TENNCARE PARTNERS

BEHAVIORAL HEALTH CONTRACTOR AGREEMENT

BETWEEN

THE STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

AND

TENNESSEE BEHAVIORAL HEALTH, INC.
IN THE TENNESSEE EAST GRAND REGION

July 1, 2004

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BEHAVIORAL HEALTH CONTRACTOR AGREEMENT

between

THE STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

AND

TENNESSEE BEHAVIORAL HEALTH, INC.
IN TENNESSEE EAST GRAND REGION

This CONTRACT is entered into by and between the State of Tennessee, through the Department of Mental Health and Developmental Disabilities, hereinafter referred to as **"TDMHDD"** or "State", and **Tennessee Behavioral Health, Inc.** hereinafter referred to as the "**Contractor**", for the provision of covered behavioral health services to **Enrollees** in the **TennCare Partners Program** and to certain other persons identified by **TDMHDD** in the Tennessee East Grand Region, as described below.

WHEREAS, behavioral health services are covered under the current **TennCare Program**; and

WHEREAS, **TDMHDD**, as the State's mental health authority, provides and coordinates the delivery of additional behavioral health services for the public mental health system which are funded with various State and/or non-Title XIX federal funds; and

WHEREAS, it is in the best interests of persons needing behavioral health services to have them delivered in a coordinated manner by entities experienced in providing managed care services for persons with mental illness and substance abuse problems; and

WHEREAS, it is in the best interests of the State to bring behavioral health services together in an efficient and effective service delivery system; and

WHEREAS, it is the intent of the State to continue a component of the **TennCare Program** called the **TennCare Partners Program** to provide behavioral health services through a managed care arrangement separate from the **TennCare** Managed Care Organizations (MCOs); and

WHEREAS, it is the intent of **TennCare** and **TDMHDD** that **TDMHDD** oversee and administer the **TennCare Partners Program**; and

WHEREAS, it is the intent of **TDMHDD** to contract with at least one (1) Behavioral Health Organization (BHO) per grand region for the purpose of delivering behavioral health services covered by the **TennCare Partners Program** as well as certain services for specified non-**TennCare** eligibles including **Judicials** and **State-Onlys** (individuals whose coverage is limited and for whom federal financial participation is not available);

WHEREAS, the purpose of this CONTRACT is to assure Tennesseans of quality behavioral health services while managing the cost of such services; and

WHEREAS, consistent with waivers granted by the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services (DHHS), the State of Tennessee has been granted the authority to pay monthly prepaid capitated amounts to BHOs for rendering or arranging necessary behavioral health services to persons currently enrolled in the State of Tennessee's **TennCare Program**, which includes Tennesseans who are Medicaid-eligible under the **Medicaid Program** and Tennesseans who are uninsured and meet **TennCare** Rules for eligibility or are medically eligible as well as certain non-**TennCare** individuals who are described within the body of this CONTRACT hereinafter referred to as the **TennCare Partners Program**; and

WHEREAS, **TDMHDD** is the State agency responsible for administration of the **TennCare Partners Program** in Tennessee and is authorized to CONTRACT with BHOs for the purpose of providing the services specified herein for the benefit of Tennesseans who are eligible for the **TennCare Partners Program**; and

WHEREAS, the **Contractor** is a Behavioral Health Organization (BHO), has met qualifications established by the State, is capable of providing or arranging for behavioral health services to covered persons 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; and

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties have agreed and do hereby enter into this CONTRACT in accordance with the provisions set forth herein.

SECTION 1. PREAMBLE

1.1 Titles

Titles of sections, paragraphs, and clauses used in this CONTRACT are for the purpose of facilitating use or reference only and shall not be construed to imply a contractual construction of language.

1.2 Notice

All notices required to be given under this CONTRACT 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 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:

State of Tennessee
Virginia Trotter Betts, MSN, JD, RN, FAAN
Commissioner
Tennessee Department of Mental Health and Developmental Disabilities
425 5th Avenue, North
3rd Floor, Cordell Hull Building
Nashville, Tennessee 37243

Tennessee Behavioral Health, Inc.
Ann Boughtin
General Manager
222 2nd Avenue, North
Suite 220
Nashville, Tennessee 37201

1.3 Entire CONTRACT

This CONTRACT, including any amendments or attachments, represents the entire CONTRACT between the **Contractor** and **TDMHDD** with respect to the subject matter stated herein. This CONTRACT supersedes any and all other agreements between the parties with regard to the provision of the behavioral health services described herein. Any communications made before the parties entered into this CONTRACT, whether verbal or in writing, shall not be considered as part of or explanatory of any part of this CONTRACT.

In the event of a conflict of language between the CONTRACT and any amendments, the provisions of the amendments shall govern. All applicable laws, rules, regulations, court orders and policies (hereinafter referred to as Applicable Requirements), including those described in Section 6.1 of this CONTRACT are incorporated by reference into this CONTRACT. Any changes in those Applicable Requirements shall be automatically incorporated into this CONTRACT by reference as soon as they become effective.

1.4 Amendments

This CONTRACT may be amended at any time as provided in this Section. This CONTRACT shall be amended automatically without action by the parties whenever required by changes in state or federal law, court orders, or regulations. In the event of a Partial Default, the CONTRACT shall be amended automatically to conform with written notices from **TDMHDD** to the **Contractor** regarding the effect of the Partial Default upon this CONTRACT. No other modification or change of any provision of the CONTRACT shall be made or be construed to have been made unless such modification is mutually agreed to in writing by the **Contractor** and **TDMHDD**, approved by CMS, incorporated as a written amendment to this CONTRACT prior to the effective date of such modification or change, and approved by State officials as required by state laws and regulations.

1.5 Incorporation by Reference

All applicable laws, rules, regulations, court orders and policies, including those described in Section 6.1 of this CONTRACT and the BHO proposal submitted by the **Contractor** are incorporated by reference into this CONTRACT. Any changes in all applicable requirements described in this CONTRACT shall be automatically incorporated by reference as soon as they become effective.

1.6 Order of Precedence

If there is a conflict of language or interpretation between this CONTRACT and the following, the order of precedence, from highest to lowest, shall be as follows:

1.6.1 All applicable court orders, federal and State laws, and associated properly promulgated federal and State rules, regulations, and policies;

1.6.2 This CONTRACT, and any amendment to this CONTRACT;

1.6.3 The terms and conditions of the waivers granted to the State of Tennessee by CMS to implement the **TennCare Partners Program**;

1.6.4 All clarifications and addenda made to the **Contractor's** proposal;

1.6.5 The Request for Proposal (RFP) and its associated amendments;

1.6.6 Technical specifications provided to the **Contractor**; and

1.6.7 The **Contractor's** proposal.

However, to the extent that State law, court orders, or terms of this CONTRACT, subcontracts, or provider agreements propose requirements that are inconsistent with the approved wavier, no federal financial participation is available.

1.7 Definitions

The terms used in this CONTRACT shall be construed and interpreted in accordance with the definitions set forth in Attachment A.

1.8 Applicability of this CONTRACT

All terms, conditions, and policies stated in this CONTRACT apply to staff, agents, officers, subcontractors, providers, volunteers and anyone else acting for or on behalf of the **Contractor**. **TennCare Enrollees** and certain non-**TennCare Enrollees** identified by **TDMHDD** 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 **TDMHDD** or the State of Tennessee by **Enrollees** beyond any that may exist under State or federal law.

SECTION 2. TENNCARE PARTNERS PROGRAM DESCRIPTION

2.1 Overview

The **TennCare Partners Program** is designed to complement the **TennCare Program** implemented through the State's Section 1115(a) waiver (No. 11-W-00151/4). The purpose of the **TennCare Partners Program** is to provide behavioral health services to all **TennCare Enrollees** and certain non-**TennCare** eligible individuals under the purview of the State of Tennessee (State). The **TennCare Partners Program** is delivered through BHO(s) operating under contract to **TDMHDD**.

