.26.1 Subcontract Relationships and Delegation

If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below:

2.26.1.1 The CONTRACTOR shall evaluate the prospective subcontractor's ability to perform the activities to be delegated;

2.26.1.2 The CONTRACTOR shall require that the agreement be in writing and specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;

2.26.1.3 The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations;

2.26.1.4 The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary; and

2.26.1.5 If the subcontract is for purposes of providing or securing the provision of covered services to enrollees, the CONTRACTOR shall ensure that all requirements described in Section 2.12 of this Agreement are included in the subcontract and/or a separate provider agreement executed by the appropriate parties.

2.26.2 **Legal Responsibility**

The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement and the MCO covered thereunder including all subcontracts/subcontractors. The CONTRACTOR shall ensure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor for purposes of this Agreement without prior written approval of the CONTRACTOR. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Agreement are carried out in compliance with the Agreement.

2.26.3 **Prior Approval**

All subcontracts, as defined in Section 1 of this Agreement, and revisions thereto shall be approved in advance in writing by TENNCARE. The CONTRACTOR shall revise subcontracts as directed by TENNCARE. Approval of subcontracts shall not be considered granted unless TENNCARE issues its approval in writing. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to TENNCARE within thirty (30) calendar days of execution. This written prior approval requirement does not relieve the CONTRACTOR of any responsibilities to submit all proposed material modifications of the CONTRACTOR's MCO operations to TDCI for prior review and approval as required by Title 56, Chapter 32, Part 2.

2.26.4 **Subcontracts for Behavioral Health Services**

If the CONTRACTOR subcontracts for the provision of behavioral health services, the CONTRACTOR shall comply with the requirements in Section 2.9.6.2 regarding coordination of physical health and behavioral health services.

2.26.5 **Standards**

The CONTRACTOR shall require and ensure that the subcontractor complies with all applicable requirements in this Agreement. This includes, but is not limited to, Sections 2.19, 2.21.6, 2.25.5, 2.25.6, 2.25.8, 2.25.9, 4.3, 4.19, 4.30, and 4.31 of this Agreement.

2.26.6 **Quality of Care**

If the subcontract is for the purpose of securing the provision of covered services, the subcontract must specify that the subcontractor adhere to the quality requirements the CONTRACTOR is held to.

2.26.7 **Interpretation/Translation Services and Limited English Proficiency (LEP) Provisions**

The CONTRACTOR shall provide instruction for all direct service subcontractors regarding the CONTRACTOR's written procedure for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, enrollees with Limited English Proficiency.

2.26.8 **Children in State Custody**

The CONTRACTOR must include in its subcontracts a provision stating that subcontractors are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical or behavioral health services covered by TENNCARE.

2.26.9 **Assignability**

Transportation and claims processing subcontracts must include language requiring that the subcontract agreement shall be assignable from the CONTRACTOR to the State, or its designee: i) at the State's discretion upon written notice to the CONTRACTOR and the affected subcontractor; or ii) upon CONTRACTOR's request and written approval by the State. Further, the subcontract agreement must include language by which the subcontractor agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the CONTRACTOR.

2.26.10 **Claims Processing**

2.26.10.1 All claims for services furnished to a TennCare enrollee filed with a CONTRACTOR must be processed by either the CONTRACTOR or by one (1) subcontractor retained by the organization for the purpose of processing claims. However, another entity can process claims related to behavioral health vision, lab or transportation if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services. However, all claims processed by any subcontractor shall be maintained and submitted by the CONTRACTOR.

2.26.10.2 As required in Section 2.30.18 of this Agreement, where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations.

2.26.11 **HIPAA Requirements**

The CONTRACTOR shall require all its subcontractors to adhere to HIPAA requirements.

2.26.12 **Compensation for Utilization Management Activities**

Should the CONTRACTOR have a subcontract arrangement for utilization management activities, the CONTRACTOR shall ensure, consistent with 42 CFR 438.210(e) that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, as provided by the Balanced Budget Act of 1997 and the provisions of 42 CFR 438.210(e).

2.26.13 **Notice of Subcontractor Termination**

2.26.13.1 When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCI.

2.26.13.2 TENNCARE reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

2.27 COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

2.27.1 As a party to this Agreement, the CONTRACTOR hereby acknowledges its designation as a covered entity under the HIPAA regulations and agrees to comply with all applicable HIPAA regulations.

2.27.2 In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum:

2.27.2.1 Comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including but not limited to the transactions and code set, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations;

2.27.2.2 Transmit/receive from/to its providers, subcontractors, clearinghouses and TENNCARE all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by TENNCARE so long as TENNCARE direction does not conflict with the law;

2.27.2.3 Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of this Agreement and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between TENNCARE and the CONTRACTOR and between the CONTRACTOR and its providers and/or

subcontractors to a halt, if for any reason the CONTRACTOR cannot meet the requirements of this Section, TENNCARE may terminate this Agreement in accordance with Section 4.4;

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

2.27.2.5 Ensure that disclosures of PHI from the CONTRACTOR to TENNCARE shall be restricted as specified in the HIPAA regulations and will be permitted for the purposes of: treatment, payment, or health care operation; health oversight; obtaining premium bids for providing health coverage; or modifying, amending or terminating the group health plan. Disclosures to TENNCARE from the CONTRACTOR shall be as permitted and/or required under the law;

2.27.2.6 Report to TENNCARE within five (5) calendar days of becoming aware of any use or disclosure of PHI in violation of this Agreement by the CONTRACTOR, its officers, directors, employees, subcontractors or agents or by a third party to which the CONTRACTOR disclosed PHI;

2.27.2.7 Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the CONTRACTOR pursuant to this Section 2.27;

2.27.2.8 Make available to TENNCARE enrollees the right to amend their PHI data in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard;

2.27.2.9 Make an enrollee's PHI data accessible to TENNCARE immediately upon request by TENNCARE;

2.27.2.10 Make available to TENNCARE within ten (10) calendar days of notice by TENNCARE to the CONTRACTOR such information as in the CONTRACTOR's possession and is required for TENNCARE to make the accounting of disclosures required by 45 CFR 164.528. At a minimum, the CONTRACTOR shall provide TENNCARE with the following information:

2.27.2.10.1 The date of disclosure;

2.27.2.10.2 The name of the entity or person who received the HIPAA protected information, and if known, the address of such entity or person;

2.27.2.10.3 A brief description of the PHI disclosed, and

2.27.2.10.4 A brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

2.27.2.11 In the event that the request for an accounting of disclosures is submitted directly to the CONTRACTOR, the CONTRACTOR shall within two (2) business days forward such request to TENNCARE. It shall be TENNCARE's responsibility to prepare and deliver any such accounting requested. Additionally, the CONTRACTOR shall institute an appropriate record keeping process and procedures and policies to enable the CONTRACTOR to comply with the requirements of this Section;

2.27.2.12 Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA regulations upon request.

2.27.2.13 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:

2.27.2.13.1 Use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI the CONTRACTOR creates, receives, maintains, or transmits on behalf of TENNCARE.

2.27.2.13.2 Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of TENNCARE agrees to use reasonable and appropriate safeguards to protect the PHI.

2.27.2.13.3 Agree to report to TENNCARE any use or disclosure of TENNCARE enrollee PHI or of any security incident of which CONTRACTOR becomes aware.

2.27.2.14 If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of an any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with Sections 2.21.6 and 2.25.6 of this Agreement. The CONTRACTOR shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in Sections 2.21.6 and 2.25.6 of this Agreement. The CONTRACTOR shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in Sections 2.21.6 and 2.25.6 of this Agreement the CONTRACTOR shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which can not feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;

2.27.2.15 Implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement and, including but not limited to, confidentiality requirements in 45 CFR Parts 160 and 164;

2.27.2.16 Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;

2.27.2.17 Create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; patients rights to amend, access, request restrictions; and right to file a complaint;

2.27.2.18 Provide an appropriate level of training to its staff and enrollees regarding HIPAA related policies, procedures, enrollee rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter;

2.27.2.19 Track training of CONTRACTOR staff and maintain signed acknowledgements by staff of the CONTRACTOR's HIPAA policies;

2.27.2.20 Be allowed to use and receive information from TENNCARE where necessary for the management and administration of this Agreement and to carry out business operations;

2.27.2.21 Be permitted to use and disclose PHI for the CONTRACTOR's own legal responsibilities;

2.27.2.22 Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by CONTRACTOR employees and other persons performing work for the CONTRACTOR to have only minimum necessary access to personally identifiable data within their organization;

2.27.2.23 Continue to protect personally identifiable information relating to individuals who are deceased;

2.27.2.24 Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations;

2.27.2.25 Make available PHI in accordance with 45 CFR 164.524;

2.27.2.26 Make available PHI for amendment and incorporate any amendments to protected health information in accordance with 45 CFR 164.526; and

2.27.2.27 Obtain a third (3rd) party certification of their HIPAA transaction compliance ninety (90) calendar days before the start date of operations.

2.27.3 In accordance with HIPAA regulations, TENNCARE shall, at a minimum, adhere to the following guidelines:

2.27.3.1 Make its individually identifiable health information available to enrollees for amendment and access as specified and restricted under the federal HIPAA regulations;

2.27.3.2 Establish policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding MCO administration and oversight;

2.27.3.3 Adopt a mechanism for resolving any issues of non-compliance as required by law; and

2.27.3.4 Establish similar HIPAA data partner agreements with its subcontractors and other business associates.

2.28 NON-DISCRIMINATION COMPLIANCE REQUIREMENTS

2.28.1 The CONTRACTOR shall comply with Section 4.31 of this Agreement regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.

2.28.2 In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section 2.29.1. This person shall provide instruction to all CONTRACTOR staff, providers and direct service subcontractors regarding non-discrimination activities.

2.28.3 The CONTRACTOR shall develop written policies and procedures for non-discrimination in the provision of services to persons with Limited English Proficiency, including but not limited to the provision of language interpretation and translation services for any member who needs such services as required in Section 2.18.2.

2.28.4 The CONTRACTOR shall, at a minimum, emphasize non-discrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.

2.28.5 The CONTRACTOR shall ask all staff to provide their race or ethnic origin and sex. The CONTRACTOR is required to request this information from all CONTRACTOR staff. CONTRACTOR staff response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts.

2.28.6 The CONTRACTOR shall ask all providers for their race or ethnic origin. Provider response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.

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

2.28.8 The CONTRACTOR shall report on non-discrimination activities as described in Section 2.30.19, Reporting Requirements.

2.29 PERSONNEL REQUIREMENTS

2.29.1 Staffing Requirements

2.29.1.1 The CONTRACTOR shall have sufficient staffing capable of fulfilling the requirements of this Agreement.

2.29.1.2 The CONTRACTOR shall submit to TENNCARE the names, resumes and contact information of the key staff identified below. In the event of a change to any of the key staff identified in Section 2.29.1.3, the CONTRACTOR shall notify TENNCARE within ten (10) business days of the change.

2.29.1.3 The minimum key staff requirements are listed below. Except as provided below, these positions do not require a full-time staff person; more than one function could be conducted by the same staff person.

2.29.1.3.1 A full-time administrator/project director who has clear authority over the general administration and day-to-day business activities of this Agreement;

2.29.1.3.2 A full-time Medical Director who is a licensed physician in the State of Tennessee to oversee and be responsible for all clinical activities, including but not limited to the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures;

2.29.1.3.3 A full-time senior executive who is a board certified psychiatrist in the State of Tennessee and has at least five (5) years combined experience in mental health and substance abuse services. This person shall oversee and be responsible for all behavioral health activities;

2.29.1.3.4 A full-time chief financial officer responsible for accounting and finance operations, including all audit activities;

2.29.1.3.5 A full-time staff person responsible for all CONTRACTOR information systems who is trained and experienced in information systems, data processing and data reporting as required to oversee all information systems functions including, but not limited to, establishing and maintaining connectivity with TennCare information systems and providing necessary and timely reports to TENNCARE;

2.29.1.3.6 A staff person designated as the contact available after hours for the “on-call” TennCare Solutions staff to contact with service issues;

2.29.1.3.7 A staff person to serve as the CONTRACTOR’s Non-discrimination Compliance Coordinator. This person will be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) on behalf of the CONTRACTOR. The CONTRACTOR shall report to TENNCARE in writing, to the attention of the Director of Non-Discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the commencement of any period of time that the CONTRACTOR does not have a designated staff person for non-discrimination

compliance. The CONTRACTOR shall report to TENNCARE at such time that the function is redirected as required in Section 2.29.1.2.

2.29.1.3.8 A full-time staff person responsible for member services, who will communicate with TENNCARE regarding member service activities;

2.29.1.3.9 A full-time staff person responsible for provider services, including all network management issues. This person shall be responsible for communicating with TENNCARE regarding provider service activities;

2.29.1.3.10 A staff person responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan, as set forth in Section 2.20 of this Agreement;

2.29.1.3.11 A staff person responsible for all UM activities, including but not limited to overseeing prior authorizations. This person shall be a physician licensed in the State of Tennessee and shall ensure that UM staff have appropriate clinical backgrounds in order to make utilization management decisions;

2.29.1.3.12 A staff person responsible for all quality management activities. This person shall be a physician or registered nurse licensed in the State of Tennessee;

2.29.1.3.13 A staff person responsible for all appeal system resolution issues;

2.29.1.3.14 A staff person responsible for all claims management activities;

2.29.1.3.15 A staff person assigned to provide legal and technical assistance for and coordination with the legal system for court ordered services;

2.29.1.3.16 A staff person responsible for all MCO case management and care coordination issues, including but not limited to, disease management activities and coordination between physical and behavioral health services;

2.29.1.3.17 A consumer advocate for members receiving, or in need of, behavioral health services. This person shall be responsible for internal representation of members' interests including but not limited to: ensuring input in policy development, planning, decision making, and oversight as well as coordination of recovery and resilience activities;

2.29.1.3.18 A staff person responsible for TENNderCare services;

2.29.1.3.19 A staff person responsible for working with the Department of Children's Services;

2.29.1.3.20 A senior executive responsible for overseeing all subcontractor activities, if the subcontract is for the provision of covered benefits;

2.29.1.3.21 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/DBM coordination. This person shall be responsible for overseeing the work of the Care Coordination Committee and the Claims Coordination Committee as described in Section 2.9.8; and

2.29.1.3.22 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/PBM coordination.

2.29.1.3.23 A staff person designated for interfacing and coordinating with the TDMHDD Planning and Policy Councils.

2.29.1.4 In addition to the key staff requirements described above, the CONTRACTOR shall have sufficient full-time clinical and support staff to conduct daily business in an orderly manner. This includes but is not limited to functions and services in the following areas: administration, accounting and finance, fraud and abuse, utilization management including prior authorizations, MCO case management and care coordination, quality management, member education and outreach, appeal system resolution, member services, provider services, claims processing, and reporting.

2.29.1.5 The CONTRACTOR shall have a sufficient number of care coordinators and claims coordinators to conduct all required activities, including but not limited to collaboration with the DBM and coordination with various state agencies.

2.29.1.6 The CONTRACTOR shall appoint specific staff to an internal audit function as specified in Section 2.21.9.

2.29.1.7 The CONTRACTOR is not required to report to TENNCARE the names of staff not identified as key staff in Section 2.29.1.3. However, the CONTRACTOR shall provide its staffing plan to TENNCARE.

2.29.1.8 The CONTRACTOR's project director, Medical Director, financial staff, member services staff, provider services staff, UM staff, appeals staff, MCO case management staff, and TENNderCare staff person shall be located in the State of Tennessee. However, TENNCARE may authorize exceptions to this requirement. The CONTRACTOR shall seek TENNCARE's written prior approval to locate any of these staff outside of the State of Tennessee. The CONTRACTOR's request to locate required in-state staff to an out-of-state locations shall include a justification of the request and an explanation of how services will be coordinated. If financial staff are not located in Tennessee the CONTRACTOR shall have the ability to issue a check within five (5) calendar days of a payment directive from TENNCARE.

2.29.1.9 The CONTRACTOR shall conduct training of staff in all departments to ensure appropriate functioning in all areas. This training shall be provided to all new staff members and on an ongoing basis for current staff.

2.29.2 **Licensure**

The CONTRACTOR is responsible for ensuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render services under applicable state law.

2.29.3 **Board of Directors**

The CONTRACTOR shall provide to TENNCARE, in writing, a list of all officers and members of the CONTRACTOR's Board of Directors. The CONTRACTOR shall notify TENNCARE, in writing, within ten (10) business days of any change thereto.

2.29.4 Employment and Contracting Restrictions

The CONTRACTOR shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the entity's equity who has been debarred or suspended by any federal agency. The CONTRACTOR may not have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State. To the best of its knowledge and belief, the CONTRACTOR certifies by its signature to this Agreement that the CONTRACTOR and its principals:

2.29.4.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or contractor;

2.29.4.2 Have not within a three (3) year period preceding this Agreement been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

2.29.4.3 Are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in Section 2.29.4.2 of this Agreement; and

2.29.4.4 Have not within a three (3) year period preceding this Agreement had one or more public transactions (federal, state, or local) terminated for cause or default.

2.30 REPORTING REQUIREMENTS

2.30.1 General Requirements

2.30.1.1 The CONTRACTOR shall comply with all the reporting requirements established by TENNCARE. TENNCARE shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required. TENNCARE may, at its discretion, change the content, format or frequency of reports.

2.30.1.2 TENNCARE may, at its discretion, require the CONTRACTOR to submit additional reports both ad hoc and recurring. If TENNCARE requests any revisions to the reports already submitted, the CONTRACTOR shall make the changes and re-submit the reports, according to the time period and format required by TENNCARE.

2.30.1.3 The CONTRACTOR shall submit all reports to TENNCARE, unless indicated otherwise in this Agreement, according to the schedule below:

DELIVERABLES		DUE DATE
Daily Reports		Within two (2) business days.
Weekly Reports		Wednesday of the following week.
Monthly Reports		20th of the following month.
Quarterly Reports		30th of the following month.
Annual Reports		Ninety (90) calendar days after the end of the calendar year
On Request Reports		Within three (3) business days from the date of the request unless otherwise specified by TENNCARE.
Ad Hoc Reports		Within ten (10) business days from the date of the request unless otherwise specified by TENNCARE.

2.30.1.4 The CONTRACTOR shall submit all reports electronically and in the manner and format prescribed by TENNCARE.

2.30.1.5 The CONTRACTOR shall transmit to and receive from TENNCARE all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by TENNCARE, so long as TENNCARE direction does not conflict with the law.

2.30.2 **Eligibility, Enrollment and Disenrollment Reports**

2.30.2.1 The CONTRACTOR shall comply with the requirements in Section 2.23.5 regarding eligibility and enrollment data exchange.

2.30.2.2 The CONTRACTOR shall submit a *Monthly Enrollment/Capitation Payment Reconciliation Report* that serves as a record that the CONTRACTOR has reconciled member eligibility data with capitation payments and verified that the CONTRACTOR has an enrollment record for all members for whom the CONTRACTOR has received a capitation payment. The CONTRACTOR shall report this information in the format prescribed by TENNCARE.

2.30.2.3 The CONTRACTOR shall submit a *Quarterly Member Enrollment/Capitation Payment Report* in the event it has members for whom a capitation payment has not been made or an incorrect payment has been made. This report shall be submitted on a quarterly basis, with a one-month lag time and is due to TENNCARE by the end of the second month following the reporting period. For example, for the quarter ending September 30, the report is due by the end of November and should include all data received through the end of October for the quarter ending September 30. These quarterly reports shall include all un-reconciled items until such time that TENNCARE notifies the CONTRACTOR otherwise. The CONTRACTOR shall report this information in the formats provided in Attachment IX, Exhibit A.

2.30.2.4 TENNCARE may provide the CONTRACTOR with information on members for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this information, the CONTRACTOR shall provide TENNCARE any information known by the CONTRACTOR that is missing or inaccurate in the report provided by TENNCARE. The CONTRACTOR shall submit this information to TENNCARE within the time frames specified by TENNCARE.

2.30.3 **Benefits/Service Requirements and Limits Reports**

The CONTRACTOR shall submit a quarterly *Service Threshold Report* in the format prescribed by TENNCARE. At minimum, the report shall include: the number of members who reached each service threshold; confirmation that all members who reached the service threshold for mandatory enrollment in MCO case management or a disease management program were enrolled; the number of members who reached the service threshold for evaluation of appropriateness for enrollment in MCO case management or disease management who were evaluated for enrollment; the number of those members evaluated who were enrolled in MCO case management or disease management (by program); and the number of those members who were evaluated but not enrolled in MCO case management or disease management by reason.

2.30.4 **Specialized Service Reports**

2.30.4.1 The CONTRACTOR shall submit a quarterly *Psychiatric Hospital/RTF Readmission Report* that provides: the percentage of members readmitted to the facility within seven (7) calendar days of discharge (the number of members readmitted divided by the total number of discharges); the percent of members readmitted within thirty (30) calendar days of discharge (the number of members readmitted divided by the total number of discharges); and an analysis of the findings with any actions or follow-up planned. The information shall be reported separately for members age eighteen (18) and over and under eighteen (18). These reports shall be submitted in a format to be prescribed by TENNCARE.

2.30.4.2 The CONTRACTOR shall submit a quarterly *Mental Health Case Management Report* that provides information on mental health case management appointments and refusals (see Section 2.7.2.6). The minimum data elements required are identified in Attachment IX, Exhibit B.

2.30.4.3 The CONTRACTOR shall submit an annual *Supported Employment Report* that reports on the percent of SPMI adults receiving supported employment services that are gainfully employed in either part-time or full-time capacity for a continuous ninety (90) day period (defined as the number of adults receiving supported employment for a continuous ninety (90) day period divided by the number of SPMI adults receiving supported employment services during the year) and an analysis of the findings with any action or follow-up planned as a result of the findings. These reports shall be submitted in a format to be prescribed by TENNCARE.

2.30.4.4 The CONTRACTOR shall submit a quarterly *Behavioral Health Crisis Response Report* that provides information on behavioral health crisis services (see Section 2.7.2.8) including the data elements listed in Attachment IX, Exhibit C. All data elements shall be reported separately for members ages eighteen (18) years and over and those under eighteen (18) years and shall be reported for each individual crisis service provider. This report shall be provided in a standardized format as specified by the State.

2.30.4.5 The CONTRACTOR shall submit a monthly *Member CRG/TPG Assessment Report* that contains information regarding the CRG assessments and TPG assessments (see Section 2.7.2.9) of members who have presented for mental health or substance abuse services or who have received CRG assessments and TPG assessments prior to obtaining such services. The CONTRACTOR shall provide this report in the format prescribed by the State. The minimum data elements required are identified in Attachment IX, Exhibit D of this Agreement.

2.30.4.6 On a quarterly basis the CONTRACTOR shall submit a *Rejected CRG/TPG Assessments Report* that provides, by agency, the number of rejected CRG/TPG assessments and the unduplicated number of and identifying information for the unapproved raters who completed the rejected assessments. This report shall be submitted in the format specified by TENNCARE.

2.30.4.7 The CONTRACTOR shall submit an annual *CRG/TPG Assessments Audit Report*. The report shall contain the results of the CONTRACTOR's audits for the prior year of CRG/TPG assessments for accuracy and conformity to state policies and procedures and shall be submitted in the format prescribed by TENNCARE.

2.30.4.8 The CONTRACTOR shall annually submit to TENNCARE its methodology for conducting the CRG/TPG assessment audits on March 1.

2.30.4.9 The CONTRACTOR shall submit a quarterly *Health Education/Outreach Report* which provides information on the programs and activities the CONTRACTOR has conducted in the areas of health education and outreach during the previous quarter. (See Section 2.7.3). The report shall be submitted in a format specified by TENNCARE.

2.30.4.10 The CONTRACTOR shall submit a quarterly *TENNderCare Report* in a format specified by TENNCARE.

2.30.5 **Disease Management Reports**

2.30.5.1 The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program (see Section 2.8), a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter. The report shall be submitted in a format prescribed by TENNCARE.

2.30.5.2 The CONTRACTOR shall submit an annual *Disease Management Report* that includes, for each disease management programs, a narrative description of the eligibility criteria and the method used to identify and enroll eligible members, the

active participation rate as defined by NCQA (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility), the total number of active members having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the disease management programs, and information on the programs' activities, benchmarks and goals as described in Section 2.8.7. The report shall be submitted in a format prescribed by TENNCARE.

2.30.6 **Service Coordination Reports**

2.30.6.1 The CONTRACTOR shall submit a quarterly *MCO Case Management Update Report* that includes a brief narrative description of the MCO case management program (see Section 2.9.4); the total number of members enrolled in the MCO case management program; number of members enrolled and disenrolled in the program during the quarter; member selection criteria; the number of members who declined case management services; a description of services provided during the quarter and an evaluation of the impact of the MCO case management program during the quarter. The CONTRACTOR shall submit these reports in a format prescribed by TENNCARE.

2.30.6.2 As necessary, the CONTRACTOR shall submit a listing of members identified as potential pharmacy lock-in candidates (see Section 2.9.7).

2.30.6.3 The CONTRACTOR shall submit a quarterly *Pharmacy Services Report* that includes a list of the providers and information on the interventions the CONTRACTOR has taken with the providers who appear to be operating outside industry or peer norms as defined by TENNCARE, have been identified as non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns and/or are failing to follow required prior authorization processes and procedures the steps the CONTRACTOR has taken to personally contact each one as well as the outcome of these personal contacts.

2.30.6.4 The CONTRACTOR shall submit a *Pharmacy Services Report, On Request* when TENNCARE requires assistance in identifying and working with providers for any reason. These reports shall provide information on the activities the CONTRACTOR undertook to comply with TENNCARE's request for assistance, outcomes (if applicable) and shall be submitted in the format and within the time frame prescribed by TENNCARE.

2.30.7 **Provider Network Reports**

2.30.7.1 The CONTRACTOR shall submit a monthly *Provider Enrollment File* that includes information on all providers of health services, including physical and behavioral health providers (see Section 2.11). This includes but is not limited to, PCPs, physician specialists, hospitals, home health agencies, CMHAs, and emergency and non-emergency transportation providers. The report shall include contract providers as well as all non-contract providers with whom the CONTRACTOR has a relationship. The report shall be sorted by provider type. The minimum data elements for this report are listed in Attachment IX, Exhibit E of this Agreement. The CONTRACTOR shall submit this report in the format to be prescribed by TENNCARE. The CONTRACTOR shall submit this report during readiness review, by the 5th of each month, and upon TENNCARE request.

2.30.7.2 The CONTRACTOR shall submit an annual *Provider Compliance with Access Requirements Report* that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access standards. (See Section 2.11.1.10.)

2.30.7.3 The CONTRACTOR shall submit a quarterly *PCP Assignment Report* that provides information on members not assigned to a primary care provider (PCP) within thirty (30) calendar days of enrollment. This report shall be submitted using the format provided in Attachment IX, Exhibit F. (See Section 2.11.2.)

2.30.7.4 The CONTRACTOR shall submit an annual *Report of Essential Hospital Services* by September 1 of each year. The CONTRACTOR shall use the format in Attachment IX, Exhibit G.

2.30.7.5 The CONTRACTOR shall submit a quarterly *Behavioral Health Initial Appointment Timeliness Report* that shall include the average time between the intake assessment appointment and the member's next scheduled appointment or admission. The report shall provide this information by type of service and shall include an analysis of the findings and any actions or follow-up planned as a result of the findings. The report shall be submitted in a format prescribed by TENNCARE.

2.30.7.6 The CONTRACTOR shall submit an annual *FQHC Report* by January 1 of each year. The CONTRACTOR shall use the form provided in Attachment IX, Exhibit H.

2.30.8 **Provider Agreement Report**

The CONTRACTOR shall submit a monthly *Single Case Agreements Report* using the format provided in Attachment IX, Exhibit I. (See Section 2.12.4.)

2.30.9 **Provider Payment Report**

The CONTRACTOR shall submit a quarterly *Related Provider Payment Report* that lists all related providers and subcontractors to whom the CONTRACTOR has made payments during the previous quarter and the payment amounts. (See Section 2.13.14.)

2.30.10 **Utilization Management Reports**

2.30.10.1 The CONTRACTOR shall submit its UM program policies and procedures, the annual evaluation (which includes an analysis of findings and actions taken) and the work plan approved by the CONTRACTOR's oversight committee to TENNCARE on April 15 of each year.

2.30.10.2 The CONTRACTOR shall submit a semi-annual *ED Utilization Report* (see Section 2.14.1.11) in a format to be specified by TENNCARE.

2.30.10.3 The CONTRACTOR shall submit quarterly *Cost and Utilization Reports*. These reports shall be submitted using the format provided in Attachment IX, Exhibit J. These reports shall be in an Excel spreadsheet format and submitted within seventy-five (75) calendar days following the quarter for which the CONTRACTOR is reporting.

2.30.10.4 The CONTRACTOR shall provide quarterly *Cost and Utilization Summaries*. These summaries shall report on services paid during the previous quarter. The summaries shall be submitted in a format specified by TENNCARE and shall include all data elements listed in Attachment IX, Exhibit K.

2.30.10.5 The CONTRACTOR shall identify and report the number of members who incurred claims in excess of twenty-five thousand dollars ($25,000) on a rolling quarterly basis (high-cost claimants). The CONTRACTOR shall report the member's age, sex, primary diagnosis, and amount paid by claim type for each member. The name of the member shall be blinded in order to maintain confidentiality.

2.30.10.6 The CONTRACTOR shall submit quarterly *Prior Authorization Reports* that include the information in Attachment IX, Exhibit L. These reports shall be submitted in the format specified in Attachment IX, Exhibit L.

2.30.10.7 The CONTRACTOR shall submit a copy of the *Referral Provider Listing* (see Section 2.14.3.5), a data file of the provider information used to create the listing in a media and format prescribed by TENNCARE, and documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity of the referral provider listings mailed to providers, the date mailed, and to whom. The CONTRACTOR shall submit this information at the same time it is sent to the providers as required in Section 2.14.3.5.

2.30.11 **Quality Management/Quality Improvement Reports**

2.30.11.1 The CONTRACTOR shall annually submit an approved (by the CONTRACTOR's QM/QI Committee) QM/QI Program Description, Associated Work Plan, and Annual Evaluation.

2.30.11.2 The CONTRACTOR shall update and submit a quarterly *Quality Update Report.* The report shall include updates on the progress made toward scheduled activities in the QM/QI work plan and barrier analysis on the activities that have been delayed with explanation of the delays and the plan for completing any delayed scheduled activities.

2.30.11.3 The CONTRACTOR shall submit an annual *Report on Performance Improvement Projects* that includes the information specified in Section 2.15.3.

2.30.11.4 The CONTRACTOR shall submit an annual *Report of Performance Indicator Results*, *Audited CAHPS Results* and *Audited HEDIS Results* by June 15 of each year (see Sections 2.15.4, 2.15.6 and 2.15.7).

2.30.11.5 The CONTRACTOR shall submit its *NCQA Accreditation Report* immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA

2.30.12 **Customer Service Reports**

2.30.12.1 The CONTRACTOR shall submit a quarterly *Member Services and UM Phone Line Report.* The data in the report shall be recorded by month and shall include the detailed rate calculations. The CONTRACTOR shall submit the report in the format specified in Attachment IX, Exhibit M.

2.30.12.2 The CONTRACTOR shall report separately any member services or utilization management phone lines operated by subcontractors.

2.30.12.3 The CONTRACTOR shall submit a quarterly *Translation/Interpretation Services Report*. The report shall list each request and include the name and member identification number for each member to whom translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter. The CONTRACTOR shall submit the report in a format to be prescribed by TENNCARE.

2.30.12.4 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that summarizes the provider survey methods and findings and provides analysis of opportunities for improvement. (see Section 2.18.7.2.)

2.30.12.5 The CONTRACTOR shall submit a quarterly *Provider Complaints Report* that provides information on the number and type of provider complaints received, either in writing or by phone. The data shall be reported by month in a format to be specified by TENNCARE.

2.30.13 **Fraud and Abuse Reports**

The CONTRACTOR shall submit an annual *Fraud and Abuse Activities Report*. This report shall summarize the results of its fraud and abuse compliance plan (see Section 2.20) and other fraud and abuse prevention, detection, reporting, and investigation measures, and should cover results for the fiscal year ending June 30. The report shall be submitted by September 30 of each year in the format reviewed and approved by TENNCARE (as part of the CONTRACTOR's compliance plan).

2.30.14 **Financial Management Reports**

2.30.14.1 <u>Third Party Liability (TPL) Resources Reports</u>

2.30.14.1.1 The CONTRACTOR shall submit a quarterly and annual *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well funds

for which the CONTRACTOR does not pay a claim due to TPL coverage or Medicare coverage. This CONTRACTOR shall calculate cost savings in categories described by TENNCARE and submit this report in a format specified by TENNCARE.

2.30.14.1.2 The CONTRACTOR shall submit an *Other Insurance Report* that provides information on any members who have other insurance. This report shall be submitted in a format and frequency described by TENNCARE.

2.30.14.2 Financial Reports to TENNCARE

2.30.14.2.1 The CONTRACTOR shall submit a *Medical Loss Ratio Report* monthly with cumulative year to date calculation using the forms in Attachment IX, Exhibit N. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report must reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections 2.30.16.2 and 2.23.4.

2.30.14.2.2 The CONTRACTOR shall submit an annual *Ownership and Financial Disclosure Report* to TENNCARE. This report shall include full and complete information regarding ownership, financial transactions and persons as described in Section 2.21.8 and shall be submitted March 1 of each calendar year and at other times as required by TENNCARE.

2.30.14.2.3 The CONTRACTOR shall submit its annual audit plan on March 1 of each year in a format to be prescribed by TENNCARE. (See Section 2.21.9.)

2.30.14.3 TDCI Financial Reports

2.30.14.3.1 By no later than December 31 of each year, the CONTRACTOR shall submit to TDCI an annual *Financial Plan and Projection of Operating Results Report.* This submission shall include the CONTRACTOR's budget projecting revenues earned and expenses incurred on a calendar year basis through the term of this Agreement. This budget shall be prepared in accordance with the form prescribed by TDCI and shall include narratives explaining the assumptions and calculations utilized in the projections of operating results.

2.30.14.3.2 By no later than July 31 of each year, the CONTRACTOR shall submit to TDCI a mid-year *Comparison of Actual Revenues and Expenses to Budgeted Amounts Report*. If necessary, the CONTRACTOR shall revise the calendar year budget based on its actual results of operations. Any revisions to the budget must include narratives explaining the assumptions and calculations utilized in making the revisions.

2.30.14.3.3 The CONTRACTOR shall submit to TDCI an *Annual Financial Report* required to be filed by all licensed health maintenance organizations pursuant to TCA 56-32-208. This report shall be on the form prescribed by the National Association of Insurance Commissioners (NAIC) for health maintenance organizations and shall be submitted to TDCI on or before March 1 of each calendar year. It shall contain an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The CONTRACTOR in preparing this annual report shall comply with any and all rules and regulations of TDCI related to the preparation and filing of this report. This Annual Report will also be accompanied by the Medical Loss Ratio report, where applicable, completed on a calendar year basis. The CONTRACTOR shall submit a reconciliation of the Medical Loss Ratio report to the annual NAIC filing using an accrual basis that includes an actuarial certification of the claims payable (reported and unreported).

2.30.14.3.4 The CONTRACTOR shall file with TDCI, a *Quarterly Financial Report.* These reports shall be on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations and shall be submitted to TDCI on or before June 1 (covering first quarter of current year), September 1 (covering second quarter of current year) and December 1 (covering third quarter of current year). Each quarterly report shall also contain an income statement detailing the CONTRACTOR's quarterly and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The second quarterly report (submitted on September 1) shall include the Medical Loss Ratio report completed on an accrual basis that includes an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with National Association of Insurance Commissioners guidelines. The CONTRACTOR shall also submit a reconciliation of the Medical Loss Ratio report to the second quarterly NAIC report.

2.30.14.3.5 The CONTRACTOR shall submit to TDCI annual *Audited Financial Statements.* Such audit shall be performed in accordance with NAIC Annual Statement Instructions regarding the annual audited financial statements. There are three (3) exceptions to the NAIC statement instructions:

2.30.14.3.5.1 The CONTRACTOR shall submit the audited financial statements covering the previous calendar year by May 1 of each calendar year.

2.30.14.3.5.2 Any requests for extension of the May 1 submission date must be granted by the Comptroller of the Treasury pursuant to the "Contract to Audit Accounts."

2.30.14.3.5.3 The report shall include an income statement addressing the TENNCARE operations of the CONTRACTOR.

2.30.14.3.5.4 These financial reporting requirements shall supersede any other reporting requirements required of the CONTRACTOR by TDCI, and TDCI shall enact any necessary rule or regulation to conform to this provision of the Agreement.

2.30.15 **Claims Management Reports**

2.30.15.1 The CONTRACTOR shall submit a quarterly *Claims Payment Accuracy Report*. The report shall include the results of the internal audit of the random sample of all "processed or paid" claims (described in Section 2.22.6) and shall report on the number and percent of claims that are paid accurately. The numbers and percents shall be reported on a monthly basis. The report shall be submitted in a format prescribed by TENNCARE.

2.30.15.2 The CONTRACTOR shall submit a quarterly *Explanation of Benefits* (*EOB) Report*. This report shall summarize the number of EOBs sent by category, member complaints, and complaint resolution (including referral to TBI/OIG). (See Section 2.22.8.)

2.30.16 **Information Systems Reports**

2.30.16.1 The CONTRACTOR shall submit an annual *Systems Refresh Plan* on December 1 for the upcoming year that meets the requirements in Section 2.23.1.6.

2.30.16.2 The CONTRACTOR shall submit *Encounter Data Files* in a standardized format as specified by TENNCARE (see Section 2.23.4) and transmitted electronically to TENNCARE on a weekly basis.

2.30.16.3 The CONTRACTOR shall provide an electronic version of a reconciliation between the amount paid as captured on the CONTRACTOR's encounter file submissions and the amount paid as reported by the CONTRACTOR in the 'CMS 1450 Claims Triangle' and 'CMS 1500 Claims Triangle' that accompanies the monthly Medical Loss Ratio report (see Section 2.30.14.2.1). In the event of any variances, the CONTRACTOR shall submit a written explanation accompanied by a 'CMS 1450 Claims Triangle' by category of service and a 'CMS 1500 Claims Triangle' by category of service, as applicable, to substantiate the explanation of the variance and identify the categories of services to which the variance is attributable. In the event that TENNCARE requires further detail of the variances listed, the CONTRACTOR shall provide any other data as requested by TENNCARE. This information shall be submitted with the MLR report.

2.30.16.4 The CONTRACTOR shall provide any information and/or data requested in a format to be specified by TENNCARE as required to support the validation, testing or auditing of the completeness and accuracy of encounter data submitted by the CONTRACTOR.

2.30.16.5 The CONTRACTOR shall submit a monthly *Systems Availability and Performance Report* that provides information on record search and retrieval time, screen edit time, new screen/page time, print initiation time, confirmation of MCO enrollment response time and online claims adjudication response time.

2.30.16.6 The CONTRACTOR shall submit a baseline *Business Continuity and Disaster Recovery (BC-DR)* plan for review and approval as specified by TENNCARE. The CONTRACTOR shall communicate proposed modifications to the BC-DR plan at least fifteen (15) calendar days prior to their proposed incorporation. Such modifications shall be subject to review and approval by TENNCARE.

2.30.17 **Administrative Requirements Reports**

The CONTRACTOR shall submit a semi-annual *Report on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee* regarding the activities of the behavioral health advisory committee established pursuant to Section 2.24.2. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year according to the format specified by the State.

2.30.18 **Subcontract Reports**

2.30.18.1 If the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations for each non-affiliated organization processing claims that represent more than twenty percent (20%) of TennCare medical expenses of the CONTRACTOR. This report shall be performed by an independent auditor ("service auditor") and shall be due annually on May 1 for the preceding year operations or portion thereof.

2.30.18.2 In a Type II report, the service auditor will express an opinion on (1) whether the service organization's description of its controls presents fairly, in all material respects, the relevant aspects of the service organization's controls that had been placed in operation as of a specific date, and (2) whether the controls were suitably designed to achieve specified control objectives, and (3) whether the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period specified. The audit of control activities over information and technology related processes related to TennCare claims processing by the subcontractor should include the following:

2.30.18.2.1 *General Controls*

2.30.18.2.1.1 Personnel Policies

2.30.18.2.1.2 Segregation of Duties

2.30.18.2.1.3 Physical Access Controls

2.30.18.2.1.4 Hardware and System Software

2.30.18.2.1.5 Applications System Development and Modifications

2.30.18.2.1.6 Computer Operations

2.30.18.2.1.7 Data Access Controls

2.30.18.2.1.8 Contingency and Business Recovery Planning

2.30.18.2.2 *Application Controls*

2.30.18.2.2.1 Input

2.30.18.2.2.2 Processing

2.30.18.2.2.3 Output

2.30.18.2.2.4 Documentation Controls

2.30.19 **Non-Discrimination Compliance Reports**

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

2.30.19.2 The CONTRACTOR shall submit a quarterly *Supervisory Personnel Report* that contains a summary listing totaling the number of supervisory personnel by race or ethnic origin and sex. This report shall provide the number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnicity as indicated by TENNCARE and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin females as indicated by TENNCARE.

2.30.19.3 The CONTRACTOR shall submit a quarterly *Alleged Discrimination Report*. The report shall include a listing of all complaints alleging discrimination filed by employees, members, providers and subcontractors in which discrimination is alleged by the CONTRACTOR's MCO. Such listing shall include, at a minimum, the identity of the party filing the complaint, the complainant's relationship to the CONTRACTOR, the circumstances of the complaint, date complaint filed, the CONTRACTOR's resolution, if resolved, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint.

2.30.19.4 On an annual basis the CONTRACTOR shall submit a copy of the CONTRACTOR's non-discrimination policy that demonstrates non-discrimination in provision of services to members with Limited English Proficiency. This shall include a listing of interpreter/translator services used by the CONTRACTOR in providing services to members with Limited English Proficiency. The listing shall provide the full name of the interpreter/translator service, address, phone number, and hours services are available.

2.30.19.5 The CONTRACTOR shall annually submit its *Non-Discrimination Compliance Plan and Assurance of Non-Discrimination* to TENNCARE in a format to be prescribed by TENNCARE.

2.30.20 **Terms and Conditions Reports**

By December 31 of each year the CONTRACTOR shall make written disclosure regarding conflict of interest that includes the elements in Section 4.19.

2.31 STATE ONLYS AND JUDICIALS

2.31.1 General

2.31.1.1 As specified in this Section 2.31, the CONTRACTOR shall provide medically necessary covered behavioral health services (see Sections 2.6 and 2.7) to State Onlys and Judicials (as defined in Section 1).

2.31.1.2 Judicials are only entitled to coverage of those behavioral health evaluation and treatment services required by state law (see Section 2.7.2.10.2) or by the court order under which the individual was referred.

2.31.1.3 State Onlys are entitled to all medically necessary covered behavioral health services.

2.31.1.4 TENNCARE shall provide pharmacy services related to behavioral health diagnoses.

2.31.1.5 Neither State Onlys nor Judicials are entitled to covered physical health services.

2.31.1.6 The requirements of this Agreement shall apply to State Onlys and Judicials as specified below. When a section/requirement applies to State Onlys and/or Judicials, the terms “TennCare enrollee,” “enrollee,” and/or “member” referenced in the requirement/section shall be read to include State Onlys and Judicials.

2.31.2 Applicability of Agreement

2.31.2.1 Section 2.1, REQUIREMENTS PRIOR TO OPERATIONS, shall apply to State Onlys and Judicials.

2.31.2.2 Section 2.2, GENERAL REQUIREMENTS, shall apply to State Onlys and Judicials.

2.31.2.3 Section 2.3, ELIGIBILITY, is not applicable to State Onlys and Judicials. However, as provided in Section 2.3.4, the State shall have sole responsibility for determining the eligibility of a Judicial or State Only. State Onlys and Judicials are not subject to any cost sharing.

2.31.2.4 Section 2.4, ENROLLMENT, applies to State Onlys and Judicials as follows:

2.31.2.4.1 Section 2.4.1, General, applies to State Onlys and Judicials. TENNCARE is solely responsible for enrollment of State Onlys and Judicials in an MCO.

2.31.2.4.2 Section 2.4.2, Authorized Service Area, applies to State Onlys and Judicials. State Onlys and Judicials will be enrolled by Grand Region, and the CONTRACTOR is only authorized to serve State Onlys and Judicials residing in a county included in the Grand Region served by the CONTRACTOR.

2.31.2.4.3 Section 2.4.3, Maximum Enrollment shall apply to State Onlys and Judicials.

2.31.2.4.4 Except for Section 2.4.4.7, Non-Discrimination, Section 2.4.4, MCO Selection and Assignment, does not apply to State Onlys and Judicials. The State will assign State Onlys and Judicials to MCOs on a random basis that ensures similar levels of enrollment for the MCOs serving a Grand Region. Section 2.4.4.7, Non-Discrimination, shall apply to State Onlys and Judicials.

2.31.2.4.5 In Section 2.4.5, Effective Date of Enrollment, Sections 2.4.5.1 through 2.4.5.3 do not apply to State Onlys and Judicials. However, as with TennCare enrollees, the effective date of enrollment in the CONTRACTOR's MCO shall be the date provided on the enrollment file from TENNCARE. State Onlys and Judicials can be retroactively eligible to the date of application. Section 2.4.5.4, Enrollment Prior to Notification, applies to State Onlys and Judicials.

2.31.2.4.6 Section 2.4.6, Eligibility and Enrollment Data, shall apply to State Onlys and Judicials. They shall be included in eligibility and enrollment data.

2.31.2.4.7 In Section 2.4.7, Enrollment Period, Section 2.4.7.1, General, and Section 2.4.7.3, Member Moving out of Grand Region, shall apply to State Onlys and Judicials. Section 2.4.7.2, Changing MCOs, shall not apply. State Onlys and Judicials will not be given the opportunity to change MCOs.

2.31.2.4.8 Section 2.4.8, Transfers from Other MCOs, shall apply to State Onlys and Judicials.

2.31.2.4.9 Section 2.4.9, Enrollment of Newborns, shall not apply to State Onlys and Judicials.

2.31.2.4.10 Section 2.4.10, Information Requirements Upon Enrollment, shall not apply to State Onlys and Judicials.

2.31.2.5 In Section 2.5, DISENROLLMENT FROM AN MCO, Section 2.5.1, General, shall apply to State Onlys and Judicials. Sections 2.5.2 through 2.5.5 shall not apply to State Onlys and Judicials. As with TennCare enrollees, TENNCARE shall be responsible for disenrolling State Onlys and Judicials, and the effective date of disenrollment shall be indicated on the termination record.

2.31.2.6 Section 2.6, BENEFITS/SERVICE REQUIREMENTS AND LIMITATIONS, shall apply as follows:

2.31.2.6.1 In Section 2.6.1, CONTRACTOR Covered Benefits, Section 2.6.1.3, CONTRACTOR Physical Health Benefits Chart, shall not apply. The CONTRACTOR is not responsible for providing physical health services to State Onlys and Judicials. Section 2.6.1.5, CONTRACTOR Behavioral Health Benefits Chart, shall apply. However, for Judicials the CONTRACTOR is only required to provide the behavioral health evaluation and treatment services required by state law (see Section 2.7.2.10.2) or by the court order under which the individual was referred.

2.31.2.6.2 In Section 2.6.2, TennCare Benefits Provided by TENNCARE, only Section 2.6.2.2, Pharmacy Services, shall apply to State Onlys and Judicials. TENNCARE will cover certain pharmacy services for the treatment of behavioral health disorders for State Onlys and Judicials. The CONTRACTOR shall be responsible for the related laboratory expenses.

2.31.2.6.3 In Section 2.6.3, Medical Necessity Determination, Sections 2.6.3.1 through 2.6.3.4 shall apply to State Onlys and Judicials. Section 2.6.3.5 shall not apply to State Onlys and Judicials.

2.31.2.6.4 Section 2.6.4, Second Opinions, shall not apply to State Onlys and Judicials.

2.31.2.6.5 Section 2.6.5, Use of Cost Effective Alternative Services, shall apply to State Onlys and Judicials.

2.31.2.6.6 Section 2.6.6, Additional Services and Use of Incentives, shall apply to State Onlys and Judicials.

2.31.2.6.7 In Section 2.6.7, Cost Sharing for Services, only Section 2.6.7.1, General, shall apply to State Onlys and Judicials. There is no cost sharing required for State Onlys and Judicials.

2.31.2.7 Section 2.7, SPECIALIZED SERVICES, shall apply as follows:

2.31.2.7.1 Section 2.7.1, Emergency Services, shall not apply to State Onlys and Judicials. However, behavioral health crisis services are covered for State Onlys and Judicials (see Section 2.31.7.2.8).

2.31.2.7.2 Section 2.7.2, Behavioral Health Services, shall apply to State Onlys and Judicials. However, Sections 2.7.2.10.2.5 and 2.7.2.10.2.6, regarding voluntary hospital admissions, shall not apply to Judicials.

2.31.2.7.3 Section 2.7.3, Health Education and Outreach, shall not apply to State Onlys and Judicials.

2.31.2.7.4 Section 2.7.4, Preventive Services, shall not apply to State Onlys and Judicials.

2.31.2.7.5 Section 2.7.5, TENNderCare, shall not apply to State Onlys and Judicials.

2.31.2.7.6 Section 2.7.6, Advance Directives, shall not apply to State Onlys and Judicials.

2.31.2.7.7 Section 2.7.8, Sterilizations, Hysterectomies and Abortions, shall not apply to State Onlys and Judicials.

2.31.2.8 Section 2.8, DISEASE MANAGEMENT, shall apply to State Onlys and Judicials for the three behavioral health conditions (bipolar disorder, major depression, and schizophrenia). State Onlys and Judicials are not eligible for the physical health disease management programs.

2.31.2.9 Section 2.9, SERVICE COORDINATION, shall apply as follows:

2.31.2.9.1 Section 2.9.1, General, shall not apply to State Onlys and Judicials.

2.31.2.9.2 Section 2.9.2, Transition of New Members, shall not apply to State Onlys and Judicials.

2.31.2.9.3 Section 2.9.3, Transition of Care, shall apply to State Onlys and Judicials for covered behavioral health services.

2.31.2.9.4 Section 2.9.4, MCO Case Management, shall apply to State Onlys and Judicials relative to covered behavioral health services.

2.31.2.9.5 Section 2.9.5, Coordination and Collaboration Between Physical Health and Behavioral Health, shall not apply to State Onlys and Judicials.

2.31.2.9.6 Section 2.9.6, Coordination and Collaboration Among Behavioral Health Providers, shall apply to State Onlys and Judicials.

2.31.2.9.7 Section 2.9.7, Coordination of Pharmacy Services, shall apply to State Onlys and Judicials for pharmacy services related to behavioral health diagnoses.

2.31.2.9.8 Section 2.9.8, Coordination of Dental Benefits, shall not apply to State Onlys and Judicials for pharmacy services related to behavioral health diagnoses.

2.31.2.9.9 Section 2.9.9, Coordination with Medicare, shall apply to State Onlys and Judicials to the extent applicable for covered behavioral health services.

2.31.2.9.10 Section 2.9.10, Institutional Services and Alternatives to Institutional Services, shall not apply to State Onlys and Judicials.

2.31.2.9.11 Section 2.9.11, Inter-Agency Coordination, shall apply to State Onlys and Judicials for covered behavioral health services.

2.31.2.10 Section 2.10, SERVICES NOT COVERED, shall apply to State Onlys and Judicials.

2.31.2.11 Section 2.11, PROVIDER NETWORK, shall apply as follows:

2.31.2.11.1 Section 2.11.1, General Provisions, shall apply to State Onlys and Judicials for covered behavioral health services.

2.31.2.11.2 Section 2.11.2, Primary Care Providers (PCPs), shall not apply to State Onlys and Judicials.

2.31.2.11.3 Section 2.11.3, Specialty Service Providers, shall apply to State Onlys and Judicials for Centers of Excellence for Behavioral Health and for psychiatry.

2.31.2.11.4 Section 2.11.4, Special Conditions for Prenatal Care Providers, shall not apply to State Onlys and Judicials

2.31.2.11.5 Section 2.11.5, Special Conditions for Behavioral Health Services, shall apply to State Onlys and Judicials.

2.31.2.11.6 In Section 2.11.6, Safety Net Providers, Section 2.11.6.2, Community Mental Health Agencies, shall apply to State Onlys and Judicials. The other sections shall not apply to State Onlys and Judicials.

2.31.2.11.7 Section 2.11.7, Credentialing and Other Certification, shall apply to State Onlys and Judicials for behavioral health providers.

2.31.2.11.8 Section 2.11.8, Network Notice Requirements, shall not apply to State Onlys and Judicials.

2.31.2.12 Except as provided below, Section 2.12, PROVIDER AGREEMENTS, shall apply to State Onlys and Judicials. The following sections do not apply to State Onlys and Judicials:

2.31.2.12.1 The first sentence of Section 2.12.7.6, regarding services to children;

2.31.2.12.2 Section 2.12.7.10 regarding delay in providing prenatal care;

2.31.2.12.3 Section 2.12.7.29, regarding cost sharing;

2.31.2.12.4 Section 2.12.7.42, regarding emergency appeals;

2.31.2.12.5 Section 2.12.7.46, regarding TENNderCare;

2.31.2.12.6 Section 2.12.7.50, regarding disclosure of information; and

2.31.2.12.7 Section 2.12.9, regarding contracts with local health departments.

2.31.2.13 Section 2.13, PROVIDER AND SUBCONTRACTOR PAYMENTS, shall apply to State Onlys and Judicials for covered behavioral health services provided by behavioral health providers and subcontractors. Section 2.13.2, Hospice, Section 2.13.4, Local Health Departments, and Section 2.13.13, Transition of New Members, shall not apply to State Onlys and Judicials.

2.31.2.14 Section 2.14, UTILIZATION MANAGEMENT (UM), shall apply to State Onlys and Judicials for covered behavioral health services.

2.31.2.15 Section 2.15, QUALITY MANAGEMENT, shall apply to State Onlys and Judicials for behavioral health services. However, State Onlys and Judicials shall not be included in the CONTRACTOR's behavioral health performance improvement project.

2.31.2.16 Section 2.16, MARKETING, shall apply to State Onlys and Judicials. The CONTRACTOR shall not conduct any marketing activities.

2.31.2.17 Section 2.17, MEMBER MATERIALS, shall not apply to State Onlys and Judicials. Member materials are not to be sent to State Onlys and Judicials.

2.31.2.18 Section 2.18, CUSTOMER SERVICE, shall apply to State Onlys and Judicials as it relates to covered behavioral health services.

2.31.2.19 Section 2.19, COMPLAINTS AND APPEALS, shall not apply to State Onlys and Judicials. State Onlys and Judicials do not have appeal rights; however, they shall have the right to file complaints with the CONTRACTOR.

2.31.2.20 Section 2.20, FRAUD AND ABUSE, shall apply to State Onlys and Judicials.

2.31.2.21 Section 2.21, FINANCIAL MANAGEMENT, shall apply to State Onlys and Judicials.

2.31.2.22 Section 2.22, CLAIMS MANAGEMENT, shall apply to State Onlys and Judicials for payment of behavioral health providers.

2.31.2.23 Section 2.23, INFORMATION SYSTEMS, shall apply to State Onlys and Judicials.

2.31.2.24 Section 2.24, ADMINISTRATIVE REQUIREMENTS, shall apply to State Onlys and Judicials for covered behavioral health services.

2.31.2.25 Section 2.25, MONITORING, shall apply to State Onlys and Judicials.

2.31.2.26 Section 2.26, SUBCONTRACTS, shall apply to State Onlys and Judicials.

2.31.2.27 Section 2.27, COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), shall apply to State Onlys and Judicials.

2.31.2.28 Section 2.28, NON-DISCRIMINATION COMPLIANCE REQUIREMENTS, shall apply to State Onlys and Judicials.

2.31.2.29 Section 2.29, PERSONNEL REQUIREMENTS, shall apply to State Onlys and Judicials.

2.31.2.30 Section 2.30 REPORTING REQUIREMENTS, shall apply to State Onlys and Judicials. State Onlys and Judicials shall be included in reports provided to TENNCARE and TDCI.

2.31.2.31 Section 3, PAYMENTS TO THE CONTRACTOR, shall apply to State Onlys and Judicials.

2.31.2.32 Section 4, TERMS AND CONDITIONS, shall apply to State Onlys and Judicials. However, in 4.3, Applicable Laws and Regulations, requirements specific to Medicaid or the TennCare program (e.g., federal Medicaid law and regulations, the TennCare waiver) shall not apply to State Onlys and Judicials. Also, liquidated damages specific to the TennCare program or physical health services shall not apply to State Onlys and Judicials. Other liquidated damages, including liquidated damages related to behavioral health services, shall apply to State Onlys and Judicials.

SECTION 3 - PAYMENTS TO THE CONTRACTOR

3.1 GENERAL PROVISIONS

3.1.1 TENNCARE shall make monthly payments to the CONTRACTOR for its satisfactory performance and provision of covered services under this Agreement. Capitation rates shall be paid according to the methodology as described in this Agreement.

3.1.2 The CONTRACTOR agrees that capitation payments, any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1, any incentive payments (if applicable) and any applicable risk-sharing settlements (see Section 3.11) are payment in full for all services provided pursuant to this Agreement.

3.2 ANNUAL ACTUARIAL STUDY

In accordance with TCA 9-9-101, the State shall retain a qualified actuary to conduct an annual actuarial study of the TennCare program. The CONTRACTOR shall provide any information requested and cooperate in any manner necessary as requested by TENNCARE in order to assist the State's actuary with completion of the annual actuarial study.

3.3 CAPITATION PAYMENT RATES

3.3.1 The CONTRACTOR will be paid a base capitation rate for each enrollee based on the enrollee's eligibility rate category and the Grand Region served by the CONTRACTOR under this Agreement in accordance with the rates specified in Attachment X.

3.3.2 The major rate categories are as follows:

3.3.2.1 Medicaid;

3.3.2.2 Uninsured/Uninsurable;

3.3.2.3 Disabled - The disabled rate is only for those enrollees who are eligible for Medicaid as a result of a disability;

3.3.2.4 Medicaid/Medicare Duals - For the purpose of capitation rates, Medicaid/Medicare dual enrollees are TennCare Medicaid enrollees who have Medicare eligibility;

3.3.2.5 Waiver/Medicare Duals - For the purpose of capitation rates, Waiver/Medicare dual enrollees are TennCare Standard enrollees who have Medicare eligibility;

3.3.2.6 State Only and Judicials; and

3.3.2.7 Priority add-on.

3.3.3 The CONTRACTOR will also be paid a priority add-on rate for behavioral health services in accordance with the rates specified in Attachment X for each priority enrollee. The CONTRACTOR will be paid the priority add-on rate for priority enrollees, as defined in this Agreement, who have received behavioral health services as reported pursuant to Section 2.23.4 of this Agreement, within the preceding twelve (12) months from the date of the calculation of the monthly payment, and who have had a valid CRG/TPG assessment within the preceding twelve (12) months from the date of the calculation of the monthly payment.

3.3.4 TENNCARE will determine the appropriate rate category to which each enrollee is assigned for payment purposes under this Agreement.