2.2 Eligibility for Covered Services Under the TennCare Partners Program

Enrollee eligibility for covered services under the **TennCare Partners Program** shall be limited to persons who meet the criteria described in **TennCare** policy and/or the **TennCare** Rules and Regulations and any Medicaid eligible authorized to be enrolled in a managed care organization under the authority of waivers issued by the Centers for Medicare and Medicaid Services (CMS).

2.2.1 Enrollees

The **Contractor** shall provide covered behavioral health services in accordance with Section 2.5 to the individuals identified below.

2.2.1.1 TennCare Medicaid Enrollees

The **Contractor** shall provide all behavioral health services as described in Section 2.5, Table 1, to all **TennCare Medicaid Enrollees** who qualify and have been determined eligible for benefits in the **TennCare Program** through Medicaid eligibility criteria as described in the Medicaid/**TennCare** Rules and Regulations.

2.2.1.2 TennCare Standard Enrollees

The **Contractor** shall provide all behavioral health services as described in Section 2.5, Table 1, to the **TennCare Standard Enrollees** who qualify and have been determined eligible for benefits in the **TennCare Program** under the **TennCare** Waiver and Rules and Regulations.

2.2.2 Judicials

The **Contractor** shall provide court-ordered mental health evaluation and treatment services to the following **Judicials** who are identified by **TDMHDD:** persons who are not **Enrollees** in the **TennCare Partners Program**, or who have not been determined to be **State-Only** participants by **TDMHDD**, and have been court ordered to receive services identified in Section 2.5.8. **Judicials** are entitled only to coverage of those mental health evaluation and treatment services required by the statute or court order under which the individuals were referred.

2.2.3 State-Onlys

The **Contractor** shall provide all behavioral health services described in Section 2.5, Table 1, to the following **State-Only** participants. These are persons not eligible for the **TennCare Program** and who are determined by **TDMHDD**, or its designee, to be Severely and/or Persistently Mentally Ill (SPMI) or Seriously Emotionally Disturbed (SED), as defined in Attachment A. These persons must have family incomes that do not exceed one hundred percent (100%) of the federal poverty level. These persons will not have coverage through a **TennCare** managed care organization (MCO). **TennCare** assigns **State-Only** participants to BHOs.

2.3 Enrollment Guidelines

2.3.1 Enrollment of TennCare Eligibles

Persons who are **TennCare Medicaid** or **TennCare Standard** eligibles identified in Section 2.2.1 will be automatically enrolled in the **TennCare Partners Program**. All enrollment, disenrollment, and re-enrollment policies of **TennCare** apply to **TennCare Medicaid** and **TennCare Standard Enrollees** participating in the **TennCare Partners Program**. **TennCare Medicaid** and **TennCare Standard Enrollees** will be assigned by **TennCare** to the **Contractor** in accordance with Section 2.3.2 below.

2.3.2 Assignment to a BHO

2.3.2.1 **TennCare Partners Program Enrollees** will be assigned to a BHO contracted with **TDMHDD** to provide behavioral health services.

2.3.2.2 These **Enrollees** will be accepted in the health condition they are in at the time of enrollment.

2.3.2.3 The **Contractor** shall accept and update daily eligibility data from the State.

2.3.2.4 Individuals are considered enrolled in the **Contractor's** Plan at 12:01am of the effective date of enrollment. Enrollment shall end at 12:00 midnight on the date that the **Enrollees** are disenrolled pursuant to the criteria in **TennCare** policy and/or **TennCare** Rules and Regulations.

2.3.2.5 The **Contractor** shall accept individuals in the order in which they are assigned without restriction.

2.3.3 Choice of Providers by Enrollee

The **Contractor** shall allow each **Enrollee** to choose his/her own mental health care and substance abuse service providers from the providers participating in the **Contractor's** provider network, subject to the capacity of the providers to accept **Enrollees**.

2.4 Disenrollment from the TennCare Partners Program

2.4.1 Disenrollment Guidelines

The **Contractor** will discontinue covered services to **Enrollees** who are disenrolled from the **TennCare Partners Program** in accordance with **TennCare** Rule 1200-13-13-.03 and 1200-13-14-.03 of the Tennessee Department of Finance and Administration (TDFA).

Regardless of the procedures followed, the effective date of an approved disenrollment must be in accordance with Section 2.3.2.4 and no later than the first calendar day of the second month following the month in which the **Enrollee** or the **Contractor** files the request.

2.4.2 Unacceptable Reasons for Disenrollment

The **Contractor** may not request disenrollment of an **Enrollee** from the **TennCare Partners Program** or a **Contractor's** plan solely for any of the following reasons:

2.4.2.1 Adverse changes in the **Enrollee's** health;

2.4.2.2 Pre-existing medical conditions;

2.4.2.3 High-cost medical bills; or

2.4.2.4 The **Enrollee's**:
i) utilization of medical services,
ii) diminished mental capacity, or
iii) uncooperative or disruptive behavior resulting from his/her special needs.

2.4.3 Effect of Disenrollment on Capitation Payments

Payment of capitation payments shall cease effective the date of disenrollment, conducted in accordance with Section 2.4.1, and the **Contractor** shall have no further responsibility for the care of the **Enrollee**. Except as indicated below, disenrollment shall not be made retroactively and the **Contractor** shall not be required to refund any capitation payments legitimately paid pursuant to this CONTRACT.

In the event of fraudulent enrollment or attempted enrollment of individuals by the **Contractor** staff, officers, subcontractors, providers, volunteers or anyone acting for or on behalf of the **Contractor**, **TennCare** shall retroactively recover capitation amounts and any other monies paid to the **Contractor** for the enrollment of those individuals.

2.4.3.1 Fraudulent enrollment by the Enrollee

If an **Enrollee** in the **TennCare Partners Program** is disenrolled under Subsection 2.4.1 because he/she falsified the application for the **TennCare Partners Program** and approval was based on false information, payment of capitation payments shall cease effective the date of disenrollment. However, the **Contractor**, at its discretion, shall refund to **TennCare** all capitation payments **TennCare** has made on behalf of the person

who fraudulently enrolled in the **TennCare Partners Program**, and the **Contractor** shall pursue full restitution for all payments the **Contractor** has made for covered services while the person was fraudulently enrolled in the **Contractor's** plan.

2.4.3.2 In the event of fraudulent enrollment or attempted enrollment of individuals by the **Contractor's** staff, others, subcontractors, providers, volunteers or anyone acting for or on behalf of the **Contractor**, **TennCare** shall retroactively recover capitation amounts and any other moneys paid to any BHO for the enrollment of that individual.

2.4.4 Contractor's Responsibilities for Disenrollment

The **Contractor** shall inform each **Enrollee** at the time of enrollment of the criteria for disenrollment as permitted by Section 2.4.1 of this CONTRACT.

2.4.5 Monthly Report

TennCare shall provide to the **Contractor** a monthly report of all disenrollments resulting from action taken by **TennCare**. This report shall delineate by county of residence, in county order, all persons disenrolled, the effective date of their disenrollment and the reasons for their disenrollment. Actions taken by **TennCare** cannot be appealed by the **Contractor**.

2.5 Services Covered Under the TennCare Partners Program

2.5.1 Covered Services

The **Contractor's** service system shall provide a uniform and consistent continuum of quality behavioral health services to all assigned **Enrollees** that includes the active involvement of the **Contractor's** Advisory Council.

2.5.1.1 The **Contractor** shall be responsible for the provision of covered services as specified in this CONTRACT to all **Enrollees** when the need for said services is the result of mental health or substance abuse treatment needs, regardless of whether the **Enrollees** have any co-occurring (MH/SA) diagnoses, including but not limited to developmental disabilities.

2.5.1.2 The **Contractor** shall provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the **Enrollee** to obtain one outside the network, at no cost to the **Enrollee**.

2.5.1.3 The **Contractor**, through its providers, shall furnish prescriptions for medically necessary psychiatric pharmacy services, but not the medications themselves. The State is responsible for all medically necessary covered pharmacy services.