3.3.5 TENNCARE's assignment of an enrollee to a rate category is for payment purposes under this Agreement, only, and is not an "adverse action" or determination of the benefits to which an enrollee is entitled under the TennCare program, TennCare rules and regulations, TennCare policies and procedures, the TennCare waiver or relevant court orders or consent decrees.

3.4 CAPITATION RATE ADJUSTMENT

3.4.1 The CONTRACTOR and TENNCARE agree that the capitation rates described in Section 3 of this Agreement may be adjusted periodically.

3.4.2 The CONTRACTOR and TENNCARE further agree that adjustments to capitation rates shall occur only by written amendment to this Agreement.

3.4.3 The following shall be applicable to adjusting the base capitation rate only:

3.4.3.1 The CONTRACTOR agrees to accept the base capitation rates originally proposed by the CONTRACTOR adjusted by the State for health plan risk in accordance with the following:

3.4.3.2 Health plan risk assessment scores will be initially recalibrated after current TennCare enrollees are assigned to the MCOs for retroactive application to payment rates effective on the start date of operations.

3.4.3.2.1 This initial recalibration will be based upon the distribution of enrollment on the start date of operations and health status information will be derived from encounter data used by the State's actuary to develop actuarially sound rate ranges for the 2006 Middle Tennessee MCO procurement.

3.4.3.2.2 If the health plan risk assessment score for any MCO deviates from the profile for the Grand Region being served by the MCO by more than three percent (3%), whether a negative or positive change in scores, the base capitation rates proposed by all MCOs will be proportionally adjusted.

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

3.4.3.4 TENNCARE will recalibrate health plan risk assessment scores on an ongoing basis for the purpose of monitoring shifts in enrollment. If warranted prior to the next scheduled annual recalibration as demonstrated by a significant change in health plan risk assessment scores, defined as a change of three percent (3%) or more, whether a negative or positive change in scores, TENNCARE may adjust the base capitation rates originally proposed by all MCOs as subsequently adjusted for all MCOs.

3.4.3.5 In addition to the annual recalibration of risk adjustment factors, those factors will be updated when there is a significant change in program participation. This may occur when an MCO enters or leaves a Grand Region. If an MCO withdraws from a Grand Region, that MCO's membership may be temporarily distributed to TennCare Select or distributed to the remaining MCOs or to new MCOs. New risk adjustment values for the remaining MCOs or new MCO(s) will be calculated that consider the population that will be enrolled in the MCO for the remainder of the contract year only. In this instance, MCOs would be given the option to provide TENNCARE, in writing, with a six (6) months notice of termination. This is the only instance when MCOs will be given the opportunity to give a notice of termination outside of the provisions in Section 4.4 of this Agreement. This notice option is not available for rate adjustments as described in Sections 3.4.3.1 through 3.4.3.4.

3.4.3.6 An individual's health status will be determined using the John Hopkins ACG® Case-Mix System (ACG System). In the event the State elects to use a different system to calculate an adjustment for MCO health status risk, the State will notify the CONTRACTOR prior to its implementation.

3.4.4 In addition to other adjustments specified in Section 3.4 of this Agreement, the base capitation rate originally proposed by the CONTRACTOR as subsequently adjusted and the priority add-on rate and State Only and Judicials rate originally specified by the State shall be adjusted annually for inflation in accordance with the recommendation of the State's actuary.

3.4.5 If (i) changes are required pursuant to federal or state statute, federal regulations, the action of a federal agency, a state or federal court, or rules and regulations of a State of Tennessee agency other than the TennCare Bureau and (ii) the changes are likely to impact the actuarial soundness of the capitation rate(s) described in Section 3, as determined by TENNCARE, TENNCARE shall have its independent actuary review the required change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TENNCARE's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

3.4.6 In the event TENNCARE amends TennCare rules or regulations or initiates a policy change not addressed in Section 3.4.5 above that is likely to impact the capitation rate(s) described in Section 3, as determined by TENNCARE, TENNCARE shall have its independent actuary review the proposed change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TENNCARE's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

3.4.7 In the event the amount of the two percent (2%) premium tax is increased during the term of this Agreement, the payments shall be increased by an amount equal to the increase in premium payable by the CONTRACTOR.

3.4.8 Any rate adjustments shall be subject to the availability of state appropriations.

3.5 CAPITATION PAYMENT SCHEDULE

TENNCARE shall make payment by the fifth (5th) business day of each month to the CONTRACTOR for the CONTRACTOR's satisfactory performance of its duties and responsibilities as set forth in this Agreement.

3.6 CAPITATION PAYMENT CALCULATION

3.6.1 When eligibility has been established by the State for enrollees, the amount owed to the CONTRACTOR shall be calculated as described herein and the amount due the CONTRACTOR shall be included in the current month payment of the base capitation rate and priority add-on rate.

3.6.1.1 Each month payment to the CONTRACTOR shall be equal to the number of enrollees enrolled in the CONTRACTOR's MCO five (5) business days prior to the date of the capitation payment multiplied by the appropriate capitation rate for the enrollee.

3.6.1.2 The base capitation rates and priority add-on rates stated in Attachment X will be the amounts used to determine the amount of the monthly capitation payment.

3.6.1.3 The actual amount owed the CONTRACTOR for each member shall be determined by dividing the appropriate monthly rate(s) by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the member was enrolled in the CONTRACTOR's MCO.

3.6.1.4 The amount paid to the CONTRACTOR shall equal the total of the amount owed for all enrollees determined pursuant to Section 3.6.1.3 less the withhold amount (see Section 3.9), capitation payment adjustments made pursuant to Section 3.7 or 3.10, and any other adjustments, which may include withholds for penalties, damages, liquidated damages, or adjustments based upon a change of enrollee status.

3.7 CAPITATION PAYMENT ADJUSTMENTS

3.7.1 The State has the discretion to retroactively adjust the capitation payment for any enrollee if TENNCARE determines an incorrect payment was made to the CONTRACTOR; provided, however:

3.7.1.1 For determining the capitation rate only, the Grand Region being served by the enrollee's MCO under this Agreement will be used to determine payment. The capitation payment shall not be retroactively adjusted to reflect a different Grand Region of residence so long as the enrollee's MCO assignment is effective.

3.7.1.2 For individuals enrolled with a retroactive effective date on the date of enrollment, the payment rate for retroactive periods shall be the capitation rate for the applicable rate category and the Grand Region in which the enrollee's assigned MCO is operating under this Agreement as specified in Attachment X, except that:

3.7.1.2.1 The CONTRACTOR agrees to manually process claims and reimburse providers for services incurred prior to the start date of operations of this Agreement; however, the CONTRACTOR will not be at risk for these services. The CONTRACTOR shall be paid two dollars ($2.00) per claim as reimbursement for processing claims for services incurred prior to the start date of operations. Actual expenditures for covered services and the allowed amount for claims processing are subject to TCA 56-32-224. The CONTRACTOR shall prepare checks for payment of providers for the provision of covered services incurred during an enrollee's period of eligibility prior to the start date of operations on an as needed basis. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and format at least forty-eight (48) hours in advance of distribution of any provider payment related to this requirement. TENNCARE shall remit payment to the CONTRACTOR in an amount equal to: the amount to be paid to providers; plus, two dollars ($2.00) per claim processed by the CONTRACTOR; plus, an amount sufficient to cover any payment due in accordance with TCA 56-32-224 within forty-eight (48) hours of receipt of notice. The CONTRACTOR shall then release payments to providers within twenty-four (24) hours of the receipt of funds from the State. The CONTRACTOR is responsible for any payments required pursuant to TCA 56-32-224.

3.7.1.3 If a provider seeks reimbursement for a service provided during a retroactive period of eligibility, the CONTRACTOR shall assess cost sharing responsibilities in accordance with the cost sharing schedules in effect on the date of service for which reimbursement is sought (see Attachment II).

3.7.1.4 Should TENNCARE determine after the capitation payment is made that an enrollee's capitation rate category had changed or the enrollee was deceased, TENNCARE shall retroactively adjust the payment to the CONTRACTOR to accurately reflect the enrollee's capitation rate category for the period for which payment has been made. TENNCARE shall initially retroactively adjust the payment to the CONTRACTOR, not to exceed twelve (12) months. Subsequently, TENNCARE shall further retroactively adjust the payment to the CONTRACTOR to accurately reflect the enrollee's capitation rate category for the period prior to the twelve (12) month adjustment initially made by TENNCARE. TENNCARE will make the subsequent adjustment at least semi-annually.

3.7.1.4.1 TENNCARE and the CONTRACTOR agree that the twelve (12) month limitation described in Sections 3.7.1.4 is applicable only to retroactive capitation rate payment adjustments described in those paragraphs and shall in no way be construed as limiting the effective date of eligibility or enrollment in the CONTRACTOR's MCO.

3.7.1.5 Payment adjustments resulting in a reduction or increase of the capitation rate shall be accomplished through the monthly capitation reconciliation process.

3.8 SERVICE DATES

Except where required by this Agreement or by applicable federal or state law, the CONTRACTOR shall not make payment for the cost of any services provided prior to the effective date of eligibility in the CONTRACTOR's MCO. The CONTRACTOR shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the CONTRACTOR's MCO.

3.9 WITHHOLD OF THE CAPITATION RATE

3.9.1 A withhold of the aggregate capitation payment shall be applied to ensure CONTRACTOR compliance with the requirements of this Agreement and to provide an agreed incentive for assuring CONTRACTOR compliance with the requirements of this Agreement.

3.9.2 The amount due for the first monthly payment, and for each month thereafter, calculated pursuant to Section 3.6 shall be reduced by the appropriate cash flow withhold percentage amount and set aside for distribution to the CONTRACTOR in the next regular monthly payment, unless retained as provided below.

3.9.2.1 Except as further provided below, the applicable capitation payment withhold amount will be equivalent to ten percent (10%) of the monthly capitation payment for the first six months following the start date of operations, and for any consecutive six (6) month period following the CONTRACTOR's receipt of a notice of deficiency as described in Section 2.25.9;

3.9.2.2 If, during any consecutive six (6) month period following the start date of operations, TENNCARE determines that the CONTRACTOR has no deficiencies and has not issued a notice of deficiency, the monthly withhold amount will be reduced to five percent (5%) of the monthly capitation payment.

3.9.2.3 If, during any consecutive six (6) month period following a reduction of the monthly withhold amount to five percent (5%) of the monthly capitation payment, TENNCARE determines that the CONTRACTOR has no deficiencies and has not issued a notice of deficiency, the monthly withhold amount will be reduced to two and one half percent (2.5%) of the monthly capitation payment.

3.9.2.4 If the CONTRACTOR is notified by TENNCARE of a minor deficiency and the CONTRACTOR cures the minor deficiency to the satisfaction of TENNCARE within a reasonable time prior to the next regularly scheduled capitation payment cycle, TENNCARE may disregard the minor deficiency for purposes of determining the withhold.

3.9.2.5 If TENNCARE has determined the CONTRACTOR is not in compliance with a requirement of this Agreement in any given month, TENNCARE will issue a written notice of deficiency and TENNCARE will retain the amount withheld for the month prior to TENNCARE identifying the compliance deficiencies.

3.9.2.6 The withhold amounts for subsequent months thereafter in which the CONTRACTOR has not cured the deficiencies shall be in accordance with Section 3.9.2.1 as described above. If the CONTRACTOR has attained a two and one half percent (2.5%) withhold and TENNCARE subsequently determines the CONTRACTOR is not in compliance with a requirement of this Agreement, TENNCARE will provide written notice of such determination and TENNCARE will re-institute the retention of the withhold as described in Section 3.9.2.1 at the next capitation payment cycle. Monthly retention of the withhold amount will continue for each subsequent month so long as the identified deficiencies have not been corrected. These funds will not be distributed to the CONTRACTOR unless it is determined by TENNCARE the CONTRACTOR has come into compliance with the Agreement requirement(s) within six (6) months of TENNCARE identifying these deficiencies. For example, if a specified deficiency(s) is corrected within four (4) months and there are no other identified deficiencies which the CONTRACTOR has been given written notice of by TENNCARE, the withhold for the four (4) consecutive months will be paid to the CONTRACTOR upon TENNCARE determination that the deficiency(s) was corrected. However, any amounts withheld by TENNCARE for six (6) consecutive months for the same or similar compliance deficiency(s) shall be retained by TENNCARE on the anniversary of the sixth consecutive month and shall not be paid to the CONTRACTOR. If the same or similar specified deficiency(s) continues beyond six (6) consecutive months, TENNCARE may declare the MCO ineligible for future distribution of the ten percent (10%) incentive withhold. Such ineligibility will continue for each month TENNCARE determines the same or similar specified deficiency(s) continues to exist. Once a CONTRACTOR corrects the deficiency(s), TENNCARE may reinstate the MCO's eligibility for distribution of the ten percent (10%) compliance incentive payment of future withholds. If TENNCARE determines that distribution of the ten percent (10%) withhold is appropriate, distribution of the ten percent (10%) shall be made at the time of the next scheduled monthly check write which includes all other payments due the CONTRACTOR.

3.9.3 No interest shall be due to the CONTRACTOR on any sums withheld or retained under this Section. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Agreement.

3.9.4 If TENNCARE has not identified CONTRACTOR deficiencies, TENNCARE will pay to the CONTRACTOR the withhold of the CONTRACTOR's payments withheld in the month subsequent to the withhold.

3.10 EFFECT OF DISENROLLMENT ON CAPITATION PAYMENTS

Payment of capitation payments shall cease effective the date of the member's disenrollment from the CONTRACTOR's MCO, and the CONTRACTOR shall have no further responsibility for the care of the enrollee. Except for situations involving enrollment obtained by fraudulent applications or death, disenrollment from TennCare shall not be made retroactively.

3.10.1 **Fraudulent Enrollment**

3.10.1.1 In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the CONTRACTOR, at its discretion, may refund to TENNCARE all capitation payments made on behalf of persons who obtained enrollment in TennCare through such means and the CONTRACTOR may pursue full restitution for all payments made on behalf of the individual while the person was inappropriately enrolled in the CONTRACTOR's MCO.

3.10.1.2 In the event of enrollment obtained by fraud, misrepresentation or deception by the CONTRACTOR's staff, officers, employees, providers, volunteers, subcontractors, or anyone acting for or on behalf of the CONTRACTOR, TENNCARE may retroactively recover capitation amounts plus interest, as allowed by TCA 47-14-103, and any other monies paid to the CONTRACTOR for the enrollment of that individual. The refund of capitation payments plus interest will not preclude the State from exercising its right to criminal prosecution, civil penalties, trebled damages and/or other remedial measures.

3.11 RISK-SHARING ARRANGEMENTS

3.11.1 The CONTRACTOR has the option to participate in one of the three risk-sharing options described below.

3.11.2 The risk-sharing option elected by the CONTRACTOR will be effective for the original term of this Agreement. In the event the State elects to extend the term of the Agreement, the CONTRACTOR may opt to change risk-sharing options for the term of the extension period so long as the CONTRACTOR elects an option that increases the CONTRACTOR's risk share of a net loss (e.g., the CONTRACTOR may change from Option 1 to Option 2, or from Option 1 to Option 3, or from Option 2 to Option 3). The CONTRACTOR shall provide notice of the change in the CONTRACTOR's elected risk share option in writing within fourteen (14) calendar days of receipt of written notice from the State of its intention to extend the Agreement term.

3.11.3 The risk-sharing 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.

3.11.4 TENNCARE reserves the right to modify the optional risk-sharing program prior to the beginning of each contract year with the mutual agreement of the CONTRACTOR.

3.11.5 **Risk-Sharing Calculations**

Calculations showing profit and loss shall be:

3.11.5.1 Based upon generally accepted accounting principles.

3.11.5.2 Reconciled on an annual basis and submitted to the State within ninety (90) calendar days of the end of the calendar year, and,

3.11.5.3 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.

3.11.6 **Risk-Sharing Options**

3.11.6.1 **Option 1** – TENNCARE and the CONTRACTOR share in all gains and losses as defined below:

3.11.6.1.1 The State will pay for fifty percent (50%) of losses in excess of the CONTRACTOR's total TennCare Revenue.

3.11.6.1.2 The CONTRACTOR shall pay the State seventy-five percent (75%) of gains in excess of the CONTRACTOR's total TennCare Revenue.

3.11.6.2 **Option 2** – TENNCARE and the CONTRACTOR share in all gains and losses as defined below:

3.11.6.2.1 The State will pay for twenty-five percent (25%) of losses in excess of the CONTRACTOR's total TennCare Revenue.

3.11.6.2.2 The CONTRACTOR shall pay the State fifty percent (50%) of gains in excess of the CONTRACTOR's total TennCare Revenue.

3.11.6.3 **Option 3** – The CONTRACTOR assumes all risk.

3.11.6.3.1 The State will pay for zero percent (0%) of any loss.

3.11.6.3.2 The CONTRACTOR shall pay the State zero percent (0%) of any gain.

3.11.6.4 The CONTRACTOR shall initial the option that the CONTRACTOR chooses to execute under this Agreement:

___Option 1 ___Option 2 ___ Option 3

3.11.7 **Risk-Sharing Settlements**

3.11.7.1 Risk-sharing settlements shall be determined on an annual basis. The CONTRACTOR shall submit a preliminary risk-sharing settlement calculation within ninety (90) calendar days of the end of each calendar year.

3.11.7.2 TENNCARE shall calculate the CONTRACTOR's net income/net loss by subtracting medical expenses, premium tax and administrative expenses from the CONTRACTOR's total TennCare revenue. Profits and losses shall be calculated as a percentage of the CONTRACTOR's total TennCare Revenue.

3.11.7.3 For the purpose of the risk-sharing settlement calculation:

3.11.7.3.1 The CONTRACTOR's TennCare Revenue will reflect the value of total capitation payments prior to the application of withholds or any other deduction and any additional income generated by investment income as a result of the deposit of the capitation payment from TENNCARE into an interest bearing account. The CONTRACTOR shall establish an account solely for the deposit of capitation payments from TENNCARE and shall not co-mingle said payments with funds from any other source.

3.11.7.3.2 All calculations of medical expenses shall include the net impact of: pharmacy rebates, if applicable; any third party liability recoveries or subrogation activities; and any reinsurance program.

3.11.7.3.3 The cost of any intermediate sanctions, including withholds and liquidated damages, shall be born by the CONTRACTOR and shall not be treated as an expense for the purpose of risk-sharing settlement calculations.

3.11.7.3.4 Excluding the premium tax, a limit on administrative costs equal to seven percent (7%) will be established. In the event that the CONTRACTOR's actual administrative costs exceed this amount, the excess amount shall not be considered in the CONTRACTOR's settlement calculation. Administrative costs may be audited for reasonableness when the State is sharing in a loss.

3.11.7.3.5 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 42 CFR Part 455, Subpart B shall demonstrate as a part of its risk-sharing calculation whether the MCO pays more for similar services rendered by a related provider or subcontractor or applies differing utilization management criteria than the MCO 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 that are not related for similar services. If TENNCARE determines the MCO pays related providers more than other providers or applies significantly different utilization management criteria, any risk-sharing settlement amount shall be adjusted as determined appropriate by TENNCARE.

3.11.7.3.6 All reimbursement paid to providers and policies that affect the determination of the amount to be paid are subject to audit by the State.

3.11.7.3.7 If this calculation results in a gain, or income (revenue exceeds expenses), all expenditures below the one-hundred percent (100%) of the total TennCare revenue, net of premium tax, will be shared according to the applicable description above.

3.11.7.3.8 If the calculation results in a loss (expenses exceed revenues), all expenditures above one-hundred percent (100%) of total TennCare revenue, net of the premium tax, will be shared according to the applicable description above.

3.11.7.4 Upon approval of the CONTRACTOR's preliminary risk-sharing calculation, TENNCARE or the CONTRACTOR, depending on whether the CONTRACTOR has incurred a profit or loss, will make monthly payments to the other party based on actual profits or losses for the settlement period as reported on the CONTRACTOR's MLR report. For the purpose of this requirement, actual profits or losses shall not include incurred but not reported expenses. After receipt and approval of the CONTRACTOR's preliminary risk-sharing calculation, risk-sharing settlements if applicable shall be made on a cash basis as documented on the CONTRACTOR's MLR report (see Section 2.30.14.2.1). In the event TENNCARE is sharing in a loss, TENNCARE shall remit payment for its share of the loss within thirty (30) calendar days of receipt of the CONTRACTOR's MLR report and any administrative cost

information requested by TENNCARE. In the event of a gain, the CONTRACTOR shall remit payment for TENNCARE's share of the gain with submission of the CONTRACTOR's MLR report

3.12 HMO PAYMENT TAX

The CONTRACTOR shall be responsible for payment of applicable taxes pursuant to TCA 56-32-224. In the event the amount due pursuant to TCA 56-32-224 is increased during the term of this Agreement, the payments to the CONTRACTOR shall be increased by an amount equal to the increase in the amount due by the CONTRACTOR.

3.13 PAYMENT TERMS AND CONDITIONS

3.13.1 Maximum Liability

3.13.1.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed [WRITTEN DOLLAR AMOUNT] ($[NUMBER AMOUNT]).

3.13.1.2 If the Agreement maximum would be exceeded as a result of an increase in enrollment, a change in mix of enrollment among rate cells or any rate adjustment pursuant to Section 3.4 above; or if there is a reduction in the total available funds for the payment of services under this Agreement, the State and the CONTRACTOR shall negotiate in good faith to reduce Agreement expenditures to the Agreement maximum level, or the State shall adjust the Agreement maximum liability to accommodate the aforementioned circumstances in consultation with the State's independent actuary.

3.13.1.3 This Agreement does not obligate the State to pay a fixed minimum amount and does not create in the CONTRACTOR any rights, interests or claims of entitlement in any funds.

3.13.1.4 The CONTRACTOR is not entitled to be paid the maximum liability for any period under the Agreement or any extensions of the Agreement. The maximum liability represents available funds for payment to the CONTRACTOR and does not guarantee payment of these funds to the CONTRACTOR under this Agreement.

3.13.2 Compensation Firm

The capitation rates and the Maximum Liability of the State under this Agreement are firm for the duration of the Agreement and are not subject to escalation for any reason unless amended.

3.13.3 Capitation Payment Amounts After the First Year

The base capitation rates (see Section 3) for calendar year 2007 for all rate categories except 'State Only and Judicials' will be established through a competitive bid process, and the base capitation rate for the 'State Only and Judicials' rate category and the priority add-on rate will be established by the State. The base capitation rates and priority add-on rate for subsequent years will be established through the amendment process (see Section 4.21) in accordance with Section 3.

3.13.4 **Payment Methodology**

The CONTRACTOR shall be compensated in accordance with Section 3 above as authorized by the State in a total amount not to exceed the Agreement Maximum Liability established in Section 3.13.1 above. The CONTRACTOR's compensation shall be contingent upon the satisfactory completion of requirements under this Agreement.

3.13.5 **Return of Funds and Deductions**

3.13.5.1 The CONTRACTOR shall refund to TENNCARE any overpayments due or funds disallowed pursuant to this Agreement within thirty (30) calendar days of the date of written notification from TENNCARE, unless otherwise authorized by TENNCARE in writing.

3.13.5.2 The State reserves the right to deduct from amounts which are or shall become due and payable to the CONTRACTOR under this or any Agreement or contract between the CONTRACTOR and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the CONTRACTOR.

3.13.6 **Automatic Deposits**

The CONTRACTOR shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits)" form. This form shall be provided to the CONTRACTOR by the State. Once this form has been completed and submitted to the State by the CONTRACTOR all payments to the CONTRACTOR, under this or any other Agreement/contract the CONTRACTOR has with the State of Tennessee shall be made by Automated Clearing House (ACH). The CONTRACTOR shall not be paid under this Agreement until the CONTRACTOR has completed this form and submitted it to the State.

SECTION 4 - TERMS AND CONDITIONS

4.1 NOTICE

All notices required to be given under this Agreement shall be given in writing, and shall be sent by United States certified mail, postage prepaid, return receipt requested; in person; or by other means, so long as proof of delivery and receipt is given, and the cost of delivery is borne by the notifying party, to the appropriate party at the address given below, or at such other address (or addresses) as may be provided by notice given under this Section.

If to TENNCARE:

Deputy Commissioner
Bureau of TennCare
310 Great Circle Rd
Nashville, Tennessee 37243

If to the CONTRACTOR:

4.2 AGREEMENT TERM

4.2.1 Term of the Agreement

This Agreement, including any amendments, shall be effective for three (3) years commencing on [START DATE] and ending on [END DATE].

4.2.2 Term Extension

The State reserves the right to extend this Agreement for an additional period or periods of time representing increments of no more than one (1) year and a total term of no more than five (5) years, provided that the State notifies the CONTRACTOR in writing of its intention to do so at least six (6) months prior to the Agreement expiration date. An extension of the term of this Agreement will be effected through an amendment to the Agreement.

4.2.3 Exigency Extension

4.2.3.1 At the option of the State, the CONTRACTOR agrees to continue services under this Agreement when TENNCARE determines that there is a public exigency that requires the services to continue. Continuation of services pursuant to this Section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) calendar days written notice shall be given by TENNCARE before this option is exercised.

4.2.3.2 A written notice of exigency extension shall constitute an amendment to the Agreement, may include a revision of the maximum liability and other adjustments permitted under Section 3, and shall be approved by the F&A Commissioner and the Comptroller of the Treasury.

4.2.3.3 During any periods of public exigency, TENNCARE shall continue to make payments to the CONTRACTOR as specified in Section 3 of this Agreement.

4.3 APPLICABLE LAWS AND REGULATIONS

The CONTRACTOR agrees to comply with all applicable federal and state laws, rules and regulations, policies (including TennCare Standard Operating Procedures (so long as said TennCare Standard Operating Procedure does not constitute a material change to the obligations of the CONTRACTOR pursuant to this Agreement)), consent decrees, and court orders, including Constitutional provisions regarding due process and equal protection of the law, including but not limited to:

4.3.1 42 CFR Chapter IV, Subchapter C (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

4.3.2 45 CFR Part 74, General Grants Administration Requirements.

4.3.3 Titles 4, 47, 56, and 71, Tennessee Code Annotated, including, but not limited to, the TennCare Drug Formulary Accountability Act, Public Chapter 276 and The Standardized Pharmacy Benefit Identification Card Act.

4.3.4 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 (42 USC 7401, *et seq*.).

4.3.5 Title VI of the Civil Rights Act of 1964 (42 USC 2000d) and regulations issued pursuant thereto, 45 CFR Part 80.

4.3.6 Title VII of the Civil Rights Act of 1964 (42 USC 2000e) in regard to employees or applicants for employment.

4.3.7 Section 504 of the Rehabilitation Act of 1973, 29 USC 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84.

4.3.8 The Age Discrimination Act of 1975, 42 USC 6101 *et seq*., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.

4.3.9 The Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.

4.3.10 Americans with Disabilities Act, 42 USC 12101 *et seq*., and regulations issued pursuant thereto, 28 CFR Parts 35, 36.

4.3.11 Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare, SCHIP and/or Medicaid program.

4.3.12 Tennessee Consumer Protection Act, TCA 47-18-101 *et seq*.

4.3.13 The TennCare Section 1115 waiver and all Special Terms and Conditions which relate to the waiver.

4.3.14 Executive Orders, including Executive Order 1 effective January 26, 1995 and Executive Order 3 effective February 3, 2003.

4.3.15 The Clinical Laboratory Improvement Amendments (CLIA) of 1988.

4.3.16 Requests for approval of material modification as provided at TCA 56-32-201 *et seq*.

4.3.17 Investigatory Powers of TDCI pursuant to TCA 56-32-232.

4.3.18 42 USC 1396 *et seq*. (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

4.3.19 The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Section 1171(5)(E) of the Social Security Act as enacted by HIPAA.

4.3.20 Title IX of the Education Amendments of 1972 regarding education programs and activities.

4.3.21 Title 42 CFR 422.208 and 210, Physician Incentive Plans.

4.3.22 Equal Employment Opportunity (EEO) Provisions.

4.3.23 Copeland Anti-Kickback Act.

4.3.24 Davis-Bacon Act.

4.3.25 Contract Work Hours and Safety Standards.

4.3.26 Rights to Inventions Made Under a Contract or Agreement.

4.3.27 Byrd Anti-Lobbying Amendment.

4.3.28 Subcontracts in excess of one-hundred thousand dollars ($100,000) shall require compliance with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15).

4.3.29 Mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (P. L. 94-165.)

4.3.30 TennCare Reform Legislation signed May 11, 2004.

4.3.31 Federal Pro-Children Act of 1994 and the Tennessee Children's Act for Clean Indoor Air of 1995.

4.3.32 Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2.

4.3.33 Title 33 (Mental Health Law) of the Tennessee Code Annotated.

4.3.34 Rules of the Tennessee Department of Mental Health and Developmental Disabilities, Rule 0940 *et seq*.

4.3.35 TennCare rules and regulations.

4.4 TERMINATION

In the event of termination, it is agreed that neither party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred during the course of this Agreement. For terminations pursuant to Sections 4.4.1, 4.4.2, 4.4.3, or 4.4.5, TENNCARE will assume responsibility for informing all affected enrollees of the reasons for their termination from the CONTRACTOR's MCO.

4.4.1 Termination Under Mutual Agreement

Under mutual agreement, TENNCARE and the CONTRACTOR may terminate this Agreement for any reason if it is in the best interest of TENNCARE and the CONTRACTOR. Both parties will sign a notice of termination which shall include, inter alia, the date of termination, conditions of termination, and extent to which performance of work under this Agreement is terminated.

4.4.2 Termination by TENNCARE for Cause

4.4.2.1 The CONTRACTOR shall be deemed to have breached this Agreement if any of the following occurs:

4.4.2.1.1 The CONTRACTOR fails to perform in accordance with any term or provision of the Agreement;

4.4.2.1.2 The CONTRACTOR only renders partial performance of any term or provision of the Agreement; or

4.4.2.1.3 The CONTRACTOR engages in any act prohibited or restricted by the Agreement.

4.4.2.2 For purposes of Section 4.4.2, items 4.4.2.1.1 through 4.4.2.1.3 shall hereinafter be referred to as "Breach."

4.4.2.3 In the event of a Breach by the CONTRACTOR, TENNCARE shall have available any one or more of the following remedies in addition to or in lieu of any other remedies set out in this Agreement or available in law or equity:

4.4.2.3.1 Recover actual damages, including incidental and consequential damages, and any other remedy available at law or equity;

4.4.2.3.2 Require that the CONTRACTOR prepare a plan to immediately correct cited deficiencies, unless some longer time is allowed by TENNCARE, and implement this correction plan;

4.4.2.3.3 Recover any and/or all liquidated damages provided in Section 4.20.2; and

4.4.2.3.4 Declare a default and terminate this Agreement.

4.4.2.4 In the event of a conflict between any other Agreement provisions and Section 4.4.2.3, Section 4.4.2.3 shall control.

4.4.2.5 In the event of Breach by the CONTRACTOR, TENNCARE may provide the CONTRACTOR written notice of the Breach and twenty (20) calendar days to cure the Breach described in the notice. In the event that the CONTRACTOR fails to cure the Breach within the time period provided, then TENNCARE shall have available any and all remedies described herein and available at law.

4.4.2.6 In the event the CONTRACTOR disagrees with the determination of noncompliance or designated corrective action described in the notice, the CONTRACTOR shall nevertheless implement said corrective action, without prejudice to any rights the CONTRACTOR may have to later dispute the finding of noncompliance or designated corrective action.

4.4.3 **Termination for Unavailability of Funds**

In the event that federal and/or state funds to finance this Agreement become unavailable, TENNCARE may terminate the Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR shall be entitled to receive and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date. Availability of funds shall be determined solely by TENNCARE.

4.4.4 **Termination for CONTRACTOR Financial Inviability, Insolvency or Bankruptcy**

4.4.4.1 If TENNCARE reasonably determines that the CONTRACTOR's financial condition is not sufficient to allow the CONTRACTOR to provide the services as described herein in the manner required by TENNCARE, TENNCARE may terminate this Agreement in whole or in part, immediately or in stages. Said termination shall not be deemed a Breach by either party. The CONTRACTOR's financial condition shall be presumed not sufficient to allow the CONTRACTOR to provide the services described herein in the manner required by TENNCARE if the CONTRACTOR can not demonstrate to TENNCARE's satisfaction that the CONTRACTOR has risk reserves and a net worth to meet the applicable net worth requirement specified in Section 2.21.5 of this Agreement.

4.4.4.2 CONTRACTOR insolvency or the filing of a petition in bankruptcy by or against the CONTRACTOR shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor or provider or the insolvency of said subcontractor or provider, the CONTRACTOR shall immediately advise TENNCARE.

4.4.5 **Termination by TENNCARE for Convenience**

TENNCARE may terminate this Agreement for convenience and without cause upon thirty (30) calendar days written notice. Said termination shall not be a Breach of the Agreement by TENNCARE, and TENNCARE shall not be responsible to the CONTRACTOR or any other party for any costs, expenses, or damages occasioned by said termination, i.e., without penalty.

4.4.6 **Termination Procedures**

4.4.6.1 The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall specify the provision of this Agreement giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective.

4.4.6.2 Upon receipt of notice of termination, and subject to the provisions of this Section, on the date and to the extent specified in the notice of termination, the CONTRACTOR shall:

4.4.6.2.1 Stop work under the Agreement, but not before the termination date;

4.4.6.2.2 At the point of termination, assign to TENNCARE in the manner and extent directed by TENNCARE all the rights, title and interest of the CONTRACTOR for the performance of the subcontracts to be determined at need in which case TENNCARE shall have the right, in its discretion, to settle or pay any of the claims arising out of the termination of such agreements and subcontracts;

4.4.6.2.3 Complete the performance of such part of the Agreement that shall have not been terminated under the notice of termination;

4.4.6.2.4 Take such action as may be necessary, or as a contracting officer may direct, for the protection of property related to this Agreement which is in possession of the CONTRACTOR and in which TENNCARE has or may acquire an interest;

4.4.6.2.5 In the event the Agreement is terminated by TENNCARE, continue to serve or arrange for provision of services to the enrollees in the CONTRACTOR's MCO for up to forty-five (45) calendar days from the Agreement termination date or until the members can be transferred to another MCO, whichever is longer. During this transition period, TENNCARE shall continue to make payment as specified in Section 3;

4.4.6.2.6 Promptly make available to TENNCARE, or another MCO acting on behalf of TENNCARE, any and all records, whether medical, behavioral or financial, related to the CONTRACTOR's activities undertaken pursuant to this Agreement. Such records shall be in a usable form and shall be provided at no expense to TENNCARE;

4.4.6.2.7 Promptly supply all information necessary to TENNCARE or another MCO acting on behalf of TENNCARE for reimbursement of any outstanding claims at the time of termination;

4.4.6.2.8 Submit a termination plan to TENNCARE for review, which is subject to TENNCARE approval. This plan must, at a minimum, contain the provisions in Sections 4.4.6.2.9 through 4.4.6.2.14 below. The CONTRACTOR shall agree to make revisions to the plan as necessary in order to obtain approval by TENNCARE. Failure to submit a termination plan and obtain approval of the termination plan by TENNCARE shall result in the withhold of ten percent (10%) of the CONTRACTOR's monthly capitation payment;

4.4.6.2.9 Agree to maintain claims processing functions as necessary for a minimum of nine (9) months (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims;

4.4.6.2.10 Agree to comply with all duties and/or obligations incurred prior to the actual termination date of the Agreement, including but not limited to, the appeal process as described in Section 2.19;

4.4.6.2.11 File all reports concerning the CONTRACTOR's operations during the term of the Agreement in the manner described in this Agreement;

4.4.6.2.12 Take whatever other actions are necessary in order to ensure the efficient and orderly transition of members from coverage under this Agreement to coverage under any new arrangement developed by TENNCARE;

4.4.6.2.13 In order to ensure that the CONTRACTOR fulfills its continuing obligations both before and after termination, maintain the financial requirements (as described in this Agreement as of the CONTRACTOR's date of termination notice), fidelity bonds and insurance set forth in this Agreement until the State provides the CONTRACTOR written notice that all continuing obligations of this Agreement have been fulfilled; and

4.4.6.2.14 Upon expiration or termination of this Agreement, submit reports to TENNCARE every thirty (30) calendar days detailing the CONTRACTOR's progress in completing its continuing obligations under this Agreement. The CONTRACTOR, upon completion of these continuing obligations, shall submit a final report to TENNCARE describing how the CONTRACTOR has completed its continuing obligations. TENNCARE shall within twenty (20) calendar days of receipt of this report advise in writing whether TENNCARE agrees that the CONTRACTOR has fulfilled its continuing obligations. If TENNCARE finds that the final report does not evidence that the CONTRACTOR has fulfilled its continuing obligations, then TENNCARE shall require the CONTRACTOR to submit a revised final report. TENNCARE shall in writing notify the CONTRACTOR once the CONTRACTOR has submitted a revised final report evidencing to the satisfaction of TENNCARE that the CONTRACTOR has fulfilled its continuing obligations.

4.5 ENTIRE AGREEMENT

4.5.1 This Agreement, including any amendments or attachments, represents the entire Agreement between the CONTRACTOR and TENNCARE with respect to the subject matter stated herein, and supersedes all other contracts between the parties with regard to the provision of services described herein. Any communications made before the parties entered into this Agreement, whether verbal or in writing, shall not be considered as part of or explanatory of any part of this Agreement.

4.5.2 In the event of a conflict of language between the Agreement and any amendments, the provisions of the amendments shall govern.

4.5.3 All applicable state and federal laws, rules and regulations, consent decrees, court orders and policies and procedures (hereinafter referred to as Applicable Requirements), including those described in Section 4.3 of this Agreement are incorporated by reference into this Agreement. Any changes in those Applicable Requirements shall be automatically incorporated into this Agreement by reference as soon as they become effective. However, as provided in Section 3.4.5 of this Agreement, changes that are likely to impact the actuarial soundness of the capitation rate(s) shall be reviewed by TENNCARE's actuary and the appropriate adjustment to the impacted capitation rate(s) will be made via amendment pursuant to Section 4.21.

4.5.4 Nothing contained herein shall prejudice, restrict or otherwise limit the CONTRACTOR's right to initiate action challenging such Applicable Requirements in a court of competent jurisdiction, including seeking to stay or enjoin the applicability or incorporation of such requirements into this Agreement.

4.6 INCORPORATION OF ADDITIONAL DOCUMENTS

4.6.1 Included in this Agreement by reference are the following documents:

4.6.1.1 The Agreement document and its attachments, as defined in Section 4.5 above;

4.6.1.2 All clarifications and addenda made to the CONTRACTOR's Proposal;

4.6.1.3 The Request for Proposal and its associated amendments;

4.6.1.4 Technical Specifications provided to the CONTRACTOR; and

4.6.1.5 The CONTRACTOR's Proposal.

4.6.2 In the event of a discrepancy or ambiguity regarding the CONTRACTOR's duties, responsibilities, and performance under this Agreement, these documents shall govern in order of precedence detailed above.

4.7 APPLICABILITY OF THIS AGREEMENT

4.7.1 All terms, conditions, and policies stated in this Agreement apply to staff, agents, officers, subcontractors, providers, volunteers and anyone else acting for or on behalf of the CONTRACTOR.

4.7.2 TennCare enrollees are the intended third party beneficiaries of contracts between the State and the CONTRACTOR and of any subcontracts or provider agreements entered into by the CONTRACTOR with subcontracting providers, and, as such, enrollees are entitled to the remedies accorded to third party beneficiaries under the law. This provision is not intended to provide a cause of action against TENNCARE or the State of Tennessee by enrollees beyond any that may exist under state or federal law.

4.8 TECHNICAL ASSISTANCE

Technical assistance shall be provided to the CONTRACTOR when deemed appropriate by TENNCARE.

4.9 PROGRAM INFORMATION

Upon request, TENNCARE shall provide the CONTRACTOR complete and current information with respect to pertinent statutes, regulations, rules, policies, procedures, and guidelines affecting the CONTRACTOR's operation pursuant to this Agreement.

4.10 QUESTIONS ON POLICY DETERMINATIONS

On an ongoing basis, should the CONTRACTOR have a question on policy determinations, benefits or operating guidelines, the CONTRACTOR shall request a determination from TENNCARE in writing. The State shall have thirty (30) calendar days to make a determination and respond unless specified otherwise. Should TENNCARE not respond in the required amount of time, the CONTRACTOR shall not be penalized as a result of implementing items awaiting approval. However, failure to respond timely shall not preclude the State from requiring the CONTRACTOR to respond or modify the policy or operating guideline prospectively. The CONTRACTOR shall be afforded at least sixty (60) calendar days to implement the modification.

4.11 INTERPRETATIONS

Any dispute between the CONTRACTOR and TENNCARE concerning the clarification, interpretation and application of all federal and state laws, regulations, or policy or consent decrees or court orders governing or in any way affecting this Agreement shall be determined by TENNCARE. When a clarification, interpretation and application is required, the CONTRACTOR shall submit a written request to TENNCARE. TENNCARE will contact the appropriate agencies in responding to the request by submitting the written request to the agency within thirty (30) calendar days after receiving that request from the CONTRACTOR. Any clarifications received pursuant to requests for clarification, interpretation and application shall be forwarded upon receipt to the CONTRACTOR. Nothing in this Section shall be construed as a waiver by the CONTRACTOR of any legal right it may have to contest the findings of either the state or federal governments or both as they relate to the clarification, interpretation and application of statute, regulation, or policy or consent decrees or court orders.

4.12 CONTRACTOR APPEAL RIGHTS

The CONTRACTOR shall have the right to contest TENNCARE decisions pursuant to the provisions of TCA 9-8-301 *et seq*. for the resolution of disputes under this Agreement. Written notice describing the substance and basis of the contested action must be submitted to TENNCARE within thirty (30) calendar days of the action taken by TENNCARE. The CONTRACTOR shall comply with all requirements contained within this Agreement pending the final resolution of the contested action.

4.13 DISPUTES

Any claim by the CONTRACTOR against TENNCARE arising out of the breach of this Agreement shall be handled in accordance with the provision of TCA 9-8-301, *et seq*. Provided, however, the CONTRACTOR agrees that the CONTRACTOR shall give notice to TENNCARE of its claim thirty (30) calendar days prior to filing the claim in accordance with TCA 9-8-301, *et seq*.

4.14 NOTIFICATION OF LEGAL ACTION AGAINST THE CONTRACTOR

The CONTRACTOR shall give TENNCARE and TDCI immediate notification in writing by certified mail of any administrative or legal action filed regarding any claim made against the CONTRACTOR by a provider or enrollee which is related to the CONTRACTOR's responsibilities under this Agreement, including but not limited to notice of any arbitration proceedings instituted between a provider and the CONTRACTOR. The CONTRACTOR shall ensure that all tasks related to the provider agreement are performed in accordance with the terms of this Agreement.

4.15 DATA THAT MUST BE CERTIFIED

4.15.1 In accordance with 42 CFR 438.606 and 438.606, when State payments to the CONTRACTOR are based on data submitted by the CONTRACTOR, the CONTRACTOR shall certify the data. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals and related documents including the medical loss ratio (MLR) report. The data must be certified by one of the following: the CONTRACTOR's Chief Executive Officer, the CONTRACTOR's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the CONTRACTOR's Chief Executive Officer or Chief Financial Officer. The certification must attest, based on best knowledge, information, and belief, as follows:

4.15.1.1 To the accuracy, completeness and truthfulness of the data; and

4.15.1.2 To the accuracy, completeness and truthfulness of the documents specified by the State.

4.15.2 The CONTRACTOR shall submit the certification concurrently with the certified data.

4.16 USE OF DATA

TENNCARE shall have unlimited but not exclusive rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the CONTRACTOR resulting from this Agreement. However, TENNCARE shall not disclose proprietary information that is afforded confidential status by state or federal law.

4.17 WAIVER

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Agreement may be waived except by written agreement of the Agreement signatories or in the event the signatory for a party is no longer empowered to sign such Agreement, the signatory's replacement. Forbearance, forgiveness, or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings, the other party shall have the right to invoke any remedy available under law or equity notwithstanding any such forbearance, forgiveness or indulgence.

4.18 AGREEMENT VARIATION/SEVERABILITY

If any provision of this Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both TENNCARE and the CONTRACTOR shall be relieved of all obligations arising under such provision. If the remainder of the Agreement is capable of performance, it shall not be affected by such declaration of finding and shall be fully performed. In addition, if the laws or regulations governing this Agreement should be amended or judicially interpreted as to render the fulfillment of the Agreement impossible or economically unfeasible, both TENNCARE and the CONTRACTOR will be discharged from further obligations created under the terms of the Agreement.

4.19 CONFLICT OF INTEREST

4.19.1 The CONTRACTOR warrants that no part of the total Agreement amount provided herein shall be paid directly or indirectly to any 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 otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration. The authorization may be requested in writing to the Commissioner of Finance and Administration. (See 45 CFR 93.100 *et seq.*, 31 USC 1352, TCA 3-6-101 *et seq*., 3-6-201 *et seq*., 3-6-301 *et seq*., and 8-50-505.)

4.19.2 By December 31 of each year 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 the following:

4.19.2.1 A list of any officer or employee of the State of Tennessee who receives wages or compensation in connection with work performed under this Agreement;

4.19.2.2 A statement of the reason or purpose for the wages or compensation; and

4.19.2.3 A statement that the Commissioner of Department of Finance and Administration has authorized this arrangement.

4.19.3 This Agreement may be terminated by TENNCARE if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any officials or employees of the State of Tennessee. The CONTRACTOR certifies that no member of or delegate of Congress, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially from this Agreement.

4.19.4 The CONTRACTOR shall include the substance of this clause in all subcontracts and provider agreements.

4.20 FAILURE TO MEET AGREEMENT REQUIREMENTS

It is acknowledged by TENNCARE and the CONTRACTOR that in the event of CONTRACTOR's failure to meet the requirements provided in this Agreement and all documents incorporated herein, TENNCARE will be harmed. The actual damages which TENNCARE will sustain in the event of and by reason of such failure are uncertain, are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the CONTRACTOR shall be subject to damages and/or sanctions as described below. It is further

agreed that the CONTRACTOR shall pay TENNCARE liquidated damages as directed by TENNCARE; provided however, that if it is finally determined that the CONTRACTOR would have been able to meet the Agreement requirements listed below but for TENNCARE's failure to perform as provided in this Agreement, the CONTRACTOR shall not be liable for damages resulting directly therefrom.

4.20.1 **Intermediate Sanctions**

4.20.1.1 TENNCARE may impose any or all of the sanctions as described in this Section upon TENNCARE's reasonable determination that the CONTRACTOR failed to comply with any corrective action plan (CAP) as described under Section 2.25.9 or Section 2.23.13 of this Agreement, or is otherwise deficient in the performance of its obligations under the Agreement, which shall include, but may not be limited to the following:

4.20.1.1.1 Fails substantially to provide medically necessary covered services;

4.20.1.1.2 Imposes on members cost sharing responsibilities that are in excess of the cost sharing permitted by TENNCARE;

4.20.1.1.3 Acts to discriminate among enrollees on the basis of their health status or need for health care services;

4.20.1.1.4 Misrepresents or falsifies information that it furnishes to CMS or to the State;

4.20.1.1.5 Misrepresents or falsifies information that it furnishes to a member, potential member, or provider;

4.20.1.1.6 Fails to comply with the requirements for physician incentive plans, as required by 42 CFR 438.6(h) and set forth (for Medicare) in 42 CFR 422.208 and 422.210;

4.20.1.1.7 Has distributed directly, or indirectly through any agent or independent contractor, marketing or member materials that have not been approved by the State or that contain false or materially misleading information; and

4.20.1.1.8 Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

4.20.1.2 TENNCARE shall only impose those sanctions it determines to be appropriate for the deficiencies identified. However, TENNCARE may impose intermediate sanctions on the CONTRACTOR simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe and/or numerous. Intermediate sanctions may include:

4.20.1.2.1 Liquidated damages as described in Section 4.20.2;

4.20.1.2.2 Suspension of enrollment in the CONTRACTOR's MCO;

4.20.1.2.3 Disenrollment of members;

4.20.1.2.4 Limitation of the CONTRACTOR's service area;

4.20.1.2.5 Civil monetary penalties as described in 42 CFR 438.704;

4.20.1.2.6 Appointment of temporary management for an MCO as provided in 42 CFR 438.706;

4.20.1.2.7 Suspension of all new enrollment, including default enrollment, after the effective date of the sanction;

4.20.1.2.8 Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; or

4.20.1.2.9 Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance.

4.20.2 **Liquidated Damages**

4.20.2.1 Reports and Deliverables

4.20.2.1.1 For each day that a report or deliverable is late, incorrect, or deficient, the CONTRACTOR shall be liable to TENNCARE for liquidated damages in the amount of one-hundred dollars ($100) per day per report or deliverable unless specified otherwise in this Section. Liquidated damages for late reports/deliverables shall begin on the first day the report/deliverable is late.

4.20.2.1.2 Liquidated damages for incorrect reports or deficient deliverables shall begin on the first day after the report/deliverable was due.

4.20.2.1.3 For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due as specified elsewhere in this Agreement or by TENNCARE.

4.20.2.2 Program Issues

4.20.2.2.1 Liquidated damages for failure to perform specific responsibilities or responsibilities as described in this Agreement are shown in the chart below. Damages are grouped into three categories: **Level A**, **Level B**, and **Level C** program issues.

4.20.2.2.2 Failure to perform specific responsibilities or requirements categorized as **Level A** are those which pose a significant threat to patient care or to the continued viability of the TENNCARE program.

4.20.2.2.3 Failure to perform specific responsibilities or requirements categorized as **Level B** are those with pose threats to the integrity of the TENNCARE program, but which do not necessarily imperil patient care.

4.20.2.2.4 Failure to perform specific responsibilities or requirements categorized as **Level C** are those which represent threats to the smooth and efficient operation of the TENNCARE program but which do not imperil patient care or the integrity of the TENNCARE program.

4.20.2.2.5 TENNCARE may also assess liquidated damages for failure to meet performance standards as provided in Section 2.24.3 and Attachment VII of this Agreement.

4.20.2.2.6 TENNCARE reserves the right to assess a general liquidated damage of five-hundred dollars ($500) per occurrence with any notice of deficiency.

4.20.2.2.7 *Liquidated Damages Chart*

LEVEL	PROGRAM ISSUES		DAMAGE
A.1	Failure to comply with claims processing as described in Section 2.22 of this Agreement		$10,000 per month, for each month that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of Section 2.22 of this Agreement
A.2	Failure to comply with licensure requirements in Section 2.29.2 of this Agreement		$5,000 per calendar day that staff/provider/agent/subcontractor is not licensed as required by applicable state law plus the amount paid to the staff/provider/agent/subcontractor during that period
A.3	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child at risk of entering DCS custody		The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater
A.4	Failure to comply with obligations and time frames in the delivery of TENNderCare screens and related services		The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater
A.5	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized by the TENNCARE Chief Medical Officer		The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater

LEVEL	PROGRAM ISSUES		DAMAGE
A.6(a)	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TENNCARE (pursuant to an appeal) to do so or within a longer period of time which has been approved by TENNCARE upon the CONTRACTOR's demonstration of good cause		$500 per day beginning on the next calendar day after default by the CONTRACTOR
A.6(b)	Failure to provide proof of compliance to TENNCARE within five (5) calendar days of a reasonable and appropriate directive from TENNCARE or within a longer period of time which has been approved by TENNCARE upon the CONTRACTOR's demonstration of good cause		$500 per day beginning on the next calendar day after default by the CONTRACTOR
A.7	Failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/ Hysterectomies as outlined in Section 2.7.7 of this Agreement		$500 per occurrence or the actual amount of the federal penalty created by the CONTRACTOR's failure to comply, whichever is greater
A.8	Failure to provide coverage for prenatal care without a delay in care and in accordance with Section 2.7.4.2 of this Agreement		$500 per day, per occurrence, for each calendar day that care is not provided in accordance with the terms of this Agreement
A.9	Failure to provide continuation or restoration of services where enrollee was receiving the service as required by TENNCARE rules or regulations, applicable state or federal law, and all court orders and consent decrees governing appeal procedures as they become effective		An amount sufficient to at least offset any savings the CONTRACTOR achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense $500 per day for each calendar day beyond the 2nd business day after an On Request Report regarding a member's request for continuation of benefits is sent by TENNCARE

LEVEL	PROGRAM ISSUES		DAMAGE
A.10	Failure to comply with the notice requirements of this Agreement, TennCare rules and regulations or any subsequent amendments thereto, and all court orders and consent decrees governing appeal procedures, as they become effective		$500 per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE
A.11	Failure to forward an expedited appeal to TENNCARE in twenty-four (24) hours or a standard appeal in five (5) days		$500 per calendar day
A.12	Failure to provide complete documentation and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing appeals procedures as they become effective		$500 per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE
A.13	Failure to submit a timely corrected notice of adverse action to TENNCARE for review and approval prior to issuance to the member		$1,000 per occurrence if the notice remains defective plus a per calendar day assessment in increasing increments of $500 ($500 for the first day, $1,000 for the second day, $1,500 for the third day, etc.) for each day the notice is late and/or remains defective

LEVEL	PROGRAM ISSUES		DAMAGE
A.14	Per the Revised Grier Consent Decree, "Systemic problems or violations of the law" (i.e., 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.)
B.1	Failure to provide referral provider listings to PCPs as required by Section 2.14.3.5 of this Agreement		$500 per calendar day
B.2	Failure to complete or comply with corrective action plans as required by TENNCARE		$500 per calendar day for each day the corrective action is not completed or complied with as required
B.3	Failure to submit Audited HEDIS and CAHPS results annually by June 15 as described in Sections 2.15.6 and 2.15.7		$250 per day for every calendar day reports are late
B.4	Failure to submit NCQA Accreditation Report as described in Sections 2.15.6		$500 per day for every calendar day beyond the 10th calendar day Accreditation Status is not reported
B.5	Failure to comply with Conflict of Interest, Lobbying, and/or Gratuities requirements described in Section 4.19, 4.23, or 4.24		110% of the total amount of compensation paid by the CONTRACTOR to inappropriate individuals
B.6	Failure to disclose lobbying activities as required by Section 4.24 and 2.30.20		$1000 per day that disclosure is late
B.7	Failure to comply with Offer of Gratuities constraints described in Section 4.23		110 % of the total benefit provided by the CONTRACTOR to inappropriate individuals

LEVEL	PROGRAM ISSUES		DAMAGE
B.8	Failure to obtain approval of member materials as required by Section 2.17 of this Agreement		$500 per day for each calendar day that TENNCARE determines the CONTRACTOR has provided member material that has not been approved by TENNCARE
B.9	Failure to comply with time frames for providing Member Handbooks, I.D. cards, Provider Directories, and Quarterly Member Newsletters as required in Section 2.17		$5000 for each occurrence
B.10	Failure to achieve and/or maintain financial requirements in accordance with TCA		$500 per calendar day for each day that financial requirements have not been met
B.11	Failure to submit the CONTRACTOR's annual NAIC filing as described in Section 2.30.14.1		$500 per calendar day
B.12	Failure to submit the CONTRACTOR's quarterly NAIC filing as described in Section 2.30.14.1		$500 per calendar day
B.13	Failure to submit audited financial statements as described in Section 2.30.14.1		$500 per calendar day
B.14	Failure to comply with fraud and abuse provisions as described in Section 2.20 of this Agreement		$500 per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions
B.15	Failure to require and ensure compliance with Ownership and Disclosure requirements as required in Section 2.21.8 and 2.30.14.12 of this Agreement		$5000 per provider application for each application that is signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B
B.16	Failure to maintain a complaint and appeal system as required in Section 2.9 of this Agreement		$500 per calendar day
B.17	Failure to maintain required insurance as required in Section 2.21.7 of this Agreement		$500 per calendar day

LEVEL	PROGRAM ISSUES		DAMAGE
B.18	Failure to provide a written discharge plan or provision of a defective discharge plan for discharge from a psychiatric inpatient facility or mental health residential treatment facility as required in Section 2.9.6.3.2 of this Agreement		$1,000 per occurrence per case
B.19	Imposing arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section 2.6.3 and 2.14.1 of this Agreement		$500 per occurrence
B.20	Failure to provide CRG/TPG assessments within the time frames specified in Section 2.7.2.9 of this Agreement		$500 per month per Enrollee
B.21	Failure to provide CRG/TPG assessments by TDMHDD-certified raters or in accordance with TDMHDD policies and procedures as required in Section 2.7.2.9 of this Agreement		$500 per occurrence per case
C.1	Failure to comply in any way with staffing requirements as described in Section 2.29.1 of this Agreement		$250 per calendar day for each day that staffing requirements are not met
C.2	Failure to report provider notice of termination of participation in the CONTRACTOR's MCO		$250 per day
C.3	Failure to comply in any way with encounter data submission requirements as described in Section 2.23 of this Agreement (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE)		$25,000 per occurrence
C.4	Failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE		An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TENNCARE

4.20.2.3 Payment of Liquidated Damages

4.20.2.3.1 It is further agreed by TENNCARE and the CONTRACTOR that any liquidated damages assessed by TENNCARE shall be due and payable to TENNCARE within thirty (30) calendar days after CONTRACTOR receipt of the notice of damages. If payment is not made by the due date, said liquidated damages may be withheld from future payments by TENNCARE without further notice, as provided in Section 3.13.5 of this Agreement. It is agreed by TENNCARE and the CONTRACTOR that the collection of liquidated damages by TENNCARE shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Agreement; however, in the event an appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by TENNCARE will be immediately returned to the CONTRACTOR. Any cure periods referenced in this Agreement shall not apply to the liquidated damages described in this Section. With respect to **Level B** and **Level C** program issues (failure to perform responsibilities or requirements), the due dates mentioned above may be delayed if the CONTRACTOR can show good cause as to why a delay should be granted. TENNCARE has sole discretion in determining whether good cause exists for delaying the due dates.

4.20.2.3.2 Liquidated damages as described in Section 4.20.2 shall not be passed to a provider and/or subcontractor unless the damage was caused due to an action or inaction of the provider and/or subcontractor. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

4.20.2.3.3 All liquidated damages imposed pursuant to this Agreement, whether paid or due, shall be paid by the CONTRACTOR out of administrative costs and profits.

4.20.2.4 Waiver of Liquidated Damages

TENNCARE may waive the application of liquidated damages and/or withholds upon the CONTRACTOR if the CONTRACTOR is placed in rehabilitation or under administrative supervision if TENNCARE determines that such waiver is in the best interests of the TennCare program and its enrollees.

4.20.3 **Claims Processing Failure**

If it is determined that there is a claims processing deficiency related to the CONTRACTOR's ability/inability to reimburse providers in a reasonably timely and accurate fashion as required by Section 2.22, TENNCARE shall provide a notice of deficiency and request corrective action. The CONTRACTOR may also be subject to the application of liquidated damages and/or intermediate sanctions specified in Sections 4.20.1 and 4.20.2 and the retention of withholds as specified in Section 3.9. If the CONTRACTOR is unable to successfully implement corrective action and demonstrate adherence with timely claims processing requirements within the time approved by TENNCARE, the State may terminate this Agreement in accordance with Section 4.4 of this Agreement.

4.20.4 **Failure to Manage Medical Costs**

If TENNCARE determines the CONTRACTOR is unable to successfully manage costs for covered services, TENNCARE may terminate this Agreement with ninety (90) calendar days advance notice in accordance with Section 4.4 of this Agreement.

4.20.5 **Sanctions by CMS**

Payments provided for under this Agreement will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730.

4.20.6 **Temporary Management**

TENNCARE may impose temporary management if it finds that the CONTRACTOR has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

4.21 MODIFICATION AND AMENDMENT

This Agreement may be modified only by a written amendment executed by all parties hereto and approved by the appropriate State of Tennessee officials in accordance with applicable State of Tennessee laws and regulations. Such amendment shall be effective on the date agreed to by TENNCARE and the CONTRACTOR.

4.22 TITLES/HEADINGS

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

4.23 OFFER OF GRATUITIES

By signing this Agreement, the CONTRACTOR certifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the United States General Accounting Office, United States Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially due to influence in obtaining this Agreement. This Agreement may be terminated by TENNCARE if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the CONTRACTOR or the CONTRACTOR's agent or employees.

4.24 LOBBYING

4.24.1 The CONTRACTOR certifies by signing this Agreement, to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. (See also TCA 3-6-101 *et seq*., 3-6-201 *et seq*., 3-6-301 *et seq*., and 8-50-505.).

4.24.2 The CONTRACTOR shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

4.25 ATTORNEY'S FEES

In the event that either party deems it necessary to take legal action to enforce any provision of this Agreement, and TENNCARE prevails, the CONTRACTOR agrees to pay all expenses of such action, including attorney's fees and cost of all state litigation as may be set by the court or hearing officer. Legal actions are defined to include administrative proceedings.

4.26 GOVERNING LAW AND VENUE

4.26.1 This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee. The CONTRACTOR agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Agreement.

4.26.2 For purposes of any legal action occurring as a result of or under this Agreement between the CONTRACTOR and TENNCARE, the place of proper venue shall be Davidson County, Tennessee.

4.27 ASSIGNMENT

This Agreement and the monies which may become due hereunder are not assignable by the CONTRACTOR except with the prior written approval of TENNCARE.

4.28 INDEPENDENT CONTRACTOR

It is expressly agreed that the CONTRACTOR and any subcontractors or providers, and agents, officers, and employees of the CONTRACTOR or any subcontractors or providers, in the performance of this Agreement shall act in an independent capacity and not as agents, officers and employees of TENNCARE or the State of Tennessee. It is further expressly agreed that this Agreement shall not be construed as a partnership or joint venture between the CONTRACTOR or any subcontractor or provider and TENNCARE and the State of Tennessee.

4.29 FORCE MAJEURE

TENNCARE shall not be liable for any excess cost to the CONTRACTOR for TENNCARE's failure to perform the duties required by this Agreement if such failure arises out of causes beyond the control and without the result of fault or negligence on the part of TENNCARE. In all cases, the failure to perform must be beyond the control without the fault or negligence of TENNCARE. The CONTRACTOR shall not be liable for performance of the duties and responsibilities of this Agreement when its ability to perform is prevented by causes beyond its control. These acts must occur without the fault or negligence of the CONTRACTOR. Such acts include destruction of the facilities due to hurricanes, fires, war, riots, and other similar acts. However, in the event of damage to its facilities, the CONTRACTOR shall be responsible for ensuring swift correction of the problem so as to enable it to continue its responsibility for the delivery of covered services. The failure of the CONTRACTOR's fiscal intermediary to perform any requirements of this Agreement shall not be considered a 'force majeure'.

4.30 DATE/TIME HOLD HARMLESS

As required by TCA 12-4-118, the CONTRACTOR shall hold harmless and indemnify the State of Tennessee; its officers and employees; and any agency or political subdivision of the State for any Breach caused directly or indirectly by the failure of computer software or any device containing a computer processor to accurately or properly recognize, calculate, display, sort or otherwise process dates or times.

4.31 INDEMNIFICATION

4.31.1 The CONTRACTOR shall indemnify and hold harmless the State as well as its officers, agents, and employees (hereinafter the "Indemnified Parties") from all claims, losses or suits incurred by or brought against the Indemnified Parties as a result of the failure of the CONTRACTOR to comply with the terms of this Agreement. The State shall give the CONTRACTOR written notice of each such claim or suit and full right and opportunity to conduct CONTRACTOR's own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to the CONTRACTOR, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.

4.31.2 The CONTRACTOR shall indemnify and hold harmless the Indemnified Parties as well as their officers, agents, and employees from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from the CONTRACTOR's or Indemnified Parties performance under this Agreement. In any such action, brought against the Indemnified Parties, the CONTRACTOR shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. The State shall give the CONTRACTOR written notice of each such claim or suit and full right and opportunity to conduct the CONTRACTOR's own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to the CONTRACTOR, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.

4.31.3 While the State will not provide a contractual indemnification to the CONTRACTOR, such shall not act as a waiver or limitation of any liability for which the State may otherwise be legally responsible to the CONTRACTOR. The CONTRACTOR retains all of its rights to seek legal remedies against the State for losses the CONTRACTOR may incur in connection with the furnishing of services under this Agreement or for the failure of the State to meet its obligations under the Agreement.

4.32 NON-DISCRIMINATION

4.32.1 No person on the grounds of handicap, and/or disability, age, race, color, religion, sex, or national origin, shall be excluded from participation in, except as specified in Section 2.3.5 of this Agreement, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this Agreement or in the employment practices of the CONTRACTOR.

4.32.2 The CONTRACTOR shall upon request show proof of such non-discrimination.

4.32.3 The CONTRACTOR shall post notices of non-discrimination in conspicuous places, available to all employees and applicants.

4.33 CONFIDENTIALITY OF INFORMATION

4.33.1 The CONTRACTOR shall comply with all state and federal law regarding information security and confidentiality of information. In the event of a conflict among these requirements, the CONTRACTOR shall comply with the most restrictive requirement.

4.33.2 All material and information, regardless of form, medium or method of communication, provided to the CONTRACTOR by the State or acquired by the CONTRACTOR pursuant to this Agreement shall be regarded as confidential information in accordance with the provisions of state and federal law and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the CONTRACTOR to safeguard the confidentiality of such material or information in conformance with state and federal law and ethical standards.

4.33.3 The CONTRACTOR shall ensure that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the CONTRACTOR's performance under this Agreement, whether verbal, written, tape, or otherwise, shall be treated as confidential information to the extent confidential treatment is provided under state and federal laws. The CONTRACTOR shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Agreement and in compliance with federal and state law.

4.33.4 All information as to personal facts and circumstances concerning members or potential members obtained by the CONTRACTOR shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of TENNCARE or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Agreement and shall be in compliance with federal and state law.

4.34 TENNESSEE CONSOLIDATED RETIREMENT SYSTEM

The CONTRACTOR acknowledges and understands that, subject to statutory exceptions contained in TCA 8-36-801, *et seq*., the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to TCA, Title 8, Chapter 35, Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Agreement to the contrary, the CONTRACTOR agrees that if it is later determined that the true nature of the working relationship between the CONTRACTOR and the State under this Agreement is that of "employee/employer" and not that of an independent contractor, the CONTRACTOR may be required to repay to TCRS the amount of retirement benefits the CONTRACTOR received from TCRS during the period of this Agreement.

4.35 ACTIONS TAKEN BY THE TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE

The parties acknowledge that the CONTRACTOR is licensed to operate as a health maintenance organization in the State of Tennessee, and is subject to regulation and supervision by TDCI. The parties acknowledge that no action by TDCI to regulate the activities of the CONTRACTOR as a health maintenance organization, including, but not limited to, examination, entry of a remedial

order pursuant to TCA 56-9-101, *et seq*., and regulations promulgated thereunder, supervision, or institution of delinquency proceedings under state law, shall constitute a breach of this Agreement by TENNCARE.

4.36 EFFECT OF THE FEDERAL WAIVER ON THIS AGREEMENT

The provisions of this Agreement are subject to the receipt of and continuation of a federal waiver granted to the State of Tennessee by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. Should the waiver cease to be effective, the State shall have the right to immediately terminate this Agreement. Said termination shall not be a breach of this Agreement by TENNCARE and TENNCARE shall not be responsible to the CONTRACTOR or any other party for any costs, expenses, or damages occasioned by said termination.

4.37 TENNCARE FINANCIAL RESPONSIBILITY

Notwithstanding any provision which may be contained herein to the contrary, TENNCARE shall be responsible solely to the CONTRACTOR for the amount described herein and in no event shall TENNCARE be responsible, either directly or indirectly, to any subcontractor or any other party who may provide the services described herein.

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

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

DATE: _____

CONTRACTOR
COMPANY NAME

BY: _____
NAME
TITLE

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

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

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: _____
John G. Morgan
Comptroller

DATE: _____

ATTACHMENTS

ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS

ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS

The CONTRACTOR shall provide medically necessary mental health case management and psychiatric rehabilitation services according to the requirements herein.

SERVICE	**Mental Health Case Management**

DEFINITION

Mental health case management is a supportive service provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. Mental health case management is consumer-centered, consumer focused and strength-based, with services provided in a timely, appropriate, effective, efficient and coordinated fashion. It consists of activities performed by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the individual/family access to services.

Mental health case management requires that the mental health case manager and the individual and/or family have a strong productive relationship which includes viewing the individual/family as a responsible partner in identifying and obtaining the necessary services and resources. Services rendered to children and youth shall be consumer-centered and family-focused with case managers working with multiple systems (e.g. education, child welfare, juvenile justice). Mental health case management is provided in community settings, which are accessible and comfortable to the individual/family. The service should be rendered in a culturally competent manner and be outcome driven. Mental health case management shall be available 24 hours a day, 7 days a week. The service is not time limited and provides the individual/family the opportunity to improve their quality of life.

The CONTRACTOR shall ensure mental health case management is rendered in accordance with all of the service components and guidelines herein.

SERVICE DELIVERY

The CONTRACTOR shall:

- Determine caseload size based on an average number of individuals per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1 and 2 (Levels 1 and 2 are defined below); and
- Ensure that caseload sizes and minimum contacts are met as follows:

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Level 1 (Non-Team Approach)*	25 individuals:1 case manager	One (1) contact per week
Level 1 (Team Approaches):		
Adult CTT	20 individuals:1 team 20 individuals:1 case manager	One (1) contact per week
Children & Youth (C&Y) CTT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
CCFT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
ACT	100 individuals:1 team	One (1) contact per week

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
	15 individuals:1 case manager	
PACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
Level 2*	35 individuals:1 case manager	Two (2) contacts per month

*For case managers having a combination of Level 1 & Level 2 (non-team) individuals, the maximum caseload size shall be no more than 30 individuals:1 case manager.

The CONTRACTOR shall ensure that the following requirements are met:

1) All mental health case managers shall have, at a minimum, a bachelor's degree;
2) Supervisors shall maintain no greater than a 1:30 supervisory ratio with mental health case managers;
3) Mental health case managers who are assigned to both a parent(s) and child in the same family, should have skills and experience needed for both ages;
4) Eighty percent (80%) of all mental health case management services should take place outside the case manager's office;
5) The children and youth (C&Y) (under age eighteen (18)) mental health case management model shall provide a transition from C&Y services into adult services, including adult mental health case management services. The decision to serve an 18-year old youth via the C&Y case management system versus the adult system shall be a clinical one made by a provider. Transition from children's services, including mental health case management, shall be incorporated into the child's treatment plan; and
6) All mental health case management services shall be documented in a treatment plan. Mental health case management activities are correlated to expected outcomes and outcome achievement and shall be monitored, with progress being noted periodically in a written record.

Level 1

Level 1 mental health case management is the most intense level of service. It provides frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of level 1 mental health case management to the most severely disabled adults and emotionally disturbed children and youth, including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Level 1 mental health case management can be rendered through a team approach or by individual mental health case managers. Team approaches may include such models as ACT, CTT, CCFT and PACT, as described below:

Assertive Community Treatment (ACT)

ACT is a way of delivering comprehensive and effective services to adults diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. The principles of ACT include:

1) Services targeted to a specific group of individuals with severe mental illness;
2) Treatment, support and rehabilitation services provided directly by the ACT team;
3) Sharing of responsibility between team members and individuals served by the team;
4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
5) Comprehensive and flexible range of treatment and services;
6) Interventions occurring in community settings rather than in hospitals or clinic settings;
7) No arbitrary time limit on receiving services;
8) Individualized treatment, support and rehabilitation services;

9) Twenty-four (24) hour a day availability of services; and
10) Engagement of individuals in treatment and monitoring.

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited services designed for children and youth to provide stabilization and deter the "imminent" risk of State custody for the individual. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals. The primary goal of CCFT is to reach an appropriate point of stabilization so the individual can be transitioned to a less intense outpatient service.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community.

Level 2

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

SERVICE COMPONENTS

The CONTRACTOR shall ensure that mental health case management incorporates the following service components:

Crisis Facilitation

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific individual or other person(s) in relation to a specific individual. It is the process of accessing and coordinating services for an individual in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the individual.

Assessment of Daily Functioning

Assessment of daily functioning involves the on-going monitoring of how an individual is coping with life on a day to day basis for the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the individual in his or her natural environment.

Assessment/Referral/Coordination

Assessment/referral/coordination involves assessing the needs of the individual for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the individual's natural environment.

Mental Health Liaison

Mental health liaison services are offered to persons who are not yet assigned to mental health case management. It is a short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

SERVICE	Psychiatric Rehabilitation

DEFINITION

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual's recovery journey.

Services included under psychiatric rehabilitation are as follows.

SERVICE COMPONENTS

Psychosocial Rehabilitation

Psychosocial rehabilitation services utilize a comprehensive approach (mind, body, and spirit) to work with the whole person for the purposes of improving an individuals' functioning, promoting management of illness(s), and facilitating recovery. The goal of psychosocial rehabilitation is to support individuals as active and productive members of their communities. Individuals, in partnership with staff, form goals for skills development in the areas of vocational, educational, and interpersonal growth (e.g. household management, development of social support networks) that serve to maximize opportunities for successful community integration. Individuals proceed toward goal attainment at their own pace and may continue in the program at varying levels intensity for an indefinite period of time.

Supported Employment

Supported employment consists of a range of services to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals' preferences, strengths, and experiences. This service also includes a variety of support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer Support

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

Illness Management & Recovery

Illness management and recovery services refers to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery.

Supported Housing

Supported housing services refers to facilities staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require treatment services and supports in a highly structured setting. These facilities are for persons with serious and/or persistent mental illnesses (SPMI) and are not residential treatment facilities. Supported housing is intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings with appropriate mental health supports. Given this goal, every effort should be made to place individuals near their families and other support systems and original areas of residence. Supported housing does not include the payment of room and board.

ATTACHMENT II
COST SHARING SCHEDULE

ATTACHMENT II
COST SHARING SCHEDULE

Non-Pharmacy Copayment Schedule
(unless otherwise directed by TENNCARE)

Poverty Level	Copayment Amounts
0% - 99%	$0.00
100% - 199%	$25.00, Hospital Emergency Room (waived if admitted) $5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $15.00, Physician Specialists (including Psychiatrists) $100.00, Inpatient Hospital Admission
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $25.00, Physician Specialists (including Psychiatrists) $200.00, Inpatient Hospital Admission

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

ATTACHMENT III
TERMS AND CONDITIONS FOR ACCESS

ATTACHMENT III
TERMS AND CONDITIONS FOR ACCESS

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

- Primary Care Physician or Extender:

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

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

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

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

  (e) Documentation/Tracking requirements:

    + Documentation - Plans must have a system in place to document appointment scheduling times. The State must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the survey required in special term and condition 4.

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

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

- Hospitals

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

- General Dental Services:

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

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

- General Optometry Services:

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

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

- Pharmacy Services:

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

- Lab and X-Ray Services:

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

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

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

Definition of "Usual and Customary" - access that is equal to or greater than the currently existing practice in the fee-for-service system.

Guidelines for State Monitoring of Plans

- State will require, by contract, that Plans meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434.

- State will monitor, on a periodic or continuous basis (but no less often than every 12 months), Plans adherence to these standards, through the following mechanisms: review of each plan's written QAP, review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes, and on-site monitoring of the implementation of the QAP standards.

- Recipient access to care will be monitored through the following State activities: periodic comparison of the number and types of providers before and after the waiver, periodic surveys which contain questions concerning recipient access to services, measurement of waiting periods to obtain health care services, and measurement of referral rates to specialists.

Guidelines for Plan Monitoring of Providers

- Plans will require, by contract, that providers meet specified standards as required by the State contract.

- Plans will monitor, on a periodic or continuous basis, providers' adherence to these standards, and recipient access to care.

ATTACHMENT IV
SPECIALTY NETWORK STANDARDS

ATTACHMENT IV
SPECIALTY NETWORK STANDARDS

The CONTRACTOR shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. A provider is considered a "specialist" if he/she has a provider agreement with the CONTRACTOR to provide specialty services to members.

Access to Specialty Care

The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

(1) The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Neonatology, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent), and Urology; and

(2) The following access standards are met:

- Travel distance does not exceed 60 miles for at least 75% of non-dual members and
- Travel distance does not exceed 90 miles for ALL non-dual members

Availability of Specialty Care

The CONTRACTOR shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each Grand Region was compared to the size of the population in each Grand Region. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000

Specialty	Number of Non-Dual Members
Orthopedic Surgery	15,000
Otolaryngology	30,000
Psychiatry (adult)	25,000
Psychiatry (child & adolescent)	150,000
Urology	30,000

ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

Service Type	Geographic Access Requirement for the Service	Maximum Time for Admission/Appointment
Psychiatric Inpatient Hospital Services	In accordance with Attachment III for Hospitals	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Within 100 miles of an individual's residence	Within 30 calendar days
Outpatient Mental Health Services:		
MD Services (Psychiatry)	In accordance with Attachment IV for Psychiatry	Within 14 calendar days; if urgent, within 3 business days
Outpatient Non-MD Services	Within 30 miles of an individual's residence	Within 14 calendar days; if urgent, within 3 business days
Intensive Outpatient/ Partial Hospitalization	Within 60 miles of an individual's residence	Within 14 calendar days; if urgent, within 3 business days
Inpatient, Residential & Outpatient Substance Abuse Services:		
Inpatient Facility Services	Within 60 miles of an individual's residence	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
Residential Treatment Services	Within 100 miles of an individual's residence	Within 14 calendar days
Outpatient Treatment Services	Within 30 miles of an individual's residence	Within 14 calendar days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to access standards	Within 7 calendar days
Psychiatric Rehabilitation Services:		
Psychosocial Rehabilitation	Within 60 miles of an individual's residence	Within 14 calendar days
Supported Employment	Within 60 miles of an individual's residence	Within 14 calendar days
Peer Support	Not subject to access standards	Within 30 calendar days
Illness Management & Recovery	Within 60 miles of an individual's residence	Within 30 calendar days
Supported Housing	Not Applicable*	Within 30 calendar days
Behavioral Health Crisis Services		
Entry into Behavioral Health Crisis Services	Not subject to access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Respite	Not subject to access standards	Within 2 hours of referral
Crisis Stabilization	Not subject to access standards	Within 4 hours of referral

*Placement of an individual more than 60 miles from his/her residence must be prior approved by the member or his/her legally appointed representative.

ATTACHMENT VI
FORMS FOR REPORTING FRAUD AND ABUSE

TENNESSEE BUREAU OF INVESTIGATION
MEDICAID FRAUD CONTROL UNIT

FRAUD ALLEGATION REFERRAL FORM

DATE: _____

TO (circle recipient): **SAC Bob Schlafly [*fax (615) 744-4659]***
ASAC Stephen Phelps [*fax (731) 668-9769]*
ASAC Norman Tidwell [*fax (615) 744-4659]*

FROM: _____ **(TennCare Contractor)**

Contact Person: _____
Telephone: _____
E-Mail: _____

SUBJECT NAME: _____ **d/b/a**_____
SUBJECT ADDRESS: _____ _____
_____ _____
_____
_____

PROVIDER NUMBER(S): _____
_____
_____

SUMMARY OF COMPLAINT:_____
_____
_____
_____
_____
_____
_____
_____
_____

ADDITIONAL SUBJECT INFORMATION: _____
_____
_____
_____

REPORT TENNCARE RECIPIENT FRAUD OR ABUSE

Date:

Please complete as much information as possible.

Name of Recipient/Person you are Reporting recipient name or name of individual suspected of fraud

Other Names Used (If known) alias

Social Security Number (If known)

Date of Birth

Children's Name (if applicable) SSN, if known DOB, if known

SSN, if known DOB, if known

Spouse's Name (if applicable)

Street Address physical address

Apartment #

City, State, Zip city state zip

Other Addresses Used

Home Phone Number

area code

Work Phone Number (Please include)

area code

Employer's Name

Employer's Address

Employer's Phone #

area code

What is your complaint? (In your own words, explain the problem)describe suspected fraudulent behavior

Have you notified the Managed Care Contractor of this problem? ☐ Yes ☐ No

Who did you notify? (Please provide name and phone number, if known)name phone number dept/ business

Have you notified anyone else? ☐ No ☐ Yes name phone dept/ business

Requesting Drug Profile ☐ Yes ☐ No Have already received drug profile ☐ Yes ☐ No

If you are already working with a PID staff person, who?

***Please attach any records of proof that may be needed to complete the initial review.**

OIG/CID Investigator: your name

Phone number

STATE OF TENNESSEE
OFFICE OF TENNCARE INSPECTOR GENERAL
PO BOX 282368
NASHVILLE, TENNESSEE 37228
FRAUD TOLL FREE HOTLINE 1-800-433-3982 •FAX (615) 256-3852
E-Mail Address: www.tennessee.gov/tenncare (follow the prompts that read "Report Fraud Now")

ATTACHMENT VII
PERFORMANCE STANDARDS

ATTACHMENT VII
PERFORMANCE STANDARDS

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
1	Timely Claims Processing	Report from TDCI	90% of claims (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of claim. 99.5% of claims are processed within sixty (60) calendar days.	Percentage of claims paid within 30 calendar days of receipt of claim, determined for each month in the quarter Percentage of claims processed within 60 calendar days of receipt of claim, determined for each month in the quarter	Quarterly	$10,000 for each month determined not to be in compliance
2	Claims Payment Accuracy	Self-reported results based on an internal audit conducted on a statistically valid random sample will be validated by TDCI	97% of claims paid accurately upon initial submission	Percentage of total claims paid accurately; determined for each month in the quarter	Quarterly	$5,000 for each full percentage point accuracy is below 97% for each quarter
3	Telephone Response Time/Call Answer Timeliness -Member Services Line	Member Services and UM Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month
4	Telephone Response Time/Call Answer Timeliness - Utilization Management Line	Member Services and UM Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
5	Telephone Call Abandonment Rate (unanswered calls) – Member Services Line	Member Services and UM Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month
6	Telephone Call Abandonment Rate (unanswered calls) – UM Line	Member Services and UM Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
7	Specialist Provider Network	Provider Enrollment File	1. Physician Specialists: Executed specialty physician contracts in all areas required by this Agreement for the following specialists: allergy; cardiology; dermatology; endocrinology; gastroenterology; general surgery; nephrology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; psychiatry (adults); psychiatry (child/adolescent); and urology 2. Essential Hospital Services: Executed contract with at least one (1) tertiary care center for each essential hospital service 3. Center of Excellence for People with AIDS: Executed contract with at least two (2) Center of Excellence for AIDS within the CONTRACTOR's approved Grand Region(s) 4. Center of Excellence for Behavioral Health: Executed contract with all COEs for Behavioral Health within the CONTRACTOR's approved Grand Region(s)	Executed contract is a signed provider agreement with a provider to participate in the Contractor's network as a contract provider	Monthly	$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis The liquidated damage may be waived for Physician Specialists if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of physicians practicing in the area. The liquidated damage may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
8	Provider Listing Accuracy	EQRO report	At least 90% of listed providers confirm participation in the CONTRACTOR's network	A statistically valid sample of records for participating providers on the most recent monthly provider listing used to contact the provider and confirm the provider is participating in the CONTRACTOR's network	Quarterly	$25,000 per quarter if less than 90% of listed providers confirm participation. The liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or waived if the CONTRACTOR submits sufficient documentation to demonstrate 90% of providers are participating
9	Distance from provider to member	Provider Enrollment File	In accordance with Attachments III through V	Time and travel distance as measured by GeoAccess	Monthly	$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis. The liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE
10	Initial appointment timeliness for behavioral health services	Behavioral Health Initial Appointment Timeliness Report	85% of all initial appointments for behavioral health services for outpatient mental health services (MD and Non-MD) and outpatient substance abuse services shall meet the access and availability standards indicated in Attachment V	Average time between the intake assessment appointment and the member's next appointment scheduled or admission by type of service	Quarterly	$2,000 for each service type for which less than 85% of all initial appointments for the specified provider types meet the access and availability standards indicated in Attachment V
11	Percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment)	Claims and encounter data	The percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment) will not be less than 76%	The number of SPMI/SED members receiving a behavioral health service (excluding a CRG/TPG assessment) during the fiscal year divided by the MCO's number of SPMI/SED members during the fiscal year is not less than the benchmark	Annually	$25,000 for each year determined to not be in compliance

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
12	Non-IMD Inpatient Use	Behavioral Health Crisis Service Response Reports and utilization data	10% decrease of total inpatient days at freestanding psychiatric hospitals subject to IMD exclusion compared to the base year's utilization	Total inpatient psychiatric hospital days at IMD exclusion facilities for members reduced by 10% after base line year	Annually	$10,000 for each year determined to not be in compliance
13	TENNderCare Screening	MCO encounter data	TENNderCare screening ratio, 80%	The EPSDT screening ratio, calculated by TENNCARE utilizing MCO encounter data submissions in accordance with specifications for the CMS-416 report	Quarterly	$5,000 for each full percentage point TENNderCare screening ratio is below 80% for the most recent rolling twelve month period
14	Increase in utilization of supported employment	Supported Employment Reports	15% of all adults (21 – 64 years of age) designated as SPMI actively receiving supported employment services will be gainfully employed in either part time or full time capacity for a continuous 90 day period	Total number of SPMI adults receiving supported employment services as defined in Attachment I employed for a continuous 90-day period divided by the total number of SPMI adults	Annually	$25,000 for each year determined to not be in compliance
15	Generic Prescription Drug Utilization	Encounter data	Sixty percent (60%)	Number of generic prescriptions divided by the total number of prescriptions	Quarterly	$5,000 for each full percentage point Generic Prescription Utilization ratio is below 60%
16	Length of time between psychiatric hospital/RTF discharge and first subsequent mental health case management service	Mental Health Case Management Report	90% of discharged members *receive* a mental health case management service as medically necessary within seven (7) calendar days of discharge, excluding situations involving member reschedules, no shows, and refusals	(1) Number of members discharged by length of time between discharge and first subsequent mental health case management service as medically necessary reported by CMHA and type of service received; determined for each month (2) Average length of time between hospital discharge and first subsequent medically necessary MHCM visit reported by CMHA and type of service received excluding member reschedules, no shows, and refusals; determined for each month	Quarterly	$3,000 for each quarter determined to not be in compliance

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
17	Seven (7) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 10% of members discharged from an inpatient or residential facility are readmitted within seven (7) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within seven (7) calendar days of discharge; determined for each month in the quarter	Quarterly	$1,500 for each quarter determined to not be in compliance
18	Thirty (30) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 15% of members discharged from an inpatient or residential facility are readmitted within thirty (30) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within thirty (30) calendar days of discharge; determined for each month in the quarter	Quarterly	$1,500 for each quarter determined to not be in compliance
19	Members are satisfied with the services they receive from behavioral health providers	Annual consumer satisfaction survey administered by TDMHDD	85% of respondents rate their experience to be fair or better	Distribution of members by satisfaction score	Annually	$10,000 for each response below 85%

ATTACHMENT VIII
DELIVERABLE REQUIREMENTS

ATTACHMENT VIII
DELIVERABLE REQUIREMENTS

GENERAL

This is a preliminary list of deliverables. The CONTRACTOR and TENNCARE shall agree to the appropriate deliverables, deliverable format/submission requirements, submission and approval time frames, and technical assistance as required. Deliverables shall be submitted to the TennCare Bureau unless otherwise specified.

TENNCARE will require that some or all deliverables be reviewed and/or approved by TENNCARE during the readiness review and/or during operations. As specified by TENNCARE, material modifications to certain deliverables must be reviewed and/or approved by TENNCARE.

DELIVERABLE ITEMS

1. Evidence of TDCI license for CONTRACTOR and subcontractors (as applicable) to ensure compliance with Section 2.1.1

2. Notification that a member may satisfy any of the conditions for termination from the TennCare program in accordance with Section 2.5.4

3. Request for prior approval/notice of use of cost effective alternative services in accordance with Section 2.6.5

4. Request for prior approval of incentives in accordance with Section 2.6.6

5. Description of health education and outreach programs and activities to ensure compliance with Section 2.7.3

6. TENNderCare policies and procedures that ensure compliance with the requirements of Section 2.7.5

7. Policies and procedures for advance directives that ensure compliance with Section 2.7.6

8. Disease management program policies and procedures that ensure compliance with Section 2.8

9. Service coordination policies and procedures that ensure compliance with Section 2.9.1

10. Policies and procedures for transition of new members that ensure compliance with the requirements of Section 2.9.2

11. Transition of care polices and procedures that ensure compliance with Section 2.9.3

12. MCO case management policies and procedures that ensure compliance with Section 2.9.4

13. Policies and procedures for coordination of physical and behavioral health services that ensure compliance with Section 2.9.5

14. If CONTRACTOR subcontracts for the provision of behavioral health services, agreement with the subcontractor in accordance with Section 2.9.5.2 to ensure compliance with Section 2.9.5

15. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section 2.9.6

16. Policies and procedures for coordination of pharmacy services that ensure compliance with Section 2.9.7

17. Policies and procedures for coordination of dental services that ensure compliance with Section 2.9.8

18. Identification of members serving on the claims coordination committee in accordance with Section 2.9.8.5.3

19. Policies and procedures for coordination with Medicare that ensure compliance with Section 2.9.9

20. Policies and procedures to increase the use of HCBS waivers in compliance with Section 2.9.10

21. Policies and procedures for inter-agency coordination that ensure compliance with Section 2.9.11

22. Polices and procedures regarding non-covered services that ensure compliance with Section 2.10

23. Policies and procedures to develop and maintain a provider network that ensure compliance with Section 2.11.1, including policies and procedures for selection and/or retention of providers

24. Policies and procedures for PCP selection and assignment that ensure compliance with Section 2.11.2, including policies and procedures regarding change of PCP and use of specialist as PCP

25. Plan to identify, develop, or enhance existing inpatient and residential treatment capacity for adults and adolescents with co-occurring mental health and substance abuse disorders to ensure compliance with Section 2.11.5.2

26. Credentialing manual and policies and procedures that ensure compliance with Section 2.11.7

27. Policies and procedures that ensure compliance with notice requirements in Section 2.11.8

28. Notice of provider and subcontractor termination and additional documentation as required by Section 2.11.8.2

29. Provider agreement template(s) and revisions to TDCI as required in Section 2.12

30. Indemnity language in provider agreements if different than standard indemnity language (see Section 2.12.7.39)

31. Intent to use a physician incentive plan (PIP) to TennCare Bureau and TDCI (see Section 2.13.5)

32. Any provider agreement templates or subcontracts that involve a PIP for review as a material modification (to TDCI) as required by (see Section 2.13.5)

33. Pricing policies for emergency services provided by non-contract providers that ensure compliance with Section 2.13.6.1

34. Policies and procedures for PCP profiling to ensure compliance with Section 2.14.5

35. Information on PCP profiling as requested by TENNCARE (see Section 2.14.5)

36. QM/QI policies and procedures to ensure compliance with Section 2.15

37. Clinical practice guidelines to ensure compliance with Section 2.15.5

38. Copy of signed contract with NCQA approved vendor to perform 2008 CAHPS as required by Section 2.15.6.1

39. Copy of signed contract with NCQA approved vendor to perform 2008 HEDIS audit as required by Section 2.15.6.1

40. Evidence that NCQA accreditation application submitted and fee paid (Section 2.15.6.1)

41. HEDIS BAT as required by Section 2.15.6.1

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

43. Notice of date for ISS submission and NCQA onsite review as required by Section 2.15.6.1

44. Notice of final payment to NCQA as required by Section 2.15.6.1

45. Notice of submission of ISS to NCQA as required by Section 2.15.6.1

46. Copy of completed NCQA survey and final report as required by Section 2.15.6.1

47. Notice of any revision to NCQA accreditation status

48. Member materials as described in Section 2.17, including but not limited to, member handbook, quarterly member newsletter, identification card, and provider directory along with any required supporting materials

49. Member services phone line policies and procedures that ensure compliance with Section 2.18.1

50. Policies and procedures regarding interpreter and translation services that ensure compliance with Section 2.18.2

51. Provider services and utilization management phone line policies and procedures that ensure compliance with Section 2.18.4

52. Provider handbook that is in compliance with requirements in Section 2.18.5

53. Provider education and training plan and materials that ensure compliance with Section 2.18.6

54. Policies and procedures to monitor and ensure provider compliance with the Agreement (see Section 2.18.7.1)

55. Policies and procedures for a provider complaint system that ensure compliance with Section 2.18.8

56. Policies and procedures regarding member involvement with behavioral health services that ensure compliance with Section 2.18.9

57. Appeal and complaint policies and procedures that ensure compliance with Section 2.19

58. Fraud and abuse policies and procedures that ensure compliance with Section 2.20

59. Report all confirmed or suspected fraud and abuse to the appropriate agency as required in Section 2.20.2

60. Fraud and abuse compliance plan (see Section 2.20.3)

61. TPL policies and procedures that ensure compliance with Section 2.21.4

62. Accounting policies and procedures that ensure compliance with Section 2.21.6

63. Proof of insurance coverage (see Section 2.21.7)

64. Claims management policies and procedures that ensure compliance with Section 2.22

65. Internal claims dispute procedure (see Section 2.22.5)

66. EOB policies and procedures to ensure compliance with Section 2.22.8

67. Systems policies and procedures, manuals, etc. to ensure compliance with Section 2.23 (see Section 2.23.10)

68. Information security plan as required by Section 2.23.6.11

69. Notification of Systems problems in accordance with Section 2.23.7

70. Systems Help Desk services in accordance with Section 2.23.8

71. Notification of changes to Systems in accordance with Section 2.23.9

72. Notification of changes to membership of behavioral health advisory committee and current membership lists in accordance with Section 2.24.2

73. Medical record keeping policies and procedures that ensure compliance with Section 2.24.4

74. Subcontracts (see Section 2.26)

75. HIPAA policies and procedures that ensure compliance with Section 2.27

76. Accounting of disclosures in accordance with Section 2.27.2.10

77. Third (3rd) party certification of HIPAA transaction compliance in accordance with Section 2.27.2.27

78. Names, resumes, and contact information of key staff as required by Section 2.29.1.2

79. Changes to key staff as required by Section 2.29.1.2

80. Staffing plan as required by Section 2.29.1.7

81. Changes to location of staff from in-state to out-of-state as required by Section 2.29.1.8

82. List of officers and members of Board of Directors (see Section 2.29.3)

83. Changes to officers and members of Board of Directors (see Section 2.29.3)

84. Eligibility and Enrollment Data (see Section 2.30.2.1)

85. Monthly Enrollment/Capitation Payment Reconciliation Report (see Section 2.30.2.2)
86. Quarterly Member Enrollment/Capitation Payment Report (see Section 2.30.2.3)
87. Information on members (see Section 2.30.2.4)
88. Service Threshold Report (see Section 2.30.3)
89. Psychiatric Hospital/RTF Readmission Report (see Section 2.30.4.1)
90. Mental Health Case Management Report (see Section 2.30.4.2)
91. Supported Employment Report (see Section 2.30.4.3)
92. Behavioral Health Crisis Response Report (see Section 2.30.4.4)
93. Member CRG/TPG Assessment Report (see Section 2.30.4.5)
94. Rejected CRG/TPG Assessment Report (see Section 2.30.4.6)
95. CRG/TPG Assessments Audit Report (see Section 2.30.4.7)
96. Methodology for conducting CRG/TPG assessment audits (see Section 2.30.4.8)
97. Health Education/Outreach Report (see Section 2.30.4.9)
98. TENNderCare Report (see Section 2.30.4.10)
99. Disease Management Update Report (see Section 2.30.5.1)
100. Disease Management Report (see Section 2.30.5.2)
101. MCO Case Management Update Report (see Section 2.30.6.1)
102. Members identified as potential pharmacy lock-in candidates (see Section 2.30.6.2)
103. Pharmacy Services Report (see Section 2.30.6.3)
104. Pharmacy Services Report, On Request (see Section 2.30.6.4)
105. Provider Enrollment File (see Section 2.30.7.1)
106. Provider Compliance with Access Requirements Report (see Section 2.30.7.2)
107. PCP Assignment Report (see Section 2.30.7.3)
108. Report of Essential Hospital Services (see Section 2.30.7.4)
109. Behavioral Health Initial Appointment Timeliness Report (see Section 2.30.7.5)
110. FQHC Reports (see Section 2.30.7.6)
111. Single Case Agreements Report (see Section 2.30.8)

112. Related Provider Payment Report (see Section 2.30.9)

113. UM P&P, annual evaluation, and work plan (see Section 2.30.10.1)

114. ED Utilization Report (see Section 2.30.10.2)

115. Cost and Utilization Reports (see Section 2.30.10.3)

116. Cost and Utilization Summaries (see Section 2.30.10.4)

117. Identification of high-cost claimants (see Section 2.30.10.5)

118. Prior Authorization Reports (see Section 2.30.10.6)

119. Referral Provider Listing and supporting materials (see Section 2.30.10.7)

120. QM/QI Program Description, Associated Work Plan and Annual Evaluation (see Section 2.30.11.1)

121. Quality Update Report (see Section 2.30.11.2)

122. Report on Performance Improvement Projects (see Section 2.30.11.3)

123. Reports of Performance Indicator Results, Audited CAHPS Results, and Audited HEDIS Results (see Section 2.30.11.4)

124. NCQA Accreditation Report (see Section 2.30.11.5)

125. Member Services and UM Phone Line Report (see Section 2.30.12.1)

126. Translation/Interpretation Services Report (see Section 2.30.12.3)

127. Provider Satisfaction Survey Report (see Section 2.30.12.4)

128. Provider Complaints Report (see Section 2.30.12.5)

129. Fraud and Abuse Activities Report (see Section 2.30.13)

130. Recovery and Cost Avoidance Report (see Section 2.30.14.1.1)

131. Other Insurance Report (see Section 2.30.14.1.2)

132. Medical Loss Ratio (MLR) Report (see Section 2.30.14.2.1)

133. Ownership and Financial Disclosure Report (see Section 2.30.14.2.2)

134. Annual audit plan (see Section 2.30.14.2.3)

135. Financial Plan and Projection of Operating Results Report (to TDCI) (see Section 2.30.14.3.1)

136. Comparison of Actual Revenues and Expenses to Budgeted Amounts Report (to TDCI) (see Section 2.30.14.3.2)

137. Annual Financial Report (to TDCI) (see Section 2.30.14.3.3)

138. Quarterly Financial Report (to TDCI) (see Section 2.30.14.3.4)

139. Audited Financial Statements (to TDCI) (see Section 2.30.14.3.5)

140. Claims Payment Accuracy Report (see Section 2.30.15.1)

141. EOB Report (see Section 2.30.15.2)

142. Systems Refresh Plan (see Section 2.30.16.1)

143. Encounter Data Files (see Section 2.30.16.2)

144. Electronic version of claims paid reconciliation (see Section 2.30.16.3)

145. Information and/or data to support encounter data submission (see Section 2.30.16.4)

146. Systems Availability and Performance Report (see Section 2.30.16.5)

147. Business Continuity and Disaster Recovery Plan (see Section 2.30.16.6)

148. Reports on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee (see Section 2.30.17)

149. Subcontracted claims processing report (see Section 2.30.18.1)

150. Summary Listings of Servicing Providers (see Section 2.30.19.1)

151. Supervisory Personnel Report (see Section 2.30.19.2)

152. Alleged Discrimination Report (see Section 2.30.19.3)

153. Non-discrimination policy (see Section 2.30.19.4)

154. Non-Discrimination Compliance Plan and Assurance of Non-Discrimination (see Section 2.30.19.5)

155. Disclosure of conflict of interest (see Section 2.30.20)

156. Risk-sharing option selection in accordance with Section 3.11

157. Risk-sharing settlement calculation in accordance with Section 3.11.7

158. Return of funds in accordance with Section 3.13.5

159. Termination plan in accordance with Section 4.4.6.2.8

ATTACHMENT IX
REPORTING REQUIREMENTS

ATTACHMENT IX, EXHIBIT A
QUARTERLY ENROLLMENT/CAPITATION PAYMENT RECONCILIATION REPORTS

ATTACHMENT IX, EXHIBIT A.1
QUARTERLY ENROLLMENT/CAPITATION PAYMENT RECONCILIATION REPORTS

<INSERT MCO NAME>
SUMMARY REPORT
For the Quarter Ended **<INSERT DATE >**

Report Title:	**Members**	**Over (Under) Paid**
Premium Discrepancy Report	5	$ (419.61)
No Premium Report	2	(282.70)
No Eligibility Report	2	535.68
Total	9	$ (166.63)

Note: The first row of member detail on each report provides the detail the MCO has on file, based on information from eligibility files received from the State. This row also includes a calculation of the amount of premium/capitation payment expected. The second row (State Info) details the premium/capitation payment actually received from the State, per the monthly premium/capitation payment file.

Report Definitions

Calculated Age	The age of the member is calculated based on the Start Date, per the premium/capitation payment file received from the State, less the member's Date of Birth, per the eligibility information maintained by the MCO based on the eligibility files received. Neither the member's age nor the Date of Birth is on the premium file.
MCO Effective Date	The date the MCO has the member effective. The source of this information is the eligibility file received from the State.
MCO Term Date	The date the MCO has the member termed. The source of this information is the eligibility file received from the State.
State Start Date	The starting date for which the State is paying premiums/capitation payments, per the premium file received from the State.
State End Date	The ending date for which the State is paying premiums/capitation payments, per the premium file received from the State.
Amount Expected	The expected amount of premium/capitation payment to be paid per reporting period, based upon eligibility information.

ATTACHMENT IX, EXHIBIT A.2
QUARTERLY ENROLLMENT/CAPITATION PAYMENT RECONCILIATION REPORTS

<INSERT MCO NAME>
PREMIUM/CAPITATION PAYMENT DISCREPANCY REPORT
For the Quarter Ended **<INSERT DATE >**

MCO Info	Member Name	ID	Date of Birth	Calc. Age	Sex	County	Program Code	Effective Date	Term Date	Amount Expected	Over (Under)
State Info	*Member Name*	*ID*	*Date of Birth*	*Calc. Age*	*Sex*	County	*Program Code*	*Start Date*	*End Date*	*Received*	Paid
	Smith, John	444-33-1111	08/24/66	41	M	2	87	8/1/07	8/31/07	96.40	
	Smith, John	444-33-1111			M	2	17	8/1/07	8/31/07	14.84	(81.56)
	Smith, Jane	444-33-2222	07/13/67	39	F	2	67	7/1/06	12/31/06	714.54	
	Smith, Jane	444-33-2222			F	2	67	7/1/07	8/15/07	357.27	(357.27)
	Jones, Alice	444-33-3333	06/25/57	44	F	4	87	7/1/06	12/31/06	475.41	
	Jones, Alice	444-33-3333			F	4	87	7/1/07	9/30/07	899.10	423.69
	Jones, Steve	444-33-4444	09/30/72	28	M	3	97	8/1/05	12/31/05	508.09	
	Jones, Steve	444-33-4444			M	4	97	8/1/07	9/30/07	501.76	(6.28)
	Robertson, Pat	444-33-5555	11/11/76	22	F	1	67	4/1/05	12/31/05	682.08	
	Robertson, Pat	444-33-5555			M	1	67	7/1/07	9/30/07	283.89	(398.19)

ATTACHMENT IX, EXHIBIT A.3
QUARTERLY ENROLLMENT/CAPITATION PAYMENT RECONCILIATION REPORTS

<INSERT MCO NAME>
NO PREMIUM/CAPITATION PAYMENT REPORT
For the Quarter Ended **<INSERT DATE >**

										Amount	
MCO Info	Member Name	ID	Date of Birth	Calc. Age	Sex	County	Program Code	Start Date	End Date	Expected	Over (Under)
State Info	*Member Name*	*ID*	*Date of Birth*	*Calc. Age*	*Sex*	*County*	*Program Code*	*Start Date*	*End Date*	*Received*	Paid
	Doe, John	555-44-3333	09/29/39	54	M	2	17	1/1/00	12/31/06	44.52	
	-	-			-	-	-	-	-	0.00	(44.52)
	Doe, Jane	555-44-4444	01/18/52	49	F	2	67	9/1/07	9/30/07	238.18	
	-	-			-	-	-	-	-	0.00	(238.18)

ATTACHMENT IX, EXHIBIT A.4
QUARTERLY ENROLLMENT/CAPITATION PAYMENT RECONCILIATION REPORTS

<INSERT MCO NAME>
NO ELIGIBILITY REPORT
For the Quarter Ended **<INSERT DATE >**

										Amount	
MCO Info	Member Name	ID	Date of Birth	Calc. Age	Sex	County	Program Code	Start Date	End Date	Expected	Over (Under)
State Info	*Member Name*	*ID*	*Date of Birth*	*Calc. Age*	*Sex*	*County*	*Program Code*	*Start Date*	*End Date*	*Received*	Paid
-	-	-	-	-	-	-	-	-	-	0.00	
Jones, John	777-66-5555			M	1	67	7/1/07	7/31/07		94.63	94.63
-	-	-	-	-	-	-	-	-	-	0.00	
Jones, Jane	777-66-6666			F	3	97	7/1/07	7/31/07		441.05	441.05

ATTACHMENT IX, EXHIBIT B
MENTAL HEALTH CASE MANAGEMENT REPORT

ATTACHMENT IX, EXHIBIT B
MENTAL HEALTH CASE MANAGEMENT REPORT

The *Mental Health Case Management Report* required in Section 2.30.4.2 shall include, at a minimum, the following data elements:

1. MCO ID number
2. Number and percentage of compliance for appointments scheduled within 7 calendar days of the date of discharge from psychiatric inpatient or residential treatment facility
3. Number and percentage of compliance for appointments occurring within 7 calendar days of the date of discharge from psychiatric inpatient or residential treatment facility, excluding member no shows, reschedules, and refusals
4. Number and percentage of appointment no shows
5. Number and percentage of appointment reschedules
6. Number and percentage of members meeting medical necessity for mental health case management and refusing the service
7. Data elements #2 - #6 broken down by mental health case management agency
8. DCS status

ATTACHMENT IX, EXHIBIT C
BEHAVIORAL HEALTH CRISIS RESPONSE REPORT

ATTACHMENT IX, EXHIBIT C
BEHAVIORAL HEALTH CRISIS RESPONSE REPORT

The *Behavioral Health Crisis Response Report* required in Section 2.30.4.4 shall include, at a minimum, the following data elements:

1. Number of calls by age category (18 and over/under 18)
2. Total Number of calls
3. Average response time for face to face interventions by level of acuity
4. Number of calls by payer source (TennCare/Non-TennCare)
5. Number of calls by level of acuity
6. Number of consumers whose behavioral health provider was notified of crisis situation
7. Location of face to face intervention
8. Total number of face-to-face contacts
9. Final disposition
10. Number per type of barrier to diversion from inpatient admission
11. Average time for admission to crisis respite

ATTACHMENT IX, EXHIBIT D
MEMBER CRG/TPG ASSESSMENT REPORT

ATTACHMENT IX, EXHIBIT D
MEMBER CRG/TPG ASSESSMENT REPORT

The *Member CRG/TPG Assessment Report* required in Section 2.30.4.5 shall include, at a minimum, the following data elements:

CRG assessment of members age 18 years or older

1. MCO's ID number
2. Member's last name
3. Member's first name
4. Member's birth date
5. Member's Social Security Number (SSN)
6. Principal diagnosis
7. Dual principal/secondary diagnosis
8. Measure of member's level of functioning in activities of daily living
9. Measure of member's level of functioning in interpersonal functioning
10. Measure of member's level of functioning in concentration, task performance, and pace
11. Measure of member's level of functioning in adaptation to change
12. Measure of member's severity of impairment
13. Measure of member's duration of mental illness
14. Indicator of member's former severe impairment
15. Member's need for services to prevent relapse
16. Member's Clinically Related Group (CRG)
17. Reason for assessment
18. Date of request for assessment
19. Date of CRG assessment
20. Measure of rater's adequacy of information in order to complete assessment
21. Member's current Global Assessment of Functioning (GAF) scale score
22. Member's highest GAF scale score (past year)
23. Member's lowest GAF scale score (past year)
24. Program code
25. Rater's TennCare provider ID number

TPG assessment of members under age 18

1. MCO's ID number
2. Member's last name
3. Member's first name
4. Member's date of birth
5. Member's social security number
6. Principal diagnosis
7. Dual principal/secondary diagnosis
8. Member's current Global Assessment of Functioning (GAF) scale score
9. Member's highest GAF scale score (past year)
10. Member's lowest GAF scale score (past year)
11. Severity of impairment
12. Serious Emotional Disturbance (SED) status
13. Environmental issues
14. Family issues
15. Trauma issues
16. Social skills issues
17. Abuse/neglect issues
18. Child at risk of SED

19. Member's Target Population Group (TPG)
20. Reason for assessment
21. Date of request for assessment
22. Date of TPG assessment
23. Measure of rater's adequacy of information in order to complete assessment
24. Program code
25. Rater's TennCare provider ID number

ATTACHMENT IX, EXHIBIT E
PROVIDER ENROLLMENT FILE

ATTACHMENT IX, EXHIBIT E
PROVIDER ENROLLMENT FILE

The *Provider Enrollment File* required in Section 2.30.7.1 shall include, at a minimum, the following data elements for all providers:

1. Provider name (last, first, middle initial)
2. Title
3. Name of business
4. Type: business or individual
5. Address area
6. Service site address
7. Service site phone
8. Service site fax
9. Service site e-mail
10. Social Security Number
11. Specialty code
12. License number and type
13. Medicaid ID
14. TennCare ID
15. Contract/non-contract indicator
16. Unique physician identifier number (UPIN)
17. National provider identifier (NPI)
18. Drug Enforcement Agency (DEA) number
19. Effective date of participation in the MCO
20. End date of participation in the MCO
21. Employer ID number (EIN)
22. Other service site address
23. Other service site phone
24. Other service site fax
25. Other service site e-mail
26. Discipline/Degree
27. Location
28. Previous TennCare begin date
29. Previous TennCare end date
30. County
31. Youngest age which the provider will accept as a patient
32. Oldest age which the provider will accept as a patient
33. Assistance category code (ACC) present eligibility
34. Provides prenatal care (yes/no)
35. Accepts new patients (yes/no)
36. Number of patients assigned
37. Subspecialty type
38. Board certified eligibility status
39. Treats both sexes indicator
40. Provides obstetrics services indicator
41. Provides general surgery services indicator
42. Provides primary care services indicator
43. Provides TENNderCare services indicator
44. Subspecialty board certified eligibility status
45. Best practice network indicator
46. Original credential date
47. Most current recredential date
48. MCO Name

ATTACHMENT IX, EXHIBIT F
PCP ASSIGNMENT REPORT

ATTACHMENT IX, EXHIBIT F
PCP ASSIGNMENT REPORT

The CONTRACTOR shall use the following grid to complete the *PCP Assignment Report* required in Section 2.30.7.3.

MCO NAME: **REPORTING PARTY:** **TELEPHONE # :**		**REPORTING PERIOD:** **QTR 1 QTR 2 QTR 3 QTR 4** (Please circle)	
QTR	**Numerator: Members not assigned to a PCP within 30 days of enrollment by Grand Region during the reporting period**	**Denominator: Total number of new members in the Grand Region during the reporting period**	**Rate**
1/1- 3/31			
4/1-6/30			
7/1-9/30			
10/1-12/31			

ATTACHMENT IX, EXHIBIT G
REPORT OF ESSENTIAL HOSPITAL SERVICES

ATTACHMENT IX, EXHIBIT G
REPORT OF ESSENTIAL HOSPITAL SERVICES

Instructions for Completing *Report of Essential Hospital Services*

The chart for the *Report of Essential Hospital Services* required in Section 2.30.7.4 is to be prepared based on the CONTRACTOR's provider network for essential hospital services in each Grand Region in which the CONTRACTOR has (or expects to have) TennCare members.

- Fill out one report for each Grand Region. In the top portion of the grid, indicate the MCO name, the Grand Region, the total number of MCO members in the Grand Region and the date that such total enrollment was established.

- Provide information on each contract and non-contract facility that serves (or will serve) members in the identified Grand Region. The MCO should use a separate row to report information on each such facility.

1. In the first column, "Name of Facility" indicate the complete name of the facility.

2. In the second column: "City/Town" indicate the city or town in which the designated facility is located.

3. In the third column: "County", indicate the name of the county in which this facility is located.

4. In the fourth through the tenth columns indicate the status of the CONTRACTOR's relationship with the specific facility for each of these covered hospital services, e.g. Neonatal, Perinatal, Pediatric, Trauma, Burn, Center of Excellence for AIDS, and Centers of Excellence for Behavioral Health. For example:

   - If the CONTRACTOR has an executed provider agreement with the facility for neonatal services, insert an "E" in the column labeled "Neonatal".

   - If the CONTRACTOR does not have an executed provider agreement with this facility for "Neonatal", but has another type of arrangement with this facility, the CONTRACTOR should indicate the code that best describes its relationship (L=letter of intent; R=on referral basis; N=in contract negotiations; O=other arrangement). For any facility in which the CONTRACTOR does not have an executed provider agreement and is using as a non-contract provider, the CONTRACTOR should submit a brief description (one paragraph) of its relationship with the facility including an estimated timeline for executing a provider agreement, if any.

   - If the CONTRACTOR does not have any relationship for neonatal services with the facility on this row, the CONTRACTOR should leave the cell labeled "neonatal" blank.

ATTACHMENT IX, EXHIBIT G
ESSENTIAL HOSPITAL SERVICES REPORT

MCO Name:_____

Grand Region: _____

Number of TennCare Members:_____

as of (date): _____

Name of Facility	City/Town	County	Neonatal	Perinatal	Pediatric	Trauma	Burn	AIDS Center of Excellence	Center of Excellence for Behavioral Health	Comments

E = Executed Provider Agreement
L = Letter of Intent
R = On Referral Basis
N = In Contract Negotiations
O = Other Arrangement
If no relationship for a particular service leave cell blank

ATTACHMENT IX, EXHIBIT H
FQHC REPORT

ATTACHMENT IX, EXHIBIT H
FQHC REPORT

MCO Name: _____

As of January 1, _____

Please provide the information identified below for each FQHC with which the MCO has a provider agreement.

1. FQHC Name: _____
2. FQHC Address: _____
   _____

3. Total Amount Paid for the previous twelve (12) month period from July 1 through June 30: _____

ATTACHMENT IX, EXHIBIT I
SINGLE CASE AGREEMENTS REPORT

ATTACHMENT IX, EXHIBIT I
SINGLE CASE AGREEMENTS REPORT

MCO Name:_____
Month/Year:_____

Date of Agreement	Name of Member	Name of Provider	Specialty	Service Reason	Amount to be Paid

ATTACHMENT IX, EXHIBIT J
COST AND UTILIZATION REPORTS

ATTACHMENT IX, EXHIBIT J.1

[MCO NAME]
Cumulative Year to Date
Physical Health Cost & Utilization Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months										
Member Months										
Total Claims Health Care Expense										
Classified Health Care Expense										
Inpatient										
Outpatient										
Total Practitioner										
R.A.P. – Hospital Based										
Primary Care										
Specialist										
Total Miscellaneous										
Transportation										
Total Capitation										
Vendor A										
Vendor B										
Vendor C										
Vendor D										
Vendor E										

ATTACHMENT IX, EXHIBIT J.2

[MCO NAME]
Cumulative Year to Date
Physical Health Inpatient Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months										
Member Months										
Total Inpatient										
Payment Per Admission										
Payment Per Day										
Payment PMPM										
Admission per 1,000										
Days per 1,000										
Average Length of Stay										
Medical										
Payment Per Admission										
Payment Per Day										
Payment PMPM										
Admission per 1,000										
Days per 1,000										
Average Length of Stay										
Surgical										
Payment Per Admission										
Payment Per Day										
Payment PMPM										
Admission per 1,000										
Days per 1,000										
Average Length of Stay										
Obstetrical										
Payment Per Admission										
Payment Per Day										
Payment PMPM										
Admission per 1,000										
Days per 1,000										
Average Length of Stay										

ATTACHMENT IX, EXHIBIT J.3

[MCO NAME]
Cumulative Year to Date
Physical Health Outpatient Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Change	MCO Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months										
Member Months										
Total Outpatient										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
Surgery										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
ER-Emergency										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
ER Non-Emergency										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
Diagnostic										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										
Other Services [MCO to id what is here]										
Payment Per Visit										
Payment PMPM										
Visits per 1,000										

ATTACHMENT IX, EXHIBIT J.4

[MCO NAME]
Cumulative Year to Date
Physical Health Practitioner Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months										
Member Months										
Payment PMPM										
Total Practitioner										
Radiology										
Anesthesiology										
Pathology										
Total R.A.P.										
Primary Care Adult										
Primary Care Child										
Primary Care Total										
OB-GYN										
Cardiology										
Dermatology										
Endocrinology										
Gastroenterology										
General Surgery										
Nephrology										
Neurology										
Neurosurgery										
Oncology/Hematology										
Ophthalmology/Optometry										
Orthopedic Surgery										
Otolaryngology										
Pulmonology										
Urology										
Emergency Medicine										
Other										
Total Specialist (excluding psychiatry)										
Total Primary & Specialty										
Visits Per 1,000										
Total Practitioner										
Radiology										
Anesthesiology										
Pathology										
Total R.A.P.										