2.5.1.4 The **Contractor** is not responsible for Mental Health/Substance Abuse services rendered by Primary Care Providers.

Table 1: Covered Behavioral Health Benefits

Benefit	***TennCare Medicaid, State-Only & Standard Coverage***
Psychiatric Inpatient Hospital Services (including physician services)	As medically necessary
Outpatient Mental Health Services (including physician services)	As medically necessary
Inpatient/Residential & Outpatient Substance Abuse Benefits[1]	**Under age 21:** As medically necessary **Age 21 & older, including SPMI:** Limited to ten days detox, $30,000 in medically necessary lifetime benefits
24-hour Psychiatric Residential Treatment[2]	As medically necessary
Mental Health Crisis Services	As necessary for anyone regardless of **TennCare** eligibility
Mental Health Case Management	As medically necessary
Non-Emergency Transportation	As necessary to get the **Enrollee** to and from covered services for **Enrollees** lacking access to transportation
Emergency Air & Ground Ambulance Services	As medically necessary
Laboratory Services	As medically necessary
Psychiatric-Rehabilitation Services	As medically necessary

[1]When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone detoxification and methadone maintenance shall only be a covered behavioral health benefit for Enrollees under 21 years after August 1, 2005.

[2]The **Contractor** is not responsible for the provision of 24-hour psychiatric residential treatment for children under age 21 years when the child is in State custody as specified in Section 2.5.11.

2.5.2 Medical Necessity

The **Contractor** shall arrange or provide for all medically necessary covered benefits in accordance with the definition set forth in Attachment A or as later revised and approved by CMS.

2.5.3 Assessments

The **Contractor** shall ensure that its provider network is trained and has sufficient capacity to perform assessments. **TDMHDD** shall provide trainer training to all providers authorized by **TDMHDD** to perform assessments. Certified trainers will be responsible for providing rater training within their agencies. The **Contractor** shall require providers to use the Clinically Related Group (CRG) assessment form(s) or Target Population Group (TPG) assessment form(s), as appropriate, prescribed by and in accordance with the policies of **TDMHDD**. These assessments shall be subject to review and approval by **TDMHDD**.

2.5.3.1 The **Contractor** must provide a CRG or TPG assessment in response to a request from an **Enrollee**, or in the case of a minor, the **Enrollee's** parent(s), legal guardian(s), or legal custodian(s), or at the request of a behavioral health or primary care provider (PCP), **TDMHDD**, or the **Enrollee's** MCO if the **Enrollee** consents. The **Contractor** must complete these assessments within fourteen (14) calendar days of the request. The **Contractor** shall not require prior authorization in order for an **Enrollee** to receive a mental health assessment.

2.5.3.2 Once an **Enrollee** is assessed as Severely and/or Persistently Mentally Ill (SPMI) or Seriously Emotionally Disturbed (SED), the **Contractor** must reassess the **Enrollee** at least every twelve (12) months, or sooner if an individual's CRG/TPG status has changed to a degree

which would cause a difference in rating. The **Contractor** shall not limit the number of assessments that may be completed.

2.5.3.3 The **Contractor** shall identify persons in need of CRG/TPG assessments. The **Contractor** shall use the assessments to identify persons who are Severely and/or Persistently Mentally Ill (SPMI) or Seriously Emotionally Disturbed (SED) for reporting and tracking purposes, in accordance with the definitions contained in Attachment A. Failure to complete the assessments within the timeframes indicated in this Section, to utilize **TDMHDD**-certified raters, or to complete the assessments in accordance with **TDMHDD** policies and procedures may result in the application of liquidated damages in accordance with Section 5.3.3.

2.5.4 TENNderCare

2.5.4.1 The **Contractor** shall provide any medically necessary services covered under the federal Medicaid program to **TennCare Enrollees** under the age of twenty-one (21) years without regard as to whether such services are covered under the **TennCare Program** State plan and without regard to any service limits otherwise established in this CONTRACT. The federal Early Periodic Screening, Diagnosis & Treatment (EPSDT) program shall be referred to as TENNderCare and all **Enrollee** and provider materials shall contain the term and logo for TENNderCare as of January 1, 2005. The **Contractor** shall comply with federal EPSDT requirements at 42 CFR 441.62 in the provision of the following EPSDT services:

2.5.4.1.1 Mental health and/or substance abuse diagnosis requested as follow-up to an TENNderCare screening;

2.5.4.1.2 Mental health and/or substance abuse assessments provided as inter-periodic screenings in accordance with Section 5140B of the State Medicaid Manual;

2.5.4.1.3 Other necessary diagnostic services, treatment, and other measures to correct, ameliorate, or prevent from worsening defects and mental illnesses and conditions; and

2.5.4.1.4 Transportation assistance for an **Enrollee** including related travel expenses, cost of meals, and lodging en route to and from care, and the cost of an attendant to accompany an **Enrollee** if necessary. Blanket restrictions may not be imposed when determining coverage for transportation services. Each request for transportation services is to be reviewed individually and documented by the **Contractor** and/or the transportation vendor.

The requirement to provide the cost of meals applies only when an **Enrollee** has to be transported to a major health facility for services and care cannot be completed in one (1) calendar day thereby requiring an overnight stay.

In the event a TENNderCare **Enrollee** had previously been transported and the treating provider refused to treat the **Enrollee** because he/she was not accompanied by a parent(s), legal guardian(s), or legal custodian(s) who could authorize treatment, written permission from the treating physician and parent, legal guardian(s), or legal custodian(s) may be required for future transportation. Circumstances that may permit the **Contractor** and/or its transportation vendor to refuse, on a case by case basis, the transportation request would be as follows:

2.5.4.1.4.1 The TENNderCare **Enrollee** is under the age of sixteen (16) years and the **Enrollee's** attendant is not a parent(s), legal guardian(s), or legal custodian(s) and cannot legally sign for the **Enrollee** to receive medical care if legal authority is required. For example, some foster or stepparents do not have legal authority to sign for medical care for foster or stepchildren. The **Contractor** and transportation

vendors must verify signing authority when scheduling transportation; or

2.5.4.1.4.2 According to a reasonable person's standards, the **Enrollee** is noticeably indisposed [disorderly conduct, intoxicated, armed (firearms), possession of illegal drugs, knives and/or other weapons], or has any other condition that may affect the safety of the driver or persons being transported.

2.5.4.2 The **Contractor** shall establish a procedure for primary care providers or other providers completing TENNderCare screenings to refer **Enrollees** under the age of twenty-one (21) years for a mental health and/or substance abuse diagnosis in order to enable the **Contractor** to complete the requirements specified in Sections 2.5.4.5 through 2.5.4.9.

2.5.4.3 In the event that the **Enrollee** is under sixteen (16) years and the **Enrollee's** parent(s), legal guardian(s), or legal custodian(s) is unable to accompany the child to the examination, the **Contractor** shall require providers to contact the **Enrollee's** parent(s), legal guardian(s), or legal custodian(s) to discuss the findings and inform the family of any other necessary health care, diagnostic services, treatment or other measures recommended for the child, or notify the **Contractor** to contact the parent(s), legal guardian(s), or legal custodian(s) with the results.

2.5.4.4 The **Contractor** shall require providers to refer **Enrollees** for health care, diagnostic services, treatment and other measures necessary to correct, ameliorate, or prevent from worsening any defects, mental illnesses or other conditions discovered by the screening service, and to document said referrals in the **Enrollee's** medical record.