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Primary Care Adult										
Primary Care Child										
Primary Care Total										
OB-GYN										
Cardiology										
Dermatology										
Endocrinology										
Gastroenterology										
General Surgery										
Nephrology										
Neurology										
Neurosurgery										
Oncology /Hematology/										
Ophthalmology/Optometry										
Orthopedic Surgery										
Otolaryngology										
Pulmonology										
Urology										
Emergency Medicine										
Other										
Total Specialist (excluding psychiatry)										
Total Primary & Specialty (excluding psychiatry)										

ATTACHMENT IX, EXHIBIT J.5

[MCO NAME]
Cumulative Year to Date
Physical Health Miscellaneous Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Cumulative Member Months										
Member Months										
Total Miscellaneous [MCO needs to id and adjust as appropriate]										
Payment PMPM										
Durable Medical Equipment										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Home Infusion Therapy										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Home Health Agency										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Orthotics/Prosthetics										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Vision Hardware										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard
Transportation - Emergency										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Transportation - NET										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										
Other										
Payment PMPM										
Cost Per Unit										
Utilization per 1,000										

ATTACHMENT IX, EXHIBIT J.6

[MCO NAME]
Cumulative Year to Date
Behavioral Health Cost & Utilization Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard	State Only & Judicial
Cumulative Member Months											
Member Months											
Total Claims Behavioral Health Expenses											
Priority Behavioral Health Expenses											
Psychiatric Inpatient											
Psychiatric Residential											
Substance Abuse Inpatient											
Substance Abuse Inpatient Detox											
Substance Abuse Residential											
Total Mental Health Outpatient											
MD Services (Psychiatry)											
Non-MD Services											
Partial Hospital/IOP											
Total Substance Abuse Outpatient (including Detox)											
Substance Abuse Outpatient											
Substance Abuse Outpatient Detox											
Total Miscellaneous											
Lab											
Transportation											
Total Crisis Services											
Crisis Intervention											
Crisis Respite											
Crisis Stabilization											
Mental Health Case Management											
Total Psychiatric Rehabilitation											
Psychosocial											
Supported Employment											

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard	State Only & Judicial
Peer Support											
Illness Management & Recovery											
Supported Housing											
Non-Priority Behavioral Health Expenses											
Psychiatric Inpatient											
Psychiatric Residential											
Substance Abuse Inptatient											
Substance Abuse Inpatient Detox											
Substance Abuse Residential											
Total Mental Health Outpatient											
MD Services (Psychiatry)											
Non-MD Services											
Partial Hospital/IOP											
Total Substance Abuse Outpatient (including Detox)											
Substance Abuse Outpatient											
Substance Abuse Outpatient Detox											
Total Miscellaneous											
Lab											
Transportation											
Total Crisis Services											
Crisis Intervention											
Crisis Respite											
Crisis Stabilization											
Mental Health Case Management											
Total Psychiatric Rehabilitation											
Psychosocial											
Supported Employment											
Peer Support											
Illness Management & Recovery											
Supported Housing											

ATTACHMENT IX, EXHIBIT J.7

[MCO NAME]
Cumulative Year to Date
Behavioral Health Inpatient Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Cumulative Member Months											
Member Months											
Total Psychiatric Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Priority Psychiatric Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Non-Priority Psychiatric Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Total Psychiatric Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Days per 1,000											
Average Length of Stay											
Priority Psychiatric Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Non-Priority Psychiatric Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Total Substance Abuse Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Priority Substance Abuse Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Non-Priority Substance Abuse Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Average Length of Stay											
Total Substance Abuse Inpatient Detox											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Priority Substance Abuse Inpatient Detox											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Non-Priority Substance Abuse Inpatient Detox											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Total Substance Abuse /Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Priority Substance Abuse Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Non-Priority Substance Abuse Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											

ATTACHMENT IX, EXHIBIT J.8

[MCO NAME]
Cumulative Year to Date
Behavioral Health Outpatient Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Change	MCO Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Cumulative Member Months											
Member Months											
Total Mental Health Outpatient Services											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Priority MD Services (Psychiatry)											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Non-Priority MD Services (Psychiatry)											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Priority Non-MD Services											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Non-Priority Non-MD Services											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											

Managed Care Metrics	YTD % Change	MCO Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Priority Partial Hospitalizations/IOP											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Non-Priority Partial Hospitalizations/IOP											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Total Substance Abuse Outpatient including detox											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Priority Substance Abuse Outpatient											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Non-Priority Substance Abuse Outpatient											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Priority Substance Abuse Outpatient Detox											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Non-Priority Substance Abuse Outpatient Detox											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											

ATTACHMENT IX, EXHIBIT J.9

[MCO NAME]
Cumulative Year to Date
Behavioral Health Miscellaneous Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles / Standard	State Only & Judicial
Cumulative Member Months											
Member Months											
Total Miscellaneous											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Lab											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Lab											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Transportation											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Transportation											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											

ATTACHMENT IX, EXHIBIT J.10

[MCO NAME]
Cumulative Year to Date
Behavioral Health Specialized Community Services Report
Incurred Period: XX/XX/XXXX – XX/XX/XXXX
Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligibles/ Standard	State Only & Judicial
Cumulative Member Months											
Member Months											
Total Crisis Services											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Crisis Intervention											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Crisis Intervention											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Crisis Respite											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Crisis Respite											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											

Priority Crisis Stabilization											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Crisis Stabilization											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Total Mental Health Case Management											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Mental Health Case Management											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Mental Health Case Management											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Total Psychiatric Rehabilitation											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Psychosocial											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Psychosocial											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											

Priority Supported Employment											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non Priority Supported Employment											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Peer Support											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Peer Support											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Illness Management & Recovery											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Non-Priority Illness Management & Recovery											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											
Priority Supported Housing											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											

Non-Priority Supported Housing											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											

ATTACHMENT IX, EXHIBIT K
COST AND UTILIZATION SUMMARIES

ATTACHMENT IX, EXHIBIT K
COST AND UTILIZATION SUMMARIES

The quarterly *Cost and Utilization Summaries* required in Section 2.30.10.4 shall include information for each of the following populations:

- Medicaid
- Uninsured
- Medically Eligible
- Disabled
- Duals

Summaries for the following shall be provided:

1) Data elements for *Top 25 Providers (broken down by facilities, practitioners, ancillary providers, transportation providers) by Amount Paid*

    - Rank
    - Provider type
    - Provider Name
    - Street Address (Physical Location)
    - City
    - State
    - Zip Code
    - Amount Paid to Each Provider
    - Amount Paid as a Percentage of Total Provider Payments

2) Data elements for *Top 25 Inpatient Diagnoses by Number of Admissions*

    - Rank
    - DRG Code (Diagnosis Code)
    - Description
    - Amount Paid
    - Admits
    - Admits as a Percentage of Total Admits

3) Data elements for *Top 25 Inpatient Diagnoses by Amount Paid*

    - Rank
    - DRG Code (Diagnosis Code)
    - Description
    - Admits
    - Amount Paid
    - Amount Paid as a Percentage of Total Inpatient Dollars

4) Data elements for *Top 25 Outpatient Diagnoses by Number of Visits*

    - Rank
    - Diagnosis code
    - Description
    - Amount Paid
    - Visits

- Visits as a percentage of Total Outpatient Visits

5) Data elements for *Top 25 Outpatient Diagnoses by Amount Paid*

- Rank
- Diagnosis Code
- Description
- Visits
- Amount Paid
- Amount Paid as a Percentage of Total Outpatient Payments

6) Data elements for *Top 10 Inpatient Surgical/Maternity Procedures (DRGs) by Number of Admissions*

- Rank
- DRG Code
- Description
- Amount Paid
- Number of Admissions
- Admissions as a Percentage of Total Admissions

7) Data elements for *Top 10 Inpatient Surgical/Maternity Procedures (DRGs) by Amount Paid*

- Rank
- DRG Code
- Description
- Number of Procedures
- Amount Paid
- Amount Paid as a Percentage of Total Inpatient Surgical/Maternity Payments

8) Data elements for *Top 10 Outpatient Surgical/Maternity Procedures by Number of Procedures*

- Rank
- Procedure Code
- Description
- Amount Paid
- Number of Procedures
- Procedures as a Percentage of Total Surgical/Maternity Procedures

9) Data elements for *Top 10 Outpatient Surgical/Maternity Procedures by Amount Paid*

- Rank
- Procedure Code
- Description
- Number of Procedures
- Amount Paid
- Amount Paid as a Percentage of Total Outpatient Surgical/Maternity Payments

ATTACHMENT IX, EXHIBIT L
PRIOR AUTHORIZATION REPORTS

ATTACHMENT IX, EXHIBIT L.1
PRIOR AUTHORIZATION REPORT

REPORTING GRID (Children)

MCO NAME: REPORTING PARTY: TELEPHONE # :					REPORTING PERIOD: QTR 1 QTR 2 QTR 3 QTR 4 (Please Indicate QTR)
Service Types	**Total # Received**	**Total # Processed**	**Total # Approved**	**Total # Denied**	**Denial Reason(s) - Identify the # of denials for each denial reason indicated**
Inpatient (medical)					
Inpatient (psychiatric)					
Psychiatric RTF					
Home Health					
Private Duty Nursing					
Hospice					
Hospice (Institutional)					
Outpatient Surgery (Facility)					
Referrals (Specialist)					
Transportation					
Skilled Nursing Facility					

ATTACHMENT IX, EXHIBIT L.2
PRIOR AUTHORIZATION REPORT

REPORTING GRID (Adults)

MCO NAME: REPORTING PARTY: TELEPHONE # :					REPORTING PERIOD: QTR 1 QTR 2 QTR 3 QTR 4 (Please Indicate QTR)
Service Types	**Total # Received**	**Total # Processed**	**Total # Approved**	**Total # Denied**	**Denial Reason(s) - Identify the # of denials for each denial reason indicated**
Inpatient (medical)					
Inpatient (psychiatric)					
Home Health					
Private Duty Nursing					
Hospice					
Hospice (Institutional)					
Outpatient Surgery (Facility)					
Referrals (Specialist)					
Transportation					
Skilled Nursing Facility					

ATTACHMENT IX, EXHIBIT M
MEMBER SERVICES AND UTILIZATION MANAGEMENT PHONE LINE REPORT

ATTACHMENT IX, EXHIBIT M
MEMBER SERVICES AND UTILIZATION MANAGEMENT PHONE LINE REPORT

Instructions for Completing the *Member Services and Utilization Management Phone Line Report*

The following definitions shall be used:

Abandoned Call: A call in the phone line queue that is terminated by the caller before reaching a live voice.

Average Time to Answer: The average time that callers waited in the phone line queue (when the call was placed during the hours the phone line is open for services) before speaking to a MCO representative. This shall be reported in minutes: seconds (e.g. one minute and twenty-five seconds should be reported as 1:25).

Call Abandonment Rate: The number of calls (where the member/provider called directly into the phone line or selected a member/provider services option and was put in the call queue) that are abandoned by the caller or the system before being answered by a live voice, divided by the number of calls received by the phone line (during hours when the line is staffed with personnel—hours open for services) during the measurement period.

Call Answer Timeliness: The number of calls (where the member called directly into the phone line or selected a member/provider services option and was put in the call queue) that are answered by a live voice within thirty (30) seconds, divided by the number of calls received by the phone line (during hours when the line is staffed with personnel—hours open for services) during the measurement period.

ATTACHMENT IX, EXHIBIT M
MEMBER SERVICES AND UTILIZATION MANAGEMENT
PHONE LINE REPORT

MCO Name:_____

Report Submission Date:_____

Reporting Quarter:_____

		[Month 1]	[Month 2]	[Month 3]
Member Services Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Nurse Triage Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Utilization Management Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			

ATTACHMENT IX, EXHIBIT N
MEDICAL LOSS RATIO REPORT

ATTACHMENT IX, EXHIBIT N
MEDICAL LOSS RATIO REPORT

Instructions for Completing the *Medical Loss Ratio Report*

The CONTRACTOR shall submit the *Medical Loss Ratio* Report (as required in Section 2.30.14.2.1) monthly. The CONTRACTOR shall also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report must reconcile to NAIC filings. A letter shall accompany this report from an actuary indicating that the reports, including the estimate for incurred but not reported expenses, have been reviewed for accuracy. A printed copy and electronic version of the report is to be submitted to the following:

Keith Gaither
Deputy Chief Financial Officer
Bureau of TennCare
Department of Finance and Administration
310 Great Circle Rd
Nashville, TN 37243

Email: keith.gaither@state.tn.us

John R. Mattingly
TennCare Examinations Director
Department of Commerce and Insurance
TennCare Division
500 James Robertson Parkway, Suite 750
Nashville, TN 37243-1169

Email: john.mattingly@state.tn.us

Instructions for completing the report:

- Enter the MCO name.
- Enter the reporting month.
- Enter the monthly number of **TennCare members**.
- Aggregate payments by **Grand Region** based on member residence.
- Each month report the amount of **Payments for Medical Services** made as of the effective date of the Agreement for services incurred through the end of the report month on a cumulative calendar year to date basis.
- Report the amount of **Payments by the Claims Processing System.** For Medical Services these payments should be reported by category of service.
- Report the amount of **Payments by the Claims Processing System** made for **CMS 1450** and **CMS 1500** claim types in the appropriate supporting triangle lag reports. The amounts entered into the triangle lag reports must tie to the amounts entered in the *Medical Loss Ratio Report - Total*. If a subcontractor processes transportation and/or other services then these payments should be reported on the Subcontractor Payments for Medical Services line and not entered into the triangle lag report. In addition, the CONTRACTOR shall reconcile the amount of **Payments by the Claims Processing System** made for **CMS 1450** and **CMS 1500** claim types to the amount paid as captured on the CONTRACTOR's encounter file submissions for the corresponding period. The format for the reconciliation shall be provided by TENNCARE.

- Report for each month the total amount of **Capitation Payments.** Capitation payments should include payments made directly to a service provider on a capitated basis.

- Report for each month the total amount of **Subcontractor Payments for Medical Services**. Subcontract payments should include payments made for services that are coordinated or arranged by a subcontractor. A description of each service and expenditure amount.

- Report for each month the total amount of **Reinsurance Payments**. Reinsurance payments are payments made to a licensed or authorized reinsurer to limit medical and hospital expenses by reducing maximum expenses on an individual basis, on an aggregate basis, or both.

- Report for each month the total amount of **Other Payments/Adjustments to Medical Costs**. Other payments may include settlements and claims payments made outside the claims processing system. Other payments/adjustments made for services incurred prior to January 1, 2007 must be excluded.

- Report for each month the total amount of **Grant Payments,** if applicable.

- Report for each month the amount of the **Crisis Services Team Pass Through.**

- Report for each month the total amount of **Recoveries Not Reflected in Payments by the Claims System**. Recoveries may include reinsurance payments, subrogation payments, and other settlement payments received. Details of the recoveries shall be provided in a supplemental schedule.

- The Excel spreadsheet calculates the **Total Payments for the Month**.

- Report the **Remaining IBNR for the Month**. The remaining IBNR is the estimated amount to be paid for services incurred through the report month but not yet reported. IBNR should not include estimated bonus payments, unless specifically accounted for in the provider's contract. A brief explanation of the IBNR estimate should be attached. All prior periods should be updated each month.

- The Excel spreadsheet calculates the **Payments and Remaining IBNR for the Month**.

- The Excel spreadsheet calculates the **Medical Loss Ratio** as Capitation Payments per Quarter (from TennCare) and Remaining IBNR divided by the Capitation Payments.

- Complete a separate Medical Loss Ratio report for base capitation only and the priority add-on payment. The 'Medical Loss Ratio Report – Base Capitation Only' should only reflect base capitation payments in revenue and payments for services excluding behavioral health services for Priority enrollees. The 'Medical Loss Ratio Report – Priority Add-On Only' should only reflect priority add-on payments in revenue and payments for behavioral health services for Priority enrollees. The 'Medical Loss Ratio Report – Total' should equal be equal to the Medical Loss Ratio Report – Base Capitation Only plus The Medical Loss Ratio Report – Priority Add-On.

ATTACHMENT IX, EXHIBIT N.1
MEDICAL LOSS RATIO REPORT

Medical Loss Ratio Report - Total
Grand Region

MCO

Insert MCO Name

Reporting Month		2007						For the Year Ended 6/30/2007	2007					
		Incurred Month							Incurred Month					
	Pr. To 1/07	January	February	March	April	May	June		July	August	September	October	November	December
Enrollment														
Capitation Revenue														
Payments for Covered Services for the Month														
Medical Services														
CMS 1450/UB 92 Payments by the Claims Processing System														
Inpatient - Maternity														
Inpatient - Newborn														
Inpatient -Medical														
Inpatient - Surgery														
Inpatient Other														
Outpatient - Emergency Room														
Outpatient - Laboratory														
Outpatient - Radiology														
Outpatient - Surgery														
Outpatient - Other														
CMS 1500 Payments by the Claims Processing System														
Prof - E&M														
Prof - Maternity														
Prof - Surgery														
Prof - DME														
Prof - Lab														
Prof - Radiology														
Prof - Transportation														
Prof - Other														
Capitation Payments														
Subcontractor Payments for Medical Services														
Other Medical (provide description)														
Behavioral Health														
Inpatient Payments by the Claims Processing System														
Outpatient Payments by the Claims Processing System														
Supported Housing Payments by the Claims Processing System														
Intensive Outpatient Payments by the Claims Processing System														
Partial Hospitalization Payments by the Claims Processing System														
In Home Payments by the Claims Processing System														
Transportation Payments by the Claims Processing System														
Twenty-Three Hour Payments by the Claims Processing System														
CMHA Capitation Payments														
Other Capitation Payments														
Grant Payments														
Non-FFS Inpatient														
Subcontractor Payments for Mental Health and Substance Abuse Services														
Crisis Services Team Pass Through														
Less:														
Recoveries not Reflected in Claims Payments														
Total Payments														
Remaining IBNR														
Payments and Remaining IBNR														
Medical Loss Ratio														
Per Member Expense														

ATTACHMENT IX, EXHIBIT N.1
MEDICAL LOSS RATIO REPORT

Medical Loss Ratio Report - Base Capitation Only
Grand Region

MCO														
Insert MCO Name														
Reporting Month		2007						For the Year Ended 6/30/2007	2007					
		Incurred Month							Incurred Month					
	Pr. To 1/07	January	February	March	April	May	June		July	August	September	October	November	December
Enrollment														
Capitation Revenue (For base capitation only)														
Payments for Covered Services for the Month														
Medical Services														
CMS 1450/UB 92 Payments by the Claims Processing System														
Inpatient - Maternity														
Inpatient - Newborn														
Inpatient -Medical														
Inpatient - Surgery														
Inpatient Other														
Outpatient - Emergency Room														
Outpatient - Laboratory														
Outpatient - Radiology														
Outpatient - Surgery														
Outpatient - Other														
CMS 1500 Payments by the Claims Processing System														
Prof - E&M														
Prof - Maternity														
Prof - Surgery														
Prof - DME														
Prof - Lab														
Prof - Radiology														
Prof - Transportation														
Prof - Other														
Capitation Payments														
Subcontractor Payments for Medical Services														
Other Medical (provide description)														
Behavioral Health (Excluding payments on behalf of Priority enrollees)														
Inpatient Payments by the Claims Processing System														
Outpatient Payments by the Claims Processing System														
Supported Housing Payments by the Claims Processing System														
Intensive Outpatient Payments by the Claims Processing System														
Partial Hospitalization Payments by the Claims Processing System														
In Home Payments by the Claims Processing System														
Transportation Payments by the Claims Processing System														
Twenty-Three Hour Payments by the Claims Processing System														
CMHA Capitation Payments														
Other Capitation Payments														
Grant Payments														
Non-FFS Inpatient														
Subcontractor Payments for Mental Health and Substance Abuse Services														
Crisis Services Team Pass Through														
Less:														
Recoveries not Reflected in Claims Payments														
Total Payments														
Remaining IBNR														
Payments and Remaining IBNR														
Medical Loss Ratio														
Per Member Expense														

ATTACHMENT IX, EXHIBIT N.1
MEDICAL LOSS RATIO REPORT

Medical Loss Ratio Report - Priority Add-On Only
Grand Region

MCO

Insert MCO Name

Reporting Month		2007						For the Year Ended 6/30/2007	2007					
		Incurred Month							Incurred Month					
	Pr. To 1/07	January	February	March	April	May	June		July	August	September	October	November	December
Enrollment (For Priority Enrollees Only)														
Capitation Revenue (Priority add-on payment only)														
Payments for Covered Services for the Month														
Medical Services														
CMS 1450/UB 92 Payments by the Claims Processing System														
Inpatient - Maternity														
Inpatient - Newborn														
Inpatient -Medical														
Inpatient - Surgery														
Inpatient Other														
Outpatient - Emergency Room														
Outpatient - Laboratory														
Outpatient - Radiology														
Outpatient - Surgery														
Outpatient - Other														
CMS 1500 Payments by the Claims Processing System														
Prof - E&M														
Prof - Maternity														
Prof - Surgery														
Prof - DME														
Prof - Lab														
Prof - Radiology														
Prof - Transportation														
Prof - Other														
Capitation Payments														
Subcontractor Payments for Medical Services														
Other Medical (provide description)														
Behavioral Health (On behalf of Priority enrollees only)														
Inpatient Payments by the Claims Processing System														
Outpatient Payments by the Claims Processing System														
Supported Housing Payments by the Claims Processing System														
Intensive Outpatient Payments by the Claims Processing System														
Partial Hospitalization Payments by the Claims Processing System														
In Home Payments by the Claims Processing System														
Transportation Payments by the Claims Processing System														
Twenty-Three Hour Payments by the Claims Processing System														
CMHA Capitation Payments														
Other Capitation Payments														
Grant Payments														
Non-FFS Inpatient														
Subcontractor Payments for Mental Health and Substance Abuse Services														
Crisis Services Team Pass Through														
Less:														
Recoveries not Reflected in Claims Payments														
Total Payments														
Remaining IBNR														
Payments and Remaining IBNR														
Medical Loss Ratio														
Per Member Expense														

ATTACHMENT IX, EXHIBIT N.2
CMS 1450 Payments by the Claims Processing System

Month Paid by the Claims System		Total	Prior to Jan-07	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
		Incurred Month of Service																																											
102,641	Jan-07	123,207	20,567	102,641																																									
1,390,011	Feb-07	1,397,549	7,538	1,277,436	112,575																																								
1,400,529	Mar-07	1,397,046	(3,483)	374,761	973,587	52,181																																							
1,538,049	Apr-07	1,539,089	1,040	160,992	348,987	1,014,047	14,024																																						
2,001,139	May-07	2,001,163	24	30,850	150,351	569,387	1,189,875	60,675																																					
2,036,767	Jun-07	2,036,767	0	35,029	61,188	273,447	582,938	1,039,330	44,834																																				
1,871,969	Jul-07	1,875,816	3,848	53,407	13,052	36,137	76,441	573,771	1,013,842	105,318																																			
1,357,234	Aug-07	1,357,234	0	18,788	12,958	156,125	40,600	116,648	269,898	688,651	53,567																																		
1,413,909	Sep-07	1,422,937	9,028	6,781	3,511	14,789	(3,231)	52,546	145,158	432,451	720,115	41,790																																	
1,498,241	Oct-07	1,498,241	0	615	279	20,931	38,358	33,995	116,021	112,256	353,581	808,119	14,086																																
3,556,603	Nov-07	3,556,603	0	494	(3,911)	28,804	22,781	8,345	16,781	635,370	517,427	1,023,113	1,166,241	141,157																															
1,813,104	Dec-07	1,813,104	0	10,587	14,419	(4,837)	14,688	26,962	7,194	35,228	86,031	99,288	415,192	1,038,164	70,187																														
1,670,936	Jan-08	1,670,936	0	(79)	(261)	(2,184)	48,019	26,745	4,471	11,584	35,362	25,194	160,313	375,211	947,733	38,828																													
2,420,889	Feb-08	2,421,959	1,070	1,242	10,824	17,181	6,400	70,185	4,594	2,777	3,990	60,895	136,793	170,616	647,970	1,168,790	118,634																													
1,878,065	Mar-08	1,878,065	0	897	3,772	(1,072)	(177)	(288)	3,071	8,267	41,055	225,216	31,100	38,261	148,391	465,675	899,830	14,068																											
3,184,573	Apr-08	3,184,573	0	(191)	1,874	2,996	(1,311)	4,102	4,709	6,284	2,662	21,512	10,270	41,129	219,338	247,123	892,758	1,549,711	181,606																											
2,303,770	May-08	2,303,770	0	(3,824)	(119)	(216)	(4,929)	(700)	1,261	14,105	(5,651)	4,278	10,374	13,304	128,073	125,515	235,464	514,055	1,166,110	105,671																										
1,516,584	Jun-08	1,516,584	0		975	185	524	(4,373)	250	941	728	(292)	1,620	13,662	23,431	12,753	35,784	101,292	258,634	1,013,387	57,084																									
2,222,204	Jul-08	2,222,204	0	80	80	(4)	0	(19)	(152)	1,039	(3,061)	13	13,607	709	182,034	4,413	81,590	75,546	176,518	327,680	1,232,445	129,684																								
2,387,471	Aug-08	2,387,471	0	(13)	(300)	114	(821)	(606)	(81)	(92)	(669)	(595)	2,609	6,979	7,174	6,233	4,006	456,013	60,162	197,131	361,646	1,207,347	81,236																							
2,504,634	Sep-08	2,504,634	0		(21)	845		456	(408)	20,084	19,411	16,164	2,306	31,469	2,487	135,073	47,835	83,913	16,111	72,769	162,136	601,531	1,190,664	101,811																					
2,358,341	Oct-08	2,358,341	0	(1,138)	(1,900)	(807)	(4,162)	(2,655)	(2,492)	(4,287)	4,284	(8,065)	8,957	36,905	13,817	5,197	3,930	4,165	33,148	53,291	69,559	128,585	537,964	1,311,326	172,720																				
1,818,059	Nov-08	1,818,059	0		(577)	(1,269)	(236)	4,350	(599)	725	789	708	(2,972)	74	633	17,265	21,464	20,361	1,959	4,661	66,749	155,292	122,195	231,696	1,114,737	60,054																			
1,877,089	Dec-08	1,877,089	0	38	85	0	38	(134)	436	(31)	170	8,900	668	4,955	519	28,019	9,040	20,169	5,057	967	24,836	119,679	59,430	77,780	343,697	1,127,488	45,282																		
2,184,885	Jan-09	2,184,885	0	(395)	0		(1,200)	(6,792)	(482)	125	(263)	(3,443)	(878)	328	(696)	11,911	1,506	19,855	690	117,162	(378)	45,809	54,017	64,689	180,572	488,457	1,122,939	91,352																	
2,383,775	Feb-09	2,383,775	0	(48)		0	22		(78)	0	0	(520)	395	(2,197)	(3,073)	(1,174)	(2,384)	(4,217)	238	1,139	(673)	43,274	27,873	21,946	88,850	252,904	603,867	1,287,489	70,143																
1,812,451	Mar-09	1,812,451	0	(5,046)		0				2,324	375	(217,849)	238	(17,810)	(10,103)	(10,270)	33	(756)	(925)	(1,193)	3,780	156,823	7,360	22,940	43,428	62,846	173,442	354,362	1,227,326	21,126															
2,890,996	Apr-09	2,890,996	0			(361)	(31)	(393)		(1,800)	364	(207)	(842)	(118)	(395)	(7,613)	(11,714)	2,184	2,291	3,003	3,904	9,364	217,250	114,812	29,594	47,601	87,888	127,476	725,829	1,418,727	124,184													
2,170,849	May-09	2,170,849	0	(225)		(100)		(188)	1,300	(114)	0	(769)	0	0	(1,888)	0	2,418	(487)	6,519	28,368	(2,981)	944	5,201	14,724	27,959	11,729	40,208	38,213	138,319	653,398	1,153,708	54,592													
2,868,999	Jun-09	2,868,999	0	(12,077)	(13,430)	(13,799)	(16,337)	(15,513)	(16,078)	(15,819)	(14,101)	(15,193)	(13,980)	(13,575)	(15,983)	(17,441)	(19,382)	(14,573)	(15,736)	(10,979)	(24,471)	(14,168)	(8,477)	(2,046)	85,816	14,072	340,251	147,044	188,989	263,712	858,694	1,202,549	71,040												
2,423,385	Jul-09	2,423,385	0			0				0		2,850	2,718	(19)	0		(320)	127	99,087	5,313	13,846	5,738	1,949	1,992	11,400	51,311	38,609	135,488	48,747	72,881	165,822	682,066	1,049,238	34,543											
2,844,587	Aug-09	2,844,587	0					134	0	0				(550)		0	(96)	0	(2,431)	(86)	(2,226)	3,346	9,748	16,209	42,801	1,448	65,249	28,341	74,922	25,519	200,233	213,674	957,170	1,174,079	37,105										
2,817,010	Sep-09	2,817,010	0		(151)	38			503	48	(1,255)	(449)	114	2,171		0	(1,180)	(2,000)	0	48	526	0	100,048	(312)	8,081	4,506	(564)	34,786	129,282	114,071	131,742	118,089	122,958	920,503	1,107,392	28,014										
3,885,472	Oct-09	3,885,472	0	0	(1,280)				241	300			(76)			0		(464)	100	(6,664)	0	3,946	18,614	53	(3,578)	(573)	19,655	10,211	121,540	47,763	223,212	81,374	170,770	631,561	1,090,217	1,419,198	59,350									
2,935,716	Nov-09	2,935,716	0			1,726				0		2,052			76	0	5,879		635	297	0	(1,449)	51	5,243	3,679	10,143	5,472	23,058	35,065	44,339	26,824	76,022	133,331	126,576	271,858	750,036	1,367,141	47,663							
2,827,098	Dec-09	2,827,098	0	0		(51)		(109)			(1,279)	(327)	0						0	2,400	142	236	78	151	35,014	106	(430)	5,765	4,490	37,842	21,478	25,270	98,867	64,300	199,357	324,439	897,640	1,088,490	23,230						
3,970,747	Jan-10	3,970,747	0									0			0	(76)		(141)	71	1,425	70	286	73	(135)	3,128	443	1,573	2,734	67,047	18,082	(24,086)	44,568	96,947	75,710	180,835	115,569	474,391	1,255,210	1,588,142	68,880					
3,457,830	Feb-10	3,457,830	0											0		0		3,096	19,775	0	133	336	231	560	(673)	891	361	1,576	(1,213)	59,587	18,472	42,558	12,443	99,166	75,824	113,588	218,061	305,032	954,651	1,469,531	63,844				
2,845,624	Mar-10	2,845,624	0			(208)		60		(1,137)	(1,470)		(96)		5,060				(1,860)	(1,614)	(1,422)	(954)	(1,850)	779	(2,560)	(2,491)	(612)	(7,243)	(7,169)	(1,828)	(1,808)	(11,639)	(822)	19,199	37,363	71,607	206,603	(16,737)	240,536	846,075	1,403,929	77,933			
3,021,773	Apr-10	3,021,773	0												0					0			0	223	582	660	(922)	10,216	5,279	(76)	55,850	12,518	15,055	13,195	29,569	25,975	160,409	91,803	101,688	223,653	961,190	1,212,824	102,083		
3,211,499	May-10	3,211,499	0	0													0	0	0			0	1,520	0	(76)	86	4,874	943	1,910	2,492	3,793	3,025	2,928	53,524	(5,181)	92,219	97,811	201,859	189,717	173,497	310,389	638,728	1,376,870	60,572	
3,626,133	Jun-10	3,626,133	0	24							114						114					48	(114)	2,400	14,019	483	94	743	511	7,308	2,944	10,352	18,052	1,879	32,272	7,250	21,335	46,904	323,002	159,220	141,824	132,648	859,142	1,655,399	188,166
Totals		98,341,273	39,630	2,051,627	1,686,569	2,164,023	2,002,271	1,986,401	1,614,327	2,054,596	1,812,277	2,092,384	1,958,759	1,880,824	2,365,775	2,230,220	2,325,206	2,841,917	2,007,759	1,914,175	1,964,705	2,595,698	2,425,060	1,986,843	2,199,189	2,132,165	2,547,234	2,292,553	2,831,018	2,784,944	2,961,062	2,555,019	2,747,978	3,214,234	3,056,610	2,947,896	3,502,741	3,020,224	3,420,965	2,940,857	2,881,175	2,062,132	2,338,094	1,715,970	188,166

FY 10	20,133,606
FY 09	32,045,225
FY 08	26,142,616
FY 07	19,980,196

98,341,273 Total for Dates of Service after 1/1/2007

ATTACHMENT IX, EXHIBIT N.3
CMS 1500 Payments by the Claims Processing System

Month Paid by the Claims System		Total	Prior to Jan-07	Incurred Month of Service Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
62,077	Jan-07	63,829	1,752	62,077																																									
1,322,171	Feb-07	1,326,517	4,346	1,154,878	167,293																																								
1,557,207	Mar-07	1,558,613	1,406	394,464	1,078,194	94,549																																							
1,635,356	Apr-07	1,636,068	713	129,683	423,246	1,017,855	64,572																																						
2,208,817	May-07	2,209,919	1,102	78,433	162,815	571,542	1,237,594	158,432																																					
1,718,864	Jun-07	1,719,584	720	19,048	58,913	105,160	457,887	934,722	143,135																																				
1,983,763	Jul-07	1,983,763	0	10,870	26,097	54,322	158,656	456,856	1,041,330	235,631																																			
1,793,839	Aug-07	1,793,934	95	8,619	7,131	13,378	63,229	153,365	393,808	981,587	172,723																																		
1,863,463	Sep-07	1,863,566	103	5,227	14,683	14,926	24,488	53,415	150,544	421,099	1,011,925	167,157																																	
1,887,286	Oct-07	1,887,286	0	14,175	6,885	9,604	20,401	15,745	47,127	153,640	367,664	1,152,086	99,960																																
2,364,287	Nov-07	2,364,287	0	2,257	533	3,532	4,216	9,612	33,106	116,169	204,494	553,549	1,246,567	190,252																															
1,876,238	Dec-07	1,876,205	(33)	2,194	1,778	4,370	4,534	8,202	8,021	24,248	38,626	109,844	402,466	1,111,665	160,289																														
1,718,344	Jan-08	1,718,344	0	(3,246)	(3,048)	170	955	5,527	2,709	6,221	18,049	54,879	136,770	356,846	1,056,262	86,250																													
2,364,591	Feb-08	2,364,591	0	1,415	237	2,147	1,781	9,046	8,867	(1,852)	(560)	5,936	62,376	192,005	528,762	1,352,404	202,028																												
2,097,183	Mar-08	2,097,183	0	1,569	11,643	8,729	14,852	10,457	23,665	37,620	29,717	31,139	39,904	62,492	109,617	425,721	1,162,715	127,342																											
2,480,764	Apr-08	2,480,764	0	3,596	3,994	6,044	3,518	6,630	1,711	825	(2,065)	7,303	8,077	13,790	55,519	129,746	520,453	1,400,232	321,389																										
2,197,467	May-08	2,197,467	0	(8,994)	192	(133)	(620)	(391)	(123)	4,793	(2,930)	6,074	1,830	6,272	25,026	53,952	175,821	391,638	1,329,291	215,771																									
1,799,772	Jun-08	1,799,772	0	(75)	(105)	1,585	1,111	(1,533)	656	1,072	3,357	2,001	2,178	800	21,209	5,412	50,533	141,882	310,905	1,060,804	197,979																							
2,319,568	Jul-08	2,319,568	0	477	710	1,054	4,676	257	(432)	151	(101)	678	186	7,941	5,431	6,437	20,193	69,713	215,668	458,086	1,314,835	213,608																							
2,063,218	Aug-08	2,063,591	373	5,068	4,055	41	193	83	(6)	157	(1,165)	8,390	7,071	1,388	2,727	5,391	791	40,764	41,321	109,553	416,222	1,219,605	201,567																						
2,046,212	Sep-08	2,046,212	0	419	606	23	1,872	628	(803)	(589)	(2,268)	(2,144)	2,563	7,428	(417)	9,948	15,171	21,038	23,782	59,731	127,604	379,961	1,186,407	215,249																					
2,442,187	Oct-08	2,441,874	(314)	(877)	(304)	(558)	(711)	(130)	(1,951)	(447)	(2,062)	(3,331)	4,007	2,393	3,645	3,168	4,656	24,942	10,434	18,570	75,469	174,421	444,590	1,419,631	266,633																				
1,994,508	Nov-08	1,994,508	0	(287)	(707)	(335)	23	148	878	4,414	1,847	2,303	1,980	2,301	7,418	7,152	1,633	6,700	6,343	13,193	37,504	71,898	127,708	378,756	1,155,245	168,392																			
1,884,204	Dec-08	1,884,204	0	38	(145)	(103)	(293)	(138)	244	(160)	225	419	1,107	(988)	113	657	2,418	4,945	3,179	4,683	8,835	26,258	61,834	136,807	376,865	1,132,093	125,309																		
2,604,533	Jan-09	2,604,533	0	(805)	(99)	4,701	(301)	(894)	(879)	(430)	(2,670)	(1,489)	558	710	1,558	4,436	10,905	14,772	19,668	21,758	27,302	24,728	40,754	96,604	205,285	525,845	1,397,725	214,794																	
2,146,477	Feb-09	2,146,477	0	(79)	(129)	57	(6)	68	(53)	85	501	2,236	4,316	6,713	7,705	5,137	6,236	8,494	8,439	2,448	14,141	12,406	9,950	29,851	85,338	147,128	379,990	1,220,455	195,046																
2,081,571	Mar-09	2,081,571	0	877	3,342	8,266	4,519	3,416	2,505	2,401	4,171	4,015	(11,010)	2,137	7,437	5,030	916	2,044	734	(70)	2,204	2,178	5,732	14,684	20,746	85,563	161,075	388,323	1,276,512	83,826															
2,555,559	Apr-09	2,555,559	0	(99)	0	(455)	(464)	(60)	(26)	490	378	433	670	438	991	(1,377)	(1,667)	(334)	52	6,828	5,430	813	12,307	12,665	12,955	22,473	97,006	204,480	545,697	1,429,214	206,721														
2,062,110	May-09	2,062,110	0	(158)	0	(84)	0	(146)	(502)	(726)	(172)	(268)	(30)	(742)	(2,213)	2,866	176	260	(1,063)	(750)	(2,645)	(688)	2,107	7,821	5,381	12,827	29,294	66,476	113,529	433,061	1,231,121	167,378													
2,265,262	Jun-09	2,265,262	0	(5)	(30)	(243)	(175)	354	(178)	544	(14)	(450)	(17)	417	3,215	(1,383)	(1,425)	(1,349)	(796)	(926)	(1,761)	1,509	344	10,097	8,981	13,897	15,386	28,389	126,321	186,428	464,584	1,210,499	203,048												
2,040,013	Jul-09	2,040,013	0	388	212	145	33	(209)	(108)	(29)	(151)	(117)	(405)	(103)	(143)	(61)	(623)	173	233	(259)	2,125	946	3,535	4,265	(211)	6,158	9,730	18,521	52,508	91,084	212,451	535,744	985,162	119,020											
2,220,604	Aug-09	2,220,604	0	0	85	159	0	10	(208)	(5)	0	0	143	76	0	132	(130)	(144)	(2,649)	(1,406)	(730)	939	5,468	(7,066)	2,940	6,605	17,099	10,674	15,752	32,691	88,216	180,392	665,432	1,113,663	92,466										
2,252,066	Sep-09	2,252,066	0	0	(280)	0	(82)	0	94	336	(240)	(80)	263	983	57	0	(294)	(329)	(1,301)	(831)	520	1,399	(104)	2,303	(494)	(646)	3,972	5,517	9,014	23,646	36,092	86,981	181,740	711,971	1,104,523	87,337									
2,751,305	Oct-09	2,751,305	0	146	(717)	(35)	0	(66)	46	199	0	116	(74)	21	(469)	74	0	(336)	(103)	(51)	127	1,445	62	(563)	(3,684)	(1,735)	800	5,186	9,999	17,329	10,309	24,542	104,899	253,640	744,300	1,408,349	177,549								
2,263,850	Nov-09	2,263,850	0	0	(16)	81	0			0		(440)	0	50	257	(1,242)	(11)	122	452	(129)	1,309	342	6,003	1,900	1,275	1,240	10,814	(2,163)	3,434	18,805	27,416	19,475	52,449	84,229	169,153	519,165	1,195,331	154,549							
2,210,655	Dec-09	2,210,655	0	(99)	83	(144)	0	(158)			(1,781)	0	0	(13)	0	1,321	67	(16)	(182)	20	(13)	0	(40)	252	99	181	1,001	3,210	(3,823)	1,131	10,157	8,555	11,847	15,072	107,269	188,976	596,826	1,180,932	89,925						
3,063,438	Jan-10	3,063,438	0	0	58	(61)	(232)		143	0		(94)	28	0	0	(163)	(3)	(15)	(30,589)	215	154	865	1,038	761	690	1,116	2,313	1,989	4,711	20,673	14,496	11,209	12,151	33,395	51,131	152,388	273,508	856,940	1,497,036	157,566					
2,283,695	Feb-10	2,283,695	0	0	0	(60)	(5)	(96)	(70)		0	167	(5)	(87)	0	(5)	428	(3)	(9)	(10)	8	343	294	(487)	(50)	(257)	599	916	182	2,328	2,461	11,032	8,233	15,238	8,822	34,681	88,742	146,389	531,319	1,297,189	135,469				
2,582,015	Mar-10	2,582,015	0	0	0	(61)		19	(2)	(119)	(35)	52	237	(10)	0	(108)	0	(96)	(246)	(544)	(1,007)	(1,111)	200	1,253	(855)	(542)	3,751	(6,329)	(1,647)	2,979	245	(5,737)	7,996	13,896	17,671	19,967	38,365	84,683	178,220	661,540	1,418,732	150,661			
2,254,135	Apr-10	2,254,135	0	(46)	0	0	0		(38)		0		0		(46)	0	(218)	(40)	(12)	(92)	0	(202)	0	247	143	171	276	2,384	58	5,065	2,755	3,394	2,089	5,014	3,070	9,145	15,045	33,225	73,483	157,594	651,590	1,140,596	149,484		
2,384,881	May-10	2,384,881	0	(15)		0	0	0	0		(10)	46	0	(106)	0	0	(74)	0	(63)	0	0	203	37	75	97	197	1,129	822	149	319	952	784	3,202	2,039	3,588	9,100	8,817	8,962	34,161	94,517	202,063	601,703	1,272,133	140,051	
2,523,845	Jun-10	2,523,845	0	38	(14)	72	(68)			0	137	87	0	0	0	(10)	84	(223)	0	(226)	(153)	114	(146)	68	(59)	221	387	114	17	645	(158)	234	22	304	704	4,761	9,038	10,997	20,821	37,444	97,705	140,079	558,829	1,380,995	260,987
Totals		88,237,664	10,263	1,871,172	1,967,190	1,920,237	2,066,154	1,823,171	1,853,211	1,987,323	1,837,593	2,100,499	2,011,716	1,965,069	1,993,951	2,100,883	2,170,782	2,252,177	2,254,877	1,966,365	2,225,460	2,131,999	2,109,651	2,325,175	2,137,320	2,120,928	2,257,655	2,163,757	2,347,459	2,349,224	2,307,817	2,254,482	2,238,269	2,367,480	2,302,698	2,433,870	2,403,221	2,476,676	2,424,966	2,405,850	2,505,559	2,033,038	1,980,446	1,521,046	260,987

FY 10	15,092,009
FY 09	27,454,005
FY 08	25,408,019
FY 07	20,273,369

88,237,664 Total for Dates of Service after 1/1/2007

ATTACHMENT X
CAPITATION RATES

ATTACHMENT X
CAPITATION RATES

[INSERT CAPITATION RATES FOR CONTRACTOR]

ATTACHMENT 6.2

PROPOSAL TRANSMITTAL AND STATEMENT OF CERTIFICATIONS AND ASSURANCES

The Proposer must complete and sign this Technical Proposal Transmittal. It must be signed, in the space below, by an individual empowered to bind the proposing entity to the provisions of this RFP and any contract/Agreement awarded pursuant to it. If said individual is not the Proposer's chief executive, this document shall attach evidence showing the individual's authority to bind the proposing entity.

PROPOSER LEGAL ENTITY NAME:	
PROPOSER FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	

The Proposer does hereby affirm and expressly declare confirmation, certification, and assurance of the following:

1) This proposal constitutes a commitment to provide all services as defined in the RFP Attachment 6.1, *Pro Forma* Contract for the total contract period and confirmation that the Proposer shall comply with all of the provisions in this RFP and shall accept all terms and conditions and requirements set out in the RFP Attachment 6.1, *Pro Forma* Contract.

2) The information detailed in the proposal submitted herewith in response to the subject RFP is accurate.

3) The proposal submitted herewith in response to the subject RFP shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract/Agreement pursuant to the RFP.

4) The Proposers shall comply with:

   a) the laws of the State of Tennessee;

   b) Title VI of the federal Civil Rights Act of 1964;

   c) Title IX of the federal Education Amendments Act of 1972;

   d) the Equal Employment Opportunity Act and the regulations issued there under by the federal government;

   e) the Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government;

   f) Title XIX of the Social Security Act and the regulations issued there under by the federal government;

   g) the Health Insurance Portability and Accountability Act of 1996 and the regulations issued there under by the federal government;

   h) the condition that the submitted proposal was independently arrived at, without collusion, under penalty of perjury; and

   i) the condition that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Proposer in connection with the Procurement under this RFP.

5) The Proposer has read RFP Section 4.3.9 regarding conflict of interest and certifies that the Proposer is not prohibited from receiving payment from the State due to a conflict of interest.

SIGNATURE & DATE:	

ATTACHMENT 6.3

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION A	
PROPOSER NAME:	

SECTION A — MANDATORY REQUIREMENTS

The Proposer must address ALL Mandatory Requirements section items and provide, in sequence, the information and documentation as required (referenced with the associated item references). The RFP Coordinator will review all general mandatory requirements, including but not limited to the following:

- **Proposal received on or before the Proposal Deadline.**
- **Technical Proposal copies and Cost Proposal packaged separately.**
- **Technical Proposal contains NO cost data.**
- **Proposer did NOT submit alternate proposals.**
- **Proposer did NOT submit multiple proposals in a different form.**
- **Technical Proposal does NOT contain any restrictions of the rights of the State or other qualification of the proposal.**

The RFP Coordinator will also review the proposal to determine if the Mandatory Requirement Items (below) are met and mark each with pass or fail. For each requirement that is not met, the Proposal Evaluation Team must review the proposal and attach a written determination.

NOTICE: In addition to these requirements, the State will also evaluate compliance with ALL RFP requirements.

Proposal Page # (to be completed by Proposer)	**Mandatory Requirement Items**	**State Use ONLY**
		Pass/Fail
	A.1 Provide the Proposal Transmittal and Statement of Certifications and Assurances (detailed in RFP Attachment 6.2) completed and signed, in the space provided, by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract/ Agreement. ***Each Proposer <u>must</u> sign the Proposal Transmittal and Statement of Certifications and Assurances without exception or qualification.***	

Proposal Page # (to be completed by Proposer)	Mandatory Requirement Items	State Use ONLY Pass/Fail
	A.2 Provide the following as documentation of financial responsibility and stability: ▪ a current written bank reference, in the form of a standard business letter, indicating that the Proposer's business relationship with the financial institution is in positive standing; ▪ two current written, positive credit references, in the form of standard business letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by a accredited credit bureau within the last 6 months; ▪ a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars ($1,000,000**)** per occurrence and three million dollars ($3,000,000) in the aggregate; and ▪ a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars ($500,000.00).	
	A.3 Provide a statement of whether the Proposer or any individual who shall perform work under the contract/Agreement has a possible conflict of interest as defined in RFP Section 4.3.9 (*e.g.,* employment by the State of Tennessee) and, if so, the nature of that conflict. ***Any questions of conflict of interest shall be solely within the discretion of the State, and the State reserves the right to cancel any award.***	
	A.4 Provide evidence that the Proposer has applied to TDCI for a certificate of authority to establish and operate an HMO in Tennessee.	

Proposal Page # (to be completed by Proposer)	Mandatory Requirement Items	State Use ONLY Pass/Fail
	A.5 Provide the following as documentation of sufficient financial strength and resources to provide the scope of services as required: ▪ Two of the most recent independently audited financial statements and associated enrollment figures from your company. Include the parent company's most recent financial statements as well if applicable. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be: (1) prepared with all monetary amounts detailed in U.S. currency; (2) prepared under U.S. generally accepted accounting principles; and (3) audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements. ▪ Your company's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to-Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows. ▪ Verification of any contributions made to your company to improve its financial position after its most recent audit.	

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION B	
PROPOSER NAME:	

SECTION B — QUALIFICATIONS & EXPERIENCE

The Proposer must address ALL Qualifications and Experience section items and provide, in sequence, the information and documentation as required (referenced with the associated item references and text).

Proposal Evaluation Teams, made up of three or more State employees, will independently evaluate and score the proposal's "qualifications and experience" responses.

The Proposal Evaluation Teams may elect to not evaluate any part of the Qualifications and Experience response that exceeds the 55 page maximum.

Proposal Page # (to be completed by Proposer)	Qualifications & Experience Items (55 page maximum for items B.1 through B.18)
	B.1 Describe the Proposer's form of business (*i.e.*, individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing addresses, and telephone numbers of its officers and directors as well as the person the State should contact regarding the proposal. Please also provide your federal taxpayer identification number.
	B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of the Proposer's company within the last ten years, and if so, an explanation providing relevant details.
	B.3 Provide a statement of whether the Proposer or any of the Proposer's employees, agents, independent contractors, or subcontractors have been convicted of, pled guilty to, or pled *nolo contendere* to any felony, and if so, an explanation providing relevant details.
	B.4 Provide a statement of whether there is any pending litigation against the Proposer including in particular any litigation involving failure to provide timely, adequate or quality physical or behavioral health services. If such litigation exists, describe the damages being sought and the extent to which adverse judgment would be covered by insurance or reserves set aside for this purpose. Include an opinion of counsel as to the degree of risk presented by the pending litigation whether the pending litigation will impair the Proposer's performance in a contract under this RFP.
	B.5 Provide a statement of whether, in the last ten years, the Proposer or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which your company emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan.
	B.6 Provide a statement of whether there are any pending Securities Exchange Commission investigations involving the Proposer, and if such are pending or in progress, an explanation providing relevant details and an attached opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP.

Proposal Page # (to be completed by Proposer)	Qualifications & Experience Items (55 page maximum for items B.1 through B.18)
	B.7 Describe the Proposer organization's number of employees, client base, and location of offices.
	B.8 Provide a narrative description of the proposed project team, its members, and organizational structure.
	B.9 Provide a personnel roster and resumes of key people who shall be assigned by the Proposer to perform duties or services under the contract as well as an organizational chart highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrating the lines of authority.
	B.10 Provide a statement of whether the Proposer intends to use subcontractors, and if so, the names and mailing addresses of the committed subcontractors and a description of the scope and portions of the work the subcontractors will perform. Also specify whether the subcontractor is currently providing services for the Proposer in other states and where the subcontractor is located.

Proposal Page # (to be completed by Proposer)	Qualifications & Experience Items (55 page maximum for items B.1 through B.18)
	B.11 Provide documentation of Proposer commitment to diversity as represented by its business strategy, business relationships, and workforce — this documentation should detail: ▪ a description of the Proposer's existing programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities, women, persons with a disability and small business enterprises; ▪ a listing of the Proposer's current contracts with business enterprises owned by minorities, women, persons with a disability and small business enterprises, including the following information: o contract description and total value; o contractor name and ownership characteristics (*i.e.*, ethnicity, sex, disability); and o contractor contact and telephone number. ▪ an estimate of the level of participation by business enterprises owned by minorities, women, persons with a disability and small business enterprises in a contract awarded to the Proposer pursuant to this RFP, including the following information: o participation estimate (expressed as a percent of the total contract value that will be dedicated to business with subcontractors and supply contractors having such ownership characteristics); o descriptions of anticipated contracts; and o names and ownership characteristics (*i.e.*, ethnicity, sex, disability) of anticipated subcontractors and supply contractors anticipated. ▪ the percent of the Proposer's total current employees by ethnicity, sex, and disability. ***Proposers that demonstrate a commitment to diversity will advance State efforts to expand opportunity to do business with the State as contractors and sub-contractors. Proposal evaluations will recognize the positive qualifications and experience of a Proposer that does business with enterprises owned by minorities, women, persons with a disability and small business enterprises and that offers a diverse workforce to meet service needs.***
	B.12 Identify all other publicly-funded managed care contracts for Medicaid/SCHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, please provide a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types, the contract costs, whether payment was capitated or other, and the role of subcontractors, if any.

Proposal Page # (to be completed by Proposer)	Qualifications & Experience Items (55 page maximum for items B.1 through B.18)
	B.13 List the states in which you are NCQA accredited and indicate the accreditation status by product line; also list the states in which you have applied for NCQA accreditation and indicate the status of the application by product line.
	B.14 Provide a statement of any debarment or suspension, regulatory action, sanctions, and/or fines imposed by any federal or state regulatory entity within the last five (5) years, including a description of any letters of deficiencies, corrective actions or fines, if any, were related to Medicaid or SCHIP programs.
	B.15 Provide specific client references (minimum of three, maximum of five) with at least one for a state Medicaid program or other large similar government or large private industry project within the last five (5) years. Each reference must include the contact name and phone number, brief description of the services provided, and the period of service.
	B.16 Identify whether you have had a contract terminated or not renewed within the past five (5) years. If so, please describe the issues, the parties involved, and provide the address and telephone number of the principle terminating party. Please describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal.
	B.17 Provide, in chart format, information regarding sanctions, penalties and/or liquidated damages that have been assessed against your company during the past five (5) years under a contract to provide physical health or behavioral health benefits. List each violation and the associated amount of the sanction, penalty or liquidated damage.
	B.18 Identify all prior work experience with the State of Tennessee within the past five (5) years. Please be advised that, in the evaluation phase of this procurement, the State will consider the performance history from those proposers who previously have or are currently doing business with TFA or any other agency in the State of Tennessee.
(Maximum Section B Score = 200)	
SCORE *(for all Section B items above, B.1 through B.18)*:	

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION C	
PROPOSER NAME:	

SECTION C — TECHNICAL APPROACH

The Proposer must address ALL Technical Approach section items and provide, in sequence, the information and documentation as required (referenced with the associated item references and text).

The Proposal Evaluation Teams, made up of three or more State employees, will independently evaluate and score the proposal's response to each item.

The Proposal Evaluation Teams may elect to not evaluate any part of the response that exceeds the maximum number of pages provided below.

Each evaluator will use the following whole number, raw point scale for scoring each item:
0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The RFP Coordinator will multiply each item score by the assigned weight with the product being the item's raw weighted score for purposes of calculating the section score as detailed at the end of this table.

All Section references (e.g. Section 2.6) in Technical Proposal & Evaluation Guide – Section C are to RFP Attachment 6.1, *Pro Forma* Contract.

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	Covered Benefits and Services (Section 2.6 of RFP Attachment 6.1) (Responses to items C.1 through C.4 shall not exceed 19 pages.)			
	C.1 Provide a narrative describing how you intend to deliver the physical health benefits available to TennCare members. As part of your narrative describe how you will meet the requirements regarding soft limits/service thresholds. To the extent that you intend to use subcontractors to deliver any of the benefits, please describe how you will choose and monitor those subcontractors to assure compliance with all provisions of the Agreement. If you have not had experience providing physical health benefits to a comparable population, describe how you would approach delivering the covered services differently for this population than for non-comparable (e.g. commercial) populations.		**6**	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.2 Provide a narrative describing how you intend to deliver the mental health and substance abuse benefits available to TennCare members, State Onlys and Judicials, including court-ordered services. To the extent that you intend to use subcontractors to deliver any of the benefits, please describe how you will choose and monitor those subcontractors to assure compliance with all provisions of the Agreement. If you have not had experience providing mental health and substance abuse benefits to a comparable population, describe how you would approach delivering the covered services differently for this population than for non-comparable (e.g. commercial) populations.		6	
	C.3 Describe how you will fulfill the requirements for medical necessity determinations as described in Attachment 6.1, Section 2.6.3.		5	
	C.4 Describe how you will monitor your provider network to ensure compliance with the cost sharing provisions described in Attachment 6.1, Section 2.6.7.		3	
	Specialized Services (Section 2.7 of RFP Attachment 6.1) (Responses to items C.5 through C.10 shall not exceed 22 pages.)			
	C.5 Describe how you will make determinations and advise your contract providers regarding what constitutes emergency services.		3	
	C.6 Describe your approach to the use of psychiatric residential treatment facilities (PRTFs) for both children and adults. Include in your narrative how you will ensure RTFs are only utilized as the least restrictive alternative for care and that those serving members under 21 years of age comply with federal regulations regarding the use of seclusion and restraints.		3	
	C.7 Describe your approach to providing mental health case management services. Include in your narrative specific information about how you will assure coordination of care between a mental health provider and the member's primary care provider (PCP).		3	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.8 Describe your approach to offering psychiatric rehabilitation services with a focus on resilience and recovery. Include in your narrative specific information about how you will ensure that appropriate psychiatric rehabilitation services are available and how you will ensure that each service component (supported employment, supported housing, psychosocial rehabilitation, illness management and recovery, and peer support) are delivered in such a way as to promote individuals' recovery and resilience.		4	
	C.9 Describe your approach to providing behavioral health crisis services. Include in your narrative specific information about how you will ensure that appropriate crisis services are available and what kind of follow up you will provide to ensure that once stabilized, individuals will have appropriate follow-up and aftercare.		9	
	C.10 Describe your approach to ensuring that members with behavioral health issues will be given a proper and timely CRG/TPG assessment. Please include in your narrative specific information about how you will: (1) Identify members that need an assessment; (2) Meet all required timeframes; (3) Ensure the proper capacity and training for providers who will perform these assessments; and (4) Audit accuracy of results.		3	
	TENNderCare (Section 2.7.5 of RFP Attachment 6.1) (Responses to items C.11 through C.17 shall not exceed 12 pages.)			
	C.11 Describe your approach to outreach and informing members about the TENNderCare (EPSDT) program. In particular, include in your narrative how you will monitor your outreach program, what steps you will take to identify and reach out to members who have missed screening appointments or who have specifically declined services, and describe how you will adjust your outreach strategies to target adolescents and youth in the transitional age group (18-20 years).		4	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.12 Describe your approach to ensuring that providers deliver and document all required components of TENNderCare screening.		4	
	C.13 Please provide a narrative to describe what you will do to motivate parents to comply with periodicity schedules. If non-cash incentives are used, please describe them. In your narrative, provide specific examples of how your incentive program has worked in other states.		4	
	C.14 Describe your internal processes for tracking referrals from a screening and ensuring that needs identified in a screening are met with timely and appropriate services. In addition, describe the tracking system you will use to monitor each child's receipt of the required screening, diagnosis, and treatment.		5	
	C.15 Describe your approach for assuring service coordination for children as required in Attachment 6.1, Section 2.7.5.4.5.		3	
	C.16 Please describe how you will comply with the requirements related to non-emergency transportation for those members under 21 who do not have access to transportation.		2	
	C.17 Please provide a narrative describing how you will comply with inspections required for children with elevated blood lead levels.		2	
	Disease Management (Section 2.8 of RFP Attachment 6.1) (Responses to items C.18 through C.20 shall not exceed 10 pages.)			
	C.18 Describe in detail your proposed approach to disease management for at least one of the physical health conditions required in Attachment 6.1, Section 2.8.1. In your narrative, describe how you identify members, inform and enroll them, educate providers, and monitor the results of the program.		10	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.19 Describe in detail your proposed approach to disease management for at least one of the behavioral health conditions required in Attachment 6.1, Section 2.8.1. In your narrative, describe how you identify members, inform and enroll them, educate providers, and monitor the results of the program.		10	
	C.20 Provide a narrative that documents statistically significant outcomes from one of the disease management programs you currently operate.		5	
	Service Coordination (Section 2.9 of RFP Attachment 6.1) (Responses to items C.21 through C.26 shall not exceed 22 pages.)			
	C.21 Describe your approach to MCO case management (see Attachment 6.1, Section 2.9.4). In particular, describe the characteristics of members that you target for MCO case management services, how you identify these members (including members who have reached service thresholds), what interventions are utilized to address identified problems, how you develop and implement individualized plans of care, and the techniques you use to encourage the member's participation in your MCO case management program.		9	
	C.22 Describe in detail your approach to coordinating behavioral health benefits with physical health benefits (see Attachment 6.1, Section 2.9.5). In your narrative, describe any innovative approaches you use or will use either at the provider or MCO level.		9	
	C.23 Describe in detail your approach to the coordination of mental health and substance abuse benefits when a member presents with co-occurring conditions.		9	
	C.24 Describe how you will assure coordination of care between behavioral health providers and primary care providers (PCPs) and between inpatient and outpatient mental health providers as required in Attachment 6.1, Sections 2.9.5 and 2.9.6.		5	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.25 Describe your approach to coordinating benefits with Tennessee's Pharmacy Benefits Manager to ensure compliance with Attachment 6.1, Section 2.9.7. In particular, describe your approach to using pharmacy data to contact and educate physicians about prescribing patterns and identifying and working with pharmacy abusing members.		4	
	C.26 Describe your approach to coordinating benefits and services with other providers including, but not limited to services provided by schools, long-term care providers and through Medicare.		4	
	Provider Network (Section 2.11 of RFP Attachment 6.1) (Responses to items C.27 through C.31 shall not exceed 19 pages.)			
	C.27 Describe in detail your plan to build and maintain a provider network that meets all required access standards. As a part of your description, describe to what extent, if any, you will contract with safety net providers, and, if safety net providers will not be utilized, how you will ensure that similar services are provided.		8	
	C.28 Describe your process for enrolling providers in your network. Be specific about how you will assure proper credentialing and licensing.		5	
	C.29 Describe your process for monitoring a provider network to ensure adherence to all required access standards, including distance and timely appointments.		4	
	C.30 Describe your PCP assignment process and the measures taken to ensure that every member in your MCO is assigned a PCP. Your description should include your process for permitting members with chronic conditions to select a specialist as their PCP.		6	
	C.31 Describe the role your MCO expects the PCP to play and how the PCPs are trained and evaluated regarding that role.		2	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	Provider Agreements (Section 2.12 of RFP Attachment 6.1) (Responses to items C.32 through C.34 shall not exceed 5 pages.)			
	C.32 Describe the monitoring and oversight measures to be used to ensure provider compliance with provider agreements. Please include in your description: (1) Types of monitoring activities; (2) Frequency of monitoring; (3) Timeframes required for provider notification once a violation is identified; (4) Any sanctions, penalties, or incentives that may be imposed or implemented; and (5) Required timeframes for provider to respond and take necessary corrective measures.		**6**	
	C.33 Provide an example from your previous experience of how you have handled provider noncompliance with agreement requirements.		**4**	
	C.34 Describe in detail how you will educate and train providers. Please include: (1) Curriculum for initial orientation; (2) Frequency and type of on-going training; (3) Methods and locations for training (workshops, office visits, memos); and (4) The extent, if any, training varies depending on provider type and location.		**5**	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	Utilization Management (Section 2.14 of RFP Attachment 6.1) (Responses to items C.35 through C.39 shall not exceed 10 pages.)			
	C.35 Provide a description of the UM program you plan to use for all covered services, in keeping with the requirements in Attachment 6.1, Section 2.14. Your description should include: (1) Type of services that will require prior authorization and/or concurrent review; (2) Rationale for and methods used to establish prior authorization and concurrent review criteria; (3) Measures taken to ensure requests are responded to within required time frames, including requests for urgent care; and (4) Other UM strategies that will be utilized by your plan such as requiring PCP referrals for specialty care.		**11**	
	C.36 Please describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope.		**7**	
	C.37 Describe how you will reduce inappropriate ER utilization, per requirements in Attachment 6.1, Section 2.14.1.11.		**5**	
	C.38 Provide a description of your previous experience and actions taken in obtaining medical record information from uncooperative providers. You should include a description of any financial penalties imposed and the extent of these penalties.		**2**	
	C.39 Describe how you will operationalize your prior authorization process for members requiring services from non-contract providers or services for conditions that threaten the member's life or health.		**3**	
	Quality Management (Section 2.15 of RFP Attachment 6.1) (Responses to items C.40 through C.42 shall not exceed 10 pages.)			
	C.40 Please provide a description of your QM/QI program, including the proposed members of the QM/QI committee.		**5**	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.41 In order to assess your ability to fulfill the requirements for the performance improvement activities, for each of the three required activities, please indicate your proposed: (1) Measurable performance goals and benchmarks; (2) Specific interventions; (3) Relevant clinical practice guidelines; and (4) Timeframes for measurement.		**12**	
	C.42 As required by Attachment 6.1, Section 2.15.5, please indicate the four evidence-based clinical practice guidelines you will select for use in your QM/QI plan. For each also include: (1) Your rationale for its relevance to the TennCare population; (2) The measures you will take to increase compliance; and (3) Your process for developing, updating and disseminating clinical practice guidelines to contract providers.		**8**	
	Member Materials (Section 2.17 of RFP Attachment 6.1) (Responses to item C.43 shall not exceed 5 pages.)			
	C.43 Describe your process to ensure that member handbooks, ID cards, member newsletters, and provider directories are distributed to members in a timely manner. Include in your narrative the education plan/content for the member newsletters and your strategy for keeping the information in your provider directory current.		**7**	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	Customer Service (Section 2.18 of RFP Attachment 6.1) (Responses to items C.44 through C.48 shall not exceed 10 pages.)			
	C.44 Provide a narrative with the following details regarding your member services line: (1) Training of customer service staff; (2) Required timeframe for problem resolution and reporting back to caller; (3) Monitoring process to determine adherence to performance standards as required in Attachment 6.1, Section 2.18.1.9; (4) Process for routing calls to appropriate persons; (5) Process for handling calls from non-English proficient persons and persons who are deal or hard of hearing; and (6) After hours procedures.		**7**	
	C.45 Describe how you will ensure that services are provided in an appropriate manner to persons with limited English proficiency and persons who are deaf or hard of hearing, including the provision of interpreter services.		**5**	
	C.46 Please describe how you will deliver services in a culturally competent manner.		**3**	
	C.47 Provide a narrative with the following details regarding your UM phone line: (1) Required timeframe for problem resolution and reporting back to caller; (2) Monitoring process to determine adherence to performance standards as required in Attachment 6.1, Section 2.18.4.8; (3) Process for routing calls to appropriate persons; and (4) Process for handling calls from non-English proficient persons.		**4**	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.48 In keeping with requirements in Attachment 6.1, Section 2.18.9, describe to what extent members, parents, or legally appointed representatives will be involved in behavioral health treatment planning. Your description should include: (1) How individuals are informed of their right to participate; (2) The circumstances, if any, that would preclude persons from participating; and (3) Your activities to monitor provider compliance with the requirement for member, parent(s), or legally appointed representative(s) involvement in treatment planning.		6	
	Complaints and Appeals (Section 2.19 of RFP Attachment 6.1) (Responses to item C.49 shall not exceed 6 pages.)			
	C.49 Describe in detail how you will tailor your current complaints and appeals process to comply with state requirements.		20	
	Fraud & Abuse (Section 2.20 of RFP Attachment 6.1) (Responses to items C.50 through C.51 shall not exceed 3 pages.)			
	C.50 Describe in detail your compliance plan to prevent and identify provider fraud and abuse. Your description should include your plan to prevent, detect, and notify appropriate entities as required by Attachment 6.1, Section 2.20.		10	
	C.51 Describe in detail your compliance plan to prevent and identify member fraud and abuse. Your description should include your plan to prevent, detect, and notify appropriate entities as required by Attachment 6.1, Section 2.20.		10	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	Financial Management (Section 2.21 of RFP Attachment 6.1) (Responses to item C.52 shall not exceed 3 pages.)			
	C.52 Describe how you will comply with the requirements for cost avoidance and the collection of third party liability (TPL) in Attachment 6.1, Section 2.21.4. Discuss barriers you have encountered and how you have overcome them in your work in other states.		**10**	
	Claims Management (Section 2.22 of RFP Attachment 6.1) (Responses to items C.53 through C.59 shall not exceed 6 pages.)			
	C.53 Describe the processes you will use to ensure that claims submitted by providers who are excluded from the Medicare, Medicaid or SCHIP programs are not paid as required in the Agreement.		**3**	
	C.54 Describe the methodology you will use to establish your IBNR liability.		**5**	
	C.55 Describe the capabilities of your claims management systems as it relates to each of the requirements in Attachment 6.1, Section 2.22.2. In your response, explain whether and how your systems meet (or exceed) each of these requirements. Additionally, please cite at least 3 examples from current experience where you have successfully implemented a claims management system that meets or exceeds the requirements of Attachment 6.1, Section 2.22.2. Finally if your systems do not meet the requirements at present, please indicate the effort and time that will be required for you to acquire the capabilities needed to meet the requirements.		**8**	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.56 Describe your methodology for ensuring that claims payment accuracy standards will be achieved, per Attachment 6.1, Section 2.22.6. At a minimum please address the following in your response: (1) The process for auditing a sample of claims as described in Attachment 6.1, Section 2.22.6.3, (2) The sampling methodology itself, (3) Documentation of the results of these audits, and (4) The processes for implementing any necessary any corrective actions resulting from an audit.		**8**	
	C.57 Describe your methodology for ensuring that the claims processing requirements identified in Attachment 6.1, Section 2.22.7, including adherence to all service authorization procedures, are met.		**4**	
	C.58 Please attach a recent copy of a claims payment performance report for your largest Medicaid program customer.		**1**	
	C.59 Please attach a recent copy of a claims report for incurred but not paid claims for your largest Medicaid program customer.		**1**	
	Information Systems (Section 2.23 of RFP Attachment 6.1) (Responses to items C.60 through C.73 shall not exceed 23 pages.)			
	C.60 Please describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to TennCare. Additionally, please describe how you will accommodate TennCare-initiated data integrity, validity and completeness audits.		**3**	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.61 a. Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in Attachment 6.1, Section 2.23. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan. b. Please identify the timing of implementation of the mix of technologies and management (policies and procedures) strategies described in your response to (a), or indicate whether these technologies and management strategies are already in place. c. Please elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients. d. As part of your response, provide diagrams that illustrate (a) point-to-point interfaces, (b) information flows, (c) internal controls and (d) the networking arrangement (AKA “network diagram”) associated with the information systems profiled. These diagrams should provide insight into how your Systems will be organized and interact with TennCare systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with TennCare.		**8**	
	C.62 Please describe how your organization’s systems have been designed to support relational database conventions, how they are compliant with SQL and/or ODBC, and your capabilities to report on and/or extract data from your core transaction systems.		**1**	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.63 a. Describe your plan to store and codify data generated by, and documents used by, members and providers to interact and/or transact with you so as to maintain the logical relationships between certain documents and certain data as described in Attachment 6.1, Section 2.23.2.3. b. Explain how you will enable data and documents related to the same entity (i.e. member, provider, claim) to be accessible via a singular process and/or System – if your Systems possess this functionality at present, please elaborate.		**1**	
	C.64 Describe in detail the processes and tools you will employ to ensure the validity and completeness of the encounter data you submit to TennCare as required in Attachment 6.1, Section 2.23.4.		**3**	
	C.65 Please cite at least three currently-live instances where you are successfully providing encounter data in accordance with TennCare coding, data exchange format and transmission standards and specifications, with at least two of these instances involving the provision of encounter information from providers with whom you have capitation arrangements. In elaborating on these instances, please address all of the requirements in Attachment 6.1, Section 2.23.4. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.		**3**	

Proposal Page # (to be completed by Proposer)	Technical Approach Items		State Use ONLY		
			Score	Item Weight	Raw Weighted Score
	C.66	Please cite at least three currently-live instances where you are successfully receiving, processing and updating enrollment data in accordance with TennCare coding, data exchange format and transmission standards and specifications. In elaborating on these instances, please address all of the requirements in Attachment 6.1, Section 2.23.5. If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.		4	
	C.67	Describe the ability within your systems to meet (or exceed) each of the requirements in Attachment 6.1, Section 2.23.6 - System and Information Security and Access Management Requirements. Please address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.		2	
	C.68	Describe how you will provide TennCare with sufficient system access during and subsequent to readiness review to perform necessary tests, as required in Attachment 6.1, Section 2.23.9.		2	
	C.69	Describe how you plan to deliver and/or provide access (on a secure and read-only basis) to management information to authorized TennCare staff.		1	
	C.70	Describe the methodologies you currently follow for: identifying, developing and finalizing System requirements; managing the life cycle of application development within your enterprise and that of your Systems contractors; and conducting technical and usability testing of Systems before their implementation.		1	
	C.71	Using the instructions and format in RFP Attachment 6.4, provide a detailed profile of the key information systems within your span of control.		6	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.72 Provide a sample System availability and performance report from a current contract/program.		1	
	C.73 Following the instructions and format in RFP Attachment 6.5 provide a profile of your Information Systems (IS) organization.		2	
	Administration Requirements (Section 2.24 of RFP Attachment 6.1) (Responses to items C.74 through C.75 shall not exceed 5 pages.)			
	C.74 Please describe how you will ensure compliance with the requirements in Attachment 6.1, Section 2.14. As part of your response, provide your proposed approach to the development of a contract compliance plan.		7	
	C.75 Please describe your proposed performance goals to assess the quality of medical record keeping.		4	
	Monitoring (Section 2.25 of RFP Attachment 6.1) (Responses to item C.76 shall not exceed 3 pages.)			
	C.76 Describe how you will ensure that all monitoring requirements, as stated in Attachment 6.1, Section 2.25, are fulfilled. Your description should include your oversight process to ensure provider and subcontractor compliance.		7	
	Personnel Requirements (Section 2.29 of RFP Attachment 6.1) (Responses to items C.77 through C.79 shall not exceed 5 pages.)			
	C.77 Describe your monitoring functions to ensure that all staff, providers, and subcontractors meet all applicable laws and regulations. Your description should include how monitoring will occur, the individuals responsible for monitoring, any reporting requirements, the penalties for noncompliance and the timeframes required for staff, provider, and subcontractor compliance.		7	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.78 Identify those functions you anticipate providing in Tennessee and those out-of-State. Also, describe your plan to coordinate functions between all sites both in and out of Tennessee and how you will provide sufficient oversight of the entire organization.		6	
	C.79 In table format, please provide your proposed staffing plan, including proposed staffing numbers for functions described in Attachment 6.1, Sections 2.29.1.4, 2.29.1.5 and 2.29.1.6.		7	
	Scenarios (Responses to items C.80 through C.84 shall not exceed 15 pages.)			
	C.80 The member is a 38-year-old male who has lost his job and as a result may potentially lose his housing. He has never been diagnosed with a mental illness however he begins to feel suicidal. He expresses his suicidal thoughts, including his method, to his family. His family contacts mobile crisis for assistance. Behavioral health crisis services makes a determination that he meets criteria for hospitalization. How would you ensure that behavioral health crisis services responds appropriately to this emergency? How would you ensure that coordination between the behavioral health crisis services provider and the hospital is efficient? Once hospitalized, how would you ensure that he receives appropriate services following discharge? How would you ensure that he is assessed for mental health case management services?		7	
	C.81 The member is a 36 year old female and has been a chronic substance abuse user since age 12. She has also been diagnosed as having Bipolar I Disorder. How would you ensure that the co-occurring substance abuse and mental health needs of this individual are addressed?		7	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.82 The member is a 4 year old girl. The child is severely underweight for her age and small in stature. Screening tests have revealed that her condition may be due to a genetic disorder; however, additional tests are warranted to reach a definitive conclusion. Her mother has repeatedly failed to follow through on referrals and routine appointments. What measures would you take to motivate the mother to adhere to periodicity schedules and to follow through on referrals?		7	
	C.83 The member is a 14 year old with Autistic Disorder and has a Full Scale IQ of 65. He is in the 7th grade in the public school system and has an individual education plan (IEP). What services would you consider and what measures would you take to coordinate services for this child? How would you avoid and prevent duplicative delivery of and billing for services?		7	
	C.84 The member is a 22 year old young woman who is in her 2nd trimester of pregnancy. She lives in a very rural, remote area of the state and her family does not own a car or have access to adequate public transportation. How would you ensure that this young woman receives all necessary OB-GYN services, in keeping with required access standards?		7	

Proposal Page # (to be completed by Proposer)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	Key Actuarial Assumptions (Responses to item C.85 shall not exceed 5 pages.)			
	C.85 Please specify the percentage change in utilization upon which your cost proposal is predicated utilizing the format provided in Attachment 6.6. In addition, please provide a narrative explanation of how your organization will achieve the percentage change in utilization indicated in your completed Attachment 6.6 including key operational activities upon which the percentage change is dependent (e.g. utilization management, case management, etc.). **Do NOT provide any information other than the anticipated impact on utilization, which shall be stated as a percentage. The inclusion, reference or mention of the Proposer's cost proposal or its contents including any dollar amount in response to this question will result in the disqualification of the Proposer's entire proposal.**		**50**	
			Total Raw Weighted Score: *(sum of Raw Weighted Scores above)*	
Total Raw Weighted Score / **maximum possible raw weighted score** *(i.e., 5 x the sum of item weights above)*			**X 500** *(maximum Section score)* **= SCORE:**	

ATTACHMENT 6.4
INFORMATION SYSTEMS PROFILE

Please provide a detailed profile of the key information systems within your span of control that will be used to perform the following:

a) Maintenance of member enrollment and other information, both current and historical;
b) Maintenance of claims information (and/or equivalent encounter information for providers with whom the MCO has a capitated arrangement), both current and historical;
c) Maintenance of authorization and care coordination information, both current and historical;
d) Maintenance of provider network and other information;
e) Maintenance of EPSDT (TENNderCare)-specific information;
f) Maintenance of information related to enrollee health status and outcomes;
g) Maintenance of MCO financial data;
h) Maintenance of information related to interactions with enrollees and providers, including complaints and appeals;
i) Maintenance of internal operations data, e.g. call center statistics and system availability;
j) Maintenance of records of serious incidents;
k) Maintenance of data collected via satisfaction surveys;
l) Maintenance of information related to program integrity and compliance activities;
m) Generation of the reports stipulated in Section 2.30 of the *pro forma* contract;
n) Processing of claims; and
o) Processing of transactions between the MCO and its members and between the MCO and providers including but not limited to: provider applications for network participation; enrollee and/or provider inquiries, suggestions, complaints, etc.

In the Systems profile, please indicate whether these systems will be:

a) Used solely for the administration and management of TennCare activities, or
b) Multi-client Systems, where information and transactions related to TennCare will be captured and/or processed along with information and transactions of other clients.

Additionally, as part of your Systems profile indicate:

a) Name and version/release level of each application (e.g. Amisys 3000, Diamond 950 release 8.0, etc.);
b) Operating hardware vendor and model/series ID (e.g. SUN Microsystems Sunfire 4800 Series);
c) Operating system vendor and ID along with version/release level (e.g. SUN Microsystems Solaris version 8); and
d) Whether operation of the application and/or operating hardware is being outsourced to a third party; if so, indicate the third party to which the operation is or will be outsourced.

Finally, identify whether any of the aforementioned applications will be undergoing a major upgrade or whether any of these applications will be replaced (and by what application, if known), in the next eighteen months.

INFORMATION SYSTEMS PROFILE: FORMAT

	System/Information Management Function:	APPLICATION						OPERATING ENVIRONMENT					
		App. Mgt. Outsourced? (Yes/No)	If Yes, to Whom ?	Dedicated or Multi Client?	If Multi-Client, Indicate Other Users	Name of Application(s):	App. Version/ Release Level:	Optg. Env. Mgt. Outsourced? (Yes/No)	If Yes, to Whom ?	Operating Hardware Vendor	Optg. Hardware Model/ Series ID	Operating System Vendor	Optg. System Model/ Series ID
1	Maintenance of member enrollment and other information, both current and historical												
2	Maintenance of claims information, and/or encounter information for providers with whom the MCO has a capitated arrangement, both current and historical												
3	Maintenance of authorization and care coordination information, both current and historical												
4	Maintenance of provider network and other information												
5	Maintenance of EPSDT-specific information												
6	Maintenance of information related to member health status and outcomes												
7	Maintenance of MCO financial data												
8	Maintenance of information related to interactions with members and providers, including complaints and appeals												

INFORMATION SYSTEMS PROFILE: FORMAT

		APPLICATION						OPERATING ENVIRONMENT					
	System/Information Management Function:	App. Mgt. Outsourced? (Yes/No)	If Yes, to Whom ?	Dedicated or Multi Client?	If Multi-Client, Indicate Other Users	Name of Application(s):	App. Version/ Release Level:	Optg. Env. Mgt. Outsourced? (Yes/No)	If Yes, to Whom ?	Operating Hardware Vendor	Optg. Hardware Model/ Series ID	Operating System Vendor	Optg. System Model/ Series ID
9	Maintenance of internal operations data, e.g. call center statistics and system availability												
10	Maintenance of information related to reported incidents that may have compromised patient safety												
11	Maintenance of data collected via satisfaction surveys												
12	Maintenance of information related to program integrity and compliance activities												
13	Generation of the reports stipulated in the contract												
14	Processing of claims including electronic submission and, where applicable, automated and/or rules-based adjudication												
15	Processing of transactions between the MCO and its members and between the MCO and providers including but not limited to: provider applications for network participation; enrollee and/or provider inquiries, suggestions, complaints etc) - "workflow"												

ATTACHMENT 6.5

INFORMATION SYSTEMS ORGANIZATIONAL PROFILE

Provide a profile of your Information Systems (IS) organization using the following table. Include information on whether there are (or will be) in-house or outsourced IS personnel within your span of control, including a roster by job type/class of: number of in-house vs. outsourced IS staff, average years of experience in the IS field, average number of years working in your IS organization, and number of staff within the IS organization that support TennCare systems.

IS ORGANIZATIONAL PROFILE - PERSONNEL ROSTER TABLE EXAMPLE

Job Class:	# In-House FTEs	Avg. Years of Experience in Field	Avg. Years in Org.	# Outsourced FTEs	Avg. Years of Experience in Field	Avg. Years in Org.	# FTEs (In-House and Outsourced) Supporting TennCare Systems
System Analysis							
Application Programming							
Network Administration							
Data Comm. Analysis/Engineering							
Job Control/Computer Operations							
Etc.							

ATTACHMENT 6.6
SUMMARY OF KEY UTILIZATION ASSUMPTIONS

		Managed Care Utilization Impact (State as a Percentage)
Home Health Care		
IP - Maternity		
IP - Newborn		
IP - Medical		
IP - Surgery		
IP - Other		
OP - Emergency Room		
OP - Laboratory		
OP - Radiology		
OP - Surgery		
OP - Other		
Prof - Evaluation & Management		
Prof - Maternity		
Prof - Surgery		
Prof - DME/Supplies		
Prof - Lab		
Prof - Radiology		
Prof - Transportation		
Prof - Evaluation & Management		
Prof - Maternity		
Prof - Surgery		
Prof - DME/Supplies		
Prof - Lab		
Prof - Radiology		
Prof - Transportation		
Prof - Other		
Prof - Evaluation & Management		
Prof - Maternity		
NPMH - Inpatient (FFS)		
NPMH - Inpatient (RMHI)		
NPMH - Outpatient		
NPMH - Case Rates		
NPMH - Grants		
NPMH - In-Home Services		
NPMH - Supported Housing		
NPMH - 23 Hour		
NPMH - Intensive Outpatient		
NPMH - Partial Hospitalization		
NPMH - Transportation		

Actuary Signature _____

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ATTACHMENT 6.7
COST SCORING AND COST PROPOSAL FORMS

Cost Scoring and Cost Proposal Forms - Scoring Summary
Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: Vendor A - Midpoint Rate

Aid Category	Age Group	(1) Member Months	(2) Capitation Rate	(3) = (1) x (2) Total
Medicaid (TANF & Related)	Age Under 1	78,672		$ -
	Age 1 - 13	1,418,489		$ -
	Age 14 - 20 Female	268,804		$ -
	Age 14 - 20 Male	214,018		$ -
	Age 21 - 44 Female	624,958		$ -
	Age 21 - 44 Male	117,795		$ -
	Age 45 - 64	115,001		$ -
	Age 65+	22,305		$ -
Uninsured/Uninsurable	Age Under 1	7		$ -
	Age 1 - 13	97,544		$ -
	Age 14 - 19 Female	28,569		$ -
	Age 14 - 19 Male	30,138		$ -
Disabled	Age <21	20,972		$ -
	Age 21+	336,119		$ -
Duals	All Ages	737,005		$ -
Waiver Duals	All Ages	19,787		$ -
State Only & Judicials	All Ages	14,509	$ 408.49	$ 5,926,747
Priority Add-On	Age <21	82,418	$ 351.48	$ 28,968,241
	Age 21+	177,939	$ 434.95	$ 77,395,485

A. Weighted Average	Total 2007 Calendar Year	4,144,692	$ -	

	Points	
B. Minimum Capitation Rate	300	$ 818,018,393
C. Maximum Capitation Rate	0	$ 922,448,958
D. Cost Spread (B) - (C)	300	$ 104,430,565

E. Baseline Points Awarded = 300 * ((C-A)/D)	

Note: The rates and/or risk option recorded on this page shall constitute the proposer's cost proposal for evaluation and shall prevail should there be any discrepancy resulting from mathematical errors or the transcription of rates from the supporting pages. The supporting pages for each rate cell must be completed as well. The shaded areas will be completed by the State.

Cost Scoring and Cost Proposal Forms - Scoring Summary
Rates Effective January 1, 2007 through December 31, 2007

Level Of Risk Proposed

Risk Option	Risk Sharing - Losses	Risk Sharing - Gains	% of Capitation Points Retained Awarded	Choice by Proposer (Check Risk Choice)
Option 1	TennCare would cover 50%	TennCare would receive 75%	50%	
Option 2	TennCare would cover 25%	TennCare would receive 50%	75%	
Option 3	TennCare would cover 0%	TennCare would receive 0%	100%	

F. Level of Risk Proposed	**INSERT OPTION**		

G. Final Cost Points Awarded = (E) x (F)	**-**

Note: The rates and/or risk option recorded on this page shall constitute the proposer's cost proposal for evaluation and shall prevail should there be any discrepancy resulting from mathematical errors or the transcription of rates from the supporting pages. The supporting pages for each rate cell must be completed as well. The shaded areas will be completed by the State.

Authorized Signature _____
Printed Name _____
Title _____
Date _____
Actuary Signature _____
Actuary Name (Printed) _____
Actuary's Firm, if any _____
Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Medicaid (TANF & Related)

Age/Sex Category: Age Under 1

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

Authorized Signature _____

Printed Name _____

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Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Medicaid (TANF & Related)

Age/Sex Category: Age 1 - 13

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

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Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Medicaid (TANF & Related)

Age/Sex Category: Age 14 - 20 Female

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

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Date _____

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Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Medicaid (TANF & Related)

Age/Sex Category: Age 14 - 20 Male

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

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Printed Name _____

Title _____

Date _____

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Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Medicaid (TANF & Related)

Age/Sex Category: Age 21 - 44 Female

	Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care			$ -
2	IP - Maternity			$ -
3	IP - Newborn			$ -
4	IP - Medical			$ -
5	IP - Surgery			$ -
6	IP - Other			$ -
7	Subtotal - Inpatient (Sum of 2-6)			$ -
8	OP - Emergency Room			$ -
9	OP - Laboratory			$ -
10	OP - Radiology			$ -
11	OP - Surgery			$ -
12	OP - Other			$ -
13	Subtotal - Outpatient (Sum of 8-12)			$ -
14	Prof - Evaluation & Management			$ -
15	Prof - Maternity			$ -
16	Prof - Surgery			$ -
17	Prof - DME/Supplies			$ -
18	Prof - Lab			$ -
19	Prof - Radiology			$ -
20	Prof - Transportation			$ -
21	Prof - Other			$ -
22	Subtotal - Professional (Sum of 14-21)			$ -
23	NPMH - Inpatient			$ -
24	NPMH - Outpatient			$ -
25	NPMH - Case Rates			$ -
26	NPMH - Grants			$ -
27	NPMH - In-Home Services			$ -
28	NPMH - Supported Housing			$ -
29	NPMH - 23 Hour			$ -
30	NPMH - Intensive Outpatient			$ -
31	NPMH - Partial Hospitalization			$ -
32	NPMH - Transportation			$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)			$ -
34	Total Covered Services			$ -
35	Third Party Liability (TPL) Recoveries	0%	% Of Capitation Rate	$ -
36	Administrative Rate	0%	% Of Capitation Rate	$ -
37	Premium Tax	2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**			**$ -**

Authorized Signature _____

Printed Name _____

Title _____

Date _____

Actuary Signature _____

Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Medicaid (TANF & Related)

Age/Sex Category: Age 21 - 44 Male

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

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Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Medicaid (TANF & Related)

Age/Sex Category: Age 45 - 64

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

Authorized Signature _____

Printed Name _____

Title _____

Date _____

Actuary Signature _____

Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Medicaid (TANF & Related)

Age/Sex Category: Age 65+

	Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care			$ -
2	IP - Maternity			$ -
3	IP - Newborn			$ -
4	IP - Medical			$ -
5	IP - Surgery			$ -
6	IP - Other			$ -
7	Subtotal - Inpatient (Sum of 2-6)			$ -
8	OP - Emergency Room			$ -
9	OP - Laboratory			$ -
10	OP - Radiology			$ -
11	OP - Surgery			$ -
12	OP - Other			$ -
13	Subtotal - Outpatient (Sum of 8-12)			$ -
14	Prof - Evaluation & Management			$ -
15	Prof - Maternity			$ -
16	Prof - Surgery			$ -
17	Prof - DME/Supplies			$ -
18	Prof - Lab			$ -
19	Prof - Radiology			$ -
20	Prof - Transportation			$ -
21	Prof - Other			$ -
22	Subtotal - Professional (Sum of 14-21)			$ -
23	NPMH - Inpatient			$ -
24	NPMH - Outpatient			$ -
25	NPMH - Case Rates			$ -
26	NPMH - Grants			$ -
27	NPMH - In-Home Services			$ -
28	NPMH - Supported Housing			$ -
29	NPMH - 23 Hour			$ -
30	NPMH - Intensive Outpatient			$ -
31	NPMH - Partial Hospitalization			$ -
32	NPMH - Transportation			$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)			$ -
34	Total Covered Services			$ -
35	Third Party Liability (TPL) Recoveries	0%	% Of Capitation Rate	$ -
36	Administrative Rate	0%	% Of Capitation Rate	$ -
37	Premium Tax	2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**			**$ -**

Authorized Signature _____

Printed Name _____

Title _____

Date _____

Actuary Signature _____

Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Uninsured/Uninsurable

Age/Sex Category: Age Under 1

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

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Date _____

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Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Uninsured/Uninsurable

Age/Sex Category: Age 1 - 13

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

Authorized Signature _____

Printed Name _____

Title _____

Date _____

Actuary Signature _____

Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Uninsured/Uninsurable

Age/Sex Category: Age 14 - 19 Female

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

Authorized Signature _____

Printed Name _____

Title _____

Date _____

Actuary Signature _____

Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Uninsured/Uninsurable

Age/Sex Category: Age 14 - 19 Male

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

Authorized Signature _____

Printed Name _____

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Date _____

Actuary Signature _____

Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Disabled

Age/Sex Category: Age <21

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

Authorized Signature _____

Printed Name _____

Title _____

Date _____

Actuary Signature _____

Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Disabled

Age/Sex Category: Age 21+

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

Authorized Signature _____

Printed Name _____

Title _____

Date _____

Actuary Signature _____

Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Duals

Age/Sex Category: All Ages

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

Authorized Signature _____

Printed Name _____

Title _____

Date _____

Actuary Signature _____

Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name: _____

Category Of Aid: Waiver Duals

Age/Sex Category: All Ages

	Service Category	Utilization Rates Per 1,000		Expenditure Per Unit	Paid Expenditures PMPM
1	Home Health Care				$ -
2	IP - Maternity				$ -
3	IP - Newborn				$ -
4	IP - Medical				$ -
5	IP - Surgery				$ -
6	IP - Other				$ -
7	Subtotal - Inpatient (Sum of 2-6)				$ -
8	OP - Emergency Room				$ -
9	OP - Laboratory				$ -
10	OP - Radiology				$ -
11	OP - Surgery				$ -
12	OP - Other				$ -
13	Subtotal - Outpatient (Sum of 8-12)				$ -
14	Prof - Evaluation & Management				$ -
15	Prof - Maternity				$ -
16	Prof - Surgery				$ -
17	Prof - DME/Supplies				$ -
18	Prof - Lab				$ -
19	Prof - Radiology				$ -
20	Prof - Transportation				$ -
21	Prof - Other				$ -
22	Subtotal - Professional (Sum of 14-21)				$ -
23	NPMH - Inpatient				$ -
24	NPMH - Outpatient				$ -
25	NPMH - Case Rates				$ -
26	NPMH - Grants				$ -
27	NPMH - In-Home Services				$ -
28	NPMH - Supported Housing				$ -
29	NPMH - 23 Hour				$ -
30	NPMH - Intensive Outpatient				$ -
31	NPMH - Partial Hospitalization				$ -
32	NPMH - Transportation				$ -
33	Subtotal - Non-Priority Mental Health (Sum of 23-32)				$ -
34	Total Covered Services				$ -
35	Third Party Liability (TPL) Recoveries		0%	% Of Capitation Rate	$ -
36	Administrative Rate		0%	% Of Capitation Rate	$ -
37	Premium Tax		2%	% Of Capitation Rate	$ -
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**				**$ -**

Authorized Signature _____

Printed Name _____

Title _____

Date _____

Actuary Signature _____

Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name:
Category Of Aid: State Only & Judicials
Age/Sex Category: All Ages

	Service Category			Paid Expenditures PMPM
27	MH - Inpatient			$ 214.59
28	MH - Outpatient			$ 14.30
29	MH - Case Rates			$ 90.44
30	MH - Grants			$ 29.74
31	MH - In-Home Services			$ 0.70
32	MH - Supported Housing			$ 4.35
33	MH - 23 Hour			$ 0.07
34	MH - Intensive Outpatient			$ 9.65
35	MH - Partial Hospitalization			$ 0.67
36	MH - Transportation			$ 4.61
37	Subtotal - Mental Health (Sum of 23-32)			$ 369.09
34	Total Covered Services			$ 369.09
35	Third Party Liability (TPL) Recoveries			$ (5.54)
36	Administrative Rate			$ 36.76
37	Premium Tax			$ 8.17
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**			* **$ 408.49**

Authorized Signature
Printed Name
Title
Date
Actuary Signature
Actuary Name (Printed)
Actuary's Firm, if any
Date

* See data book for additional detail

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name:
Category Of Aid: BHO Priority
Age/Sex Category: Age <21

	Service Category			Paid Expenditures PMPM
27	PMH - Inpatient			$ 98.81
28	PMH - Outpatient			$ 11.39
29	PMH - Case Rates			$ 156.05
30	PMH - Grants			$ 20.80
31	PMH - In-Home Services			$ 21.20
32	PMH - Supported Housing			$ 1.27
33	PMH - 23 Hour			$ -
34	PMH - Intensive Outpatient			$ 3.16
35	PMH - Partial Hospitalization			$ 0.13
36	PMH - Transportation			$ 4.78
37	Subtotal - Priority Mental Health (Sum of 23-32)			$ 317.58
34	Total Covered Services			$ 317.58
35	Third Party Liability (TPL) Recoveries			$ (4.76)
36	Administrative Rate			$ 31.63
37	Premium Tax			$ 7.03
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**			*** $ 351.48**

Authorized Signature
Printed Name
Title
Date
Actuary Signature
Actuary Name (Printed)
Actuary's Firm, if any
Date

* See data book for additional detail

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Managed Care Organization Name:
Category Of Aid: BHO Priority
Age/Sex Category: Age 21+

	Service Category			Paid Expenditures PMPM
27	PMH - Inpatient			$ 120.65
28	PMH - Outpatient			$ 17.92
29	PMH - Case Rates			$ 150.87
30	PMH - Grants			$ 47.17
31	PMH - In-Home Services			$ -
32	PMH - Supported Housing			$ 30.29
33	PMH - 23 Hour			$ 0.04
34	PMH - Intensive Outpatient			$ 4.46
35	PMH - Partial Hospitalization			$ 1.06
36	PMH - Transportation			$ 20.55
37	Subtotal - Priority Mental Health (Sum of 23-32)			$ 393.00
34	Total Covered Services			$ 393.00
35	Third Party Liability (TPL) Recoveries			$ (5.90)
36	Admin %			$ 39.15
37	Premium Tax			$ 8.70
38	**CAPITATION RATE = [34]+[35]+[36]+[37]**			*** $ 434.95**

Authorized Signature
Printed Name
Title
Date
Actuary Signature
Actuary Name (Printed)
Actuary's Firm, if any
Date

* See data book for additional detail

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Proposed Level Of Risk

Managed Care Organization Name: _____

Level Of Risk (please select one):

Option 1 _____
TennCare covers 50% of losses
TennCare receives 75% of gains

Option 2 _____
TennCare covers 25% of losses
TennCare receives 50% of gains

Option 3 _____
TennCare covers 0% of losses
TennCare receives 0% of gains

Comments

Authorized Signature _____
Printed Name _____
Title _____
Date _____
Actuary Signature _____
Actuary Name (Printed) _____
Actuary's Firm, if any _____
Date _____

Cost Scoring and Cost Proposal Forms

Rates Effective January 1, 2007 through December 31, 2007

Acceptance Of Health Status Risk Adjustment

Managed Care Organization Name: _____

Risk Adjustment:

TennCare will analyze the risk profile enrolled in each MCO using the Medicaid-ACG Risk Classification System developed by John's Hopkins University. Each members will be assigned an ACG which has a calculated relative value that reflects anticipated utilization of services. These relative weights were developed using TennCare data over the last two fiscal years. If the risk profile for any MCO deviates from the regional profile by more than 3%, each MCO's actual reimbursement rate will be proportionally adjusted. The overall risk adjustment will have no financial impact on total payments in aggregate from TennCare to all MCOs.

Authorized Signature _____

Printed Name _____

Title _____

Date _____

Actuary Signature _____

Actuary Name (Printed) _____

Actuary's Firm, if any _____

Date _____

ATTACHMENT 6.8

State of Tennessee

Department of Finance and Administration

Bureau Of TennCare

Middle Tennessee Data Book

Fiscal Years 2004 and 2005

Prepared by:

Aon Consulting, Inc.

Aon Consulting, Inc.
One Piedmont Center
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Atlanta, GA 30305
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A. Overview of Report

About the Data Book

This data book summarizes, for the Middle Region, the cost, utilization, and membership history for the categories of aid and categories of service that will be covered by MCOs other than TennCare Select in Middle Tennessee. The data book should enable interested offerors to forecast program membership, utilization and service costs as they prepare their bids to TennCare.

Two fiscal years of incurred claims are included: fiscal years 2004 and 2005. This baseline data is appropriately adjusted and projected forward to calendar year 2007. Details of the adjustments applied as well as the methodologies and assumptions used in the projection are included in sections D and E of this report.

Although pharmacy benefits are not part of the capitation rate, Aon has included an exhibit showing the utilization and cost since the August 1, 2005 benefits changes.

Counties Included In the Data Book

This data book and accompanying capitation rates cover plan members who live in Middle Tennessee Region only. Below is a complete listing of all the covered counties:

Bedford	Humphreys	Putnam
Cannon	Jackson	Robertson
Cheatham	Lawrence	Rutherford
Clay	Lewis	Smith
Coffee	Lincoln	Stewart
Cumberland	Macon	Sumner
Davidson	Marshall	Trousdale
DeKalb	Maury	Van Buren
Dickson	Moore	Warren
Fentress	Montgomery	Wayne
Giles	Overton	White
Hickman	Perry	Williamson
Houston	Pickett	Wilson

B. Data Sources

All available data options were researched, considered and analyzed in order to develop the most credible and actuarially sound basis for forecasting TennCare enrollment and service costs into the contract period. There are various reimbursement arrangements and sources of data that are detailed in this section. Aon has tried to be as detailed as possible to assist vendors in developing actuarially sound capitation rates. It is extremely important to the State to have an open rate development process.

Eligibility Data

The Bureau of TennCare provided detailed eligibility data for the period July, 2002 through November, 2005. From this data, the last two fiscal years of information were selected. This was consistent with the most recent baseline encounter data available. Aon calculated member months of eligibility from this data, segregated by aid category, demographic group, health plan, region and month. The calculations include counts of fractional months for members who started or ended their eligibility in the middle of the month or had any type of status change during the month.

Aon also received a detailed listing of 191,000 members who were to be disenrolled as a result of the new reforms to the TennCare program. There were only a small percentage of these members still enrolled as of January 2006. Those who were currently disenrolled, as well as those remaining to be disenrolled, had their data removed. Others that were re-classified as Medicaid members, approximately 14,000, had their historical eligibility and claims experience mapped to their new aid category. Moving their claims and exposure more accurately represents experience within the rate cells.

The Bureau also provided a file detailing each enrollee's Severely and Permanently Mentally Ill/Seriously Emotionally Disturbed (SPMI/SED - priority) status since enrollment in the Partners program. An individual assessed as SPMI/SED remains in that category for 12 months before requiring a re-assessment. This information was used to segregate the behavioral health data between priority and non-priority members. To verify the accuracy of the assessment date and resulting exposure, Aon received summary eligibility data from Advocare for the period October 1, 2003 through December 31, 2005. The summary report was broken down by age group, priority status, and contract. Results varied by less than 1%.

Final figures were compared to self-reported reports produced by the MCOs and BHOs.

Medical Fund Target Reports and Medical Loss Ratio Reports

MCOs are required to submit monthly reports that show how their experience compares to the medical fund targets. This was historically a loss ratio report, but the fund targets reported were not relevant to the MCOs due to their movement to an ASO relationship. These reports are valuable as a check to the claims data received. A separate report was produced for the Middle Tennessee region.

BHOs continue to submit a medical loss ratio report that compares their experience to their capitation or funding level. These reports are not available for Middle Tennessee only, so the statewide report was utilized.

Aon received the MFT and MLR Reports for the period July 2002 through November 2005.

TennCare Claims and Encounter Data

Detailed claims and encounter data were received from TennCare Select and Windsor Health Plan of TN, Inc. These two MCOs currently service TennCare members in the Middle Tennessee Region. Aon received paid claims extracts for the period July 1, 2003 through November 30, 2005.

To ensure the completeness of the data, we reconciled the encounter data for each plan to the paid expenditure data reported in the monthly Medical Fund Target reports that are submitted to the Bureau of TennCare and the Department of Commerce and Insurance. Results varied by less than 1% in total.

TennCare Partners Claims and Encounter Data

Data for behavioral health benefits was received from three main sources: Advocare, the current behavioral health service provider; the Tennessee Department of Mental Health and Developmental Disabilities (TMHDD); and the Bureau of TennCare.

Submitted encounter data must be supplemented with other data sources because many services are capitated or paid through other aggregated payment methods. Many of these sources do not have adequate payment information available within the encounter data. Consequently, utilization and service cost data was not consistently available for many of the service categories. Each source is discussed in greater detail below.

Fee-For-Service Encounter Data

Detailed FFS encounter data was received directly from Advocare. Hospital data was reported in the standard UB92 format and includes inpatient and outpatient detailed encounter data with dates of payment from July 1, 2001 through December 31, 2005. CMS 1500 professional detailed encounter data was also received for the same period.

Advocare provided a detailed breakout of the FFS data into Inpatient, Outpatient, In Home Services, Supported Housing, 23-Hour, Intensive Outpatient, Partial Hospitalization and Transportation categories. This ensured the mapping algorithms appropriately categorized each service type and reconciled to the MLR report.

Community Mental Health Centers (CMHCs)

CMHCs are paid case rates for their services; consequently payment information is not readily available from the encounter data. The current vendor provided detailed payments by person, by month, for services paid from July 1, 2002 through January 31, 2006. The total amount was reconciled to the MLR report.

Regional Mental Health Institutes (RMHI)

RMHIs are paid an agreed upon amount for a specified number of days. When the specified number of days is exceeded, additional payments are made to the Regional Mental Health Institutes. Aon received from TMHDD a detailed admission report by SSN for Fiscal Years 2004, 2005 and year-to-date. A per diem was tied to each admission record, resulting in a financial allocation. Annual reports were also received and used to verify the final calculations.

Tennessee Christian Medical Center (TCMC)

TCMC data was on the MLRs as other non-FFS inpatient. These hospitals were paid a capitation rate with anticipated utilization expectations. Encounter data was available on this component and Aon allocated the capitation by days of service utilized. This agreement has since been terminated effective 7/1/2005. This is only a small percentage of the behavioral health inpatient spend.

Grants

Grant payments for Fiscal Years 2004 and 2005 were provided to Aon from the current BHO. Information as to whether the services by grant type were provided to adults only, children only or both adults and children was also provided. Incorporating this information, the dollars were spread over the appropriate demographic rate cells assuming the same distribution of services as the other behavioral services. These amounts are on a per member per month basis and have no associated utilization component.

Below is a summary of the grant categories reported for calendar year 2005:

C & Y Case Coordination	Hospital Admission Diversion
Child Psychologist	Crisis Continuum Services
Community & Consumer Outreach	CM @ Nashville Rescue Mission
Crisis/Respite	Jail Care Coordination
CTT	Journey of Hope Program
Housing Developer	Childrens' Respite Network
Mobile Crisis Team	Bridges Program
PACT	Walk-in Center
Sex Offender Program	Planned Respite
Case Rate Enhancement	Teen Screen Program
Psychiatric Rehabilitation	CTT Study
Supervised Residential	Triage Center
SA/MH Dual Program	

Crisis services are provided for individuals other than those eligible for TennCare Partners. Expenditures reported on the MLR reports include payments for all users and are not limited to those eligible under the Partners program. Based on discussions with TDMHDD staff, we have assumed that 80% of the payments are attributable to the enrolled population.

Pharmacy Claims and Encounter Data

Although Aon has a historical database of pharmaceutical claims, major changes in the program make much of this information unusable. To accurately assess the current pharmaceutical spend, Aon relied on incurred data after September 1, 2005. Pharmacy claims were collected from the TennCare Bureau for the period September 2005 through December 2005. The TennCare Bureau receives this information directly from the pharmacy benefit manager, currently FirstHealth. This data was verified against the weekly invoices payments to the PBM.

Note that the pharmacy component is carved out of this contract and included in this data book for information only.

Invoices

Aon received detailed invoices form the TennCare Bureau for all the major service groups, including the MCOs, BHOs, and Pharmacy. These invoices were used to validate both the claims data and MFT/MLR reports utilized. The validation produced no major inconsistencies. The invoices were available from July, 2003 through December, 2005.

Disclaimer

The data within this book, like most Medicaid and SCHIP program data, may contain manual or systematic errors that may have occurred without the State's knowledge. The user of this data book is cautioned against relying solely upon the data contained herein. The State provides no guarantee, either written or implied, that this book is 100 percent accurate or error-free.

C. Data Organization and Presentation

All available data options were researched, considered and analyzed in order to develop the most credible and sound basis for forecasting TennCare enrollment and service costs for the Middle Region.

Fee-for-service (FFS) encounter data from the MCOs in Middle Tennessee was used for the development of the raw database supplied in this data book. The data in the raw database was used in the development of the actuarially sound capitation rate ranges addressed in section D of this report. The entire process requires that the data be adjusted appropriately for claims completion, trend, any program changes, recent disenrollments and other factors.

The data book contains summaries of the Middle Region's FFS cost, utilization and membership experience broken down by time period, category of aid, category or service, and age/sex rate cell.

The FFS data contained in this book is organized and presented as a function of the:

- Aid Groups
- Age & Gender, and
- Service Categories

This level of detail has been provided to facilitate a more specific and accurate portrayal of the recent experience associated with TennCare members.

Aid Groups

TennCare is divided into TennCare Medicaid and TennCare Standard, the expansion population. Below is a brief summary of each category.

TennCare Medicaid
TennCare Medicaid is available for both children and adults. There are many different eligibility groups under TennCare Medicaid. In general, the primary groups covered by TennCare Medicaid will include:

- Children under age 21
- Women who are pregnant
- Single parents or caretakers of a minor child
  (The child must live with the covered adult and be a close relative.)
- Two-parent families with a minor child living at home when one of the parents:
  - Has lost their job or had their work hours cut, or
  - Has a health or behavioral health problem expected to last 30 days

- Women in need of treatment for breast or cervical cancer
- People who get an SSI check (Supplemental Security Income)

- A person who:

  - Lives in a nursing home and has income below $1,737 per month, **or**
  - Gets other long term care services that TennCare pays for

If any of the above are true, there are additional requirements relating to income, size of household, financial resources, etc.

TennCare Standard
TennCare Standard is the expansion population. The most recent disenrollment has left this category only available to children under age 19 who are already enrolled in TennCare Medicaid and:

- who lack access to group health insurance through their parents' employer, or
- their time of eligibility is ending and they will no longer qualify for TennCare Medicaid.

DHS will determine if they qualify for TennCare Standard. There are two ways (Uninsured and Medically Eligible) they can qualify and be able to keep their healthcare benefits:

1. Uninsured
To qualify as uninsured:

- the child's eligibility through TennCare Medicaid must be ending,
- the child must be under the age of 19,
- the child lacks access to group health insurance through their own job or a parent's job, and
- the child's family income is below 200 percent of poverty.

If the family's income is above 200 percent of poverty, the child may qualify for TennCare Standard as Medically Eligible.

2. Medically Eligible
To qualify as "medically eligible":

- the child must be under the age of 19,
- the child must have a health condition which makes the child "uninsurable", (or unable to access private health insurance because of their health condition)
- the child lacks access to group health insurance through their job or a parent's job.

Given the above eligibility criteria, Aon has developed rates separately for each of the major aid categories summarized below:

Aid Category
Medicaid (TANF & Related)
Uninsured/Uninsurable
Disabled
Duals
Waiver Duals
State Only & Judicials
Priority add-on

The "Priority add-on" rate is an add-on to the MCO capitation rate and is for behavioral health services for priority members only. The "State Only & Judicials" rate is for priority and non-priority behavioral health services only.

Age and Gender

In addition to the eligibility categories, per capita costs will vary significantly by demographic group. Age and gender groupings are used for most eligibility categories. When variation is within minimal, the cells are merged together. The "Duals", "Waiver Duals" and "State Only/Judicials" categories are the only groups without an age breakout. Below is a summary of the demographic groups:

Age Groups	Gender Split
Age Under 1	Combined
Age 1 – 13	Combined
Age 14 – 20	Male/Female
Age 21 – 44	Male/Female
Age 45 – 64	Combined
Age 65+	Combined

Aid categories in the expansion population (Uninsured and Uninsurable) do not have any ages over 20 enrolled. Due to utilization patterns in the data, Disabled and Priority add-on rate cells are only divided by children (<21) and adults (21+) categories.

The combination of aid category and age groups result in the following rate cells:

Aid Category	Age Group
Medicaid (TANF & Related)	Age Under 1
	Age 1 – 13
	Age 14 - 20 Female
	Age 14 - 20 Male
	Age 21 - 44 Female
	Age 21 - 44 Male
	Age 45 - 64
	Age 65+
Uninsured/Uninsurable	Age Under 1
	Age 1 - 13
	Age 14 - 19 Female
	Age 14 – 19 Male
Disabled	Age <21
	Age 21+
Duals	All Ages
Waiver Duals	All Ages
State Only & Judicials	All Ages
Priority add-on	Age <21
	Age 21+

Note that the Uninsured/Uninsurable rate is the Medicaid (TANF & Related) rate for Age Under 1 due to low volume in that rate cell.

Service Categories

The data book summarizes each of the rate cells by major categories of service. The categories of services are as follows:

Physical Health

Data was received from the two MCOs servicing the Middle Region. The data was then mapped into four major service categories: Inpatient Hospital, Outpatient Hospital, Professional Services and Home Health.

Inpatient Hospital

Admission data received was in the standard UB92 format but did not include a grouped DRG. The data was formatted into admission episodes and run through the HCFA DRG grouper. The resulting DRGs were summarized and grouped into the following:

Major Category	Diagnosis Related Groups (DRGs)
Medical	009-035, 043-048, 064-074, 078-102, 121-145, 172-190, 202-208, 235-256, 271-284, 294-301, 316-333,346-352, 366-369, 376, 378-380, 382-384, 395-399, 403-405, 409-414, 416-423, 444-455, 462-467, 469, 475,487, 489-490, 492, 505, 508-511
Surgical	001-008, 036-042, 049-063, 075-077, 104-120, 146-171, 191-201, 209-234,257-270, 285-293, 303-315, 334-345, 353-365, 377, 381,392-394, 400-402,406-408, 415, 439-443, 461, 468, 471, 473, 476-479, 482-486, 488, 491,493-494, 496-504, 506-507, 514-520
Maternity	370-371, 372-375
Newborn	385-389, 390-391
Other	424-432,433, 521-523,103, 302, 480, 481, 495, 512, 513,470

Since many of the provider agreements are not DRG based, the data split within the subcategories may not be 100% accurate. However, it is believed that variance is minimal.

Outpatient Hospital

Outpatient procedures are prioritized for a claim based on the revenue codes included on the total claim record. A hierarchy is used to determine what the main reason for the outpatient visit. Once determined, the data can be summarized appropriately.

Outpatient Category of Care Description	Main Reason for Visit	Revenue Codes Mapping	Hierarchy Ranking
ER	ER	450-459	1
Surgery	Surgery	360-369;490-499;790-799	2
Cardiac Cath	Surgery	481	3
Birthing Center	Other	720-722;724	4
Maternity-Non-delivery	Other	723; 729	5
Observation Unit-Bed	Other	760-769	6
Dialysis	Other	800-809;820-889	7
Outpatient Rehab	Other	420-449	8
Mental Health/Substance Abuse	Other	900-919;944-945	9
Therapeutic Radiology	Radiology	330-339	10
Hospice	not used	650-659	11
Nuclear Medicine	Radiology	340-349	12
MRI	Radiology	610-619	13
CT Scan	Radiology	350-359	14
Other Cardiology	Other	480;482-489	15
Diagnostic Radiology	Radiology	320-329	16
Other Imaging	Radiology	400-409	17
Laboratory/Pathology	Laboratory	310-312;314;318-319	18
Laboratory	Laboratory	300-307;309	19
Hospital Outpatient/Other	Other	Services not included elsewhere	20

Some procedure codes are also utilized to define some of the categories above, but they represent a small percentage of the total claims submitted.

Home Health

Due to how the data was received by the MCOs, Aon had to modify our normal grouping processes. Below are the criteria we employed:

- place of service = 12 (home),
- revenue codes from 550-589, and
- provider name on the Home Health List.

If these three were all met the claim was classified as a home healthcare claim.

Professional

The final physical health service category would include all physical healthcare services not addressed above. This is primarily physician services, but it would also include a variety of other miscellaneous services.

Report Grouping	Service Category	HCPCS Code
Other	Anesthesia	00100 - 02020
Surgery	Surgery - Non-Maternity	10040 - 36414
Other	Venipuncture	36415 - 36415
Surgery	Surgery - Non-Maternity	36416 - 58999
Maternity	Surgery - Maternity – Non-Delivery	59000 - 59399
Maternity	Surgery - Maternity - Deliveries	59400 - 59410
Maternity	Surgery - Maternity – Non-Delivery	59411 - 59509
Maternity	Surgery - Maternity - Deliveries	59510 - 59515
Maternity	Surgery - Maternity – Non-Delivery	59516 - 59609
Maternity	Surgery - Maternity - Deliveries	59610 - 59622
Maternity	Surgery - Maternity – Non-Delivery	59623 - 59899
Surgery	Surgery - Non-Maternity	59900 - 69979
Radiology	Radiology	70010 - 79999
Lab	Pathology/Lab	80048 - 89399
Other	Immunizations/Injections/Infusions	90281 - 90799
Other	Psychiatry	90801 - 90911
Other	Miscellaneous	90912 - 90917
Other	Other Medicine	90918 - 91299
Other	Ophthalmology – Exams	92002 - 92014
Other	Ophthalmology - Services	92015 - 92499
Other	Other Medicine	92502 - 92599
Other	Cardiovascular	92950 - 93799
Other	Other Medicine	93875 - 94799
Other	Allergy Tests/Treatment	95004 - 95199
Other	Other Medicine	95250 - 95250
Other	Miscellaneous	95805 - 96149

Other	Other Medicine	96150 - 96155
Other	Chemotherapy	96400 - 96571
Other	Other Medicine	96900 - 96999
Other	Physical Medicine	97001 - 98943
Other	Other Medicine	99000 - 99199
Evaluation & Management	E&M - Office Visits	99201 - 99215
Evaluation & Management	E&M - Inpatient Visits	99217 - 99239
Evaluation & Management	E&M - Consultations	99241 - 99275
Evaluation & Management	E&M - Emergency Room/Critical Care	99281 - 99292
Evaluation & Management	E&M - Inpatient Visits	99295 - 99333
Evaluation & Management	E&M - Office Visits	99341 - 99350
Evaluation & Management	E&M - Miscellaneous	99354 - 99380
Evaluation & Management	E&M - Preventive Visits/Well Baby	99381 - 99387
Evaluation & Management	E&M - Preventive Visits/Well Baby	99391 - 99429
Evaluation & Management	E&M - Preventive Visits/Well Baby	99431 - 99436
Evaluation & Management	E&M - Miscellaneous	99440 - 99499
Ambulance/Transportation	Ambulance/Transportation	A0000 - A0999
Other	HCPCS	A1000 - C9999
Lab	Pathology/Lab	ATP02 - ATP22
Appliances/DME	DME/Supplies	E0000 - E9999
Other	HCPCS	G0000 - G0000
Other	Venipuncture	G0001 - G0001
Other	HCPCS	G0002 - G0007
Other	Immunizations/Injections/Infusions	G0008 - G0010
Other	HCPCS	G0011 - G9999
Other	HCPCS	H0000 - J9999
Appliances/DME	DME/Supplies	K0000 - K9999
Appliances/DME	DME/Supplies	L0000 - L9999
Other	HCPCS	M0000 - V9999

Behavioral Health

Data was received from the current BHOs servicing the Middle Region. The data for the BHO includes a combination of FFS data, case rates, grants and day allotments.

Inpatient Hospital

There are three main hospital funding methods with the current vendor: private hospitals, Tennessee Christian Medical Center (TCMC) and Regional Mental Health Institutes (RMHIs). Paid amounts for the private hospitals were available from the vendor's encounter data. TCMC encounter data was included but were zero pay claims. Aon allocated the total amounts paid to TCMC on utilization alone, assigning a single per diem to each inpatient day. Regional Mental Health Institutes are paid an agreed upon amount for a specified number of days. When the specified number of days is exceeded, additional payments are made to the Regional Mental Health Institutes. Like TCMC, the final adjusted per diem was applied to each RMHI day uniformly. We relied on the BHO encounter data for both RMHI and TCMC. All amounts reconcile to data reported on the BHO MLR reports.

Case Rates

Community Mental Health Centers (CMHCs) are paid case rates for their services; consequently payment information is not readily available from the encounter data. The current vendor provided detailed payments by person, by month. The amounts were reconciled to the MLRs.

Grants

Grant payment information by provider by month was provided to us from the current BHO vendor. Unlike the case rates and TCMC, grants will need to be pro-rated based on FFS data in each rate category. This will remain a capitated amount, with no associated utilization figures.

Outpatient Hospital, In Home Services, Supported Housing, 23-Hour, Intensive Outpatient, Partial Hospitalization and Transportation

Payment information for these services were primarily compiled from paid amounts on the encounter data. Transportation is partially subcontracted and was paid a capitated amount not linked to submitted encounter data. The utilization data for that category was increased to appropriately measure the total cost.

Besides transportation, all of the other claims groups were included on the FFS data.

Determination of Units

Encounter records were classified into the detailed service categories discussed above. After grouping and categorizing the claims, the final stage linked the eligibility data and further summarized into the rate cells.

In this summarization process, unit counts were made for each service category. The following table details the types of units that were counted for each detailed service category. In the table, "Services" indicates the actual unit counts that were recorded on each claim. "Claims" or "Prescriptions" refers to a count of "1" for each claim record in the historical database. "Days" are used for inpatient units, and represent the inpatient length of stay.