2.5.4.5 The **Contractor** shall direct its network providers to notify the **Contractor** in the event a screening reveals the need for other health care services. Upon notification that a provider is unable to make an appropriate referral for

services, the **Contractor** shall make an appropriate referral and contact the **Enrollee,** or the **Enrollee's** parent(s), legal guardian(s), or legal custodian(s)**,** to offer scheduling assistance and transportation. If the other health care is a MCO benefit, the **Contractor** shall contact the **Enrollee's** MCO and inform them of the need to contact the **Enrollee**, or the **Enrollee's** parent(s), legal guardian(s) or legal custodian(s) to offer scheduling assistance and transportation. The **Contractor** shall maintain a log of all such contacts and, at a minimum, shall record the name of the **Enrollee**, the **Enrollee's** ID number, name of the MCO contacted, date of MCO contact, time of MCO contact, and description of the required service. In the event of a dispute regarding the organization responsible for the provision of the services, the **Contractor** shall adhere to the requirements specified in Section 3.2.1.3.

2.5.4.6 The **Contractor** shall inform all **Enrollees** assigned to its plan who are under the age of twenty-one (21) years, or their parent(s), legal guardian(s) or legal custodian(s) of the availability of early and periodic screening, diagnostic, and treatment services within thirty (30) calendar days of enrollment as specified in Section 3.4.2.1.6, and annually thereafter upon the **Enrollee's** anniversary date of enrollment. All **Enrollee** material shall be submitted to **TDMHDD** for approval prior to distribution and shall be made available in accordance with the requirements specified in Section 3.4.5.

2.5.4.7 The **Contractor** shall have a process for following up with **Enrollees** who do not receive services that the **Contractor** was contacted to arrange.

2.5.4.8 The **Contractor** must have a process for documenting services declined by a parent(s), legal guardian(s), legal custodian(s) or mature competent child, specifying the particular services declined so that outreach and education for other TENNderCare services can continue. This process must meet all requirements outlined in the State Medicaid Manual, Part 4, Section 5320A.

2.5.4.9 The **Contractor** must make available to families accurate lists of names and phone numbers of contract providers who are currently accepting **TennCare** as described in Section 3.4.7 of this CONTRACT.

2.5.4.10 The **Contractor** shall report quarterly on activities conducted to meet federal TENNderCare regulations to **TDMHDD**.

2.5.4.11 The **Contractor** shall not require prior authorization in order for an **Enrollee** to obtain a mental health or substance abuse assessment, whether the screening is requested as follow-up to a TENNderCare screening or as 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 Primary Care Providers, or other providers, completing TENNderCare screenings, to refer **Enrollees** under the age of 21 for a mental health or substance abuse assessment in order to enable the **Contractor** to complete the requirements specified in Section 2.5.4.

2.5.4.12 MCCs must have the ability to conduct EPSDT outreach in formats appropriate to enrollees who are blind, deaf, illiterate, or non-English speaking. At least one attempt must advise enrollees regarding how to request and/or access such assistance and/or information. The **Contractor** shall collaborate with agencies that have established procedures for working with special populations in order to develop effective outreach materials.

2.5.5 Emergency Mental Health & Substance Abuse Treatment Services

The **Contractor** shall arrange or provide for all medically necessary covered benefits in accordance with the definition of medical necessity as set forth in Attachment A or as later revised and approved by CMS.

2.5.5.1 The **Contractor** shall provide coverage for inpatient and outpatient mental health and substance abuse treatment services, furnished by a qualified provider, needed to evaluate or stabilize an emergency medical condition, as defined in Attachment A. The **Contractor** is responsible for coverage and payment of emergency services and post-stabilization care services. The **Contractor** may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

Payment for the services rendered to evaluate or stabilize the emergency medical condition may not be denied for lack of notification within ten (10) calendar days of presentation for emergency services. However, the **Contractor** may require authorization for inpatient services or follow-up care, once the individual's condition is stabilized.

2.5.5.2 If there is a disagreement between the hospital and the **Contractor** concerning discharge or transfer, the judgment of the attending physician(s) 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 network physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the **Enrollee**, provided that such arrangement does not delay the provision of emergency mental health or substance abuse treatment services.

2.5.5.3 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.

2.5.5.4 When an **Enrollee** seeks emergency mental health or substance abuse treatment services, the **Contractor** shall pay for the medical screening examination and for other medically necessary emergency behavioral health treatment services. Further, the **Contractor** shall not deny payment when a representative of the **Contractor** instructed the **Enrollee** to seek the emergency services.

2.5.5.5 In accordance with the Balanced Budget Act of 1997, the **Contractor** shall cover the following services without requiring authorization and regardless of whether the **Enrollee** obtains the services within or outside the **Contractor's** provider network:

2.5.5.5.1 Post-stabilization care services pre-approved by the **Contractor**; or

2.5.5.5.2 Post-stabilization care services not pre-approved by the **Contractor** because the **Contractor** did not respond to the provider of post-stabilization care services' request for pre-approval within one (1) hour after being requested to approve such care, or could not be contacted for pre-approval.

2.5.5.5.3 If the **CONTRACTOR** and the treating physician cannot reach an agreement concerning the **Enrollee's** care and a physician representing the **CONTRACTOR** is not available for consultation. The treating physician shall continue with the continuity of care of the **Enrollee** until a physician representing the **CONTRACTOR** is reached or the **CONTRACTOR** attains at least one criteria detailed in this section to terminate the **CONTRACTORS** financial responsibility.

The **Contractor** can choose not to cover post-stabilization care services out-of-network except in the above stated circumstances.

2.5.5.6 An **Enrollee** who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the **Enrollee.**

2.5.6 Mental Health Case Management

2.5.6.1 The **Contractor** will provide mental health case management services only through providers licensed by **TDMHDD** to provide mental health outpatient services.

2.5.6.2 The **Contractor** will provide mental health case management services according to mental health case management agency standards set by **TDMHDD** outlined in Attachment B. Mental health case management services will consist of two (2) levels of service as specified in Attachment B.

2.5.6.3 The **Contractor** must require its providers to collect and submit individual encounter records for each mental health case management visit, regardless of how the **Contractor** pays for those services. The **Contractor** must be able to identify and separately report the "level 1" and "level 2" case management encounters outlined in Attachment B, and other therapeutic services.

2.5.6.4 The **Contractor** shall require case managers to involve the **Enrollee's** family or parent(s), legal guardian(s), or legal custodian(s), primary care provider and other agency representatives, if appropriate and authorized by the **Enrollee** as required, in case management activities.

2.5.6.5 Any **Enrollee** may choose to decline mental health case management services or to terminate these services once they have begun; however, the **Contractor** must document this refusal with a statement signed by the **Enrollee** (or the **Enrollee's** conservator, parent(s), legal guardian(s) or legal custodian(s)) which contains the following components:

2.5.6.5.1 A statement that the **Enrollee** is eligible for and based on medical necessity has been offered mental health case management services.

2.5.6.5.2 A statement explaining that mental health case management services provide support 24-hours a day, 365 days a year and provide assistance in accessing an array of services.

2.5.6.5.3 A statement that the **Enrollee** refuses mental health case management services at this time but can receive mental health case management services at a later date if he or she so chooses and if the services are determined to be medically necessary.

2.5.6.5.4 Information regarding how the **Enrollee** can request mental health services in non-emergency situations.

2.5.6.5.5 A signature and date from the **Enrollee** (or the **Enrollee's** conservator, parent(s), legal guardian(s) or legal custodian(s)) and a witness.

2.5.6.5.6 If an **Enrollee** does not have a conservator(s), parent(s), legal guardian(s) or legal custodian(s) and refuses to sign the mental health case management waiver or statement refusal, the **Contractor** shall require the signature of two witnesses attesting to the **Enrollee's** refusal to sign.

2.5.6.6 The **Contractor** must assure the continuing provision of mental health case management services to **Enrollees** under the conditions and timeframes indicated below:

2.5.6.6.1 **Enrollees** receiving mental health case management services at the date of execution of this CONTRACT must be maintained in mental health case management until such time as the **Enrollee** no longer qualifies on the basis of medical necessity or refuses treatment.

2.5.6.7 **Enrollees** discharged from psychiatric inpatient facilities and mental health residential treatment facilities must be evaluated for case management services and provided with appropriate mental health follow-up services.