Major Category	Units Counted
Physical Health	
Inpatient Hospital	Days
Outpatient Hospital*	Claims
Professional	Services
Home Health	Claims
DME/Supplies	Claims
Transportation/Ambulance	Claims
Behavioral Health	
Inpatient Hospital	Days
Outpatient Hospital	Claims
Case Rates	Claims
Grants	Not Applicable
IH, SH, 23-Hour, IOP, PH and Transportation FFS Data	Claims

* Radiology and Laboratory units counted are services

D. Adjustments to Base Data

The data provided in this data book includes unadjusted data. Some adjustments are necessary to accurately reflect the incurred cost for future services the MCOs will be responsible for providing during the contract term. The adjusted data form the baseline in the development of actuarially sound capitation rate ranges.

This data book contains data only for those included populations listed in Section 1 of this document. In addition to the separation of the data into the Middle Region, there were a few other enrollment-based adjustments.

TennCare Disenrollment

As of December, 2005 there have been approximately 137,000 members disenrolled. There are also an additional 40,000 members who are to be disenrolled before the effective data of this contract. Aon has removed the base data for both of these groups. Additional members who were reclassified into Medicaid categories had their historical data moved into their current rate cells.

Children in DCS Custody and SSI Members

Data for Children in DCS Custody and SSI children under the age of 21 who were enrolled in TennCare Select has been removed from the analysis.

Claim Completion Factors

The completion patterns of the FFS data have been examined and factors have been applied to estimate the number and dollar value of claims incurred, but not paid. The analysis was performed on statewide data for the BHO and regional data for the MCO. The factors were calculated separately by category of service, with some smaller categories combined for credibility.

Benefit Changes

There are few benefit changes that need to be considered when reviewing the accompanying data and rate buildup.

1. Changes in TennCare Medicaid August 1, 2005

Non-covered services

For all TennCare Medicaid adults age 21 or older, these services will no longer be covered:

- Medicine that can be purchased over the counter – (except for prenatal vitamins)
- Dental care of *any* kind
- Sitter services
- Convalescent care

- Payments to "hold" an unused bed in a nursing home while the member is in the hospital or out of the nursing home for any reason (beginning October 1, 2005, TennCare will pay for up to 10 days per year to "hold" a nursing home bed)
- Methadone clinic services to get or stay off drugs. (This is also called methadone detox or maintenance services.)

Services with Limits
Pharmacy – A five prescription limit per month on prescription drugs and refills. Of the five, only two can be for brand name drugs. That means at least three of the five must be for generic drugs.

There is also a $3 co-pay for each brand name drug. But, there is no co-pay for generic drugs OR for:
- Birth control
- Hospice care medications
- Drugs for emergency situations
- Pregnancy-related medications.

Children under age 21 with TennCare Medicaid will continue to receive all care that is medically necessary including the services listed above that are not covered for adults. They will also continue to have unlimited prescription drug coverage as medically necessary and will not have co-pays for their prescriptions.

2. Changes in TennCare Standard August 1, 2005
Non-covered services
For all TennCare Standard adults age 21 or older, these services will no longer be covered:
- Medicine that can be purchased over the counter – (except for prenatal vitamins)
- Dental care of *any* kind
- Sitter services
- Convalescent care
- Payments to "hold" an unused bed in a nursing home while the member is in the hospital or out of the nursing home for any reason (beginning October 1, 2005, TennCare will pay for up to 10 days per year to "hold" a nursing home bed)
- Methadone clinic services to get or stay off drugs. (This is also called methadone detox or maintenance services.)
- Pharmacy services.

Children under age 21 with TennCare Standard will continue to receive all care that is medically necessary including the services listed above that are not covered for adults. They will also continue to have unlimited prescription drug coverage. Children with family incomes at or above the poverty level will have a *reduction* in pharmacy co-pays. They will now pay $3 for each brand name drug used rather than a $5 or $10 co-pay for each prescription.

The pharmacy report uses incurred claims data after the August 1, 2005 effective date and requires no additional adjustments. Although these services are not included under the capitation amount, the impact of the pharmacy benefit reductions on non-pharmacy claims was reviewed. The utilization is being monitored and currently demonstrates that no additional adjustments to the capitation data are warranted.

Methadone clinic claims were also removed from the historical data for appropriate members to recognize the benefit change.

3. Changes in TennCare January 1, 2006

Non-covered services

For all TennCare adults age 21 or older who still have pharmacy services, the following types of medicine will no longer be covered:

- Barbiturates; and
- Benzodiazepines.

ALL TennCare members who also have MediCARE (dual eligibles) will begin receiving all of their pharmacy services through a MediCARE drug plan, as provided under Medicare Part D. TennCare will NOT pay for any pharmacy services for adults age 21 or older. BUT, for children under age 21, TennCare will pay for prescriptions ONLY IF:

- It's a class of drug that TennCare covers.
- AND, it's a class of drug that MediCARE doesn't cover.

Services with Limits

ALL TennCare adults age 21 and over will have LIFETIME limits on drug or alcohol treatment and detox. $30,000 is the maximum TennCare will pay for drug or alcohol treatment in and out of the hospital. The $30,000 includes the cost of detox. Starting January 1, 2006, 10 days is the maximum detox TennCare will pay for. This is true even if all of the $30,000 for drug or alcohol treatment has not been used.

These changes were reviewed and found to have a negligible impact on the capitation rate.

4. 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. Depending on the service, once a member reaches a threshold, the member will be enrolled in MCO case management or a disease management program.

Details of the new thresholds can be found the in RFP and contract that accompanies this data book.

The service thresholds and the MCO'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	Managed Care Requirement
Inpatient Hospital Services	20 days per SFY	Enroll member in MCO case management or a disease management program, whichever is more appropriate
Outpatient Hospital Services	8 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	12 visits per SFY	Determine whether member should be enrolled MCO case management or a disease management program and enroll member if appropriate
Lab and X-ray Services	10 visits per SFY	Determine whether member should be enrolled MCO case management or a disease management program and enroll member if appropriate

The actuarial determined savings from these changes can be found in Exhibit 20.

E. Rate Development

All available data options were researched, considered and analyzed in order to develop the most credible and sound basis for forecasting TennCare enrollment and service costs in Middle Tennessee.

Data for Basis of Rates

This data book contains two fiscal years for completeness. For the rate development Aon used fiscal year 2005. This data was determined to be the most reliable and credible source of information. The per capita costs shown in this report are developed based on actual TennCare utilization experience subset by key demographic and eligibility categories.

Aon developed baseline per capita costs using claims incurred between July 1, 2004 and June 30, 2005 and paid on or before November 30, 2005. Since five months of claim run-out was used, only a small completion factor (approximately 1%) was required to develop total incurred claims for the baseline period (Fiscal Year 2005).

The per capita costs were updated using inflation factors to estimate expected costs during calendar year 2007. The baseline data (Fiscal Year 2005) was rolled forward 18-months using projected trends to develop the final contract period rates.

Medical Cost/Trend Inflation

Trend rates are comprised of changes in cost per unit of service as well as changes in the volume of services used per person over time. Aon has examined the historical data for Fiscal Years 2003, 2004 and 2005. From this we were able to calculate combined utilization and cost trend rates using a simple regression methodology. Although many of the provider contracts were frozen, our trend rates recognize the impact of built in escalators (e.g., CPI adjustments, charge master increases, Medicare payment trends, etc.). There have also been some ad-hoc adjustments by the Bureau that have been taken into account. Historical trends are not predictors of future usage; they provide validation of past assumptions and methodologies.

The application of healthcare trend adjustments to the base data are complicated by a variety of factors. The nature of the payments being projected is the combination of three separate components of the program.

1. The first component is comprised of services that are capitated, and the analysis relies solely on the utilization information received in the encounter data, linked to payment information on the MLRs . The agreements typically only have built in CPI escalators. For a small portion of these, data was not available to determine cost trends independent of the contracted increases and were, therefore, excluded from the trend analysis. The majority of these services do not contribute to the utilization component in the trend.

2. The second component is comprised of grant payments and inpatient hospital – regional mental health institute payments. Per conversations with the Bureau, Grant payments are assumed to remain at current levels. The RMHI payments are also capped annually per conversations with TMHDD.

3. The third component is comprised of services for which data is available and benchmarks can be applied. Most of this is FFS data from the MCO and BHO. This represents a large portion of the claims data for Middle Tennessee. Trends for these components include a cost per service escalader and a utilization component.

The existence of capitation rates, case rate payments, grants and other fixed dollar services will moderate the utilization and cost trend, as measured against other similar programs.

Below are the component trends we utilized in our projections with further details in the exhibits:

- Fees-for-service data was assumed to trend at an approximate overall rate of 7%. There is significant difference by service types. Details of each component can be found in the exhibits.

- Capitation services were assumed to increase at a rate consistent with Medical CPI, 4%. This is consistent with expectation of the TennCare Bureau, current MCOs and Advocare.

- Case rates were only assumed to increase at a utilization level of 3%, with cost components currently capped. This was the case for CMHC.

- The RMHI trend was assumed to be 0% since the TennCare Bureau and the Department of Mental Health and Developmental Disabilities are negotiating a capitation rate designed to have offsetting utilization and cost components.

- Grant payments were also set to 0% since Grants are capped at a total budgeted amount and have no true trend component.

The trend has been applied from the data period to the contract period. This is effectively 18 months from the midpoints.

Administrative Costs

The rates in our actuarial review use health plan encounter data as the baseline. In order to develop a total per capita cost, it is necessary to add an amount to cover health plan administration. Aon received fee schedules from the Bureau representing the current fees paid to the MCOs and BHOs. The medical rates vary by enrollment only. Using the membership bracket, 100,000 to 200,000, the plan is currently paying 5.5% for the MCO and 10% for the BHO. A combination of these rates is 6.25%. The Bureau anticipates a higher level of medical management under the new contracts and has added 0.75% to that amount. An additional 2% is targeted for risk retention. This amount would be reduced if less than a 100% risk contract were proposed. With all these components combined, a total administrative load of 9% was assumed.

These loads were compared to other State programs and were within reasonable ranges.

Tennessee plans are also required to pay a 2% premium tax on their premium revenues. This applied to the MCOs and BHOs.

Third Party Liability and Participant Cost Sharing

The per capita costs shown are inclusive of adjustments for Third Party Liability, with the exception of subrogation. We have assumed plans will continue to collect payments for Third Party Liability at levels similar to those observed during the data period. The data received from the TennCare Bureau indicate approximately 1.2% of the projected costs are recovered in Middle Tennessee.

Managed Care Utilization Savings

The current plan utilization statistics are consistent with those of a loosely managed program overall, with BHO costs more aggressively managed. Many factors contribute to this over time and are beyond the scope of this data book.

Aon developed a lower capitation rate that represents a scenario that would move utilization to a more aggressively managed category. These factors were developed from our proprietary rating manual. The results were then compared for reasonability to published benchmarks. Details of the components are in the exhibits.

MCOs are responsible to manage the delivery of medical care. This may require utilization changes; depending on the category of service, such changes could be decreases or increases. Along with utilization changes, medical management may result in changes in cost per unit of service.

The low end of the range does not have any additional savings or cost associated with contractual changes with providers.

F. Additional Information

Pharmacy Report

Benchmarking a program's pharmacy data provides valuable insight into the program management. This is even more apparent in the TennCare program, where there have been significant pharmacy changes over the past year.

The most significant impact on TennCare costs, next to the disenrollment, was the changes in the pharmacy program. Reviewing the weekly invoices, the pharmacy claims cost were nearly cut in half by the August 1, 2005 plan changes. Due to these changes, extended historical summary data is of limited value. Aon developed a pharmacy report for the 3-months period September 2005 through November 2005. This was the most recent data available at the time of this report and provides an accurate assessment of the pharmacy spend in Middle Tennessee.

For each rate cell, the report is summarized by whether the drug was for Physical Health (MCO) or Behavioral Health (BHO), as well the drug type (brand or generic). The report summarizes paid claims and utilization data over the period.

TennCare
Middle Tennessee Data Book
Historical Encounter Data

Exhibit 1

Medicaid (TANF & Related) All Ages										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	2,763,691					2,860,042				
Home Health Care	332,258	1,177	5	282.29	0.12	241,979	1,094	5	221.19	0.08
IP - Maternity	19,500,154	24,827	108	785.44	7.06	22,161,197	26,230	110	844.88	7.75
IP - Newborn	23,750,924	33,294	145	713.37	8.59	29,962,184	39,554	166	757.50	10.48
IP - Medical	30,080,879	40,540	176	742.00	10.88	30,878,298	39,011	164	791.53	10.80
IP - Surgery	31,551,101	18,427	80	1,712.22	11.42	29,453,283	17,132	72	1,719.20	10.30
IP - Other	11,899,703	967	4	12,305.79	4.31	30,200,400	1,488	6	20,295.97	10.56
Subtotal - Inpatient	116,782,761	118,055	513	989.22	42.26	142,655,362	123,415	518	1,155.90	49.88
OP - Emergency Room	28,667,856	239,773	1,041	119.56	10.37	37,341,032	257,656	1,081	144.93	13.06
OP - Laboratory	1,630,048	130,181	565	12.52	0.59	3,222,936	176,609	741	18.25	1.13
OP - Radiology	10,069,867	120,576	524	83.51	3.64	11,687,021	165,027	692	70.82	4.09
OP - Surgery	31,839,436	52,291	227	608.89	11.52	36,579,661	52,609	221	695.31	12.79
OP - Other	9,667,671	80,727	351	119.76	3.50	10,660,297	96,324	404	110.67	3.73
Subtotal - Outpatient	81,874,878	623,548	2,707	131.30	29.63	99,490,946	748,225	3,139	132.97	34.79
Prof - Evaluation & Management	67,315,887	1,438,922	6,248	46.78	24.36	72,345,790	1,465,428	6,149	49.37	25.30
Prof - Maternity	11,843,960	24,462	106	484.18	4.29	12,836,665	25,533	107	502.75	4.49
Prof - Surgery	18,424,634	184,464	801	99.88	6.67	19,334,194	178,374	748	108.39	6.76
Prof - DME/Supplies	4,348,711	27,727	120	156.84	1.57	5,512,064	30,695	129	179.58	1.93
Prof - Lab	7,422,968	767,128	3,331	9.68	2.69	9,661,927	899,670	3,775	10.74	3.38
Prof - Radiology	12,615,866	367,403	1,595	34.34	4.56	14,548,724	383,476	1,609	37.94	5.09
Prof - Transportation	5,417,522	51,728	225	104.73	1.96	5,869,829	51,625	217	113.70	2.05
Prof - Other	29,469,363	2,430,333	10,553	12.13	10.66	30,690,119	2,419,539	10,152	12.68	10.73
Subtotal - Professional	156,858,911	5,292,167	22,979	29.64	56.76	170,799,312	5,454,340	22,885	31.31	59.72
NPMH - Inpatient	3,388,693	10,489	46	323.07	1.23	2,881,969	9,066	38	317.89	1.01
NPMH - Outpatient	1,666,714	24,620	107	67.70	0.60	1,721,291	23,060	97	74.64	0.60
NPMH - Case Rates	739,766	3,865	17	191.40	0.27	158,323	785	3	201.69	0.06
NPMH - Grants	2,086,809	-	-	-	0.76	1,859,120	-	-	-	0.65
NPMH - In-Home Services	243,098	145	1	1,676.54	0.09	168,370	93	0	1,810.43	0.06
NPMH - Supported Housing	65,790	35	0	1,879.72	0.02	8,081	8	0	1,010.13	0.00
NPMH - 23 Hour	3,946	16	0	246.62	0.00	6,440	26	0	247.69	0.00
NPMH - Intensive Outpatient	760,394	2,003	9	379.63	0.28	622,478	1,661	7	374.76	0.22
NPMH - Partial Hospitalization	27,426	43	0	637.81	0.01	33,702	68	0	495.61	0.01
NPMH - Transportation	416,776	5,293	23	78.73	0.15	463,355	3,205	13	144.57	0.16
Subtotal - Non-Priority Mental Health	9,399,413	46,509	202	202.10	3.40	7,923,129	37,972	159	208.66	2.77
Total	$ 365,248,221				$ 132.16	$ 421,110,727				$ 147.24

TennCare
Middle Tennessee Data Book
Historical Encounter Data

Exhibit 1

Medicaid (TANF & Related) Age Under 1										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	83,671					78,672				
Home Health Care	5,165	58	8	89.05	0.06	4,328	41	6	105.55	0.06
IP - Maternity	2,670	5	1	533.93	0.03	9,242	12	2	770.20	0.12
IP - Newborn	11,161,067	11,322	1,624	985.79	133.39	11,100,351	11,212	1,710	990.04	141.10
IP - Medical	1,767,732	2,533	363	697.88	21.13	1,850,182	2,381	363	777.06	23.52
IP - Surgery	1,164,918	842	121	1,383.51	13.92	1,479,816	1,074	164	1,377.86	18.81
IP - Other	1,353,112	10	1	135,311.15	16.17	4,301,748	59	9	72,910.98	54.68
Subtotal - Inpatient	15,449,498	14,712	2,110	1,050.13	184.64	18,741,339	14,738	2,248	1,271.63	238.22
OP - Emergency Room	634,817	6,678	958	95.06	7.59	711,206	6,495	991	109.50	9.04
OP - Laboratory	31,719	2,493	358	12.72	0.38	55,961	3,321	507	16.85	0.71
OP - Radiology	92,297	2,060	295	44.80	1.10	109,414	2,334	356	46.88	1.39
OP - Surgery	375,405	822	118	456.70	4.49	428,105	754	115	567.78	5.44
OP - Other	316,608	2,713	389	116.70	3.78	231,885	2,806	428	82.64	2.95
Subtotal - Outpatient	1,450,846	14,766	2,118	98.26	17.34	1,536,570	15,710	2,396	97.81	19.53
Prof - Evaluation & Management	4,564,335	80,935	11,608	56.40	54.55	5,089,870	81,262	12,395	62.64	64.70
Prof - Maternity	2,499	6	1	416.58	0.03	3,850	11	2	350.01	0.05
Prof - Surgery	412,079	4,200	602	98.11	4.92	543,268	4,352	664	124.83	6.91
Prof - DME/Supplies	214,069	1,405	202	152.36	2.56	179,849	1,271	194	141.50	2.29
Prof - Lab	35,638	4,342	623	8.21	0.43	46,665	4,962	757	9.40	0.59
Prof - Radiology	100,880	7,608	1,091	13.26	1.21	113,412	7,608	1,160	14.91	1.44
Prof - Transportation	180,780	910	131	198.66	2.16	204,438	685	104	298.45	2.60
Prof - Other	1,189,967	171,961	24,662	6.92	14.22	1,248,985	181,751	27,723	6.87	15.88
Subtotal - Professional	6,700,248	271,367	38,919	24.69	80.08	7,430,337	281,902	42,999	26.36	94.45
NPMH - Inpatient	-	-	-	-	-	-	-	-	-	-
NPMH - Outpatient	80	1	0	80.00	0.00	210	3	0	70.00	0.00
NPMH - Case Rates	-	-	-	-	-	-	-	-	-	-
NPMH - Grants	14	-	-	-	0.00	37	-	-	-	0.00
NPMH - In-Home Services	-	-	-	-	-	-	-	-	-	-
NPMH - Supported Housing	-	-	-	-	-	-	-	-	-	-
NPMH - 23 Hour	-	-	-	-	-	-	-	-	-	-
NPMH - Intensive Outpatient	-	-	-	-	-	-	-	-	-	-
NPMH - Partial Hospitalization	-	-	-	-	-	-	-	-	-	-
NPMH - Transportation	-	-	-	-	-	-	-	-	-	-
Subtotal - Non-Priority Mental Health	94	1	0	94.41	0.00	247	3	0	82.43	0.00
Total	$ 23,605,851				$ 282.13	$ 27,712,821				$ 352.26

TennCare
Middle Tennessee Data Book
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Exhibit 1

Medicaid (TANF & Related) Age 1 - 13										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	1,306,942					1,418,489				
Home Health Care	77,989	424	4	183.94	0.06	77,877	494	4	157.65	0.05
IP - Maternity	6,045	10	0	604.52	0.00	18,972	21	0	903.45	0.01
IP - Newborn	766,912	1,004	9	763.86	0.59	4,428,973	5,335	45	830.17	3.12
IP - Medical	5,008,732	7,103	65	705.16	3.83	5,415,886	7,442	63	727.75	3.82
IP - Surgery	2,052,519	1,777	16	1,155.05	1.57	2,502,385	2,070	18	1,208.88	1.76
IP - Other	723,093	68	1	10,633.71	0.55	2,772,250	138	1	20,088.76	1.95
Subtotal - Inpatient	8,557,300	9,962	91	858.99	6.55	15,138,466	15,006	127	1,008.83	10.67
OP - Emergency Room	8,119,064	88,940	817	91.29	6.21	10,138,726	93,525	791	108.41	7.15
OP - Laboratory	382,586	32,076	295	11.93	0.29	677,756	45,131	382	15.02	0.48
OP - Radiology	831,722	18,560	170	44.81	0.64	1,098,961	44,960	380	24.44	0.77
OP - Surgery	6,848,082	12,132	111	564.46	5.24	8,364,888	12,589	106	664.46	5.90
OP - Other	2,492,845	23,255	214	107.20	1.91	2,897,276	31,083	263	93.21	2.04
Subtotal - Outpatient	18,674,298	174,963	1,606	106.73	14.29	23,177,607	227,288	1,923	101.97	16.34
Prof - Evaluation & Management	22,936,611	527,866	4,847	43.45	17.55	25,678,890	560,330	4,740	45.83	18.10
Prof - Maternity	3,800	8	0	474.98	0.00	8,499	16	0	531.16	0.01
Prof - Surgery	3,020,557	46,961	431	64.32	2.31	3,415,970	52,869	447	64.61	2.41
Prof - DME/Supplies	779,675	6,651	61	117.23	0.60	973,408	7,197	61	135.25	0.69
Prof - Lab	1,199,779	155,653	1,429	7.71	0.92	1,583,459	196,364	1,661	8.06	1.12
Prof - Radiology	987,982	62,503	574	15.81	0.76	1,098,669	63,709	539	17.25	0.77
Prof - Transportation	1,004,385	9,021	83	111.34	0.77	1,054,572	8,697	74	121.26	0.74
Prof - Other	7,400,329	876,364	8,047	8.44	5.66	8,290,925	964,222	8,157	8.60	5.84
Subtotal - Professional	37,333,119	1,685,027	15,471	22.16	28.57	42,104,391	1,853,404	15,679	22.72	29.68
NPMH - Inpatient	549,171	2,177	20	252.26	0.42	424,661	1,621	14	261.97	0.30
NPMH - Outpatient	365,646	6,161	57	59.35	0.28	403,858	5,977	51	67.57	0.28
NPMH - Case Rates	208,910	1,073	10	194.70	0.16	63,419	299	3	212.10	0.04
NPMH - Grants	182,714	-	-	-	0.14	166,076	-	-	-	0.12
NPMH - In-Home Services	101,499	62	1	1,637.08	0.08	91,250	50	0	1,825.00	0.06
NPMH - Supported Housing	-	-	-	-	-	-	-	-	-	-
NPMH - 23 Hour	-	-	-	-	-	-	-	-	-	-
NPMH - Intensive Outpatient	351	5	0	70.12	0.00	6,026	36	0	167.38	0.00
NPMH - Partial Hospitalization	1,673	-	-	-	0.00	245	-	-	-	0.00
NPMH - Transportation	15,648	298	3	52.51	0.01	11,005	162	1	68.10	0.01
Subtotal - Non-Priority Mental Health	1,425,613	9,776	90	145.83	1.09	1,166,540	8,145	69	143.23	0.82
Total	$ 66,068,319				$ 50.55	$ 81,664,881				$ 57.57

TennCare
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Historical Encounter Data

Exhibit 1

Medicaid (TANF & Related) Age 14 - 20 Female										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	245,864					268,804				
Home Health Care	4,037	30	1	134.57	0.02	5,520	34	2	162.35	0.02
IP - Maternity	4,771,860	6,544	319	729.20	19.41	5,553,047	7,157	320	775.89	20.66
IP - Newborn	3,226,892	5,684	277	567.71	13.12	4,215,771	6,273	280	672.05	15.68
IP - Medical	1,763,882	2,395	117	736.49	7.17	1,943,581	2,664	119	729.57	7.23
IP - Surgery	1,309,850	709	35	1,847.46	5.33	1,290,112	706	32	1,827.35	4.80
IP - Other	1,104,199	18	1	61,344.38	4.49	2,342,888	26	1	90,111.08	8.72
Subtotal - Inpatient	12,176,682	15,350	749	793.27	49.53	15,345,399	16,826	751	912.01	57.09
OP - Emergency Room	3,081,753	24,413	1,192	126.23	12.53	4,333,250	27,192	1,214	159.36	16.12
OP - Laboratory	235,939	17,661	862	13.36	0.96	481,811	22,413	1,001	21.50	1.79
OP - Radiology	774,384	10,541	514	73.46	3.15	975,978	13,787	615	70.79	3.63
OP - Surgery	2,145,118	5,336	260	402.01	8.72	2,707,506	5,620	251	481.76	10.07
OP - Other	674,855	7,822	382	86.28	2.74	759,071	9,330	417	81.36	2.82
Subtotal - Outpatient	6,912,049	65,773	3,210	105.09	28.11	9,257,617	78,342	3,497	118.17	34.44
Prof - Evaluation & Management	6,138,643	126,335	6,166	48.59	24.97	6,975,274	136,593	6,098	51.07	25.95
Prof - Maternity	3,061,876	6,477	316	472.73	12.45	3,314,209	6,469	289	512.32	12.33
Prof - Surgery	1,012,202	10,824	528	93.51	4.12	1,210,613	12,305	549	98.38	4.50
Prof - DME/Supplies	154,493	1,037	51	148.98	0.63	221,809	1,420	63	156.20	0.83
Prof - Lab	1,184,270	113,916	5,560	10.40	4.82	1,621,691	143,257	6,395	11.32	6.03
Prof - Radiology	1,298,954	34,904	1,704	37.22	5.28	1,601,411	39,306	1,755	40.74	5.96
Prof - Transportation	481,602	4,654	227	103.48	1.96	567,146	4,778	213	118.70	2.11
Prof - Other	2,692,796	157,987	7,711	17.04	10.95	3,032,020	169,929	7,586	17.84	11.28
Subtotal - Professional	16,024,834	456,134	22,263	35.13	65.18	18,544,173	514,057	22,949	36.07	68.99
NPMH - Inpatient	476,857	1,580	77	301.81	1.94	329,783	852	38	387.07	1.23
NPMH - Outpatient	137,593	1,942	95	70.85	0.56	154,118	1,959	87	78.67	0.57
NPMH - Case Rates	61,581	326	16	188.90	0.25	17,543	95	4	184.66	0.07
NPMH - Grants	144,777	-	-	-	0.59	113,751	-	-	-	0.42
NPMH - In-Home Services	74,356	44	2	1,689.91	0.30	24,195	14	1	1,728.19	0.09
NPMH - Supported Housing	-	-	-	-	-	2,600	2	0	1,300.00	0.01
NPMH - 23 Hour	-	-	-	-	-	-	-	-	-	-
NPMH - Intensive Outpatient	85,795	223	11	384.73	0.35	76,973	202	9	381.05	0.29
NPMH - Partial Hospitalization	625	3	0	208.26	0.00	2,863	1	0	2,862.80	0.01
NPMH - Transportation	48,536	600	29	80.95	0.20	49,532	506	23	97.91	0.18
Subtotal - Non-Priority Mental Health	1,030,120	4,718	230	218.36	4.19	771,358	3,631	162	212.44	2.87
Total	$ 36,147,722				$ 147.02	$ 43,924,067				$ 163.41

TennCare
Middle Tennessee Data Book
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Exhibit 1

Medicaid (TANF & Related) Age 14 - 20 Male										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	192,151					214,018				
Home Health Care	3,308	25	2	132.30	0.02	2,563	22	1	116.49	0.01
IP - Maternity	-	-	-	-	-	-	-	-	-	-
IP - Newborn	-	-	-	-	-	482	4	0	120.54	0.00
IP - Medical	747,131	701	44	1,065.81	3.89	1,094,642	1,215	68	900.94	5.11
IP - Surgery	1,609,600	700	44	2,299.43	8.38	1,565,028	843	47	1,856.50	7.31
IP - Other	274,325	28	2	9,797.33	1.43	1,919,700	51	3	37,641.18	8.97
Subtotal - Inpatient	2,631,056	1,429	89	1,841.19	13.69	4,579,852	2,113	118	2,167.46	21.40
OP - Emergency Room	1,383,309	11,630	726	118.94	7.20	1,901,833	13,371	750	142.24	8.89
OP - Laboratory	50,442	3,488	218	14.46	0.26	104,173	13,600	763	7.66	0.49
OP - Radiology	347,555	4,794	299	72.50	1.81	460,291	5,651	317	81.45	2.15
OP - Surgery	945,614	1,419	89	666.39	4.92	1,066,666	1,498	84	712.06	4.98
OP - Other	397,387	2,868	179	138.56	2.07	443,564	3,408	191	130.15	2.07
Subtotal - Outpatient	3,124,307	24,199	1,511	129.11	16.26	3,976,527	37,528	2,104	105.96	18.58
Prof - Evaluation & Management	2,184,377	48,077	3,002	45.43	11.37	2,649,183	55,315	3,102	47.89	12.38
Prof - Maternity	720	1	0	720.30	0.00	-	2	0	-	-
Prof - Surgery	706,435	6,049	378	116.79	3.68	837,095	7,040	395	118.91	3.91
Prof - DME/Supplies	159,156	916	57	173.75	0.83	201,504	1,354	76	148.82	0.94
Prof - Lab	113,022	14,556	909	7.76	0.59	188,584	21,866	1,226	8.62	0.88
Prof - Radiology	351,061	17,097	1,068	20.53	1.83	438,255	19,459	1,091	22.52	2.05
Prof - Transportation	270,119	2,222	139	121.57	1.41	373,120	2,437	137	153.11	1.74
Prof - Other	1,026,339	97,260	6,074	10.55	5.34	1,274,777	101,087	5,668	12.61	5.96
Subtotal - Professional	4,811,229	186,178	11,627	25.84	25.04	5,962,516	208,560	11,694	28.59	27.86
NPMH - Inpatient	822,212	3,343	209	245.95	4.28	1,196,139	4,485	251	266.70	5.59
NPMH - Outpatient	116,969	1,655	103	70.68	0.61	135,015	1,618	91	83.45	0.63
NPMH - Case Rates	77,100	361	23	213.57	0.40	25,751	95	5	271.07	0.12
NPMH - Grants	214,687	-	-	-	1.12	290,692	-	-	-	1.36
NPMH - In-Home Services	67,243	39	2	1,724.18	0.35	52,925	29	2	1,825.00	0.25
NPMH - Supported Housing	3,643	3	0	1,214.22	0.02	-	-	-	-	-
NPMH - 23 Hour	-	-	-	-	-	97	-	-	-	0.00
NPMH - Intensive Outpatient	176,459	543	34	324.97	0.92	164,094	490	27	334.89	0.77
NPMH - Partial Hospitalization	2,331	2	0	1,165.39	0.01	90	2	0	44.91	0.00
NPMH - Transportation	85,398	1,193	75	71.57	0.44	102,748	901	50	114.10	0.48
Subtotal - Non-Priority Mental Health	1,566,041	7,139	446	219.36	8.15	1,967,551	7,620	427	258.23	9.19
Total	$ 12,135,940				$ 63.16	$ 16,489,008				$ 77.05

TennCare
Middle Tennessee Data Book
Historical Encounter Data

Exhibit 1

Medicaid (TANF & Related) Age 21 - 44 Female										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	614,980					624,958				
Home Health Care	37,361	236	5	158.31	0.06	33,771	211	4	160.05	0.05
IP - Maternity	14,712,991	18,262	356	805.66	23.92	16,567,843	19,025	365	870.85	26.51
IP - Newborn	8,593,141	15,276	298	562.53	13.97	10,191,146	16,701	321	610.21	16.31
IP - Medical	8,497,062	11,313	221	751.09	13.82	10,028,730	12,454	239	805.26	16.05
IP - Surgery	8,808,923	5,374	105	1,639.17	14.32	9,185,483	5,371	103	1,710.20	14.70
IP - Other	4,681,152	189	4	24,768.00	7.61	8,912,548	361	7	24,688.50	14.26
Subtotal - Inpatient	45,293,269	50,414	984	898.43	73.65	54,885,750	53,912	1,035	1,018.06	87.82
OP - Emergency Room	11,234,045	81,611	1,592	137.65	18.27	15,433,135	91,651	1,760	168.39	24.69
OP - Laboratory	650,528	51,942	1,014	12.52	1.06	1,497,950	67,185	1,290	22.30	2.40
OP - Radiology	4,539,445	49,968	975	90.85	7.38	5,425,817	59,555	1,144	91.11	8.68
OP - Surgery	12,972,410	21,479	419	603.96	21.09	15,853,019	22,938	440	691.12	25.37
OP - Other	2,922,490	27,136	529	107.70	4.75	3,320,790	33,066	635	100.43	5.31
Subtotal - Outpatient	32,318,918	232,136	4,530	139.22	52.55	41,530,710	274,395	5,269	151.35	66.45
Prof - Evaluation & Management	21,106,050	431,947	8,429	48.86	34.32	22,941,574	450,356	8,647	50.94	36.71
Prof - Maternity	8,770,343	17,960	350	488.33	14.26	9,497,695	19,008	365	499.67	15.20
Prof - Surgery	7,179,750	63,480	1,239	113.10	11.67	8,072,090	63,356	1,217	127.41	12.92
Prof - DME/Supplies	1,187,487	7,370	144	161.12	1.93	1,713,856	9,466	182	181.05	2.74
Prof - Lab	3,796,022	352,136	6,871	10.78	6.17	5,073,078	420,074	8,066	12.08	8.12
Prof - Radiology	6,193,829	150,242	2,932	41.23	10.07	7,665,655	169,465	3,254	45.23	12.27
Prof - Transportation	1,679,863	17,140	334	98.01	2.73	1,966,066	18,523	356	106.14	3.15
Prof - Other	8,277,818	537,102	10,480	15.41	13.46	9,133,396	539,172	10,353	16.94	14.61
Subtotal - Professional	58,191,163	1,577,377	30,779	36.89	94.62	66,063,409	1,689,420	32,439	39.10	105.71
NPMH - Inpatient	790,577	1,642	32	481.47	1.29	586,393	1,277	25	459.20	0.94
NPMH - Outpatient	655,836	9,795	191	66.96	1.07	708,005	9,657	185	73.32	1.13
NPMH - Case Rates	199,250	1,094	21	182.13	0.32	33,378	192	4	173.84	0.05
NPMH - Grants	862,610	-	-	-	1.40	831,805	-	-	-	1.33
NPMH - In-Home Services	-	-	-	-	-	-	-	-	-	-
NPMH - Supported Housing	-	-	-	-	-	-	-	-	-	-
NPMH - 23 Hour	1,738	7	0	248.28	0.00	4,165	17	0	245.00	0.01
NPMH - Intensive Outpatient	329,209	837	16	393.32	0.54	281,764	717	14	392.98	0.45
NPMH - Partial Hospitalization	13,961	16	0	872.54	0.02	20,356	37	1	550.17	0.03
NPMH - Transportation	153,737	1,644	32	93.52	0.25	143,584	1,088	21	131.98	0.23
Subtotal - Non-Priority Mental Health	3,006,918	15,035	293	200.00	4.89	2,609,449	12,985	249	200.96	4.18
Total	$ 138,847,628				$ 225.78	$ 165,123,090				$ 264.21

TennCare
Middle Tennessee Data Book
Historical Encounter Data

Exhibit 1

Medicaid (TANF & Related) Age 21 - 44 Male										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	138,512					117,795				
Home Health Care	13,756	95	8	144.80	0.10	13,576	76	8	178.63	0.12
IP - Maternity	-	-	-	-	-	-	-	-	-	-
IP - Newborn	1,782	2	0	891.00	0.01	17,214	15	2	1,147.58	0.15
IP - Medical	2,819,837	3,160	274	892.35	20.36	2,750,379	2,935	299	937.10	23.35
IP - Surgery	5,912,509	2,209	191	2,676.55	42.69	5,345,061	2,206	225	2,422.97	45.38
IP - Other	1,119,775	123	11	9,103.86	8.08	3,894,663	265	27	14,696.84	33.06
Subtotal - Inpatient	9,853,904	5,494	476	1,793.58	71.14	12,007,316	5,421	552	2,214.96	101.93
OP - Emergency Room	2,083,902	14,719	1,275	141.58	15.04	2,415,876	14,465	1,474	167.02	20.51
OP - Laboratory	53,044	4,532	393	11.70	0.38	101,818	8,687	885	11.72	0.86
OP - Radiology	860,243	7,448	645	115.50	6.21	1,016,687	11,485	1,170	88.52	8.63
OP - Surgery	2,041,425	2,717	235	751.35	14.74	2,234,223	2,619	267	853.08	18.97
OP - Other	573,048	3,855	334	148.65	4.14	649,487	4,303	438	150.94	5.51
Subtotal - Outpatient	5,611,662	33,271	2,882	168.67	40.51	6,418,091	41,559	4,234	154.43	54.49
Prof - Evaluation & Management	3,183,672	66,374	5,750	47.97	22.98	3,082,561	60,824	6,196	50.68	26.17
Prof - Maternity	1,250	4	0	312.38	0.01	7,103	11	1	645.69	0.06
Prof - Surgery	1,762,561	14,873	1,289	118.51	12.72	1,739,625	11,870	1,209	146.56	14.77
Prof - DME/Supplies	445,475	2,483	215	179.41	3.22	699,419	2,711	276	257.99	5.94
Prof - Lab	200,311	27,471	2,380	7.29	1.45	266,939	28,708	2,925	9.30	2.27
Prof - Radiology	991,642	28,589	2,477	34.69	7.16	1,124,822	28,815	2,935	39.04	9.55
Prof - Transportation	523,762	3,568	309	146.79	3.78	511,341	3,379	344	151.33	4.34
Prof - Other	1,533,566	108,515	9,401	14.13	11.07	1,365,189	107,618	10,963	12.69	11.59
Subtotal - Professional	8,642,239	251,877	21,821	34.31	62.39	8,796,999	243,936	24,850	36.06	74.68
NPMH - Inpatient	459,552	1,084	94	423.94	3.32	229,857	525	53	437.82	1.95
NPMH - Outpatient	168,168	1,703	148	98.75	1.21	130,341	1,270	129	102.63	1.11
NPMH - Case Rates	64,907	349	30	185.98	0.47	7,117	42	4	169.46	0.06
NPMH - Grants	381,876	-	-	-	2.76	257,312	-	-	-	2.18
NPMH - In-Home Services	-	-	-	-	-	-	-	-	-	-
NPMH - Supported Housing	36,518	15	1	2,434.53	0.26	5,481	6	1	913.50	0.05
NPMH - 23 Hour	1,473	6	1	245.49	0.01	1,934	8	1	241.69	0.02
NPMH - Intensive Outpatient	141,717	328	28	432.06	1.02	68,361	154	16	443.90	0.58
NPMH - Partial Hospitalization	2,672	1	0	2,671.90	0.02	3,465	6	1	577.57	0.03
NPMH - Transportation	82,817	958	83	86.45	0.60	139,220	294	30	473.65	1.18
Subtotal - Non-Priority Mental Health	1,339,699	4,444	385	301.47	9.67	843,088	2,305	235	365.78	7.16
Total	$ 25,461,260				$ 183.82	$ 28,079,071				$ 238.37

TennCare
Middle Tennessee Data Book
Historical Encounter Data

Exhibit 1

Medicaid (TANF & Related) Age 45 - 64										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	153,220					115,001				
Home Health Care	150,944	274	21	550.89	0.99	64,219	186	19	345.26	0.56
IP - Maternity	6,589	6	0	1,098.20	0.04	12,092	15	2	806.12	0.11
IP - Newborn	1,131	6	0	188.52	0.01	7,606	13	1	585.06	0.07
IP - Medical	8,124,834	11,562	906	702.72	53.03	6,925,219	8,971	936	771.96	60.22
IP - Surgery	9,962,435	5,349	419	1,862.49	65.02	7,596,178	4,317	450	1,759.60	66.05
IP - Other	2,135,674	474	37	4,505.64	13.94	4,982,038	563	59	8,849.09	43.32
Subtotal - Inpatient	20,230,664	17,397	1,363	1,162.88	132.04	19,523,132	13,879	1,448	1,406.67	169.76
OP - Emergency Room	1,978,791	11,051	865	179.06	12.91	2,262,094	10,405	1,086	217.40	19.67
OP - Laboratory	205,238	15,726	1,232	13.05	1.34	266,491	14,287	1,491	18.65	2.32
OP - Radiology	2,393,364	24,206	1,896	98.87	15.62	2,416,754	25,190	2,628	95.94	21.02
OP - Surgery	5,856,552	7,499	587	780.98	38.22	5,359,857	5,947	621	901.27	46.61
OP - Other	1,941,466	11,585	907	167.58	12.67	1,918,149	10,852	1,132	176.76	16.68
Subtotal - Outpatient	12,375,411	70,067	5,488	176.62	80.77	12,223,345	66,681	6,958	183.31	106.29
Prof - Evaluation & Management	6,566,902	141,253	11,063	46.49	42.86	5,462,045	109,821	11,459	49.74	47.50
Prof - Maternity	3,471	6	0	578.58	0.02	5,184	15	2	345.63	0.05
Prof - Surgery	3,957,181	35,059	2,746	112.87	25.83	3,292,828	24,248	2,530	135.80	28.63
Prof - DME/Supplies	1,271,105	7,121	558	178.50	8.30	1,429,104	6,650	694	214.90	12.43
Prof - Lab	801,353	88,851	6,959	9.02	5.23	815,948	75,899	7,920	10.75	7.10
Prof - Radiology	2,471,847	60,020	4,701	41.18	16.13	2,343,401	50,964	5,318	45.98	20.38
Prof - Transportation	1,072,038	11,736	919	91.35	7.00	1,020,932	11,066	1,155	92.26	8.88
Prof - Other	6,479,767	427,620	33,491	15.15	42.29	5,741,621	309,630	32,309	18.54	49.93
Subtotal - Professional	22,623,665	771,666	60,436	29.32	147.65	20,111,064	588,293	61,387	34.19	174.88
NPMH - Inpatient	280,005	637	50	439.57	1.83	108,107	292	30	370.23	0.94
NPMH - Outpatient	215,582	3,280	257	65.73	1.41	185,319	2,521	263	73.51	1.61
NPMH - Case Rates	124,108	642	50	193.31	0.81	10,412	58	6	179.51	0.09
NPMH - Grants	292,384	-	-	-	1.91	194,407	-	-	-	1.69
NPMH - In-Home Services	-	-	-	-	-	-	-	-	-	-
NPMH - Supported Housing	25,630	17	1	1,507.62	0.17	-	-	-	-	-
NPMH - 23 Hour	735	3	0	245.00	0.00	245	1	0	245.00	0.00
NPMH - Intensive Outpatient	26,863	67	5	400.94	0.18	25,260	62	6	407.43	0.22
NPMH - Partial Hospitalization	6,164	21	2	293.54	0.04	6,475	17	2	380.89	0.06
NPMH - Transportation	27,762	555	43	50.05	0.18	16,591	246	26	67.47	0.14
Subtotal - Non-Priority Mental Health	999,233	5,222	409	191.36	6.52	546,815	3,197	334	171.04	4.75
Total	$ 56,379,916				$ 367.97	$ 52,468,576				$ 456.24

TennCare
Middle Tennessee Data Book
Historical Encounter Data

Exhibit 1

Medicaid (TANF & Related) Age 65+										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	28,350					22,305				
Home Health Care	39,700	35	15	1,134.27	1.40	40,126	30	16	1,337.53	1.80
IP - Maternity	-	-	-	-	-	-	-	-	-	-
IP - Newborn	-	-	-	-	-	641	1	1	641.18	0.03
IP - Medical	1,351,671	1,773	750	762.36	47.68	869,681	949	511	916.42	38.99
IP - Surgery	730,346	1,467	621	497.85	25.76	489,219	545	293	897.65	21.93
IP - Other	508,372	57	24	8,918.81	17.93	1,074,566	25	13	42,982.63	48.18
Subtotal - Inpatient	2,590,389	3,297	1,396	785.68	91.37	2,434,107	1,520	818	1,601.39	109.13
OP - Emergency Room	152,176	731	309	208.17	5.37	144,912	552	297	262.52	6.50
OP - Laboratory	20,552	2,263	958	9.08	0.72	36,976	1,985	1,068	18.63	1.66
OP - Radiology	230,857	2,999	1,269	76.98	8.14	183,119	2,065	1,111	88.68	8.21
OP - Surgery	654,830	887	375	738.25	23.10	565,395	644	346	877.94	25.35
OP - Other	348,973	1,493	632	233.74	12.31	440,075	1,476	794	298.15	19.73
Subtotal - Outpatient	1,407,387	8,373	3,544	168.09	49.64	1,370,477	6,722	3,616	203.88	61.44
Prof - Evaluation & Management	635,295	16,135	6,830	39.37	22.41	466,394	10,927	5,879	42.68	20.91
Prof - Maternity	-	-	-	-	-	125	1	1	125.00	0.01
Prof - Surgery	373,868	3,018	1,277	123.88	13.19	222,705	2,334	1,256	95.42	9.98
Prof - DME/Supplies	137,252	744	315	184.48	4.84	93,114	626	337	148.75	4.17
Prof - Lab	92,573	10,203	4,319	9.07	3.27	65,562	8,540	4,595	7.68	2.94
Prof - Radiology	219,673	6,440	2,726	34.11	7.75	163,100	4,150	2,233	39.30	7.31
Prof - Transportation	204,973	2,477	1,048	82.75	7.23	172,215	2,060	1,108	83.60	7.72
Prof - Other	868,782	53,524	22,656	16.23	30.65	603,207	46,130	24,818	13.08	27.04
Subtotal - Professional	2,532,414	92,541	39,171	27.37	89.33	1,786,422	74,768	40,225	23.89	80.09
NPMH - Inpatient	10,319	26	11	396.89	0.36	7,029	14	8	502.04	0.32
NPMH - Outpatient	6,840	83	35	82.42	0.24	4,426	55	30	80.47	0.20
NPMH - Case Rates	3,910	20	8	195.50	0.14	703	4	2	175.69	0.03
NPMH - Grants	7,747	-	-	-	0.27	5,040	-	-	-	0.23
NPMH - In-Home Services	-	-	-	-	-	-	-	-	-	-
NPMH - Supported Housing	-	-	-	-	-	-	-	-	-	-
NPMH - 23 Hour	-	-	-	-	-	-	-	-	-	-
NPMH - Intensive Outpatient	-	-	-	-	-	-	-	-	-	-
NPMH - Partial Hospitalization	-	-	-	-	-	207	5	3	41.48	0.01
NPMH - Transportation	2,878	46	20	62.39	0.10	676	9	5	72.17	0.03
Subtotal - Non-Priority Mental Health	31,694	175	74	180.98	1.12	18,080	87	47	206.94	0.81
Total	$ 6,601,585				$ 232.86	$ 5,649,213				$ 253.27

TennCare
Middle Tennessee Data Book
Historical Encounter Data

Exhibit 2

Uninsured/Uninsurable All Ages										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	190,824					156,335				
Home Health Care	1,599	24	2	66.61	0.01	1,285	27	2	47.59	0.01
IP - Maternity	110,773	136	9	814.51	0.58	71,173	89	7	799.70	0.46
IP - Newborn	96,018	166	10	578.42	0.50	94,111	186	14	505.97	0.60
IP - Medical	438,174	902	57	485.78	2.30	548,519	603	46	909.65	3.51
IP - Surgery	280,769	1,355	85	207.21	1.47	349,237	817	63	427.46	2.23
IP - Other	115,301	1	0	115,301.38	0.60	90,774	17	1	5,339.67	0.58
Subtotal - Inpatient	1,041,035	2,560	161	406.65	5.46	1,153,815	1,712	131	673.96	7.38
OP - Emergency Room	746,435	7,599	478	98.23	3.91	714,194	5,789	444	123.37	4.57
OP - Laboratory	75,414	5,456	343	13.82	0.40	117,946	5,226	401	22.57	0.75
OP - Radiology	258,399	4,195	264	61.60	1.35	298,406	4,952	380	60.26	1.91
OP - Surgery	948,315	1,602	101	591.96	4.97	1,055,338	1,475	113	715.48	6.75
OP - Other	634,488	3,490	219	181.80	3.32	720,688	3,740	287	192.70	4.61
Subtotal - Outpatient	2,663,051	22,342	1,405	119.19	13.96	2,906,572	21,182	1,626	137.22	18.59
Prof - Evaluation & Management	2,601,755	64,345	4,046	40.43	13.63	2,311,390	53,756	4,126	43.00	14.78
Prof - Maternity	74,069	163	10	454.41	0.39	40,838	73	6	559.43	0.26
Prof - Surgery	502,663	6,211	391	80.93	2.63	639,503	5,694	437	112.31	4.09
Prof - DME/Supplies	118,027	747	47	158.00	0.62	182,029	760	58	239.51	1.16
Prof - Lab	265,359	29,585	1,860	8.97	1.39	275,099	28,865	2,216	9.53	1.76
Prof - Radiology	259,849	11,625	731	22.35	1.36	250,062	9,592	736	26.07	1.60
Prof - Transportation	116,178	781	49	148.75	0.61	133,288	720	55	185.12	0.85
Prof - Other	1,440,637	186,597	11,734	7.72	7.55	1,354,878	168,187	12,910	8.06	8.67
Subtotal - Professional	5,378,537	300,054	18,869	17.93	28.19	5,187,087	267,647	20,544	19.38	33.18
NPMH - Inpatient	124,083	540	34	229.78	0.65	82,226	306	23	268.71	0.53
NPMH - Outpatient	88,249	1,433	90	61.58	0.46	69,116	988	76	69.96	0.44
NPMH - Case Rates	71,645	348	22	205.88	0.38	9,614	50	4	192.29	0.06
NPMH - Grants	46,713	-	-	-	0.24	35,973	-	-	-	0.23
NPMH - In-Home Services	14,165	10	1	1,416.55	0.07	20,143	12	1	1,678.54	0.13
NPMH - Supported Housing	-	-	-	-	-	-	-	-	-	-
NPMH - 23 Hour	265	1	0	265.00	0.00	-	-	-	-	-
NPMH - Intensive Outpatient	31,296	94	6	332.94	0.16	21,607	45	3	480.16	0.14
NPMH - Partial Hospitalization	38	1	0	37.81	0.00	8	-	-	-	0.00
NPMH - Transportation	16,144	231	15	70.00	0.08	11,209	67	5	167.93	0.07
Subtotal - Non-Priority Mental Health	392,599	2,658	167	147.73	2.06	249,896	1,468	113	170.26	1.60
Total	$ 9,476,821				$ 49.66	$ 9,498,655				$ 60.76

TennCare
Middle Tennessee Data Book
Historical Encounter Data

Exhibit 2

Uninsured/Uninsurable
Age Under 1

Service Category	FISCAL YEAR 2004 Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	FISCAL YEAR 2005 Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	99					83				
Home Health Care	-	-	-	-	-	-	-	-	-	-
IP - Maternity	-	-	-	-	-	-	-	-	-	-
IP - Newborn	-	-	-	-	-	1,465	2	287	732.30	17.54
IP - Medical	-	-	-	-	-	22,133	14	2,012	1,580.92	265.11
IP - Surgery	3,178	127	15,399	25.02	32.11	1,782	2	287	891.00	21.34
IP - Other	-	-	-	-	-	-	-	-	-	-
Subtotal - Inpatient	3,178	127	15,399	25.02	32.11	25,379	18	2,587	1,409.97	303.99
OP - Emergency Room	224	4	485	55.94	2.26	640	5	719	128.05	7.67
OP - Laboratory	35	7	849	5.05	0.36	-	1	144	-	-
OP - Radiology	-	-	-	-	-	214	6	862	35.63	2.56
OP - Surgery	80	1	121	80.12	0.81	28	1	144	27.59	0.33
OP - Other	96	1	121	95.76	0.97	70	2	287	35.10	0.84
Subtotal - Outpatient	435	13	1,576	33.46	4.40	952	15	2,156	63.46	11.40
Prof - Evaluation & Management	1,965	48	5,820	40.94	19.85	3,573	75	10,780	47.64	42.80
Prof - Maternity	-	-	-	-	-	-	-	-	-	-
Prof - Surgery	250	2	242	124.90	2.52	959	5	719	191.88	11.49
Prof - DME/Supplies	-	-	-	-	-	-	-	-	-	-
Prof - Lab	18	2	242	9.07	0.18	64	5	719	12.77	0.76
Prof - Radiology	9	1	121	9.37	0.09	227	20	2,875	11.33	2.71
Prof - Transportation	-	-	-	-	-	3,477	2	287	1,738.50	41.65
Prof - Other	501	112	13,580	4.47	5.06	1,327	159	22,854	8.35	15.89
Subtotal - Professional	2,743	165	20,006	16.62	27.71	9,627	266	38,233	36.19	115.31
NPMH - Inpatient	-	-	-	-	-	-	-	-	-	-
NPMH - Outpatient	-	-	-	-	-	-	-	-	-	-
NPMH - Case Rates	-	-	-	-	-	-	-	-	-	-
NPMH - Grants	-	-	-	-	-	-	-	-	-	-
NPMH - In-Home Services	-	-	-	-	-	-	-	-	-	-
NPMH - Supported Housing	-	-	-	-	-	-	-	-	-	-
NPMH - 23 Hour	-	-	-	-	-	-	-	-	-	-
NPMH - Intensive Outpatient	-	-	-	-	-	-	-	-	-	-
NPMH - Partial Hospitalization	-	-	-	-	-	-	-	-	-	-
NPMH - Transportation	-	-	-	-	-	-	-	-	-	-
Subtotal - Non-Priority Mental Health	-	-	-	-	-	-	-	-	-	-
Total	$ 6,356				$ 64.22	$ 35,958				$ 430.70

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Exhibit 2

Uninsured/Uninsurable Age 1 - 13										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	119,464					97,544				
Home Health Care	787	19	2	41.40	0.01	851	22	3	38.68	0.01
IP - Maternity	-	-	-	-	-	-	-	-	-	-
IP - Newborn	37,298	35	4	1,065.64	0.31	22,033	12	1	1,836.12	0.23
IP - Medical	267,637	686	69	390.14	2.24	262,089	310	38	845.45	2.69
IP - Surgery	133,437	1,130	114	118.09	1.12	149,975	685	84	218.94	1.54
IP - Other	71,640	-	-	-	0.60	16,386	-	-	-	0.17
Subtotal - Inpatient	510,010	1,851	186	275.53	4.27	450,483	1,007	124	447.35	4.62
OP - Emergency Room	372,195	4,394	441	84.71	3.12	345,783	3,264	402	105.94	3.54
OP - Laboratory	42,127	3,216	323	13.10	0.35	75,546	3,201	394	23.60	0.77
OP - Radiology	104,922	2,238	225	46.88	0.88	130,821	3,107	382	42.11	1.34
OP - Surgery	573,082	988	99	580.04	4.80	566,146	828	102	683.75	5.80
OP - Other	328,874	2,189	220	150.24	2.75	328,067	2,343	288	140.02	3.36
Subtotal - Outpatient	1,421,200	13,025	1,308	109.11	11.90	1,446,364	12,743	1,568	113.50	14.83
Prof - Evaluation & Management	1,642,485	41,596	4,178	39.49	13.75	1,433,296	34,230	4,211	41.87	14.69
Prof - Maternity	-	-	-	-	-	-	-	-	-	-
Prof - Surgery	281,547	3,787	380	74.35	2.36	390,347	3,167	390	123.25	4.00
Prof - DME/Supplies	73,837	445	45	165.93	0.62	86,458	372	46	232.41	0.89
Prof - Lab	131,543	15,570	1,564	8.45	1.10	134,573	15,628	1,923	8.61	1.38
Prof - Radiology	100,219	5,531	556	18.12	0.84	96,320	4,457	548	21.61	0.99
Prof - Transportation	44,466	310	31	143.44	0.37	52,501	337	41	155.79	0.54
Prof - Other	902,472	122,928	12,348	7.34	7.55	800,177	106,612	13,116	7.51	8.20
Subtotal - Professional	3,176,570	190,167	19,102	16.70	26.59	2,993,672	164,803	20,274	18.17	30.69
NPMH - Inpatient	18,353	59	6	311.07	0.15	-	-	-	-	-
NPMH - Outpatient	46,414	801	80	57.95	0.39	36,187	547	67	66.16	0.37
NPMH - Case Rates	34,850	187	19	186.36	0.29	4,965	27	3	183.89	0.05
NPMH - Grants	12,746	-	-	-	0.11	6,908	-	-	-	0.07
NPMH - In-Home Services	10,452	7	1	1,493.11	0.09	68	1	0	67.53	0.00
NPMH - Supported Housing	-	-	-	-	-	-	-	-	-	-
NPMH - 23 Hour	-	-	-	-	-	-	-	-	-	-
NPMH - Intensive Outpatient	292	2	0	146.08	0.00	1,285	2	0	642.73	0.01
NPMH - Partial Hospitalization	-	-	-	-	-	-	-	-	-	-
NPMH - Transportation	1,082	13	1	83.17	0.01	1,592	15	2	104.55	0.02
Subtotal - Non-Priority Mental Health	124,189	1,069	107	116.17	1.04	51,005	592	73	86.12	0.52
Total	$ 5,232,756				$ 43.80	$ 4,942,374				$ 50.67