2.5.6.8 The **Contractor** must submit monthly reports as specified in Attachment D.5 detailing the number of **Enrollees,** below the age of twenty-one (21) years and (21) years and older, who have refused mental health case management services.

2.5.6.9 The **Contractor** shall review the cases of **Enrollees** referred by **TennCare** primary care providers or otherwise identified to the **Contractor** as potentially in need of case management services and shall contact and offer such services to all **Enrollees** who meet medical necessity criteria.

2.5.6.10 Abusive Utilizers of Pharmacy Services

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

The TENNCARE PBM shall provide a monthly report to the CONTRACTOR listing all enrollees identified for pharmacy lock-in. The CONTRACTOR shall use the report to identify enrollees requiring case management.

2.5.7 Judicial Services

The **Contractor** must provide covered court ordered mental health services to **Enrollees** in the **TennCare Partners Program** and to **Judicials** pursuant to court order. Such services shall be furnished in accordance with this CONTRACT in the same manner as services furnished to other **Enrollees**.

2.5.8 Services Required under Tennessee Law

2.5.8.1 The **Contractor** shall provide for the care of **Enrollees** and **Judicials** under Tennessee law. Specific laws employed include the following:

2.5.8.1.1 Psychiatric treatment for persons found by the court to require judicial psychiatric hospitalization (Tennessee Code Annotated, §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;

2.5.8.1.2 Judicial review of discharge for persons hospitalized by a circuit, criminal or juvenile court (Tennessee Code Annotated, §33-6-708);

2.5.8.1.3 Access to and provision of mandatory outpatient psychiatric treatment and services to persons who are discharged from psychiatric hospitals after being hospitalized (Tennessee Code Annotated, §33-6, Part 6);

2.5.8.1.4 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 (Tennessee Code Annotated, §33-3-607);

2.5.8.1.5 Voluntary psychiatric hospitalization for persons when determined to be medically necessary, subject to the availability of suitable accommodations (Tennessee Code Annotated, §33-6, Part 2); and

2.5.8.1.6 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 (Tennessee Code Annotated, §33-6, Part 3).

2.5.8.2 Forensics

2.5.8.2.1 The **Contractor** must provide mandatory outpatient treatment for individuals found not guilty by reason of insanity following a 30-60 day inpatient evaluation. Treatment can be terminated only by the court. (Tennessee Code Annotated §33-7-303(b)).

2.5.8.2.2 The State will assume responsibility for all forensic services other than the mandatory outpatient treatment service identified in Section 2.5.8.2.1. (Tennessee Code Annotated § 33-7-301(a), 33-7-301(b), 33-7-303(a) and 33-7-303(c)).

2.5.8.3 Other Requirements

The **Contractor** shall identify and assign specific staff to provide legal and technical assistance for and coordination with the legal system for services provided in these categories.

2.5.9 Crisis Services Telephone Lines

2.5.9.1 The **Contractor** must establish and operate one (1) widely published toll free telephone number for any individual in the general population (**Enrollees**, family members, providers, non-**Enrollees**, etc.) per Community Service Area (CSA) region as appropriate, for the purposes of providing immediate phone intervention by mental health staff and dispatch of mobile crisis services in the appropriate community. The same toll free telephone number may be used in multiple CSAs. This specialized telephone line will be answered by a staff person, rather than by an automated voice response system.

2.5.9.2 The **Contractor** must assure the crisis telephone lines are available 24-hours per day, 365 days per year.

2.5.9.3 The **Contractor** must assure the crisis telephone lines are linked to a crisis service team staffed by qualified crisis service providers. The **Contractor** shall require crisis service teams to provide mobile and walk-in face-to-face interventions in accordance with the standards specified in Attachment B.

2.5.9.4 The **Contractor** shall monitor crisis service providers and report information to **TDMHDD** on a quarterly basis for those indicators listed in Attachment D. All measures shall be reported separately for adults ages eighteen (18) years and over and children under eighteen (18) years for **Enrollees** and non-**Enrollees**. All information shall be reported for each individual crisis service provider in a standardized format as specified by **TDMHDD.**

2.5.10 Retroactive Eligibility

The **CONTRACTOR** shall be responsible for the payment of services during periods of retroactivity in the following circumstances:

1. The **CONTRACTOR** shall not be liable for the cost of any Behavioral Health Care services prior to the effective date of eligibility in the plan. However, the contractor shall be responsible for the costs of covered services obtained on or after 12:01am on the effective date of eligibility.

2. The **CONTRACTOR** shall include provisions governing the payment for medically necessary covered services provided to an

enrollee by a non-contracted provider or non-referred provider for services received by an enrollee any time when TennCare determines that the enrollee is eligible for TennCare and has enrolled the individual in the CONTRACTORS plan and the enrollee could not have known which BHO they were enrolled in at the time of service.

3. The effective date of enrollment may occur prior to the BHO being notified of the enrollee becoming a member of the plan. When this situation arises, the BHO shall not deny medically necessary 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 BHO the enrollee was enrolled in during the timely filing period. However, in such, cases the BHO may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

4. Requests for an informal review of denied emergency claims by TennCare and subsequent payment for covered services during a period of retroactive eligibility shall not be denied because of circumstances beyond a providers control such as the involvement of a third party payor.

2.5.11 Prior Authorization for Covered Services

2.5.11.1 General Rule

The **CONTRACTOR** and/or its sub-contractor's shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services, have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, and consult with the requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR, sub-contractor's or an agent, payment for the pre-approved service shall not be denied based on the lack of medical necessity, assuming that the enrollee is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted. Prior authorization shall not be required for emergency services. Prior authorization requests shall be reviewed subject to the guidelines described in TennCare Rules 1200-13-13 and 1200-13-14 which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of a BHO to act timely upon a request. The CONTRACTOR must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of utilization management (UM) decision making. The CONTRACTOR must have written procedures documenting access to Board Certified

Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

2.5.11.2 At time of Enrollment

In the event an enrollee entering the BHOs plan is receiving medically necessary TennCare covered services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTORS provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. If it is medically necessary that care extend beyond thirty (30) days, the CONTRACTOR may require prior authorization for continuation of the services. Care rendered to a CONTRACTORS enrollee beyond thirty (30) days that is out-of-plan or out-of-network for which a provider has not sought prior authorization need not be reimbursed.

2.5.11.3 Notice of Adverse Action Regarding Prior Authorization Requests

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

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

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

2.5.11.4 Appeals related to Prior Authorization Denials

If an enrollee appeals a prior authorization denial and the provider did not submit medical records to the CONTRACTOR as a part of the prior authorization

determination process, upon request by TENNCARE, the CONTRACTOR shall go to the provider's office, if necessary, and obtain the medical records for TennCare's use in deciding the appeal.

Should a provider fail or refuse to respond to the CONTRACTORS request for information, including but not limited to, the request to provide medical records, and the appeal is decided in favor of the enrollee, at the CONTRACTORS discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

2.6 Requirements of the Plan for Children in State Custody

2.6.1 Contractor Responsibilities

Responsibilities for the administration and operation of the plan for children in State custody are assigned to several parties (e.g. the Implementation Team, the Department of Children's Services, the Behavioral Health Organization, Centers of Excellence for children in or at risk of State custody, **TennCare** and delivery system providers). The **Contractor** agrees to arrange for services and administer the plan in collaboration with these other entities as described by **TennCare**. The **Contractor** agrees to:

2.6.1.1 Comply with any subsequent medically necessary plan for the provision of covered behavioral health services to children in State custody which has been provided and/or approved by the court on a schedule determined to be reasonable and in accordance with the requirements of the court; and

2.6.1.2 Contract with each Center of Excellence (COE) within the **Contractor's** grand region identified by the State for provision of medically necessary covered services to children in or at risk of custody of DCS. Such services shall include emergency assessments and evaluations and ongoing specialized care when requested by local providers managing the child's care.

2.6.2 Administration & Management

Staff Requirements. The **Contractor** shall appoint a specific Department of Children's Services (DCS) liaison person or persons. The DCS liaison person(s) will be responsible for assisting DCS to assure compliance with TENNderCare requirements and the coordination of care for children in State custody and at risk of State custody and shall support primary care providers as

requested. The liaison person(s) shall be available to **TDMHDD**, **TennCare** and/or the DCS case managers, and foster families for assistance. The number of specific liaison persons identified shall be adequate at all times to cover the number of children in or at risk of State custody enrolled in **TennCare Select**.

TennCare will coordinate the responsibility for training the DCS liaison(s) on issues dealing with the provision of TENNderCare services to children in or at risk of State custody. The liaisons will assist DCS with care coordination for these children and will have the responsibility of facilitating the timely delivery of TENNderCare services. Assistance with care coordination will include identifying providers, scheduling appointments, and coordinating transportation (if appropriate), when requested.

2.6.3 Provider Network for Services to Children in State Custody

2.6.3.1 Adequate Capacity. The **Contractor** must maintain a provider network with adequate capacity to deliver covered services that meet the special needs of children in State custody. Indicators of an adequate network include:

2.6.3.1.1 The **Contractor** meets the guidelines established by its CONTRACT with **TDMHDD** for a provider network (as specified in Section 2, Section 3 and Attachment B);

2.6.3.1.2 The **Contractor** has enough providers to consistently meet the time lines of scheduling initial behavioral health screenings and assessments for children in State custody when referred by a PCP for TENNderCare screenings;

2.6.3.1.3 The **Contractor** has sufficient types and numbers of providers to be able to consistently deliver services in a timely manner when ordered for a child by a provider in its network, or a Center of Excellence, within the timeframes set out elsewhere in this CONTRACT; and

2.6.3.1.4 The **Contractor** has within its network specialized behavioral health providers with sufficient expertise to deliver the covered

services recognized in the **TDMHDD** Best Practice Guidelines as being proven effective and needed by children in State custody.

2.6.3.2 Mental Health & Substance Abuse Services. In addition to the requirements specified in Section 2.5.1, the following requirements shall pertain to the coordination of mental health and substance abuse services for children in State custody:

2.6.3.2.1 The **Contractor** shall not limit the types or number of behavioral services that may be furnished by a provider;

2.6.3.2.2 The **Contractor** shall not require providers to obtain approval prior to referring children in State custody for mental health and/or substance abuse services; and

2.6.3.2.3 The **Contractor** shall provide a listing of credentialed behavioral health providers to the MCO periodically (at least once every three (3) months) to facilitate coordination of care. Posting on the website with quarterly updates may be acceptable with notification to the MCOs that the update has been done, subject to approval by **TDMHDD**.

2.6.3.3 Service Authorization. At such time that a procedure is implemented and described by **TennCare**, the Implementation Team shall be contacted for disposition when a covered service has been requested by a health care provider for a child in or at risk of State custody, and the **Contractor** denies or otherwise fails timely to provide that service or approve a less intense service which the provider or DCS feels is inadequate. The role of the Implementation Team may be modified upon receipt of a court-approved or provided plan for children in State custody.

2.6.4 Implementation Team

The Implementation Team, or any subsequently designated team by **TennCare** and shall consist of, but not be limited to representatives of TennCare, DCS, DOH, **Contractor**, and **TDMHDD.** The Implementation Team shall be involved in cases

where children are in immediate need of covered services in order to prevent their going into custody and shall

2.6.4.1 Review requests for children's services after a denial or a delay for services has been issued by the **Contractor**. A letter of authorization (LOA) for those services may be issued when determined medically necessary. The policies and procedures for issuing LOAs are governed by **TennCare**. This shall not include rate setting.

2.6.4.2 Gain access to the medical records (physical and behavioral) to assist in making clinical decisions. All of the medical records obtained by the Implementation Team shall be held in the strictest confidence in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations, Title 33 of Tennessee Code Annotated, and federal regulations.

2.6.4.3 Make a determination regarding services for children at imminent risk of State custody. (DCS identifies children at risk of State custody).

2.6.5 Services Covered by the Department of Children's Services (DCS)

DCS shall be responsible for the provision of the following services to **Enrollees** only for the period specified as follows:

2.6.5.1 24-hour psychiatric residential treatment services, only while children are in DCS legal custody. 24-hour psychiatric residential services do not include psychiatric inpatient facility services, which shall remain the responsibility of the **Contractor**;

2.6.5.2 Residential treatment services which have been identified as therapeutic intervention services, only while children are in DCS custody;

2.6.5.3 Crisis services for children in DCS custody committed to a youth development center; and

2.6.6 Services Not Covered

The responsibility for payment of medically necessary covered behavioral health services is not dependent upon the existence or absence of a specific diagnosis of the **Enrollee** for whom the service is requested. The **Contractor** is responsible for providing all medically necessary covered behavioral health and substance abuse services as delineated in this CONTRACT or as required by state or federal law.

SECTION 3. CONTRACTOR RESPONSIBILITIES

3.1 General

The **Contractor** must comply with all the provisions of this CONTRACT and any amendments thereto and must act in good faith in the performance of these provisions. The **Contractor** must respect the legal rights (including rights conferred by the CONTRACT and Title 33, Tennessee Code Annotated) of every **Enrollee**, regardless of the individual's family status as head of household, dependent, or otherwise. Nothing in this CONTRACT may be construed to limit the rights or remedies of **Enrollees** under state or federal law. The **Contractor** acknowledges that failure to comply with the above referenced provisions may result in the assessment of liquidated damages and/or termination of the CONTRACT in whole or in part, and/or imposition of other sanctions as set forth in this CONTRACT.

The **Contractor** shall mutually agree to such other requirements as may be reasonably established by **TennCare**, Tennessee Department of Commerce and Insurance (TDCI), or Tennessee Department of Mental Health and Developmental Disabilities (**TDMHDD)**.

3.1.1 Agree to not require service providers to accept **TennCare** reimbursement amounts for services provided under any non-**TennCare** or non-**TDMHDD** plan operated or administered by the **Contractor**;

3.1.2 Maintain a sufficiently staffed and working office within the State of Tennessee, including a full-time Tennessee-based administration as described in Section 3.5 specifically identified to administer the day-to-day business and programmatic activities of this CONTRACT;

3.1.3 Maintain service accessibility and availability through the existence of a network of appropriately licensed and credentialed behavioral health providers capable of providing 24-hour comprehensive behavioral health services;

3.1.4 Produce acceptable provider agreements that shall contain provisions satisfying applicable statutory requirements and Section 3.7.2 of this CONTRACT, and letters of intent with behavioral health providers which are at a minimum one (1) year in duration, with cancellation clauses of no less than ninety (90) days consistent with the terms of this CONTRACT and any amendments thereto.

3.1.5 Assure that one (1) month prior to and throughout the open enrollment period, all communication and/or materials representing the **Contractor's** provider network accurately reflect the **Contractor's** provider network that will be available to **Enrollees** on the **Enrollees'** effective date.

3.1.6 The **Contractor** shall provide interpreter services 24 hours a day, seven days a week. Interpreter services should be available in the form of in-person interpreters, sign language or access to telephonic translation assistance, such as the ATT universal line.

3.1.7 TDCI Compliance

The **Contractor** shall comply with all applicable federal, state, and local laws, ordinances, decisions, rules and regulations. The **Contractor** shall be appropriately licensed as required by the laws of the State of Tennessee. The **Contractor** shall maintain appropriate licensure during the term of the CONTRACT.

3.1.8 Financial Requirements

The **Contractor** must comply with the following financial requirements:

3.1.8.1 Establish and maintain an enhanced net worth and working capital which is the greater of either the amount as required by applicable statute; or four percent (4%) of the first one hundred fifty million dollars ($150,000,000) of annual projected premium revenue plus one and one half percent (1.5%) of annual projected premium revenue over one hundred fifty million dollars $150,000,000) where net worth is calculated as net admitted assets in excess of liability as reported in accordance with statutory accounting principles. The **Contractor** shall establish and maintain the net worth and working capital balances required by applicable statute throughout the term of the CONTRACT.