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Exhibit 2

Uninsured/Uninsurable Age 14 - 19 Female										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	34,762					28,569				
Home Health Care	748	3	1	249.31	0.02	306	3	1	101.98	0.01
IP - Maternity	110,773	136	47	814.51	3.19	71,173	89	37	799.70	2.49
IP - Newborn	58,721	131	45	448.25	1.69	70,613	172	72	410.54	2.47
IP - Medical	96,817	140	48	691.55	2.79	99,916	119	50	839.63	3.50
IP - Surgery	51,211	27	9	1,896.70	1.47	56,636	58	24	976.48	1.98
IP - Other	26,365	1	0	26,365.33	0.76	15,230	9	4	1,692.23	0.53
Subtotal - Inpatient	343,887	435	150	790.54	9.89	313,569	447	188	701.50	10.98
OP - Emergency Room	202,125	1,766	610	114.45	5.81	213,473	1,431	601	149.18	7.47
OP - Laboratory	21,796	1,561	539	13.96	0.63	24,982	1,201	504	20.80	0.87
OP - Radiology	96,304	1,125	388	85.60	2.77	84,816	950	399	89.28	2.97
OP - Surgery	211,122	380	131	555.58	6.07	273,142	359	151	760.84	9.56
OP - Other	77,390	766	264	101.03	2.23	99,373	751	315	132.32	3.48
Subtotal - Outpatient	608,736	5,598	1,932	108.74	17.51	695,786	4,692	1,971	148.29	24.35
Prof - Evaluation & Management	586,688	13,754	4,748	42.66	16.88	527,142	11,561	4,856	45.60	18.45
Prof - Maternity	74,069	163	56	454.41	2.13	40,838	73	31	559.43	1.43
Prof - Surgery	104,583	1,245	430	84.00	3.01	119,411	1,350	567	88.45	4.18
Prof - DME/Supplies	23,517	128	44	183.73	0.68	53,641	164	69	327.08	1.88
Prof - Lab	110,995	10,705	3,695	10.37	3.19	108,551	9,763	4,101	11.12	3.80
Prof - Radiology	103,942	3,331	1,150	31.20	2.99	86,433	2,575	1,082	33.57	3.03
Prof - Transportation	27,944	178	61	156.99	0.80	37,149	234	98	158.75	1.30
Prof - Other	303,022	37,271	12,866	8.13	8.72	314,673	38,663	16,240	8.14	11.01
Subtotal - Professional	1,334,761	66,775	23,051	19.99	38.40	1,287,838	64,383	27,043	20.00	45.08
NPMH - Inpatient	10,395	30	10	346.51	0.30	33,960	115	48	295.31	1.19
NPMH - Outpatient	21,150	329	114	64.29	0.61	14,252	181	76	78.74	0.50
NPMH - Case Rates	9,093	41	14	221.77	0.26	1,342	8	3	167.72	0.05
NPMH - Grants	8,233	-	-	-	0.24	9,493	-	-	-	0.33
NPMH - In-Home Services	3,714	3	1	1,237.88	0.11	-	-	-	-	-
NPMH - Supported Housing	-	-	-	-	-	-	-	-	-	-
NPMH - 23 Hour	265	1	0	265.00	0.01	-	-	-	-	-
NPMH - Intensive Outpatient	9,041	26	9	347.73	0.26	3,676	6	3	612.65	0.13
NPMH - Partial Hospitalization	-	-	-	-	-	-	-	-	-	-
NPMH - Transportation	4,162	72	25	57.70	0.12	1,837	6	2	313.77	0.06
Subtotal - Non-Priority Mental Health	66,053	502	173	131.54	1.90	64,560	316	133	204.40	2.26
Total	$ 2,354,185				$ 67.72	$ 2,362,059				$ 82.68

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Exhibit 2

Uninsured/Uninsurable Age 14 - 19 Male										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	36,499					30,138				
Home Health Care	64	2	1	32.07	0.00	128	2	1	64.00	0.00
IP - Maternity	-	-	-	-	-	-	-	-	-	-
IP - Newborn	-	-	-	-	-	-	-	-	-	-
IP - Medical	73,720	76	25	970.00	2.02	164,381	160	64	1,027.38	5.45
IP - Surgery	92,943	71	23	1,309.06	2.55	140,844	72	29	1,956.17	4.67
IP - Other	17,297	-	-	-	0.47	59,159	8	3	7,394.83	1.96
Subtotal - Inpatient	183,960	147	48	1,251.43	5.04	364,384	240	96	1,518.27	12.09
OP - Emergency Room	171,892	1,435	472	119.79	4.71	154,298	1,089	434	141.69	5.12
OP - Laboratory	11,455	672	221	17.05	0.31	17,417	823	328	21.16	0.58
OP - Radiology	57,173	832	274	68.72	1.57	82,555	889	354	92.86	2.74
OP - Surgery	164,031	233	77	704.00	4.49	216,022	287	114	752.69	7.17
OP - Other	228,127	534	176	427.20	6.25	293,178	644	256	455.24	9.73
Subtotal - Outpatient	632,679	3,706	1,218	170.72	17.33	763,470	3,732	1,486	204.57	25.33
Prof - Evaluation & Management	370,618	8,947	2,942	41.42	10.15	347,379	7,890	3,142	44.03	11.53
Prof - Maternity	-	-	-	-	-	-	-	-	-	-
Prof - Surgery	116,282	1,177	387	98.80	3.19	128,785	1,172	467	109.88	4.27
Prof - DME/Supplies	20,673	174	57	118.81	0.57	41,931	224	89	187.19	1.39
Prof - Lab	22,802	3,308	1,088	6.89	0.62	31,911	3,469	1,381	9.20	1.06
Prof - Radiology	55,678	2,762	908	20.16	1.53	67,082	2,540	1,011	26.41	2.23
Prof - Transportation	43,768	293	96	149.38	1.20	40,161	147	59	273.21	1.33
Prof - Other	234,643	26,286	8,642	8.93	6.43	238,701	22,753	9,060	10.49	7.92
Subtotal - Professional	864,464	42,947	14,120	20.13	23.68	895,950	38,195	15,208	23.46	29.73
NPMH - Inpatient	95,334	451	148	211.38	2.61	48,265	191	76	252.70	1.60
NPMH - Outpatient	20,685	303	100	68.27	0.57	18,677	260	104	71.83	0.62
NPMH - Case Rates	27,703	120	39	230.86	0.76	3,308	15	6	220.51	0.11
NPMH - Grants	25,735	-	-	-	0.71	19,572	-	-	-	0.65
NPMH - In-Home Services	-	-	-	-	-	20,075	11	4	1,825.00	0.67
NPMH - Supported Housing	-	-	-	-	-	-	-	-	-	-
NPMH - 23 Hour	-	-	-	-	-	-	-	-	-	-
NPMH - Intensive Outpatient	21,963	66	22	332.77	0.60	16,646	37	15	449.89	0.55
NPMH - Partial Hospitalization	38	1	0	37.81	0.00	8	-	-	-	0.00
NPMH - Transportation	10,900	145	48	74.93	0.30	7,780	46	18	170.35	0.26
Subtotal - Non-Priority Mental Health	202,357	1,086	357	186.25	5.54	134,331	560	223	240.02	4.46
Total	$ 1,883,524				$ 51.60	$ 2,158,264				$ 71.61

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Exhibit 3

Disabled All Ages										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	377,082					357,091				
Home Health Care	566,051	1,603	51	353.12	1.50	712,383	1,606	54	443.58	1.99
	-	-				-	-			
IP - Maternity	406,363	465	15	873.90	1.08	375,996	427	14	880.55	1.05
IP - Newborn	530,539	658	21	806.29	1.41	1,721,552	1,573	53	1,094.44	4.82
IP - Medical	33,689,125	46,786	1,489	720.07	89.34	35,180,860	47,001	1,579	748.51	98.52
IP - Surgery	25,812,978	15,901	506	1,623.36	68.45	21,833,892	12,321	414	1,772.09	61.14
IP - Other	6,825,988	1,284	41	5,316.19	18.10	14,364,138	2,694	91	5,331.90	40.23
Subtotal - Inpatient	67,264,994	65,094	2,072	1,033.35	178.38	73,476,437	64,016	2,151	1,147.78	205.76
OP - Emergency Room	7,629,198	47,214	1,503	161.59	20.23	9,975,842	49,798	1,673	200.33	27.94
OP - Laboratory	701,150	63,006	2,005	11.13	1.86	1,105,878	87,816	2,951	12.59	3.10
OP - Radiology	5,318,278	56,087	1,785	94.82	14.10	6,411,375	63,824	2,145	100.45	17.95
OP - Surgery	13,116,678	18,327	583	715.70	34.78	15,732,774	18,003	605	873.90	44.06
OP - Other	9,330,273	36,492	1,161	255.68	24.74	11,735,444	40,098	1,347	292.67	32.86
Subtotal - Outpatient	36,095,577	221,126	7,037	163.24	95.72	44,961,312	259,539	8,722	173.24	125.91
Prof - Evaluation & Management	19,077,891	399,164	12,703	47.79	50.59	19,373,510	376,214	12,643	51.50	54.25
Prof - Maternity	215,404	559	18	385.34	0.57	185,213	391	13	473.69	0.52
Prof - Surgery	8,407,347	80,913	2,575	103.91	22.30	8,567,361	66,815	2,245	128.23	23.99
Prof - DME/Supplies	8,258,221	31,592	1,005	261.40	21.90	8,883,247	33,023	1,110	269.00	24.88
Prof - Lab	1,895,417	227,004	7,224	8.35	5.03	2,518,261	242,231	8,140	10.40	7.05
Prof - Radiology	5,613,578	153,725	4,892	36.52	14.89	6,475,234	157,722	5,300	41.05	18.13
Prof - Transportation	5,563,319	71,811	2,285	77.47	14.75	5,905,372	66,934	2,249	88.23	16.54
Prof - Other	18,087,510	2,721,546	86,609	6.65	47.97	21,369,687	2,942,112	98,869	7.26	59.84
Subtotal - Professional	67,118,686	3,686,314	117,311	18.21	177.99	73,277,886	3,885,442	130,570	18.86	205.21
NPMH - Inpatient	964,187	2,292	73	420.67	2.56	645,436	1,644	55	392.60	1.81
NPMH - Outpatient	697,861	10,137	323	68.84	1.85	658,789	9,198	309	71.62	1.84
NPMH - Case Rates	145,170	768	24	189.02	0.38	19,702	117	4	168.39	0.06
NPMH - Grants	807,986	-	-	-	2.14	659,813	-	-	-	1.85
NPMH - In-Home Services	32,504	16	1	2,031.52	0.09	9,150	2	0	4,575.00	0.03
NPMH - Supported Housing	37,531	26	1	1,443.49	0.10	13,817	7	0	1,973.87	0.04
NPMH - 23 Hour	1,441	5	0	288.12	0.00	1,189	3	0	396.25	0.00
NPMH - Intensive Outpatient	95,107	213	7	446.51	0.25	61,311	155	5	395.55	0.17
NPMH - Partial Hospitalization	15,878	25	1	635.14	0.04	10,580	14	0	755.73	0.03
NPMH - Transportation	150,930	2,508	80	60.17	0.40	90,096	1,117	38	80.65	0.25
Subtotal - Non-Priority Mental Health	2,948,595	15,990	509	184.40	7.82	2,169,882	12,257	412	177.03	6.08
Total	$ 173,993,901				$ 461.42	$ 194,597,900				$ 544.95

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Exhibit 3

Disabled Age <21										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	22,714					20,972				
Home Health Care	104,753	113	60	927.02	4.61	119,687	132	76	906.72	5.71
IP - Maternity	29,019	32	17	906.83	1.28	8,789	12	7	732.41	0.42
IP - Newborn	131,075	145	77	903.97	5.77	1,329,948	938	537	1,417.85	63.42
IP - Medical	1,079,744	1,182	624	913.49	47.54	740,445	705	403	1,050.28	35.31
IP - Surgery	2,116,453	1,336	706	1,584.17	93.18	304,236	255	146	1,193.08	14.51
IP - Other	478,815	38	20	12,600.41	21.08	1,441,894	141	81	10,226.20	68.75
Subtotal - Inpatient	3,835,107	2,733	1,444	1,403.26	168.84	3,825,311	2,051	1,174	1,865.10	182.40
OP - Emergency Room	253,373	2,214	1,170	114.44	11.15	324,382	2,188	1,252	148.26	15.47
OP - Laboratory	78,272	4,218	2,228	18.56	3.45	103,807	4,267	2,442	24.33	4.95
OP - Radiology	127,143	2,067	1,092	61.51	5.60	131,443	2,167	1,240	60.66	6.27
OP - Surgery	709,392	1,217	643	582.90	31.23	565,257	869	497	650.47	26.95
OP - Other	1,566,458	5,605	2,961	279.48	68.96	1,697,167	5,311	3,039	319.56	80.93
Subtotal - Outpatient	2,734,638	15,321	8,094	178.49	120.39	2,822,057	14,802	8,470	190.65	134.56
Prof - Evaluation & Management	786,776	14,855	7,848	52.96	34.64	755,933	12,758	7,300	59.25	36.04
Prof - Maternity	17,230	34	18	506.78	0.76	6,893	9	5	765.93	0.33
Prof - Surgery	194,331	1,322	698	147.00	8.56	186,370	1,156	661	161.22	8.89
Prof - DME/Supplies	672,162	1,805	954	372.39	29.59	550,346	1,503	860	366.17	26.24
Prof - Lab	38,584	4,392	2,320	8.78	1.70	41,726	4,396	2,515	9.49	1.99
Prof - Radiology	68,780	3,268	1,727	21.05	3.03	62,527	2,954	1,690	21.17	2.98
Prof - Transportation	129,649	1,232	651	105.23	5.71	115,398	1,044	597	110.53	5.50
Prof - Other	627,394	415,526	219,525	1.51	27.62	687,255	482,103	275,855	1.43	32.77
Subtotal - Professional	2,534,905	442,434	233,740	5.73	111.60	2,406,447	505,923	289,485	4.76	114.75
NPMH - Inpatient	88,662	354	187	250.46	3.90	31,594	91	52	347.19	1.51
NPMH - Outpatient	25,171	347	183	72.54	1.11	22,579	247	141	91.41	1.08
NPMH - Case Rates	11,903	64	34	185.99	0.52	3,909	21	12	186.13	0.19
NPMH - Grants	18,717	-	-	-	0.82	10,401	-	-	-	0.50
NPMH - In-Home Services	32,504	16	8	2,031.52	1.43	3,650	2	1	1,825.00	0.17
NPMH - Supported Housing	-	-	-	-	-	-	-	-	-	-
NPMH - 23 Hour	-	-	-	-	-	-	-	-	-	-
NPMH - Intensive Outpatient	2,045	5	3	409.01	0.09	-	-	-	-	-
NPMH - Partial Hospitalization	-	-	-	-	-	-	-	-	-	-
NPMH - Transportation	2,755	56	29	49.56	0.12	1,022	16	9	62.31	0.05
Subtotal - Non-Priority Mental Health	181,758	842	445	215.97	8.00	73,154	377	216	193.84	3.49
Total	$ 9,391,161				$ 413.45	$ 9,246,656				$ 440.90

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Exhibit 3

Disabled Age 21+										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	354,368					336,119				
Home Health Care	461,298	1,490	50	309.60	1.30	592,696	1,474	53	402.10	1.76
IP - Maternity	377,344	433	15	871.47	1.06	367,207	415	15	884.84	1.09
IP - Newborn	399,464	513	17	778.68	1.13	391,604	635	23	616.70	1.17
IP - Medical	32,609,380	45,604	1,544	715.06	92.02	34,440,415	46,296	1,653	743.92	102.46
IP - Surgery	23,696,525	14,565	493	1,626.95	66.87	21,529,656	12,066	431	1,784.32	64.05
IP - Other	6,347,173	1,246	42	5,094.04	17.91	12,922,244	2,553	91	5,061.59	38.45
Subtotal - Inpatient	63,429,887	62,361	2,112	1,017.14	178.99	69,651,126	61,965	2,212	1,124.04	207.22
OP - Emergency Room	7,375,825	45,000	1,524	163.91	20.81	9,651,460	47,610	1,700	202.72	28.71
OP - Laboratory	622,878	58,788	1,991	10.60	1.76	1,002,071	83,549	2,983	11.99	2.98
OP - Radiology	5,191,135	54,020	1,829	96.10	14.65	6,279,932	61,657	2,201	101.85	18.68
OP - Surgery	12,407,286	17,110	579	725.15	35.01	15,167,517	17,134	612	885.23	45.13
OP - Other	7,763,815	30,887	1,046	251.36	21.91	10,038,276	34,787	1,242	288.56	29.87
Subtotal - Outpatient	33,360,939	205,805	6,969	162.10	94.14	42,139,255	244,737	8,738	172.18	125.37
Prof - Evaluation & Management	18,291,115	384,309	13,014	47.59	51.62	18,617,577	363,456	12,976	51.22	55.39
Prof - Maternity	198,174	525	18	377.47	0.56	178,319	382	14	466.80	0.53
Prof - Surgery	8,213,016	79,591	2,695	103.19	23.18	8,380,992	65,659	2,344	127.64	24.93
Prof - DME/Supplies	7,586,059	29,787	1,009	254.68	21.41	8,332,901	31,520	1,125	264.37	24.79
Prof - Lab	1,856,833	222,612	7,538	8.34	5.24	2,476,535	237,835	8,491	10.41	7.37
Prof - Radiology	5,544,798	150,457	5,095	36.85	15.65	6,412,707	154,768	5,525	41.43	19.08
Prof - Transportation	5,433,670	70,579	2,390	76.99	15.33	5,789,974	65,890	2,352	87.87	17.23
Prof - Other	17,460,116	2,306,020	78,089	7.57	49.27	20,682,432	2,460,009	87,826	8.41	61.53
Subtotal - Professional	64,583,780	3,243,880	109,848	19.91	182.25	70,871,438	3,379,519	120,654	20.97	210.85
NPMH - Inpatient	875,525	1,938	66	451.77	2.47	613,842	1,553	55	395.26	1.83
NPMH - Outpatient	672,689	9,790	332	68.71	1.90	636,210	8,951	320	71.08	1.89
NPMH - Case Rates	133,266	704	24	189.30	0.38	15,793	96	3	164.51	0.05
NPMH - Grants	789,269	-	-	-	2.23	649,412	-	-	-	1.93
NPMH - In-Home Services	-	-	-	-	-	5,500	-	-	-	0.02
NPMH - Supported Housing	37,531	26	1	1,443.49	0.11	13,817	7	0	1,973.87	0.04
NPMH - 23 Hour	1,441	5	0	288.12	0.00	1,189	3	0	396.25	0.00
NPMH - Intensive Outpatient	93,062	208	7	447.41	0.26	61,311	155	6	395.55	0.18
NPMH - Partial Hospitalization	15,878	25	1	635.14	0.04	10,580	14	0	755.73	0.03
NPMH - Transportation	148,175	2,453	83	60.41	0.42	89,074	1,101	39	80.92	0.27
Subtotal - Non-Priority Mental Health	2,766,837	15,149	513	182.64	7.81	2,096,728	11,880	424	176.50	6.24
Total	$ 164,602,741				$ 464.50	$ 185,351,243				$ 551.44

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Exhibit 4

Duals All Ages										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	680,800					737,005				
Home Health Care	1,332,395	803	14	1,659.27	1.96	1,839,714	1,161	19	1,584.59	2.50
IP - Maternity	4,406	6	0	734.41	0.01	30,095	42	1	716.55	0.04
IP - Newborn	88,380	89	2	993.03	0.13	54,131	128	2	422.90	0.07
IP - Medical	4,101,922	2,242	40	1,829.58	6.03	5,871,892	2,133	35	2,752.88	7.97
IP - Surgery	509,311	702	12	725.51	0.75	273,218	328	5	832.98	0.37
IP - Other	1,534,199	155	3	9,898.06	2.25	3,193,565	121	2	26,393.10	4.33
Subtotal - Inpatient	6,238,219	3,194	56	1,953.11	9.16	9,422,902	2,752	45	3,424.02	12.79
OP - Emergency Room	274,803	5,137	91	53.49	0.40	440,853	5,583	91	78.96	0.60
OP - Laboratory	32,911	4,369	77	7.53	0.05	69,524	5,722	93	12.15	0.09
OP - Radiology	196,530	6,181	109	31.80	0.29	303,038	6,103	99	49.65	0.41
OP - Surgery	476,057	2,762	49	172.36	0.70	998,215	3,367	55	296.47	1.35
OP - Other	2,081,191	3,651	64	570.03	3.06	8,184,700	7,176	117	1,140.57	11.11
Subtotal - Outpatient	3,061,492	22,100	390	138.53	4.50	9,996,329	27,951	455	357.64	13.56
Prof - Evaluation & Management	707,006	72,190	1,272	9.79	1.04	819,982	89,666	1,460	9.14	1.11
Prof - Maternity	2,249	44	1	51.11	0.00	3,263	95	2	34.34	0.00
Prof - Surgery	337,457	14,351	253	23.51	0.50	403,874	19,282	314	20.95	0.55
Prof - DME/Supplies	591,459	5,879	104	100.61	0.87	659,996	7,611	124	86.72	0.90
Prof - Lab	126,974	43,881	773	2.89	0.19	167,219	48,065	783	3.48	0.23
Prof - Radiology	185,272	23,519	415	7.88	0.27	249,229	31,264	509	7.97	0.34
Prof - Transportation	7,589,593	139,336	2,456	54.47	11.15	8,562,822	133,519	2,174	64.13	11.62
Prof - Other	1,644,008	1,453,553	25,621	1.13	2.41	2,182,812	1,779,641	28,976	1.23	2.96
Subtotal - Professional	11,184,019	1,752,753	30,895	6.38	16.43	13,049,198	2,109,143	34,341	6.19	17.71
NPMH - Inpatient	12,343	37	1	333.60	0.02	30,529	76	1	401.70	0.04
NPMH - Outpatient	43,398	724	13	59.94	0.06	84,423	1,281	21	65.90	0.11
NPMH - Case Rates	143,522	768	14	186.88	0.21	13,654	80	1	170.67	0.02
NPMH - Grants	176,673	-	-	-	0.26	185,814	-	-	-	0.25
NPMH - In-Home Services	-	-	-	-	-	-	-	-	-	-
NPMH - Supported Housing	56,960	35	1	1,627.42	0.08	14,315	9	0	1,590.53	0.02
NPMH - 23 Hour	-	-	-	-	-	-	-	-	-	-
NPMH - Intensive Outpatient	40,838	131	2	311.74	0.06	35,481	106	2	334.72	0.05
NPMH - Partial Hospitalization	421	1	0	420.65	0.00	152	-	-	-	0.00
NPMH - Transportation	204,508	4,053	71	50.46	0.30	165,462	2,834	46	58.39	0.22
Subtotal - Non-Priority Mental Health	678,664	5,749	101	118.05	1.00	529,831	4,386	71	120.80	0.72
Total	$ 22,494,788				$ 33.04	$ 34,837,975				$ 47.27

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Exhibit 5

Waiver Duals All Ages										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	44,313					19,787				
Home Health Care	23,715	20	5	1,185.76	0.54	2,003	11	7	182.13	0.10
IP - Maternity	-	-	-	-	-	-	-	-	-	-
IP - Newborn	-	-	-	-	-	-	-	-	-	-
IP - Medical	540,944	5,212	1,411	103.79	12.21	142,269	683	414	208.30	7.19
IP - Surgery	38,956	212	57	183.75	0.88	9,528	4	2	2,381.93	0.48
IP - Other	283,457	1,218	330	232.72	6.40	75,641	1,199	727	63.09	3.82
Subtotal - Inpatient	863,357	6,642	1,799	129.98	19.48	227,438	1,886	1,144	120.59	11.49
OP - Emergency Room	4,091	336	91	12.18	0.09	2,212	115	70	19.24	0.11
OP - Laboratory	867	333	90	2.60	0.02	136	87	53	1.56	0.01
OP - Radiology	9,940	912	247	10.90	0.22	1,371	304	184	4.51	0.07
OP - Surgery	9,708	316	86	30.72	0.22	1,706	99	60	17.23	0.09
OP - Other	7,140	241	65	29.63	0.16	15,338	95	58	161.45	0.78
Subtotal - Outpatient	31,746	2,138	579	14.85	0.72	20,764	700	425	29.66	1.05
Prof - Evaluation & Management	18,395	6,870	1,860	2.68	0.42	8,029	3,155	1,913	2.54	0.41
Prof - Maternity	-	-	-	-	-	-	-	-	-	-
Prof - Surgery	9,137	1,446	392	6.32	0.21	6,385	545	331	11.71	0.32
Prof - DME/Supplies	15,342	639	173	24.01	0.35	13,758	281	170	48.96	0.70
Prof - Lab	3,277	3,391	918	0.97	0.07	1,229	1,379	836	0.89	0.06
Prof - Radiology	9,611	2,557	692	3.76	0.22	2,226	1,673	1,015	1.33	0.11
Prof - Transportation	275,706	5,117	1,386	53.88	6.22	78,064	1,229	745	63.52	3.95
Prof - Other	82,338	86,671	23,471	0.95	1.86	24,064	21,395	12,975	1.12	1.22
Subtotal - Professional	413,806	106,691	28,892	3.88	9.34	133,755	29,657	17,986	4.51	6.76
NPMH - Inpatient	-	-	-	-	-	98	1	1	98.20	0.00
NPMH - Outpatient	3,903	95	26	41.09	0.09	2,527	56	34	45.13	0.13
NPMH - Case Rates	29,692	165	45	179.95	0.67	672	4	2	168.11	0.03
NPMH - Grants	20,931	-	-	-	0.47	8,225	-	-	-	0.42
NPMH - In-Home Services	-	-	-	-	-	-	-	-	-	-
NPMH - Supported Housing	32,251	14	4	2,303.66	0.73	15,760	8	5	1,969.95	0.80
NPMH - 23 Hour	-	-	-	-	-	-	-	-	-	-
NPMH - Intensive Outpatient	3,456	12	3	287.98	0.08	-	-	-	-	-
NPMH - Partial Hospitalization	-	-	-	-	-	-	-	-	-	-
NPMH - Transportation	6,395	162	44	39.47	0.14	1,860	50	31	36.94	0.09
Subtotal - Non-Priority Mental Health	96,628	448	121	215.68	2.18	29,142	119	72	244.17	1.47
Total	$ 1,429,252				$ 32.25	$ 413,102				$ 20.88

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Exhibit 6

State Only & Judicials All Ages										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	13,741					14,509				
PMH - Inpatient	329,183	892	779	369.04	23.96	606,287	1,605	1,327	377.75	41.79
PMH - Inpatient RMHI	1,745,323	6,095	5,323	286.35	127.02	2,425,378	8,127	6,722	298.43	167.16
PMH - Outpatient	81,395	587	513	138.66	5.92	185,353	1,265	1,046	146.52	12.78
PMH - Case Rates	932,198	4,919	4,296	189.51	67.84	1,255,214	7,026	5,811	178.65	86.51
PMH - Grants	238,547	-	-	-	17.36	431,479	-	-	-	29.74
PMH - In-Home Services	1,400	1	1	1,400.39	0.10	9,125	5	4	1,825.00	0.63
PMH - Supported Housing	54,467	31	27	1,756.99	3.96	56,791	29	24	1,958.31	3.91
PMH - 23 Hour	-	-	-	-	-	862	1	1	862.40	0.06
PMH - Intensive Outpatient	96,307	216	189	445.87	7.01	125,394	511	423	245.39	8.64
PMH - Partial Hospitalization	4,131	2	2	2,065.27	0.30	8,708	11	9	791.60	0.60
PMH - Transportation	28,827	416	364	69.25	2.10	60,316	1,021	845	59.07	4.16
Subtotal - Mental Health	3,511,777	13,159	11,492	266.87	255.58	5,164,907	19,601	16,212	263.50	355.98
Total	$ 3,511,777				$ 255.58	$ 5,164,907				$ 355.98

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Exhibit 7

BHO Priority All Ages										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	263,960					260,358				
PMH - Inpatient	15,121,456	42,533	1,934	355.52	57.29	15,522,424	44,817	2,066	346.35	59.62
PMH - Inpatient RMHI	11,021,471	38,489	1,750	286.35	41.75	11,996,187	40,197	1,853	298.43	46.08
PMH - Outpatient	3,429,497	38,062	1,730	90.10	12.99	3,688,620	37,049	1,708	99.56	14.17
PMH - Case Rates	36,790,986	194,858	8,859	188.81	139.38	37,985,183	201,462	9,285	188.55	145.90
PMH - Grants	9,664,089	-	-	-	36.61	10,107,350	-	-	-	38.82
PMH - In-Home Services	2,120,927	1,327	60	1,598.29	8.04	1,576,388	1,032	48	1,527.51	6.05
PMH - Supported Housing	5,105,990	2,620	119	1,948.85	19.34	4,943,985	2,853	131	1,732.91	18.99
PMH - 23 Hour	6,269	17	1	368.77	0.02	6,124	13	1	471.11	0.02
PMH - Intensive Outpatient	1,041,979	3,251	148	320.51	3.95	944,092	3,421	158	275.97	3.63
PMH - Partial Hospitalization	195,771	241	11	812.33	0.74	178,744	172	8	1,039.21	0.69
PMH - Transportation	3,703,390	67,980	3,090	54.48	14.03	3,654,083	49,832	2,297	73.33	14.03
Subtotal - Priority Mental Health	88,201,825	389,378	17,702	226.52	334.15	90,603,182	380,848	17,553	237.90	347.99
Total	$ 88,201,825				$ 334.15	$ 90,603,182				$ 347.99

TennCare
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Exhibit 7

BHO Priority Age <21										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	85,496					82,418				
PMH - Inpatient	5,638,878	20,477	2,874	275.38	65.95	6,649,548	24,563	3,576	270.71	80.68
PMH - Inpatient RMHI	360,805	1,260	177	286.35	4.22	597,466	2,002	291	298.43	7.25
PMH - Outpatient	746,467	11,308	1,587	66.01	8.73	839,282	11,272	1,641	74.46	10.18
PMH - Case Rates	10,914,166	55,436	7,781	196.88	127.66	12,303,567	62,063	9,036	198.24	149.28
PMH - Grants	1,576,775	-	-	-	18.44	1,713,902	-	-	-	20.80
PMH - In-Home Services	2,120,927	1,327	186	1,598.29	24.81	1,576,388	1,032	150	1,527.51	19.13
PMH - Supported Housing	49,109	23	3	2,135.15	0.57	94,071	55	8	1,710.38	1.14
PMH - 23 Hour	265	1	0	265.00	0.00	-	-	-	-	-
PMH - Intensive Outpatient	244,396	929	130	263.07	2.86	233,471	974	142	239.70	2.83
PMH - Partial Hospitalization	25,766	20	3	1,288.31	0.30	9,583	12	2	798.56	0.12
PMH - Transportation	306,659	5,750	807	53.33	3.59	355,020	3,794	552	93.57	4.31
Subtotal - Priority Mental Health	21,984,213	96,531	13,549	227.74	257.14	24,372,298	105,767	15,400	230.43	295.71
Total	$ 21,984,213				$ 257.14	$ 24,372,298				$ 295.71

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Exhibit 7

BHO Priority Age 21+										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	178,464					177,939				
PMH - Inpatient	9,482,578	22,056	1,483	429.93	53.13	8,872,876	20,254	1,366	438.08	49.86
PMH - Inpatient RMHI	10,660,665	37,229	2,503	286.35	59.74	11,398,721	38,195	2,576	298.43	64.06
PMH - Outpatient	2,683,031	26,754	1,799	100.29	15.03	2,849,338	25,777	1,738	110.54	16.01
PMH - Case Rates	25,876,820	139,422	9,375	185.60	145.00	25,681,616	139,399	9,401	184.23	144.33
PMH - Grants	8,087,314	-	-	-	45.32	8,393,449	-	-	-	47.17
PMH - In-Home Services	-	-	-	-	-	-	-	-	-	-
PMH - Supported Housing	5,056,882	2,597	175	1,947.20	28.34	4,849,914	2,798	189	1,733.35	27.26
PMH - 23 Hour	6,004	16	1	375.26	0.03	6,124	13	1	471.11	0.03
PMH - Intensive Outpatient	797,582	2,322	156	343.49	4.47	710,621	2,447	165	290.40	3.99
PMH - Partial Hospitalization	170,005	221	15	769.25	0.95	169,162	160	11	1,057.26	0.95
PMH - Transportation	3,396,730	62,230	4,184	54.58	19.03	3,299,064	46,038	3,105	71.66	18.54
Subtotal - Priority Mental Health	66,217,612	292,847	19,691	226.12	371.04	66,230,885	275,081	18,551	240.77	372.21
Total	$ 66,217,612				$ 371.04	$ 66,230,885				$ 372.21

TennCare
Middle Tennessee Data Book
Historical Encounter Data

Exhibit 8

Total For All Aid Categories
All Ages

Service Category	FISCAL YEAR 2004 Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	FISCAL YEAR 2005 Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
Member Months	4,070,450					4,144,768				
Home Health Care	2,256,017	3,627	11	622.01	0.55	2,797,364	3,899	11	717.46	0.67
IP - Maternity	20,021,697	25,434	75	787.20	4.92	22,638,461	26,788	78	845.10	5.46
IP - Newborn	24,465,862	34,207	101	715.23	6.01	31,831,979	41,441	120	768.13	7.68
IP - Medical	68,851,045	95,682	282	719.58	16.91	72,621,839	89,431	259	812.04	17.52
IP - Surgery	58,193,114	36,597	108	1,590.11	14.30	51,919,157	30,602	89	1,696.59	12.53
IP - Other	20,658,648	3,625	11	5,698.94	5.08	47,924,518	5,519	16	8,683.55	11.56
Subtotal - Inpatient	192,190,366	195,545	576	982.84	47.22	226,935,954	193,781	561	1,171.09	54.75
OP - Emergency Room	37,322,383	300,059	885	124.38	9.17	48,474,133	318,941	923	151.98	11.70
OP - Laboratory	2,440,389	203,345	599	12.00	0.60	4,516,420	275,460	798	16.40	1.09
OP - Radiology	15,853,014	187,951	554	84.35	3.89	18,701,211	240,210	695	77.85	4.51
OP - Surgery	46,390,194	75,298	222	616.09	11.40	54,367,694	75,553	219	719.60	13.12
OP - Other	21,720,763	124,601	367	174.32	5.34	31,316,466	147,433	427	212.41	7.56
Subtotal - Outpatient	123,726,743	891,254	2,627	138.82	30.40	157,375,923	1,057,597	3,062	148.81	37.97
Prof - Evaluation & Management	89,720,934	1,981,491	5,842	45.28	22.04	94,858,702	1,988,219	5,756	47.71	22.89
Prof - Maternity	12,135,682	25,228	74	481.04	2.98	13,065,978	26,092	76	500.77	3.15
Prof - Surgery	27,681,238	287,385	847	96.32	6.80	28,951,317	270,710	784	106.95	6.99
Prof - DME/Supplies	13,331,760	66,584	196	200.22	3.28	15,251,094	72,370	210	210.74	3.68
Prof - Lab	9,713,994	1,070,989	3,157	9.07	2.39	12,623,735	1,220,210	3,533	10.35	3.05
Prof - Radiology	18,684,177	558,829	1,647	33.43	4.59	21,525,475	583,727	1,690	36.88	5.19
Prof - Transportation	18,962,317	268,773	792	70.55	4.66	20,549,375	254,027	735	80.89	4.96
Prof - Other	50,723,856	6,878,700	20,279	7.37	12.46	55,621,561	7,330,874	21,224	7.59	13.42
Subtotal - Professional	240,953,959	11,137,979	32,836	21.63	59.20	262,447,237	11,746,229	34,008	22.34	63.32
NPMH - Inpatient	4,489,306	13,358	39	336.08	1.10	3,640,258	11,093	32	328.16	0.88
NPMH - Outpatient	2,500,126	37,009	109	67.55	0.61	2,536,146	34,583	100	73.34	0.61
NPMH - Case Rates	1,129,795	5,914	17	191.04	0.28	201,966	1,036	3	194.95	0.05
NPMH - Grants	3,139,113	-	-	-	0.77	2,748,946	-	-	-	0.66
NPMH - In-Home Services	289,768	171	1	1,694.55	0.07	197,662	107	0	1,847.31	0.05
NPMH - Supported Housing	192,532	110	0	1,750.29	0.05	51,973	32	0	1,624.14	0.01
NPMH - 23 Hour	5,651	22	0	256.89	0.00	7,629	29	0	263.06	0.00
NPMH - Intensive Outpatient	931,092	2,453	7	379.57	0.23	740,876	1,967	6	376.65	0.18
NPMH - Partial Hospitalization	43,763	70	0	625.18	0.01	44,443	82	0	541.98	0.01
NPMH - Transportation	794,754	12,247	36	64.89	0.20	731,982	7,273	21	100.64	0.18
Subtotal - Non-Priority Mental Health	13,515,900	71,354	210	189.42	3.32	10,901,881	56,202	163	193.98	2.63

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Exhibit 8

Total For All Aid Categories All Ages										
	FISCAL YEAR 2004					FISCAL YEAR 2005				
Service Category	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM
PMH - Inpatient	15,450,639	43,425	128	355.80	3.80	16,128,711	46,422	134	347.44	3.89
PMH - Inpatient RMHI	12,766,794	44,584	131	286.35	3.14	14,421,566	48,324	140	298.43	3.48
PMH - Outpatient	3,510,892	38,649	114	90.84	0.86	3,873,973	38,314	111	101.11	0.93
PMH - Case Rates	37,723,184	199,777	589	188.83	9.27	39,240,397	208,488	604	188.21	9.47
PMH - Grants	9,902,636	-	-	-	2.43	10,538,830	-	-	-	2.54
PMH - In-Home Services	2,122,328	1,328	4	1,598.14	0.52	1,585,513	1,037	3	1,528.94	0.38
PMH - Supported Housing	5,160,457	2,651	8	1,946.61	1.27	5,000,776	2,882	8	1,735.18	1.21
PMH - 23 Hour	6,269	17	0	368.77	0.00	6,987	14	0	499.06	0.00
PMH - Intensive Outpatient	1,138,286	3,467	10	328.32	0.28	1,069,487	3,932	11	272.00	0.26
PMH - Partial Hospitalization	199,902	243	1	822.64	0.05	187,452	183	1	1,024.33	0.05
PMH - Transportation	3,732,216	68,396	202	54.57	0.92	3,714,399	50,853	147	73.04	0.90
Subtotal - Priority Mental Health	91,713,602	402,537	1,187	227.84	22.53	95,768,089	400,449	1,159	239.15	23.11
Total	$ 664,356,587				$ 163.21	$ 756,226,448				$ 182.45

TennCare **Exhibit 9**

Middle Tennessee Data Book

Projected Trends

	Annual Trend	Months From Data Period To Contract Period	Trend Factor
Home Health Care	7.0%	18.0	1.107
IP - Maternity	5.0%	18.0	1.076
IP - Newborn	5.0%	18.0	1.076
IP - Medical	5.0%	18.0	1.076
IP - Surgery	5.0%	18.0	1.076
IP - Other	5.0%	18.0	1.076
OP - Emergency Room	11.0%	18.0	1.169
OP - Laboratory	11.0%	18.0	1.169
OP - Radiology	11.0%	18.0	1.169
OP - Surgery	11.0%	18.0	1.169
OP - Other	11.0%	18.0	1.169
Prof - Evaluation & Management	7.0%	18.0	1.107
Prof - Maternity	7.0%	18.0	1.107
Prof - Surgery	7.0%	18.0	1.107
Prof - DME/Supplies	7.0%	18.0	1.107
Prof - Lab	7.0%	18.0	1.107
Prof - Radiology	7.0%	18.0	1.107
Prof - Transportation	7.0%	18.0	1.107
Prof - Other	7.0%	18.0	1.107
MH - Inpatient (FFS)	7.0%	18.0	1.107
MH - Inpatient (RMHI)	0.0%	18.0	1.000
MH - Outpatient	7.0%	18.0	1.107
MH - Case Rates	3.0%	18.0	1.045
MH - Grants	0.0%	18.0	1.000
MH - In-Home Services	7.0%	18.0	1.107
MH - Supported Housing	7.0%	18.0	1.107
MH - 23 Hour	7.0%	18.0	1.107
MH - Intensive Outpatient	7.0%	18.0	1.107
MH - Partial Hospitalization	7.0%	18.0	1.107
MH - Transportation	7.0%	18.0	1.107

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Middle Tennessee Data Book

Adjustment Factors

Exhibit 10

	IBNR Completion Factor	Benefit Adjustment Factor		Managed Care Utilization Impact
		Child (<21)	Adult (21+)	
Home Health Care	1.0000	1.000	1.000	-0.3%
IP - Maternity	1.0113	1.000	1.000	-13.6%
IP - Newborn	1.0113	1.000	1.000	-13.6%
IP - Medical	1.0113	1.000	0.974	-23.7%
IP - Surgery	1.0113	1.000	0.974	-21.8%
IP - Other	1.0113	1.000	0.974	-23.4%
OP - Emergency Room	1.0113	1.000	0.987	-19.6%
OP - Laboratory	1.0113	1.000	0.979	-19.6%
OP - Radiology	1.0113	1.000	0.979	-18.3%
OP - Surgery	1.0113	1.000	0.987	-25.0%
OP - Other	1.0113	1.000	0.987	-12.7%
Prof - Evaluation & Management	1.0055	1.000	0.977	12.0%
Prof - Maternity	1.0055	1.000	1.000	2.4%
Prof - Surgery	1.0055	1.000	0.993	-11.0%
Prof - DME/Supplies	1.0055	1.000	1.000	-13.2%
Prof - Lab	1.0055	1.000	0.979	-15.0%
Prof - Radiology	1.0055	1.000	0.979	-9.6%
Prof - Transportation	1.0055	1.000	1.000	-13.6%
Prof - Other	1.0055	1.000	1.000	-11.2%
NPMH - Inpatient (FFS)	1.0253	1.000	1.000	0.0%
NPMH - Inpatient (RMHI)	1.0000	1.000	1.000	0.0%
NPMH - Outpatient	1.0110	1.000	1.000	0.0%
NPMH - Case Rates	1.0000	1.000	1.000	0.0%
NPMH - Grants	1.0000	1.000	1.000	0.0%
NPMH - In-Home Services	1.0013	1.000	1.000	0.0%
NPMH - Supported Housing	1.0040	1.000	1.000	0.0%
NPMH - 23 Hour	1.0006	1.000	1.000	0.0%
NPMH - Intensive Outpatient	1.0085	1.000	1.000	0.0%
NPMH - Partial Hospitalization	1.0075	1.000	1.000	0.0%
NPMH - Transportation	1.0016	1.000	1.000	0.0%

TennCare **Exhibit 11**

Middle Tennessee Data Book

Capitation Rate Development

Medicaid (TANF & Related) Age Under 1									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 78,672									
Home Health Care	6.3	105.55	0.06	1.107	1.000	1.000	0.06	-0.3%	0.06
IP - Maternity	2	770	0.12	1.076	1.011	1.000	0.13	-13.6%	0.11
IP - Newborn	1,710	990	141.10	1.076	1.011	1.000	153.52	-13.6%	132.60
IP - Medical	363	777	23.52	1.076	1.011	1.000	25.59	-23.7%	19.52
IP - Surgery	164	1,378	18.81	1.076	1.011	1.000	20.47	-21.8%	16.00
IP - Other	9	72,911	54.68	1.076	1.011	1.000	59.50	-23.4%	45.58
Subtotal - Inpatient	2,248	76,826	238.22				259.20		213.81
OP - Emergency Room	991	110	9.04	1.169	1.011	1.000	10.69	-19.6%	8.60
OP - Laboratory	507	17	0.71	1.169	1.011	1.000	0.84	-19.6%	0.68
OP - Radiology	356	47	1.39	1.169	1.011	1.000	1.64	-18.3%	1.34
OP - Surgery	115	568	5.44	1.169	1.011	1.000	6.44	-25.0%	4.83
OP - Other	428	83	2.95	1.169	1.011	1.000	3.49	-12.7%	3.04
Subtotal - Outpatient	2,396	824	19.53				23.10		18.49
Prof - Evaluation & Management	12,395	63	64.70	1.107	1.006	1.000	72.00	12.0%	80.68
Prof - Maternity	2	350	0.05	1.107	1.006	1.000	0.05	2.4%	0.06
Prof - Surgery	664	125	6.91	1.107	1.006	1.000	7.69	-11.0%	6.84
Prof - DME/Supplies	194	142	2.29	1.107	1.006	1.000	2.54	-13.2%	2.21
Prof - Lab	757	9	0.59	1.107	1.006	1.000	0.66	-15.0%	0.56
Prof - Radiology	1,160	15	1.44	1.107	1.006	1.000	1.60	-9.6%	1.45
Prof - Transportation	104	298	2.60	1.107	1.006	1.000	2.89	-13.6%	2.50
Prof - Other	27,723	7	15.88	1.107	1.006	1.000	17.67	-11.2%	15.69
Subtotal - Professional	42,999	1,009	94.45				105.11		109.98
NPMH - Inpatient	-	-	-	1.107	1.025	1.000	-	0.0%	-
NPMH - Outpatient	0	70	0.00	1.107	1.011	1.000	0.00	0.0%	0.00
NPMH - Case Rates	-	-	-	1.045	1.000	1.000	-	0.0%	-
NPMH - Grants	-	-	0.00	1.000	1.000	1.000	0.00	0.0%	0.00
NPMH - In-Home Services	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Supported Housing	-	-	-	1.107	1.004	1.000	-	0.0%	-
NPMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Intensive Outpatient	-	-	-	1.107	1.009	1.000	-	0.0%	-
NPMH - Partial Hospitalization	-	-	-	1.107	1.008	1.000	-	0.0%	-
NPMH - Transportation	-	-	-	1.107	1.002	1.000	-	0.0%	-
Subtotal - Non-Priority Mental Health	0	70	0.00				0.00		0.00
Total			$ 352.26				$ 387.48		$ 342.35
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 428.84**		**$ 378.89**

TennCare **Exhibit 11**

Middle Tennessee Data Book

Capitation Rate Development

Medicaid (TANF & Related) Age 1 - 13									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 1,418,489									
Home Health Care	4.2	157.65	0.05	1.107	1.000	1.000	0.06	-0.3%	0.06
IP - Maternity	0	903	0.01	1.076	1.011	1.000	0.01	-13.6%	0.01
IP - Newborn	45	830	3.12	1.076	1.011	1.000	3.40	-13.6%	2.93
IP - Medical	63	728	3.82	1.076	1.011	1.000	4.15	-23.7%	3.17
IP - Surgery	18	1,209	1.76	1.076	1.011	1.000	1.92	-21.8%	1.50
IP - Other	1	20,089	1.95	1.076	1.011	1.000	2.13	-23.4%	1.63
Subtotal - Inpatient	127	23,759	10.67				11.61		9.25
OP - Emergency Room	791	108	7.15	1.169	1.011	1.000	8.45	-19.6%	6.80
OP - Laboratory	382	15	0.48	1.169	1.011	1.000	0.57	-19.6%	0.45
OP - Radiology	380	24	0.77	1.169	1.011	1.000	0.92	-18.3%	0.75
OP - Surgery	106	664	5.90	1.169	1.011	1.000	6.97	-25.0%	5.23
OP - Other	263	93	2.04	1.169	1.011	1.000	2.42	-12.7%	2.11
Subtotal - Outpatient	1,923	906	16.34				19.32		15.34
Prof - Evaluation & Management	4,740	46	18.10	1.107	1.006	1.000	20.15	12.0%	22.57
Prof - Maternity	0	531	0.01	1.107	1.006	1.000	0.01	2.4%	0.01
Prof - Surgery	447	65	2.41	1.107	1.006	1.000	2.68	-11.0%	2.39
Prof - DME/Supplies	61	135	0.69	1.107	1.006	1.000	0.76	-13.2%	0.66
Prof - Lab	1,661	8	1.12	1.107	1.006	1.000	1.24	-15.0%	1.06
Prof - Radiology	539	17	0.77	1.107	1.006	1.000	0.86	-9.6%	0.78
Prof - Transportation	74	121	0.74	1.107	1.006	1.000	0.83	-13.6%	0.71
Prof - Other	8,157	9	5.84	1.107	1.006	1.000	6.50	-11.2%	5.78
Subtotal - Professional	15,679	932	29.68				33.03		33.96
NPMH - Inpatient	14	262	0.30	1.107	1.025	1.000	0.34	0.0%	0.34
NPMH - Outpatient	51	68	0.28	1.107	1.011	1.000	0.32	0.0%	0.32
NPMH - Case Rates	3	212	0.04	1.045	1.000	1.000	0.05	0.0%	0.05
NPMH - Grants	-	-	0.12	1.000	1.000	1.000	0.12	0.0%	0.12
NPMH - In-Home Services	0	1,825	0.06	1.107	1.001	1.000	0.07	0.0%	0.07
NPMH - Supported Housing	-	-	-	1.107	1.004	1.000	-	0.0%	-
NPMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Intensive Outpatient	0	167	0.00	1.107	1.009	1.000	0.00	0.0%	0.00
NPMH - Partial Hospitalization	-	-	-	1.107	1.008	1.000	-	0.0%	-
NPMH - Transportation	1	68	0.01	1.107	1.002	1.000	0.01	0.0%	0.01
Subtotal - Non-Priority Mental Health	69	2,602	0.82				0.91		0.91
Total			$ 57.57				$ 64.94		$ 59.51
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 71.87**		**$ 65.86**

TennCare **Exhibit 11**

Middle Tennessee Data Book

Capitation Rate Development

Medicaid (TANF & Related) Age 14 - 20 Female									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 268,804									
Home Health Care	1.5	162.35	0.02	1.107	1.000	1.000	0.02	-0.3%	0.02
IP - Maternity	320	776	20.66	1.076	1.011	1.000	22.48	-13.6%	19.41
IP - Newborn	280	672	15.68	1.076	1.011	1.000	17.06	-13.6%	14.74
IP - Medical	119	730	7.23	1.076	1.011	1.000	7.87	-23.7%	6.00
IP - Surgery	32	1,827	4.80	1.076	1.011	1.000	5.22	-21.8%	4.08
IP - Other	1	90,111	8.72	1.076	1.011	1.000	9.48	-23.4%	7.27
Subtotal - Inpatient	751	94,116	57.09				62.12		51.50
OP - Emergency Room	1,214	159	16.12	1.169	1.011	1.000	19.07	-19.6%	15.34
OP - Laboratory	1,001	21	1.79	1.169	1.011	1.000	2.12	-19.6%	1.71
OP - Radiology	615	71	3.63	1.169	1.011	1.000	4.29	-18.3%	3.51
OP - Surgery	251	482	10.07	1.169	1.011	1.000	11.91	-25.0%	8.93
OP - Other	417	81	2.82	1.169	1.011	1.000	3.34	-12.7%	2.92
Subtotal - Outpatient	3,497	815	34.44				40.73		32.40
Prof - Evaluation & Management	6,098	51	25.95	1.107	1.006	1.000	28.88	12.0%	32.36
Prof - Maternity	289	512	12.33	1.107	1.006	1.000	13.72	2.4%	14.05
Prof - Surgery	549	98	4.50	1.107	1.006	1.000	5.01	-11.0%	4.46
Prof - DME/Supplies	63	156	0.83	1.107	1.006	1.000	0.92	-13.2%	0.80
Prof - Lab	6,395	11	6.03	1.107	1.006	1.000	6.71	-15.0%	5.71
Prof - Radiology	1,755	41	5.96	1.107	1.006	1.000	6.63	-9.6%	6.00
Prof - Transportation	213	119	2.11	1.107	1.006	1.000	2.35	-13.6%	2.03
Prof - Other	7,586	18	11.28	1.107	1.006	1.000	12.55	-11.2%	11.15
Subtotal - Professional	22,949	1,007	68.99				76.78		76.54
NPMH - Inpatient	38	387	1.23	1.107	1.025	1.000	1.39	0.0%	1.39
NPMH - Outpatient	87	79	0.57	1.107	1.011	1.000	0.64	0.0%	0.64
NPMH - Case Rates	4	185	0.07	1.045	1.000	1.000	0.07	0.0%	0.07
NPMH - Grants	-	-	0.42	1.000	1.000	1.000	0.42	0.0%	0.42
NPMH - In-Home Services	1	1,728	0.09	1.107	1.001	1.000	0.10	0.0%	0.10
NPMH - Supported Housing	0	1,300	0.01	1.107	1.004	1.000	0.01	0.0%	0.01
NPMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Intensive Outpatient	9	381	0.29	1.107	1.009	1.000	0.32	0.0%	0.32
NPMH - Partial Hospitalization	0	2,863	0.01	1.107	1.008	1.000	0.01	0.0%	0.01
NPMH - Transportation	23	98	0.18	1.107	1.002	1.000	0.20	0.0%	0.20
Subtotal - Non-Priority Mental Health	162	7,020	2.87				3.17		3.17
Total			$ 163.41				$ 182.82		$ 163.64
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 202.33**		**$ 181.11**

TennCare **Exhibit 11**

Middle Tennessee Data Book

Capitation Rate Development

Medicaid (TANF & Related) Age 14 - 20 Male									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 214,018									
Home Health Care	1.2	116.49	0.01	1.107	1.000	1.000	0.01	-0.3%	0.01
IP - Maternity	-	-	-	1.076	1.011	1.000	-	-13.6%	-
IP - Newborn	0	121	0.00	1.076	1.011	1.000	0.00	-13.6%	0.00
IP - Medical	68	901	5.11	1.076	1.011	1.000	5.57	-23.7%	4.24
IP - Surgery	47	1,856	7.31	1.076	1.011	1.000	7.96	-21.8%	6.22
IP - Other	3	37,641	8.97	1.076	1.011	1.000	9.76	-23.4%	7.48
Subtotal - Inpatient	118	40,519	21.40				23.28		17.95
OP - Emergency Room	750	142	8.89	1.169	1.011	1.000	10.51	-19.6%	8.45
OP - Laboratory	763	8	0.49	1.169	1.011	1.000	0.58	-19.6%	0.46
OP - Radiology	317	81	2.15	1.169	1.011	1.000	2.54	-18.3%	2.08
OP - Surgery	84	712	4.98	1.169	1.011	1.000	5.89	-25.0%	4.42
OP - Other	191	130	2.07	1.169	1.011	1.000	2.45	-12.7%	2.14
Subtotal - Outpatient	2,104	1,074	18.58				21.97		17.56
Prof - Evaluation & Management	3,102	48	12.38	1.107	1.006	1.000	13.78	12.0%	15.44
Prof - Maternity	0	-	-	1.107	1.006	1.000	-	2.4%	-
Prof - Surgery	395	119	3.91	1.107	1.006	1.000	4.35	-11.0%	3.88
Prof - DME/Supplies	76	149	0.94	1.107	1.006	1.000	1.05	-13.2%	0.91
Prof - Lab	1,226	9	0.88	1.107	1.006	1.000	0.98	-15.0%	0.83
Prof - Radiology	1,091	23	2.05	1.107	1.006	1.000	2.28	-9.6%	2.06
Prof - Transportation	137	153	1.74	1.107	1.006	1.000	1.94	-13.6%	1.68
Prof - Other	5,668	13	5.96	1.107	1.006	1.000	6.63	-11.2%	5.89
Subtotal - Professional	11,694	512	27.86				31.01		30.68
NPMH - Inpatient	251	267	5.59	1.107	1.025	1.000	6.34	0.0%	6.34
NPMH - Outpatient	91	83	0.63	1.107	1.011	1.000	0.71	0.0%	0.71
NPMH - Case Rates	5	271	0.12	1.045	1.000	1.000	0.13	0.0%	0.13
NPMH - Grants	-	-	1.36	1.000	1.000	1.000	1.36	0.0%	1.36
NPMH - In-Home Services	2	1,825	0.25	1.107	1.001	1.000	0.27	0.0%	0.27
NPMH - Supported Housing	-	-	-	1.107	1.004	1.000	-	0.0%	-
NPMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Intensive Outpatient	27	335	0.77	1.107	1.009	1.000	0.86	0.0%	0.86
NPMH - Partial Hospitalization	0	45	0.00	1.107	1.008	1.000	0.00	0.0%	0.00
NPMH - Transportation	50	114	0.48	1.107	1.002	1.000	0.53	0.0%	0.53
Subtotal - Non-Priority Mental Health	427	2,940	9.19				10.20		10.20
Total			$ 77.04				$ 86.47		$ 76.39
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 95.70**		**$ 84.54**

TennCare **Exhibit 11**

Middle Tennessee Data Book

Capitation Rate Development

Medicaid (TANF & Related) Age 21 - 44 Female									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 624,958									
Home Health Care	4.1	160.05	0.05	1.107	1.000	1.000	0.06	-0.3%	0.06
IP - Maternity	365	871	26.51	1.076	1.011	1.000	28.85	-13.6%	24.91
IP - Newborn	321	610	16.31	1.076	1.011	1.000	17.74	-13.6%	15.33
IP - Medical	239	805	16.05	1.076	1.011	0.974	17.01	-23.7%	12.97
IP - Surgery	103	1,710	14.70	1.076	1.011	0.974	15.58	-21.8%	12.18
IP - Other	7	24,688	14.26	1.076	1.011	0.974	15.12	-23.4%	11.58
Subtotal - Inpatient	1,035	28,685	87.82				94.29		76.97
OP - Emergency Room	1,760	168	24.69	1.169	1.011	0.987	28.82	-19.6%	23.18
OP - Laboratory	1,290	22	2.40	1.169	1.011	0.979	2.77	-19.6%	2.23
OP - Radiology	1,144	91	8.68	1.169	1.011	0.979	10.05	-18.3%	8.22
OP - Surgery	440	691	25.37	1.169	1.011	0.987	29.60	-25.0%	22.20
OP - Other	635	100	5.31	1.169	1.011	0.987	6.20	-12.7%	5.41
Subtotal - Outpatient	5,269	1,073	66.45				77.45		61.25
Prof - Evaluation & Management	8,647	51	36.71	1.107	1.006	0.977	39.90	12.0%	44.71
Prof - Maternity	365	500	15.20	1.107	1.006	1.000	16.91	2.4%	17.31
Prof - Surgery	1,217	127	12.92	1.107	1.006	0.993	14.27	-11.0%	12.71
Prof - DME/Supplies	182	181	2.74	1.107	1.006	1.000	3.05	-13.2%	2.65
Prof - Lab	8,066	12	8.12	1.107	1.006	0.979	8.84	-15.0%	7.52
Prof - Radiology	3,254	45	12.27	1.107	1.006	0.979	13.36	-9.6%	12.08
Prof - Transportation	356	106	3.15	1.107	1.006	1.000	3.50	-13.6%	3.02
Prof - Other	10,353	17	14.61	1.107	1.006	1.000	16.26	-11.2%	14.44
Subtotal - Professional	32,439	1,039	105.71				116.11		114.45
NPMH - Inpatient	25	459	0.94	1.107	1.025	1.000	1.06	0.0%	1.06
NPMH - Outpatient	185	73	1.13	1.107	1.011	1.000	1.27	0.0%	1.27
NPMH - Case Rates	4	174	0.05	1.045	1.000	1.000	0.06	0.0%	0.06
NPMH - Grants	-	-	1.33	1.000	1.000	1.000	1.33	0.0%	1.33
NPMH - In-Home Services	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Supported Housing	-	-	-	1.107	1.004	1.000	-	0.0%	-
NPMH - 23 Hour	0	245	0.01	1.107	1.001	1.000	0.01	0.0%	0.01
NPMH - Intensive Outpatient	14	393	0.45	1.107	1.009	1.000	0.50	0.0%	0.50
NPMH - Partial Hospitalization	1	550	0.03	1.107	1.008	1.000	0.04	0.0%	0.04
NPMH - Transportation	21	132	0.23	1.107	1.002	1.000	0.25	0.0%	0.25
Subtotal - Non-Priority Mental Health	249	2,026	4.18				4.52		4.52
Total			$ 264.21				$ 292.44		$ 257.25
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 323.65**		**$ 284.71**

TennCare **Exhibit 11**

Middle Tennessee Data Book

Capitation Rate Development

Medicaid (TANF & Related) Age 21 - 44 Male									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 117,795									
Home Health Care	7.7	178.63	0.12	1.107	1.000	1.000	0.13	-0.3%	0.13
IP - Maternity	-	-	-	1.076	1.011	1.000	-	-13.6%	-
IP - Newborn	2	1,148	0.15	1.076	1.011	1.000	0.16	-13.6%	0.14
IP - Medical	299	937	23.35	1.076	1.011	0.974	24.75	-23.7%	18.87
IP - Surgery	225	2,423	45.38	1.076	1.011	0.974	48.09	-21.8%	37.61
IP - Other	27	14,697	33.06	1.076	1.011	0.974	35.04	-23.4%	26.85
Subtotal - Inpatient	552	19,204	101.93				108.04		83.47
OP - Emergency Room	1,474	167	20.51	1.169	1.011	0.987	23.94	-19.6%	19.25
OP - Laboratory	885	12	0.86	1.169	1.011	0.979	1.00	-19.6%	0.80
OP - Radiology	1,170	89	8.63	1.169	1.011	0.979	9.99	-18.3%	8.17
OP - Surgery	267	853	18.97	1.169	1.011	0.987	22.14	-25.0%	16.60
OP - Other	438	151	5.51	1.169	1.011	0.987	6.43	-12.7%	5.62
Subtotal - Outpatient	4,234	1,271	54.49				63.50		50.44
Prof - Evaluation & Management	6,196	51	26.17	1.107	1.006	0.977	28.45	12.0%	31.87
Prof - Maternity	1	646	0.06	1.107	1.006	1.000	0.07	2.4%	0.07
Prof - Surgery	1,209	147	14.77	1.107	1.006	0.993	16.32	-11.0%	14.53
Prof - DME/Supplies	276	258	5.94	1.107	1.006	1.000	6.61	-13.2%	5.74
Prof - Lab	2,925	9	2.27	1.107	1.006	0.979	2.47	-15.0%	2.10
Prof - Radiology	2,935	39	9.55	1.107	1.006	0.979	10.40	-9.6%	9.41
Prof - Transportation	344	151	4.34	1.107	1.006	1.000	4.83	-13.6%	4.17
Prof - Other	10,963	13	11.59	1.107	1.006	1.000	12.90	-11.2%	11.45
Subtotal - Professional	24,850	1,313	74.68				82.04		79.34
NPMH - Inpatient	53	438	1.95	1.107	1.025	1.000	2.21	0.0%	2.21
NPMH - Outpatient	129	103	1.11	1.107	1.011	1.000	1.24	0.0%	1.24
NPMH - Case Rates	4	169	0.06	1.045	1.000	1.000	0.06	0.0%	0.06
NPMH - Grants	-	-	2.18	1.000	1.000	1.000	2.18	0.0%	2.18
NPMH - In-Home Services	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Supported Housing	1	914	0.05	1.107	1.004	1.000	0.05	0.0%	0.05
NPMH - 23 Hour	1	242	0.02	1.107	1.001	1.000	0.02	0.0%	0.02
NPMH - Intensive Outpatient	16	444	0.58	1.107	1.009	1.000	0.65	0.0%	0.65
NPMH - Partial Hospitalization	1	578	0.03	1.107	1.008	1.000	0.03	0.0%	0.03
NPMH - Transportation	30	474	1.18	1.107	1.002	1.000	1.31	0.0%	1.31
Subtotal - Non-Priority Mental Health	235	3,360	7.16				7.76		7.76
Total			$ 238.37				$ 261.47		$ 221.14
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 289.38**		**$ 244.74**

TennCare **Exhibit 11**

Middle Tennessee Data Book

Capitation Rate Development

Medicaid (TANF & Related) Age 45 - 64									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 115,001									
Home Health Care	19.4	345.26	0.56	1.107	1.000	1.000	0.62	-0.3%	0.62
IP - Maternity	2	806	0.11	1.076	1.011	1.000	0.11	-13.6%	0.10
IP - Newborn	1	585	0.07	1.076	1.011	1.000	0.07	-13.6%	0.06
IP - Medical	936	772	60.22	1.076	1.011	0.974	63.83	-23.7%	48.68
IP - Surgery	450	1,760	66.05	1.076	1.011	0.974	70.01	-21.8%	54.74
IP - Other	59	8,849	43.32	1.076	1.011	0.974	45.92	-23.4%	35.18
Subtotal - Inpatient	1,448	12,772	169.76				179.94		138.76
OP - Emergency Room	1,086	217	19.67	1.169	1.011	0.987	22.96	-19.6%	18.47
OP - Laboratory	1,491	19	2.32	1.169	1.011	0.979	2.68	-19.6%	2.16
OP - Radiology	2,628	96	21.02	1.169	1.011	0.979	24.33	-18.3%	19.89
OP - Surgery	621	901	46.61	1.169	1.011	0.987	54.39	-25.0%	40.80
OP - Other	1,132	177	16.68	1.169	1.011	0.987	19.47	-12.7%	16.99
Subtotal - Outpatient	6,958	1,410	106.29				123.83		98.30
Prof - Evaluation & Management	11,459	50	47.50	1.107	1.006	0.977	51.63	12.0%	57.85
Prof - Maternity	2	346	0.05	1.107	1.006	1.000	0.05	2.4%	0.05
Prof - Surgery	2,530	136	28.63	1.107	1.006	0.993	31.64	-11.0%	28.17
Prof - DME/Supplies	694	215	12.43	1.107	1.006	1.000	13.83	-13.2%	12.01
Prof - Lab	7,920	11	7.10	1.107	1.006	0.979	7.73	-15.0%	6.57
Prof - Radiology	5,318	46	20.38	1.107	1.006	0.979	22.20	-9.6%	20.07
Prof - Transportation	1,155	92	8.88	1.107	1.006	1.000	9.88	-13.6%	8.53
Prof - Other	32,309	19	49.93	1.107	1.006	1.000	55.56	-11.2%	49.33
Subtotal - Professional	61,387	914	174.88				192.52		182.59
NPMH - Inpatient	30	370	0.94	1.107	1.025	1.000	1.07	0.0%	1.07
NPMH - Outpatient	263	74	1.61	1.107	1.011	1.000	1.80	0.0%	1.80
NPMH - Case Rates	6	180	0.09	1.045	1.000	1.000	0.09	0.0%	0.09
NPMH - Grants	-	-	1.69	1.000	1.000	1.000	1.69	0.0%	1.69
NPMH - In-Home Services	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Supported Housing	-	-	-	1.107	1.004	1.000	-	0.0%	-
NPMH - 23 Hour	0	245	0.00	1.107	1.001	1.000	0.00	0.0%	0.00
NPMH - Intensive Outpatient	6	407	0.22	1.107	1.009	1.000	0.25	0.0%	0.25
NPMH - Partial Hospitalization	2	381	0.06	1.107	1.008	1.000	0.06	0.0%	0.06
NPMH - Transportation	26	67	0.14	1.107	1.002	1.000	0.16	0.0%	0.16
Subtotal - Non-Priority Mental Health	334	1,724	4.75				5.13		5.13
Total			$ 456.24				$ 502.03		$ 425.39
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 555.62**		**$ 470.79**

TennCare **Exhibit 11**

Middle Tennessee Data Book

Capitation Rate Development

Medicaid (TANF & Related) Age 65+									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 22,305									
Home Health Care	16.1	1,337.53	1.80	1.107	1.000	1.000	1.99	-0.3%	1.99
IP - Maternity	-	-	-	1.076	1.011	1.000	-	-13.6%	-
IP - Newborn	1	641	0.03	1.076	1.011	1.000	0.03	-13.6%	0.03
IP - Medical	511	916	38.99	1.076	1.011	0.974	41.33	-23.7%	31.52
IP - Surgery	293	898	21.93	1.076	1.011	0.974	23.25	-21.8%	18.18
IP - Other	13	42,983	48.18	1.076	1.011	0.974	51.06	-23.4%	39.12
Subtotal - Inpatient	818	45,438	109.13				115.67		88.84
OP - Emergency Room	297	263	6.50	1.169	1.011	0.987	7.58	-19.6%	6.10
OP - Laboratory	1,068	19	1.66	1.169	1.011	0.979	1.92	-19.6%	1.54
OP - Radiology	1,111	89	8.21	1.169	1.011	0.979	9.50	-18.3%	7.77
OP - Surgery	346	878	25.35	1.169	1.011	0.987	29.58	-25.0%	22.19
OP - Other	794	298	19.73	1.169	1.011	0.987	23.03	-12.7%	20.10
Subtotal - Outpatient	3,616	1,546	61.44				71.62		57.70
Prof - Evaluation & Management	5,879	43	20.91	1.107	1.006	0.977	22.73	12.0%	25.47
Prof - Maternity	1	125	0.01	1.107	1.006	1.000	0.01	2.4%	0.01
Prof - Surgery	1,256	95	9.98	1.107	1.006	0.993	11.03	-11.0%	9.82
Prof - DME/Supplies	337	149	4.17	1.107	1.006	1.000	4.65	-13.2%	4.03
Prof - Lab	4,595	8	2.94	1.107	1.006	0.979	3.20	-15.0%	2.72
Prof - Radiology	2,233	39	7.31	1.107	1.006	0.979	7.97	-9.6%	7.20
Prof - Transportation	1,108	84	7.72	1.107	1.006	1.000	8.59	-13.6%	7.42
Prof - Other	24,818	13	27.04	1.107	1.006	1.000	30.10	-11.2%	26.72
Subtotal - Professional	40,225	555	80.09				88.27		83.40
NPMH - Inpatient	8	502	0.32	1.107	1.025	1.000	0.36	0.0%	0.36
NPMH - Outpatient	30	80	0.20	1.107	1.011	1.000	0.22	0.0%	0.22
NPMH - Case Rates	2	176	0.03	1.045	1.000	1.000	0.03	0.0%	0.03
NPMH - Grants	-	-	0.23	1.000	1.000	1.000	0.23	0.0%	0.23
NPMH - In-Home Services	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Supported Housing	-	-	-	1.107	1.004	1.000	-	0.0%	-
NPMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Intensive Outpatient	-	-	-	1.107	1.009	1.000	-	0.0%	-
NPMH - Partial Hospitalization	3	41	0.01	1.107	1.008	1.000	0.01	0.0%	0.01
NPMH - Transportation	5	72	0.03	1.107	1.002	1.000	0.03	0.0%	0.03
Subtotal - Non-Priority Mental Health	47	872	0.81				0.88		0.88
Total			$ 253.27				$ 278.43		$ 232.81
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 308.15**		**$ 257.67**

TennCare **Exhibit 12**

Middle Tennessee Data Book

Capitation Rate Development

Uninsured/Uninsurable
Age 1 - 13

	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 97,544									
Home Health Care	2.7	38.68	0.01	1.107	1.000	1.000	0.01	-0.3%	0.01
IP - Maternity	-	-	-	1.076	1.011	1.000	-	-13.6%	-
IP - Newborn	1	1,836	0.23	1.076	1.011	1.000	0.25	-13.6%	0.21
IP - Medical	38	845	2.69	1.076	1.011	1.000	2.92	-23.7%	2.23
IP - Surgery	84	219	1.54	1.076	1.011	1.000	1.67	-21.8%	1.31
IP - Other	-	-	-	1.076	1.011	1.000	-	-23.4%	-
Subtotal - Inpatient	124	2,901	4.45				4.84		3.75
OP - Emergency Room	402	106	3.54	1.169	1.011	1.000	4.19	-19.6%	3.37
OP - Laboratory	394	24	0.77	1.169	1.011	1.000	0.92	-19.6%	0.74
OP - Radiology	382	42	1.34	1.169	1.011	1.000	1.59	-18.3%	1.30
OP - Surgery	102	684	5.80	1.169	1.011	1.000	6.86	-25.0%	5.15
OP - Other	288	140	3.36	1.169	1.011	1.000	3.98	-12.7%	3.47
Subtotal - Outpatient	1,568	995	14.83				17.54		14.03
Prof - Evaluation & Management	4,211	42	14.69	1.107	1.006	1.000	16.35	12.0%	18.32
Prof - Maternity	-	-	-	1.107	1.006	1.000	-	2.4%	-
Prof - Surgery	390	123	4.00	1.107	1.006	1.000	4.45	-11.0%	3.96
Prof - DME/Supplies	46	232	0.89	1.107	1.006	1.000	0.99	-13.2%	0.86
Prof - Lab	1,923	9	1.38	1.107	1.006	1.000	1.54	-15.0%	1.31
Prof - Radiology	548	22	0.99	1.107	1.006	1.000	1.10	-9.6%	0.99
Prof - Transportation	41	156	0.54	1.107	1.006	1.000	0.60	-13.6%	0.52
Prof - Other	13,116	8	8.20	1.107	1.006	1.000	9.13	-11.2%	8.11
Subtotal - Professional	20,274	591	30.69				34.16		34.07
NPMH - Inpatient	-	-	-	1.107	1.025	1.000	-	0.0%	-
NPMH - Outpatient	67	66	0.37	1.107	1.011	1.000	0.42	0.0%	0.42
NPMH - Case Rates	3	184	0.05	1.045	1.000	1.000	0.05	0.0%	0.05
NPMH - Grants	-	-	0.07	1.000	1.000	1.000	0.07	0.0%	0.07
NPMH - In-Home Services	0	68	0.00	1.107	1.001	1.000	0.00	0.0%	0.00
NPMH - Supported Housing	-	-	-	1.107	1.004	1.000	-	0.0%	-
NPMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Intensive Outpatient	0	643	0.01	1.107	1.009	1.000	0.01	0.0%	0.01
NPMH - Partial Hospitalization	-	-	-	1.107	1.008	1.000	-	0.0%	-
NPMH - Transportation	2	105	0.02	1.107	1.002	1.000	0.02	0.0%	0.02
Subtotal - Non-Priority Mental Health	73	1,065	0.52				0.57		0.57
Total			$ 50.50				$ 57.12		$ 52.43
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 63.21**		**$ 58.02**

TennCare **Exhibit 12**

Middle Tennessee Data Book

Capitation Rate Development

Uninsured/Uninsurable Age 14 - 19 Female									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 28,569									
Home Health Care	1.3	101.98	0.01	1.107	1.000	1.000	0.01	-0.3%	0.01
IP - Maternity	37	800	2.49	1.076	1.011	1.000	2.71	-13.6%	2.34
IP - Newborn	72	411	2.47	1.076	1.011	1.000	2.69	-13.6%	2.32
IP - Medical	50	840	3.50	1.076	1.011	1.000	3.81	-23.7%	2.90
IP - Surgery	24	976	1.98	1.076	1.011	1.000	2.16	-21.8%	1.69
IP - Other	4	1,692	0.53	1.076	1.011	1.000	0.58	-23.4%	0.44
Subtotal - Inpatient	188	4,719	10.98				11.94		9.70
OP - Emergency Room	601	149	7.47	1.169	1.011	1.000	8.84	-19.6%	7.11
OP - Laboratory	504	21	0.87	1.169	1.011	1.000	1.03	-19.6%	0.83
OP - Radiology	399	89	2.97	1.169	1.011	1.000	3.51	-18.3%	2.87
OP - Surgery	151	761	9.56	1.169	1.011	1.000	11.31	-25.0%	8.48
OP - Other	315	132	3.48	1.169	1.011	1.000	4.11	-12.7%	3.59
Subtotal - Outpatient	1,971	1,152	24.35				28.80		22.88
Prof - Evaluation & Management	4,856	46	18.45	1.107	1.006	1.000	20.53	12.0%	23.01
Prof - Maternity	31	559	1.43	1.107	1.006	1.000	1.59	2.4%	1.63
Prof - Surgery	567	88	4.18	1.107	1.006	1.000	4.65	-11.0%	4.14
Prof - DME/Supplies	69	327	1.88	1.107	1.006	1.000	2.09	-13.2%	1.81
Prof - Lab	4,101	11	3.80	1.107	1.006	1.000	4.23	-15.0%	3.60
Prof - Radiology	1,082	34	3.03	1.107	1.006	1.000	3.37	-9.6%	3.04
Prof - Transportation	98	159	1.30	1.107	1.006	1.000	1.45	-13.6%	1.25
Prof - Other	16,240	8	11.01	1.107	1.006	1.000	12.26	-11.2%	10.88
Subtotal - Professional	27,043	1,232	45.08				50.17		49.37
NPMH - Inpatient	48	295	1.19	1.107	1.025	1.000	1.35	0.0%	1.35
NPMH - Outpatient	76	79	0.50	1.107	1.011	1.000	0.56	0.0%	0.56
NPMH - Case Rates	3	168	0.05	1.045	1.000	1.000	0.05	0.0%	0.05
NPMH - Grants	-	-	0.33	1.000	1.000	1.000	0.33	0.0%	0.33
NPMH - In-Home Services	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Supported Housing	-	-	-	1.107	1.004	1.000	-	0.0%	-
NPMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Intensive Outpatient	3	613	0.13	1.107	1.009	1.000	0.14	0.0%	0.14
NPMH - Partial Hospitalization	-	-	-	1.107	1.008	1.000	-	0.0%	-
NPMH - Transportation	2	314	0.06	1.107	1.002	1.000	0.07	0.0%	0.07
Subtotal - Non-Priority Mental Health	133	1,468	2.26				2.50		2.50
Total			$ 82.68				$ 93.43		$ 84.46
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 103.40**		**$ 93.48**

TennCare **Exhibit 12**

Middle Tennessee Data Book

Capitation Rate Development

Uninsured/Uninsurable Age 14 - 19 Male									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 30,138									
Home Health Care	0.8	64.00	0.00	1.107	1.000	1.000	0.00	-0.3%	0.00
IP - Maternity	-	-	-	1.076	1.011	1.000	-	-13.6%	-
IP - Newborn	-	-	-	1.076	1.011	1.000	-	-13.6%	-
IP - Medical	64	1,027	5.45	1.076	1.011	1.000	5.93	-23.7%	4.53
IP - Surgery	29	1,956	4.67	1.076	1.011	1.000	5.09	-21.8%	3.98
IP - Other	3	7,395	1.96	1.076	1.011	1.000	2.14	-23.4%	1.64
Subtotal - Inpatient	96	10,378	12.09				13.16		10.14
OP - Emergency Room	434	142	5.12	1.169	1.011	1.000	6.06	-19.6%	4.87
OP - Laboratory	328	21	0.58	1.169	1.011	1.000	0.68	-19.6%	0.55
OP - Radiology	354	93	2.74	1.169	1.011	1.000	3.24	-18.3%	2.65
OP - Surgery	114	753	7.17	1.169	1.011	1.000	8.48	-25.0%	6.36
OP - Other	256	455	9.73	1.169	1.011	1.000	11.50	-12.7%	10.04
Subtotal - Outpatient	1,486	1,464	25.33				29.96		24.47
Prof - Evaluation & Management	3,142	44	11.53	1.107	1.006	1.000	12.83	12.0%	14.37
Prof - Maternity	-	-	-	1.107	1.006	1.000	-	2.4%	-
Prof - Surgery	467	110	4.27	1.107	1.006	1.000	4.76	-11.0%	4.23
Prof - DME/Supplies	89	187	1.39	1.107	1.006	1.000	1.55	-13.2%	1.34
Prof - Lab	1,381	9	1.06	1.107	1.006	1.000	1.18	-15.0%	1.00
Prof - Radiology	1,011	26	2.23	1.107	1.006	1.000	2.48	-9.6%	2.24
Prof - Transportation	59	273	1.33	1.107	1.006	1.000	1.48	-13.6%	1.28
Prof - Other	9,060	10	7.92	1.107	1.006	1.000	8.81	-11.2%	7.83
Subtotal - Professional	15,208	660	29.73				33.08		32.30
NPMH - Inpatient	76	253	1.60	1.107	1.025	1.000	1.82	0.0%	1.82
NPMH - Outpatient	104	72	0.62	1.107	1.011	1.000	0.69	0.0%	0.69
NPMH - Case Rates	6	221	0.11	1.045	1.000	1.000	0.11	0.0%	0.11
NPMH - Grants	-	-	0.65	1.000	1.000	1.000	0.65	0.0%	0.65
NPMH - In-Home Services	4	1,825	0.67	1.107	1.001	1.000	0.74	0.0%	0.74
NPMH - Supported Housing	-	-	-	1.107	1.004	1.000	-	0.0%	-
NPMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Intensive Outpatient	15	450	0.55	1.107	1.009	1.000	0.62	0.0%	0.62
NPMH - Partial Hospitalization	-	-	-	1.107	1.008	1.000	-	0.0%	-
NPMH - Transportation	18	170	0.26	1.107	1.002	1.000	0.29	0.0%	0.29
Subtotal - Non-Priority Mental Health	223	2,990	4.46				4.92		4.92
Total			$ 71.61				$ 81.12		$ 71.83
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 89.78**		**$ 79.50**

TennCare **Exhibit 13**

Middle Tennessee Data Book

Capitation Rate Development

Disabled Age <21									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 20,972									
Home Health Care	75.5	906.72	5.71	1.107	1.000	1.000	6.32	-0.3%	6.30
IP - Maternity	7	732	0.42	1.076	1.011	1.000	0.46	-13.6%	0.39
IP - Newborn	537	1,418	63.42	1.076	1.011	1.000	69.00	-13.6%	59.60
IP - Medical	403	1,050	35.31	1.076	1.011	1.000	38.42	-23.7%	29.30
IP - Surgery	146	1,193	14.51	1.076	1.011	1.000	15.78	-21.8%	12.34
IP - Other	81	10,226	68.75	1.076	1.011	1.000	74.81	-23.4%	57.31
Subtotal - Inpatient	1,174	14,620	182.40				198.47		158.95
OP - Emergency Room	1,252	148	15.47	1.169	1.011	1.000	18.29	-19.6%	14.71
OP - Laboratory	2,442	24	4.95	1.169	1.011	1.000	5.85	-19.6%	4.71
OP - Radiology	1,240	61	6.27	1.169	1.011	1.000	7.41	-18.3%	6.06
OP - Surgery	497	650	26.95	1.169	1.011	1.000	31.88	-25.0%	23.91
OP - Other	3,039	320	80.93	1.169	1.011	1.000	95.71	-12.7%	83.55
Subtotal - Outpatient	8,470	1,203	134.56				159.14		132.94
Prof - Evaluation & Management	7,300	59	36.04	1.107	1.006	1.000	40.11	12.0%	44.95
Prof - Maternity	5	766	0.33	1.107	1.006	1.000	0.37	2.4%	0.37
Prof - Surgery	661	161	8.89	1.107	1.006	1.000	9.89	-11.0%	8.80
Prof - DME/Supplies	860	366	26.24	1.107	1.006	1.000	29.20	-13.2%	25.36
Prof - Lab	2,515	9	1.99	1.107	1.006	1.000	2.21	-15.0%	1.88
Prof - Radiology	1,690	21	2.98	1.107	1.006	1.000	3.32	-9.6%	3.00
Prof - Transportation	597	111	5.50	1.107	1.006	1.000	6.12	-13.6%	5.29
Prof - Other	275,855	1	32.77	1.107	1.006	1.000	36.47	-11.2%	32.38
Subtotal - Professional	289,485	1,495	114.75				127.70		122.03
NPMH - Inpatient	52	347	1.51	1.107	1.025	1.000	1.71	0.0%	1.71
NPMH - Outpatient	141	91	1.08	1.107	1.011	1.000	1.20	0.0%	1.20
NPMH - Case Rates	12	186	0.19	1.045	1.000	1.000	0.19	0.0%	0.19
NPMH - Grants	-	-	0.50	1.000	1.000	1.000	0.50	0.0%	0.50
NPMH - In-Home Services	1	1,825	0.17	1.107	1.001	1.000	0.19	0.0%	0.19
NPMH - Supported Housing	-	-	-	1.107	1.004	1.000	-	0.0%	-
NPMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Intensive Outpatient	-	-	-	1.107	1.009	1.000	-	0.0%	-
NPMH - Partial Hospitalization	-	-	-	1.107	1.008	1.000	-	0.0%	-
NPMH - Transportation	9	62	0.05	1.107	1.002	1.000	0.05	0.0%	0.05
Subtotal - Non-Priority Mental Health	216	2,512	3.49				3.85		3.85
Total			$ 440.90				$ 495.48		$ 424.08
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 548.37**		**$ 469.34**

TennCare **Exhibit 13**

Middle Tennessee Data Book

Capitation Rate Development

Disabled Age 21+									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 336,119									
Home Health Care	52.6	402.10	1.76	1.107	1.000	1.000	1.95	-0.3%	1.95
IP - Maternity	15	885	1.09	1.076	1.011	1.000	1.19	-13.6%	1.03
IP - Newborn	23	617	1.17	1.076	1.011	1.000	1.27	-13.6%	1.09
IP - Medical	1,653	744	102.46	1.076	1.011	0.974	108.60	-23.7%	82.83
IP - Surgery	431	1,784	64.05	1.076	1.011	0.974	67.89	-21.8%	53.09
IP - Other	91	5,062	38.45	1.076	1.011	0.974	40.75	-23.4%	31.22
Subtotal - Inpatient	2,212	9,091	207.22				219.70		169.26
OP - Emergency Room	1,700	203	28.71	1.169	1.011	0.987	33.51	-19.6%	26.96
OP - Laboratory	2,983	12	2.98	1.169	1.011	0.979	3.45	-19.6%	2.78
OP - Radiology	2,201	102	18.68	1.169	1.011	0.979	21.63	-18.3%	17.68
OP - Surgery	612	885	45.13	1.169	1.011	0.987	52.66	-25.0%	39.50
OP - Other	1,242	289	29.87	1.169	1.011	0.987	34.85	-12.7%	30.43
Subtotal - Outpatient	8,738	1,490	125.37				146.11		117.34
Prof - Evaluation & Management	12,976	51	55.39	1.107	1.006	0.977	60.21	12.0%	67.46
Prof - Maternity	14	467	0.53	1.107	1.006	1.000	0.59	2.4%	0.60
Prof - Surgery	2,344	128	24.93	1.107	1.006	0.993	27.55	-11.0%	24.53
Prof - DME/Supplies	1,125	264	24.79	1.107	1.006	1.000	27.59	-13.2%	23.95
Prof - Lab	8,491	10	7.37	1.107	1.006	0.979	8.03	-15.0%	6.82
Prof - Radiology	5,525	41	19.08	1.107	1.006	0.979	20.78	-9.6%	18.80
Prof - Transportation	2,352	88	17.23	1.107	1.006	1.000	19.17	-13.6%	16.56
Prof - Other	87,826	8	61.53	1.107	1.006	1.000	68.48	-11.2%	60.80
Subtotal - Professional	120,654	1,058	210.85				232.41		219.53
NPMH - Inpatient	55	395	1.83	1.107	1.025	1.000	2.07	0.0%	2.07
NPMH - Outpatient	320	71	1.89	1.107	1.011	1.000	2.12	0.0%	2.12
NPMH - Case Rates	3	165	0.05	1.045	1.000	1.000	0.05	0.0%	0.05
NPMH - Grants	-	-	1.93	1.000	1.000	1.000	1.93	0.0%	1.93
NPMH - In-Home Services	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Supported Housing	0	1,974	0.04	1.107	1.004	1.000	0.05	0.0%	0.05
NPMH - 23 Hour	0	396	0.00	1.107	1.001	1.000	0.00	0.0%	0.00
NPMH - Intensive Outpatient	6	396	0.18	1.107	1.009	1.000	0.20	0.0%	0.20
NPMH - Partial Hospitalization	0	756	0.03	1.107	1.008	1.000	0.04	0.0%	0.04
NPMH - Transportation	39	81	0.27	1.107	1.002	1.000	0.29	0.0%	0.29
Subtotal - Non-Priority Mental Health	424	4,233	6.22				6.75		6.75
Total			$ 551.43				$ 606.92		$ 514.82
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 671.71**		**$ 569.78**

TennCare **Exhibit 14**

Middle Tennessee Data Book

Capitation Rate Development

Duals All Ages									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 737,005									
Home Health Care	18.9	1,584.59	2.50	1.107	1.000	1.000	2.76	-0.3%	2.76
IP - Maternity	1	717	0.04	1.076	1.011	1.000	0.04	-13.6%	0.04
IP - Newborn	2	423	0.07	1.076	1.011	1.000	0.08	-13.6%	0.07
IP - Medical	35	2,753	7.97	1.076	1.011	0.974	8.44	-23.7%	6.44
IP - Surgery	5	833	0.37	1.076	1.011	0.974	0.39	-21.8%	0.31
IP - Other	2	26,393	4.33	1.076	1.011	0.974	4.59	-23.4%	3.52
Subtotal - Inpatient	45	31,118	12.79				13.55		10.37
OP - Emergency Room	91	79	0.60	1.169	1.011	0.987	0.70	-19.6%	0.56
OP - Laboratory	93	12	0.09	1.169	1.011	0.979	0.11	-19.6%	0.09
OP - Radiology	99	50	0.41	1.169	1.011	0.979	0.48	-18.3%	0.39
OP - Surgery	55	296	1.35	1.169	1.011	0.987	1.58	-25.0%	1.19
OP - Other	117	1,141	11.11	1.169	1.011	0.987	12.96	-12.7%	11.31
Subtotal - Outpatient	455	1,578	13.56				15.82		13.54
Prof - Evaluation & Management	1,460	9	1.11	1.107	1.006	0.977	1.21	12.0%	1.36
Prof - Maternity	2	34	0.00	1.107	1.006	1.000	0.00	2.4%	0.01
Prof - Surgery	314	21	0.55	1.107	1.006	0.993	0.61	-11.0%	0.54
Prof - DME/Supplies	124	87	0.90	1.107	1.006	1.000	1.00	-13.2%	0.87
Prof - Lab	783	3	0.23	1.107	1.006	0.979	0.25	-15.0%	0.21
Prof - Radiology	509	8	0.34	1.107	1.006	0.979	0.37	-9.6%	0.33
Prof - Transportation	2,174	64	11.62	1.107	1.006	1.000	12.93	-13.6%	11.17
Prof - Other	28,976	1	2.96	1.107	1.006	1.000	3.30	-11.2%	2.93
Subtotal - Professional	34,341	228	17.71				19.66		17.40
NPMH - Inpatient	1	402	0.04	1.107	1.025	1.000	0.05	0.0%	0.05
NPMH - Outpatient	21	66	0.11	1.107	1.011	1.000	0.13	0.0%	0.13
NPMH - Case Rates	1	171	0.02	1.045	1.000	1.000	0.02	0.0%	0.02
NPMH - Grants	-	-	0.25	1.000	1.000	1.000	0.25	0.0%	0.25
NPMH - In-Home Services	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Supported Housing	0	1,591	0.02	1.107	1.004	1.000	0.02	0.0%	0.02
NPMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Intensive Outpatient	2	335	0.05	1.107	1.009	1.000	0.05	0.0%	0.05
NPMH - Partial Hospitalization	-	-	-	1.107	1.008	1.000	-	0.0%	-
NPMH - Transportation	46	58	0.22	1.107	1.002	1.000	0.25	0.0%	0.25
Subtotal - Non-Priority Mental Health	71	2,622	0.72				0.77		0.77
Total			$ 47.27				$ 52.57		$ 44.84
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 58.18**		**$ 49.63**

TennCare **Exhibit 15**

Middle Tennessee Data Book

Capitation Rate Development

Waiver Duals All Ages									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 19,787									
Home Health Care	6.7	182.13	0.10	1.107	1.000	1.000	0.11	-0.3%	0.11
IP - Maternity	-	-	-	1.076	1.011	1.000	-	-13.6%	-
IP - Newborn	-	-	-	1.076	1.011	1.000	-	-13.6%	-
IP - Medical	414	208	7.19	1.076	1.011	0.974	7.62	-23.7%	5.81
IP - Surgery	2	2,382	0.48	1.076	1.011	0.974	0.51	-21.8%	0.40
IP - Other	727	63	3.82	1.076	1.011	0.974	4.05	-23.4%	3.10
Subtotal - Inpatient	1,144	2,653	11.49				12.18		9.32
OP - Emergency Room	70	19	0.11	1.169	1.011	0.987	0.13	-19.6%	0.10
OP - Laboratory	53	2	0.01	1.169	1.011	0.979	0.01	-19.6%	0.01
OP - Radiology	184	5	0.07	1.169	1.011	0.979	0.08	-18.3%	0.07
OP - Surgery	60	17	0.09	1.169	1.011	0.987	0.10	-25.0%	0.08
OP - Other	58	161	0.78	1.169	1.011	0.987	0.90	-12.7%	0.79
Subtotal - Outpatient	425	204	1.05				1.22		1.04
Prof - Evaluation & Management	1,913	3	0.41	1.107	1.006	0.977	0.44	12.0%	0.49
Prof - Maternity	-	-	-	1.107	1.006	1.000	-	2.4%	-
Prof - Surgery	331	12	0.32	1.107	1.006	0.993	0.36	-11.0%	0.32
Prof - DME/Supplies	170	49	0.70	1.107	1.006	1.000	0.77	-13.2%	0.67
Prof - Lab	836	1	0.06	1.107	1.006	0.979	0.07	-15.0%	0.06
Prof - Radiology	1,015	1	0.11	1.107	1.006	0.979	0.12	-9.6%	0.11
Prof - Transportation	745	64	3.95	1.107	1.006	1.000	4.39	-13.6%	3.79
Prof - Other	12,975	1	1.22	1.107	1.006	1.000	1.35	-11.2%	1.20
Subtotal - Professional	17,986	130	6.76				7.51		6.65
NPMH - Inpatient	1	98	0.00	1.107	1.025	1.000	0.01	0.0%	0.01
NPMH - Outpatient	34	45	0.13	1.107	1.011	1.000	0.14	0.0%	0.14
NPMH - Case Rates	2	168	0.03	1.045	1.000	1.000	0.04	0.0%	0.04
NPMH - Grants	-	-	0.42	1.000	1.000	1.000	0.42	0.0%	0.42
NPMH - In-Home Services	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Supported Housing	5	1,970	0.80	1.107	1.004	1.000	0.89	0.0%	0.89
NPMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
NPMH - Intensive Outpatient	-	-	-	1.107	1.009	1.000	-	0.0%	-
NPMH - Partial Hospitalization	-	-	-	1.107	1.008	1.000	-	0.0%	-
NPMH - Transportation	31	37	0.09	1.107	1.002	1.000	0.10	0.0%	0.10
Subtotal - Non-Priority Mental Health	72	2,318	1.47				1.59		1.59
Total			$ 20.88				$ 22.61		$ 18.70
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 25.03**		**$ 20.70**

TennCare **Exhibit 16**

Middle Tennessee Data Book

Capitation Rate Development

State Only & Judicials All Ages									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 14,509									
PMH - Inpatient	1,327	378	41.79	1.107	1.025	1.000	47.42	0.0%	47.42
PMH - Inpatient RMHI	6,722	298	167.16	1.000	1.000	1.000	167.16	0.0%	167.16
PMH - Outpatient	1,046	147	12.78	1.107	1.011	1.000	14.30	0.0%	14.30
PMH - Case Rates	5,811	179	86.51	1.045	1.000	1.000	90.44	0.0%	90.44
PMH - Grants	-	-	29.74	1.000	1.000	1.000	29.74	0.0%	29.74
PMH - In-Home Services	4	1,825	0.63	1.107	1.001	1.000	0.70	0.0%	0.70
PMH - Supported Housing	24	1,958	3.91	1.107	1.004	1.000	4.35	0.0%	4.35
PMH - 23 Hour	1	862	0.06	1.107	1.001	1.000	0.07	0.0%	0.07
PMH - Intensive Outpatient	423	245	8.64	1.107	1.009	1.000	9.65	0.0%	9.65
PMH - Partial Hospitalization	9	792	0.60	1.107	1.008	1.000	0.67	0.0%	0.67
PMH - Transportation	845	59	4.16	1.107	1.002	1.000	4.61	0.0%	4.61
Subtotal - Mental Health	16,212	6,743	355.98				369.09		369.09
Total			$ 355.98				$ 369.09		$ 369.09
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 408.49**		**$ 408.49**

TennCare **Exhibit 17**

Middle Tennessee Data Book

Capitation Rate Development

BHO Priority Age <21									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 82,418									
PMH - Inpatient	3,576	271	80.68	1.107	1.025	1.000	91.56	0.0%	91.56
PMH - Inpatient RMHI	291	298	7.25	1.000	1.000	1.000	7.25	0.0%	7.25
PMH - Outpatient	1,641	74	10.18	1.107	1.011	1.000	11.39	0.0%	11.39
PMH - Case Rates	9,036	198	149.28	1.045	1.000	1.000	156.05	0.0%	156.05
PMH - Grants	-	-	20.80	1.000	1.000	1.000	20.80	0.0%	20.80
PMH - In-Home Services	150	1,528	19.13	1.107	1.001	1.000	21.20	0.0%	21.20
PMH - Supported Housing	8	1,710	1.14	1.107	1.004	1.000	1.27	0.0%	1.27
PMH - 23 Hour	-	-	-	1.107	1.001	1.000	-	0.0%	-
PMH - Intensive Outpatient	142	240	2.83	1.107	1.009	1.000	3.16	0.0%	3.16
PMH - Partial Hospitalization	2	799	0.12	1.107	1.008	1.000	0.13	0.0%	0.13
PMH - Transportation	552	94	4.31	1.107	1.002	1.000	4.78	0.0%	4.78
Subtotal - Priority Mental Health	15,400	5,212	295.71				317.58		317.58
Total			$ 295.71				$ 317.58		$ 317.58
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 351.48**		**$ 351.48**

TennCare **Exhibit 17**

Middle Tennessee Data Book

Capitation Rate Development

BHO Priority Age 21+									
	FISCAL YEAR 2005			Data Adjustment Factors			Maximum		Minimum
Service Category	Utilization Rates Per 1,000	Expenditure Per Unit	Paid Expenditures PMPM	Trend To Contract Period	IBNR Completion	Benefit Adjustment	Contract Year PMPM	Managed Care Impact	Contract Year PMPM
Membership 177,939									
PMH - Inpatient	1,366	438	49.86	1.107	1.025	1.000	56.59	0.0%	56.59
PMH - Inpatient RMHI	2,576	298	64.06	1.000	1.000	1.000	64.06	0.0%	64.06
PMH - Outpatient	1,738	111	16.01	1.107	1.011	1.000	17.92	0.0%	17.92
PMH - Case Rates	9,401	184	144.33	1.045	1.000	1.000	150.87	0.0%	150.87
PMH - Grants	-	-	47.17	1.000	1.000	1.000	47.17	0.0%	47.17
PMH - In-Home Services	-	-	-	1.107	1.001	1.000	-	0.0%	-
PMH - Supported Housing	189	1,733	27.26	1.107	1.004	1.000	30.29	0.0%	30.29
PMH - 23 Hour	1	471	0.03	1.107	1.001	1.000	0.04	0.0%	0.04
PMH - Intensive Outpatient	165	290	3.99	1.107	1.009	1.000	4.46	0.0%	4.46
PMH - Partial Hospitalization	11	1,057	0.95	1.107	1.008	1.000	1.06	0.0%	1.06
PMH - Transportation	3,105	72	18.54	1.107	1.002	1.000	20.55	0.0%	20.55
Subtotal - Priority Mental Health	18,551	4,655	372.21				393.00		393.00
Total			$ 372.21				$ 393.00		$ 393.00
Third Party Liability (TPL) Recoveries							1.5%		1.5%
Admin %							9.0%		9.0%
Premium Tax							2.0%		2.0%
Total Premium Rate							**$ 434.95**		**$ 434.95**

TennCare **Exhibit 18**

Middle Tennessee Data Book

Summary Of Capitation Rate

			Capitation Rate			
			Minimum		Maximum	
Aid Category	**Age Group**	**Member Months**	**PMPM**	**Total**	**PMPM**	**TOTAL**
Medicaid (TANF & Related)	Age Under 1	78,672	$ 378.89	$ 29,808,369	$ 428.84	$ 33,737,685
	Age 1 - 13	1,418,489	$ 65.86	$ 93,426,677	$ 71.87	$ 101,946,498
	Age 14 - 20 Female	268,804	$ 181.11	$ 48,682,647	$ 202.33	$ 54,387,917
	Age 14 - 20 Male	214,018	$ 84.54	$ 18,093,133	$ 95.70	$ 20,482,105
	Age 21 - 44 Female	624,958	$ 284.71	$ 177,929,838	$ 323.65	$ 202,267,733
	Age 21 - 44 Male	117,795	$ 244.74	$ 28,829,196	$ 289.38	$ 34,087,800
	Age 45 - 64	115,001	$ 470.79	$ 54,141,824	$ 555.62	$ 63,896,683
	Age 65+	22,305	$ 257.67	$ 5,747,144	$ 308.15	$ 6,873,221
Uninsured/Uninsurable	Age Under 1*	7	$ 378.89	$ 2,636	$ 428.84	$ 2,984
	Age 1 - 13	97,544	$ 58.02	$ 5,659,612	$ 63.21	$ 6,166,086
	Age 14 - 19 Female	28,569	$ 93.48	$ 2,670,527	$ 103.40	$ 2,954,091
	Age 14 - 19 Male	30,138	$ 79.50	$ 2,395,857	$ 89.78	$ 2,705,784
Disabled	Age <21	20,972	$ 469.34	$ 9,843,066	$ 548.37	$ 11,500,421
	Age 21+	336,119	$ 569.78	$ 191,512,606	$ 671.71	$ 225,773,147
Duals	All Ages	737,005	$ 49.63	$ 36,575,191	$ 58.18	$ 42,881,109
Waiver Duals	All Ages	19,787	$ 20.70	$ 409,597	$ 25.03	$ 495,220
State Only & Judicials	All Ages	14,509	$ 408.49	$ 5,926,747	$ 408.49	$ 5,926,747
BHO Priority	Age <21	82,418	$ 351.48	$ 28,968,241	$ 351.48	$ 28,968,241
	Age 21+	177,939	$ 434.95	$ 77,395,485	$ 434.95	$ 77,395,485
Weighted Average	Total 2007 Calendar Year	4,144,692	$ 197.37	818,018,393	$ 222.56	922,448,958

Note - BHO Prioiry counts are included in other rate cells based on their aid category

* Set equal to Medicaid(TANF& Related) rate due to low volume

TennCare **Exhibit 19**

Middle Tennessee Data Book

Historical Rx Encounter Data (September 1, 2005 through November 30, 2005)

Total Rx Experience

	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures PMPM
Grand Total	**MCO and BHO Combined**										
Member Months	1,036,192										
Brand	64,039,008	596,670	2,303	107.33	61.80						
Generic	21,891,425	979,015	3,779	22.36	21.13						
Non-Drug*	1,645,622	37,563	145	43.81	1.59						
Grand Total	87,576,056	1,613,248	6,228	173.50	84.52						
Total	**MCO/Physical Health**					**BHO/Mental Health**					**MCO/BHO**
Member Months	1,036,192					1,036,192					
Brand	49,342,770	446,943	1,725	110.40	47.62	14,696,239	149,727	578	98.15	14.18	61.80
Generic	17,624,403	843,598	3,257	20.89	17.01	4,267,022	135,417	523	31.51	4.12	21.13
Non-Drug*	1,634,080	37,523	145	43.55	1.58	11,542	40	0	288.56	0.01	1.59
Grand Total	68,601,253	1,328,064	5,127	174.84	66.21	18,974,803	285,184	1,101	418.23	18.31	84.52

* Non-Drugs include medical supplies, bulk chemicals, etc.

TennCare **Exhibit 19**

Middle Tennessee Data Book

Historical Rx Encounter Data (September 1, 2005 through November 30, 2005)

Medicaid (TANF and Related)											
	MCO/Physical Health					BHO/Mental Health					MCO/BHO
	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures PMPM
Age Under 1											
Member Months	19,668					19,668					
Brand	711,226	2,967	603	239.71	36.16	1,491	37	8	40.31	0.08	36.24
Generic	76,253	6,483	1,318	11.76	3.88	1,159	247	50	4.69	0.06	3.94
Non-Drug*	2,539	79	16	32.14	0.13	-	-	-	-	-	0.13
Subtotal	790,018	9,529	1,938	283.62	40.17	2,650	284	58	45.00	0.13	40.30
Age 1-13											
Member Months	344,042					344,042					
Brand	4,852,196	52,031	605	93.26	14.10	894,741	7,948	92	112.57	2.60	16.70
Generic	1,431,946	83,134	967	17.22	4.16	176,560	5,558	65	31.77	0.51	4.68
Non-Drug*	126,283	2,673	31	47.24	0.37	3,346	8	0	418.27	0.01	0.38
Subtotal	6,410,426	137,838	1,603	157.72	18.63	1,074,647	13,514	157	562.61	3.12	21.76
Age 14-20 Female											
Member Months	63,141					63,141					
Brand	1,023,803	13,179	835	77.68	16.21	217,018	1,860	118	116.68	3.44	19.65
Generic	428,444	30,313	1,920	14.13	6.79	50,250	1,761	112	28.54	0.80	7.58
Non-Drug*	32,691	616	39	53.07	0.52	-	-	-	-	-	0.52
Subtotal	1,484,938	44,108	2,794	144.89	23.52	267,268	3,621	229	145.21	4.23	27.75
Age 14-20 Male											
Member Months	49,836					49,836					
Brand	511,145	4,632	372	110.35	10.26	221,142	1,663	133	132.98	4.44	14.69
Generic	144,963	11,263	904	12.87	2.91	47,475	1,101	88	43.12	0.95	3.86
Non-Drug*	22,402	344	28	65.12	0.45	842	3	0	280.75	0.02	0.47
Subtotal	678,511	16,239	1,303	188.34	13.61	269,460	2,767	222	456.85	5.41	19.02

* Non-Drugs include medical supplies, bulk chemicals, etc.

TennCare **Exhibit 19**

Middle Tennessee Data Book

Historical Rx Encounter Data (September 1, 2005 through November 30, 2005)

Medicaid (TANF & Related)											
	MCO/Physical Health					BHO/Mental Health					MCO/BHO
	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures PMPM
Age 21-44 Female											
Member Months	143,026					143,026					
Brand	3,333,414	37,139	1,039	89.76	23.31	1,223,740	11,385	318	107.49	8.56	31.86
Generic	1,658,943	103,606	2,898	16.01	11.60	406,332	17,019	476	23.88	2.84	14.44
Non-Drug*	160,281	3,119	87	51.39	1.12	565	3	0	188.28	0.00	1.12
Subtotal	5,152,638	143,864	4,023	157.16	36.03	1,630,637	28,407	794	319.64	11.40	47.43
Age 21-44 Male											
Member Months	27,331					27,331					
Brand	787,985	4,596	673	171.45	28.83	163,397	1,284	188	127.26	5.98	34.81
Generic	285,428	13,496	1,975	21.15	10.44	59,988	2,306	337	26.01	2.19	12.64
Non-Drug*	29,794	651	95	45.77	1.09	242	1	0	241.91	0.01	1.10
Subtotal	1,103,208	18,743	2,743	238.37	40.37	223,626	3,591	526	395.18	8.18	48.55
Age 45-64											
Member Months	26,044					26,044					
Brand	1,343,426	11,508	1,767	116.74	51.58	252,374	2,246	345	112.37	9.69	61.27
Generic	513,762	23,094	3,547	22.25	19.73	135,559	4,586	704	29.56	5.21	24.93
Non-Drug*	71,435	1,531	235	46.66	2.74	64	1	0	64.19	0.00	2.75
Subtotal	1,928,623	36,133	5,550	185.64	74.05	387,997	6,833	1,049	206.12	14.90	88.95
Age 65+											
Member Months	5,507					5,507					
Brand	395,491	4,630	3,363	85.42	71.81	86,870	860	625	101.01	15.77	87.59
Generic	112,458	6,735	4,892	16.70	20.42	25,857	1,123	816	23.02	4.69	25.11
Non-Drug*	14,292	335	243	42.66	2.60	-	-	-	-	-	2.60
Subtotal	522,240	11,700	8,498	144.78	94.83	112,727	1,983	1,440	124.04	20.47	115.30

* Non-Drugs include medical supplies, bulk chemicals, etc.

TennCare **Exhibit 19**

Middle Tennessee Data Book

Historical Rx Encounter Data (September 1, 2005 through November 30, 2005)

Medicaid (TANF & Related)											
	MCO/Physical Health					BHO/Mental Health					MCO/BHO
	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures PMPM
Total											
Member Months	678,595					678,595					
Brand	12,958,687	130,682	770	99.16	19.10	3,060,774	27,283	161	112.19	4.51	23.61
Generic	4,652,198	278,124	1,639	16.73	6.86	903,179	33,701	199	26.80	1.33	8.19
Non-Drug*	459,718	9,348	55	49.18	0.68	5,059	16	0	316.21	0.01	0.68
Total	18,070,603	418,154	2,465	165.07	26.63	3,969,012	61,000	360	455.19	5.85	32.48

* Non-Drugs include medical supplies, bulk chemicals, etc.

TennCare **Exhibit 19**

Middle Tennessee Data Book

Historical Rx Encounter Data (September 1, 2005 through November 30, 2005)

Uninsured/Uninsurable											
	MCO/Physical Health					BHO/Mental Health					MCO/BHO
	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures PMPM
Age Under 1											
Member Months	21					21					
Brand	12	1	192	11.80	0.57	-	-	-	-	-	0.57
Generic	18	2	383	8.89	0.85	-	-	-	-	-	0.85
Non-Drug*	-	-	-	-	-	-	-	-	-	-	-
Subtotal	30	3	575	20.69	1.42	-	-	-	-	-	1.42
Age 1-13											
Member Months	23,705					23,705					
Brand	374,673	3,161	533	118.53	15.81	72,231	639	108	113.04	3.05	18.85
Generic	65,791	3,597	607	18.29	2.78	11,275	280	47	40.27	0.48	3.25
Non-Drug*	14,141	197	33	71.78	0.60	515	1	0	514.59	0.02	0.62
Subtotal	454,605	6,955	1,174	208.60	19.18	84,020	920	155	667.89	3.54	22.72
Age 14-20 Female											
Member Months	6,755					6,755					
Brand	71,299	1,020	604	69.90	10.55	23,842	203	120	117.45	3.53	14.08
Generic	28,518	1,867	1,106	15.27	4.22	2,754	107	63	25.74	0.41	4.63
Non-Drug*	7,007	101	60	69.38	1.04	-	-	-	-	-	1.04
Subtotal	106,824	2,988	1,769	154.55	15.81	26,596	310	184	143.19	3.94	19.75
Age 14-20 Male											
Member Months	7,122					7,122					
Brand	122,295	639	359	191.39	17.17	29,856	221	124	135.09	4.19	21.36
Generic	16,501	1,094	614	15.08	2.32	7,222	119	67	60.69	1.01	3.33
Non-Drug*	3,639	49	28	74.26	0.51	-	-	-	-	-	0.51
Subtotal	142,435	1,782	1,001	280.73	20.00	37,077	340	191	195.78	5.21	25.21

* Non-Drugs include medical supplies, bulk chemicals, etc.

TennCare **Exhibit 19**

Middle Tennessee Data Book

Historical Rx Encounter Data (September 1, 2005 through November 30, 2005)

Uninsured/Uninsurable											
	MCO/Physical Health					BHO/Mental Health					MCO/BHO
	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures PMPM
Total											
Member Months	37,602					37,602					
Brand	568,279	4,821	513	117.88	15.11	125,928	1,063	113	118.47	3.35	18.46
Generic	110,828	6,560	698	16.89	2.95	21,251	506	54	42.00	0.57	3.51
Non-Drug*	24,787	347	37	71.43	0.66	515	1	0	514.59	0.01	0.67
Total	703,893	11,728	1,248	206.20	18.72	147,694	1,570	167	675.05	3.93	22.65

* Non-Drugs include medical supplies, bulk chemicals, etc.

TennCare **Exhibit 19**

Middle Tennessee Data Book

Historical Rx Encounter Data (September 1, 2005 through November 30, 2005)

Disabled											
	MCO/Physical Health					BHO/Mental Health					MCO/BHO
	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures PMPM
Age Under 21											
Member Months	4,432					4,432					
Brand	217,578	1,334	1,204	163.10	49.09	129,523	820	740	157.96	29.22	78.31
Generic	40,089	2,007	1,811	19.97	9.04	21,580	434	392	49.72	4.87	13.91
Non-Drug*	2,632	58	52	45.37	0.59	1,503	3	3	501.01	0.34	0.93
Subtotal	260,299	3,399	3,067	228.45	58.73	152,607	1,257	1,134	708.69	34.43	93.15
Age 21+											
Member Months	71,299					71,299					
Brand	5,529,892	43,387	2,434	127.46	77.56	1,586,907	10,174	571	155.98	22.26	99.82
Generic	2,172,535	87,607	4,915	24.80	30.47	599,234	19,856	1,114	30.18	8.40	38.88
Non-Drug*	304,006	6,689	375	45.45	4.26	799	2	0	399.32	0.01	4.28
Subtotal	8,006,433	137,683	7,724	197.70	112.29	2,186,940	30,032	1,685	585.48	30.67	142.97
Total											
Member Months	75,732					75,732					
Brand	5,747,470	44,721	2,362	128.52	75.89	1,716,430	10,994	581	156.12	22.66	98.56
Generic	2,212,624	89,614	4,733	24.69	29.22	620,815	20,290	1,072	30.60	8.20	37.41
Non-Drug*	306,638	6,747	356	45.45	4.05	2,302	5	0	460.34	0.03	4.08
Total	8,266,732	141,082	7,452	198.66	109.16	2,339,547	31,289	1,653	647.06	30.89	140.05

* Non-Drugs include medical supplies, bulk chemicals, etc.

TennCare **Exhibit 19**

Middle Tennessee Data Book

Historical Rx Encounter Data (September 1, 2005 through November 30, 2005)

Duals, Waiver Duals and State Only & Judicials											
	MCO/Physical Health					BHO/Mental Health					MCO/BHO
	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures PMPM
Duals											
Member Months	170,845					170,845					
Brand	24,067,348	217,606	5,095	110.60	140.87	5,603,115	41,111	963	136.29	32.80	173.67
Generic	7,896,153	351,738	8,235	22.45	46.22	2,251,322	75,653	1,771	29.76	13.18	59.40
Non-Drug*	561,199	14,752	345	38.04	3.28	1,037	5	0	207.35	0.01	3.29
Total	32,524,700	584,096	13,675	171.09	190.38	7,855,474	116,769	2,734	373.40	45.98	236.36
Waiver Duals											
Member Months	4,703					4,703					
Brand	1,659	18	15	92.18	0.35	192	2	2	96.19	0.04	0.39
Generic	343	25	21	13.73	0.07	74	4	3	18.40	0.02	0.09
Non-Drug*	-	-	-	-	-	-	-	-	-	-	-
Total	2,003	43	37	105.91	0.43	266	6	5	114.59	0.06	0.48
State Only & Judicials											
Member Months	1,400					1,400					
Brand	22	3	9	7.28	0.02	533	8	23	66.66	0.38	0.40
Generic	-	-	-	-	-	22	4	11	5.50	0.00	0.00
Non-Drug*	-	-	-	-	-	-	-	-	-	-	-
Total	22	3	9	7.28	0.02	555	12	34	72.16	0.38	0.40

* Non-Drugs include medical supplies, bulk chemicals, etc.

TennCare **Exhibit 19**

Middle Tennessee Data Book

Historical Rx Encounter Data (September 1, 2005 through November 30, 2005)

BHO Priority											
	MCO/Physical Health					BHO/Mental Health					MCO/BHO
	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures	Units	Units / 1000	Paid Expenditures / Unit	Paid Expenditures PMPM	Paid Expenditures PMPM
Age Under 21											
Member Months	20,814					20,814					
Brand	619,012	6,600	1,268	93.79	29.74	1,545,209	12,051	2,316	128.22	74.24	103.98
Generic	211,811	14,543	2,795	14.56	10.18	463,271	5,241	1,007	88.39	22.26	32.43
Non-Drug*	25,828	525	101	49.20	1.24	2,630	13	2	202.32	0.13	1.37
Subtotal	856,651	21,668	4,164	157.55	41.16	2,011,110	17,305	3,326	418.94	96.62	137.78
Age 21+											
Member Months	46,502					46,502					
Brand	5,380,293	42,492	3,655	126.62	115.70	2,644,056	57,215	4,922	46.21	56.86	172.56
Generic	2,540,447	102,994	8,859	24.67	54.63	7,089	18	2	393.81	0.15	54.78
Non-Drug*	255,910	5,804	499	44.09	5.50	-	-	-	-	-	5.50
Subtotal	8,176,650	151,290	13,014	195.38	175.84	2,651,145	57,233	4,923	440.02	57.01	232.85
Total											
Member Months	67,315					67,315					
Brand	5,999,305	49,092	2,917	122.21	89.12	4,189,266	69,266	4,116	60.48	62.23	151.36
Generic	2,752,257	117,537	6,984	23.42	40.89	470,360	5,259	312	89.44	6.99	47.87
Non-Drug*	281,739	6,329	376	44.52	4.19	2,630	13	1	202.32	0.04	4.22
Total	9,033,301	172,958	10,277	190.14	134.19	4,662,255	74,538	4,429	352.24	69.26	203.45

* Non-Drugs include medical supplies, bulk chemicals, etc.

TennCare
Middle Tennessee Data Book

Exhibibit 20

Impact Of Hard Benefit Limits - Draft Version 25 (1/30/2006)
No Change To Children or Institutional
Fiscal Year 2005 Incurred Claims

		Hard Limit	% Achieved		Soft Limit Savings
1. Inpatient Hospital 20 Day Limit	$	22,334,870	20%	$	4,466,974
2. Inpatient Physician for 20 Day Limit (link to 1)	$	2,535,104	20%	$	507,021
3. Outpatient Hospital 8 Visit Limit	$	8,847,727	20%	$	1,769,545
4. Physician 12 Visit Limit (exclude Lab/Rad)	$	9,530,546	20%	$	1,906,109
5. Lab/Radiology 10 Occurances Limit	$	6,061,754	20%	$	1,212,351
Total For Middle Tennessee	$	49,310,001		$	9,862,000

ATTACHMENT 6.9
PROPOSAL SCORE SUMMARY MATRIX

RFP Coordinator **Date**

QUALIFICATIONS & EXPERIENCE Maximum Points: 200	**PROPOSER NAME**		**PROPOSER NAME**		**PROPOSER NAME**	
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE SCORE:		**AVERAGE SCORE:**		**AVERAGE SCORE:**	
TECHNICAL APPROACH Maximum Points: 500						
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE SCORE:		**AVERAGE SCORE:**		**AVERAGE SCORE:**	
COST PROPOSAL Maximum Points: 300	**SCORE:**		**SCORE:**		**SCORE:**	
PROPOSAL SCORE Maximum Points: 1000	**TOTAL SCORE:**		**TOTAL SCORE:**		**TOTAL SCORE:**	

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

AMENDMENT # 1
RFP # 318.65-219

April 11, 2006

The subject RFP is hereby amended as follows.

The following RFP Schedule of Events updates or confirms scheduled RFP dates.

EVENT		TIME	DATE	UPDATED/ CONFIRMED
1.	State Issues RFP		April 7, 2006	CONFIRMED
2.	Disability Accommodation Request Deadline		April 17, 2006	CONFIRMED
3.	Pre-proposal Conference	10:00 a.m.	April 19, 2006	TIME UPDATED
4.	Notice of Intent to Propose Deadline		April 21, 2006	CONFIRMED
5.	Written Comments Deadline		April 26, 2006	CONFIRMED
6.	State Responds to Written Comments		May 9, 2006	CONFIRMED
7.	Proposal Deadline	2:00 p.m.	May 19, 2006	CONFIRMED
8.	State Completes Technical Proposal Evaluations		June 12, 2006	CONFIRMED
9.	State Opens Cost Proposals & Calculates Scores	9:00 a.m.	June 13, 2006	CONFIRMED
10.	State Issues Evaluation Notice & Opens RFP Files for Public Inspection	9:00 a.m.	June 14, 2006	CONFIRMED
11.	Contract Signing		June 26, 2006	CONFIRMED
12.	Contract Signature Deadline		July 3, 2006	CONFIRMED
13.	Contract Start Date (Readiness Review/Transition Begins; Actual Delivery of Services begins on January 1, 2007)		July 5, 2006	CONFIRMED
14.	Delivery of Services		January 1, 2007	CONFIRMED