3.1.8.2 Establish and maintain a deposit as required by applicable statute.

3.1.8.3 In the event that **TennCare** elects to transfer **Enrollees** from a failed health plan as specified in 3.2.7, the **Contractor** shall establish and maintain, during the year of the transfer, the minimum net worth of the health plan from which **Enrollees** are being transferred in addition to establishing and maintaining the minimum net worth requirement specified in Section 3.1.8.1, so that the enhanced minimum net worth requirement of the **Contractor** will be equivalent to the total of each minimum net worth requirement for both the **Contractor** and the failed health plan prior to the transfer of enrollment, after which time the minimum net worth requirements in Section 3.1.8.1 shall apply. If the accepting plan and the failed plan are owned in whole or in part by the same ultimate parent corporation, then **TennCare** may relieve the parent corporation of its obligation to provide a written and binding guarantee up to a maximum amount of seven million dollars ($7,000,000) or the **Contractor's** minimum net worth as defined at Section 3.1.8.1, whichever is greater, upon receipt of sufficient documentation that the parent corporation has sufficiently funded its obligations related to the failed health plan and agrees to maintain said funds until receipt of a final report describing how the **Contractor** has completed its continuing obligations is approved by **TennCare**, so that the parent corporation may demonstrate that the enhanced net worth requirement for the health plan to which **Enrollees** have been transferred is satisfied.

3.1.8.4 The **Contractor** shall submit medical loss ratio (MLR) reports as referenced in Section 3.10.14, to TDCI and **TDMHDD's** Office of Managed Care monthly, by the 21st of the following month, detailing the **Contractor's** progress in completing its continuing obligations under this CONTRACT.

3.1.9 Fidelity Bonds

The **Contractor** shall obtain a fidelity bond on **Contractor** employees and officers in an amount of not less than $500,000. Proof of coverage must be submitted to **TDMHDD** within sixty (60) calendar days after execution of this CONTRACT or prior to the delivery of health care, whichever comes first.

3.1.10 Insurance and Taxes

The **Contractor** or any of its subcontractors or providers shall not commence any work in connection with this CONTRACT until all the insurance coverage required in this CONTRACT has been obtained.

The **Contractor** must procure adequate professional liability, workers compensation insurance, general liability and other appropriate forms of insurance. For purposes of this CONTRACT, the amount of liability insurance may not be less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate. The **Contractor** must furnish a Certificate of Insurance issued by the insurance carrier or one or more sureties licensed in the State of Tennessee to **TDMHDD**.

Transportation subcontractors shall have auto liability insurance adequate to protect the **Enrollee** and the **Contractor,** and not be less than one million dollars ($1,000,000) aggregate.

TDMHDD 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 is the sole responsibility of the **Contractor**.

Failure to provide proof of coverage, prior to commencement of work in connection with this CONTRACT may result in termination of this CONTRACT.

The **Contractor** further agrees to pay all taxes incident to this CONTRACT.

3.1.11 Ownership and Financial Disclosure

The **Contractor** shall disclose to **TDMHDD**, the Tennessee Comptroller of the Treasury or the Center for Medicare and Medicaid Services (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 at times and on forms prescribed by the **TDMHDD** agency, but no less frequently than on an annual basis to be provided no later than March 1 of each calendar year. **TDMHDD** and/or the Secretary of the United States Department of Health and

Human Services may request information to be in the form of a consolidated financial statement. The following information shall be disclosed:

3.1.11.1 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.

3.1.11.2 The identity of any provider or subcontractor with whom the **Contractor** has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the disclosure and any significant business transactions between the **Contractor**, any wholly owned supplier, or between the **Contractor** and any provider or subcontractor, during the five (5) year period ending on the date of the disclosure.

3.1.11.3 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.

3.1.11.4 Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest.

3.1.12 Fraud & Abuse

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

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

The **CONTRACTOR** shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The **CONTRACTOR** shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the **CONTRACTOR** in preventing and detecting potential fraud and abuse activities. Failure to comply with the fraud and abuse requirement set forth in this Agreement may result in liquidated damages as described in Section 5.3 of this Agreement.

3.1.12.1 Reporting and Investigating Fraud and Abuse

3.1.12.1.1 The **CONTRACTOR** shall cooperate with all appropriate State and Federal Agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the **CONTRACTOR** shall fully comply with the provisions of Tennessee Code Annotated Sections 71-5-2601 and 71-5-2603 in performance of its' obligations under this Agreement.

3.1.12.1.2 **CONTRACTOR** shall use the Fraud Reporting Forms attached to this Agreement, or such other forms as may be deemed satisfactory by the agency to which the report is to be made under the terms of this Agreement.

3.1.12.1.3 Pursuant to T.C.A. Section 71-5-2603(c), **CONTRACTOR** shall be subject to a civil penalty, to be imposed by OIG, for willful failure to report fraud by recipients, enrollees, applicants, or providers to OIG or TBI MFCU, as appropriate.

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

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

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

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

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

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

3.1.12.1.9 The **CONTRACTOR** shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, the provider must comply with Section 3.1.12 of this Agreement.

3.1.12.1.10 Except as described in Section 3.2.4.7 of this Agreement, nothing herein shall require the **CONTRACTOR** to assure non-participating providers are compliant with **TENNCARE** contracts or state and/or federal law.

3.1.12.2 Fraud and Abuse Compliance Plan

3.1.12.2.1 The CONTRACTOR **shall have a written Fraud and Abuse compliance plan.** A paper and electronic copy of the plan shall be provided to TENNCARE. The CONTRACTOR's specific internal controls and policies and procedures shall be described in a comprehensive written plan and be maintained on file with the CONTRACTOR and submitted for review to TENNCARE within thirty (30) calendar days of the effective date of this Agreement and annually thereafter. TENNCARE shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) calendar days of receipt. The CONTRACTOR shall make any requested updates or modifications available for review to TENNCARE as requested by TENNCARE and/or the TennCare Program Integrity Unit within thirty (30) calendar days of a request. The State shall not transfer their law enforcement functions to the CONTRACTOR.

3.1.12.2.2 The fraud and abuse compliance plan shall:

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

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

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

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

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

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

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

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

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

ix. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to the OIG;

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

3.1.12.2.4 The **CONTRACTOR** shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

3.1.12.2.5 The **CONTRACTOR** shall submit an annual report to the Bureau of TennCare, Office of Contract Compliance and Performance, summarizing the results of its fraud and abuse compliance plan and other fraud and abuse prevention, detection, reporting, and investigation measures as required by section 3.1.12 of this Agreement. The report should cover results for the year ending June 30 and be submitted by September 30 each year. The information in this report shall be provided in accordance with and in a format as described in the **CONTRACTOR**S approved compliance plan.

3.2 Responsibilities Regarding Provision of Specific Services

3.2.1 Coordination of Services

3.2.1.1 The **Contractor** must assure active coordination between the following: behavioral health services; mental health care and primary health care; inpatient and outpatient care; the child and adult mental health delivery system; and the **Contractor,** the predecessor **TennCare Partners** BHOs and other current participating BHOs. This coordination must occur according to **TDMHDD** approved guidelines for the following:

3.2.1.1.1 Tennessee Department of Children's Services (DCS), for the purposes of providing covered behavioral health services to **TennCare** eligible children and youth in the custody of DCS or at risk of going into custody in such a way as to facilitate the State's efforts to provide a full range of appropriate and effective services to these children and youth.

3.2.1.1.2 Tennessee Department of Health (DOH), for the purposes of establishing and maintaining relationships with **Enrollee** groups and providers of other health and substance abuse services.

3.2.1.1.3 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.

3.2.1.1.4 Tennessee Department of Finance and Administration (TDFA) **TennCare** and the Division of Mental Retardation Services (DMRS), for the purposes of interfacing with and assuring continuity of care.

3.2.1.1.5 **TennCare** MCOs, for the purpose of coordinating care and compliance with the requirements of TENNderCare.

3.2.1.1.6 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services for **Enrollees** in inpatient, residential, and day treatment mental health facilities, and compliance with the requirements of Individuals with Disabilities Education Act (IDEA).

The Contractor is responsible for the delivery of medically necessary covered services to school-aged-children. BHOs are encouraged to work with school-based providers and the Department of Health's Project Teach staff to manage the care of students with special health care needs. The State has implemented a process, referred to as TENNderCare Connection, to facilitate notification of BHOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for behavioral health services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the BHO and for subsequently sending a copy of the parental consent and IEP to the BHO. is also responsible for clearly delineating the services on the IEP that the BHOs are to consider for payment. The **Contractor** must designate a contact person to whom correspondence concerning children with behavioral health services included in their IEPs will be directed. After receipt of an IEP, the BHO must:

3.2.1.1.6.1 Either accept the IEP as indication of a behavioral health problem and treat the IEP as a request for service authorization and assist, if necessary in making an appointment to have the child evaluated by an in-network provider in accordance with the time frames specified in the TennCare Waiver Terms and Conditions for access to care.

3.2.1.1.6.2 Send a copy of the IEP and any related information (e.g. action taken by the BHO in response to receipt of the IEP, action the BHO expects the PCP to take) to the PCP.

3.2.1.1.6.3 Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery.

3.2.1.1.7 Local law enforcement agencies and hospital emergency rooms for the purposes of Crisis Team relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.

3.2.1.1.8 Civil, criminal, and juvenile courts for the purposes of fulfilling statutory requirements of Tennessee Code Annotated for behavioral health services referenced in Section 2.5.7.

3.2.1.1.9 State and Regional Mental Health Planning Councils for the purposes of providing information necessary for fulfilling the duties of the State and Regional Mental Health Planning Councils.

3.2.1.2 The **Contractor** must ensure coordination among providers with reference to each of the following:

3.2.1.2.1 Communication and coordination between mental health providers and substance abuse providers, including:

3.2.1.2.1.1 Assignment of a responsible party to assure communication and coordination occur;

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

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

3.2.1.2.1.4 Description of how service plans will be coordinated between behavioral health service providers;

3.2.1.2.1.5 Description of the provision of cross training of behavioral health providers.

3.2.1.2.2 Smooth coordination between the children and adolescent service delivery system and the adult mental health service delivery system.

3.2.1.2.3 Coordination of inpatient and community services, including the following requirements related to hospital admission and discharge:

3.2.1.2.3.1 The outpatient provider must be involved in the admissions process when possible; if the outpatient provider is not involved, the provider must be notified promptly of the **Enrollee's** hospital admission;

3.2.1.2.3.2 Hospital and residential treatment discharges cannot occur without a realistic discharge plan in which the **Enrollee** has participated (an outpatient visit must be scheduled before discharge, which assures access to proper physician/medication follow-up; also, an appropriate placement or housing site must be secured prior to discharge);

3.2.1.2.3.3 An evaluation must be performed prior to discharge to determine if case management services are medically necessary. The

mental health case manager must be involved in discharge planning if deemed medically necessary; if there is no mental health case manager, then the outpatient provider must be involved; and

3.2.1.2.3.4 A procedure to assure continuity of care regarding medication must be developed and implemented.

3.2.1.2.3.5 The **Contractor** shall identify and develop community alternatives to inpatient hospitalization for those individuals who are receiving inpatient psychiatric facility services but who no longer require acute inpatient care and 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. The **Contractor** shall provide quarterly summary reports on the use of these alternatives in a format to be prescribed by **TDMHDD**.

3.2.1.2.3.6 The **Contractor** shall have responsibility to provide a discharge plan as outlined above in Section 3.2.1.2.3. Liquidated Damages may be assessed in accordance with Section 5.3.3 when the

Contractor fails to provide a written discharge plan or provides a defective discharge plan where an **Enrollee** files a complaint after being discharged due to an inadequate discharge plan or where an **Enrollee** appeals and the basis of the appeal is the discharge plan.

3.2.1.3 All mental health related services and substance abuse services specified in Section 2.5 of this CONTRACT provided to **Enrollees** shall be the responsibility of the **Contractor** except for behavioral health related services provided to **TennCare Medicaid** and **TennCare Standard Enrollees** by a MCO Primary Care Provider. Some MCO Primary Care Providers may appropriately treat or manage **Enrollees'** behavioral health conditions. Accordingly, the MCO shall direct its network PCPs to submit claims for covered services with a **primary** behavioral diagnosis code, defined as ICD-9-CM 290.xx – 319.xx (and subsequent revisions thereto), to the MCO for payment. The MCO shall be responsible for covered services, as described in their respective contract with **TennCare,** provided to **Enrollees** by their network PCPs.

The **Contractor** acknowledges that the MCO shall encourage its PCPs, at their discretion, to contact the **Contractor** for consultation on any covered mental health and substance abuse condition/service. The PCPs shall also be encouraged to refer to the BHO, for coordination of treatment of any covered mental health and substance abuse condition/service, for any and all of its members in accordance with its contracts with **TDMHDD** when those services can be provided by mental health professionals.

The carve out of mental health and substance abuse services provided by PCPs shall not relieve the **Contractor** from the responsibility to assist in the coordination of mental health and substance abuse care and medical care of **Enrollees**; nor shall it prohibit PCPs from referring **Enrollees** to mental health or substance abuse providers in the **Contractor's** network when determined necessary by the PCPs.

The MCO and **Contractor** shall assure active coordination between primary health care and mental health/substance abuse care, including case management and continuity of care services. The MCO and **Contractor** shall cooperate with the State's efforts to facilitate delivery of mental health services to the **TennCare** population and shall agree to abide by the MCO/BHO coordination provisions outlined herein.

3.2.1.3.1 Services & Responsibilities

The **Contractor** shall coordinate with the MCOs in accordance to the Operating Principles set forth in Attachment G of this CONTRACT. In addition, coordination of physical health care and mental health care shall, at a minimum, include:

3.2.1.3.1.1 Means for referral, which assures immediate access for emergency care and a provision of urgent and routine care according to **TennCare** guidelines;

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

3.2.1.3.1.3 Maintenance of confidentiality; and

3.2.1.3.1.4 Conducting training activities for MCOs.

3.2.1.4 Services to Prevent Children from Entering State Custody

The **Contractor** shall have a responsibility to promptly provide all medically necessary covered services required by an **Enrollee** under the age of eighteen (18) years enrolled in the **Contractor's** plan in order to prevent children from entering State custody. **TennCare** may assess liquidated damages in accordance with Section 5.3.3 from the date of entry into State custody where:

3.2.1.4.1 The **Contractor** has notice an individual under eighteen (18) years is in need of a covered medically necessary service;

3.2.1.4.2 The service is ordered and requested of the **Contractor** by the treating physician;

3.2.1.4.3 The **Contractor** fails to provide an appropriate medically necessary service in the least restrictive setting; and

3.2.1.4.4 These circumstances result in the child entering State custody.

3.2.2 TennCare Cost-Sharing for Services

The **CONTRACTOR** and all of its contracted providers and sub-contractor's shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations, including but not limited to, holding enrollees liable for debt due to insolvency of the BHO or non-payment by BHO. Furthermore, the **CONTRACTOR** and all providers and sub-contractors may not charge enrollees for missed appointments.

TennCare cost sharing responsibilities shall apply to services other than preventive services. The current cost share schedule to be used in determining applicable cost sharing responsibilities is included in this Agreement as Attachment III.

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

If, and at such time that TennCare amends any TennCare rules or regulations, including but not limited, to the TennCare cost sharing rules and regulations, the rules shall automatically be incorporated into this Agreement and become binding on the BHO and the BHOs providers. The State and the CONTRACTOR will negotiate new rates if necessary pursuant to Section 4.7.1 of this Agreement.

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

1. If the services are not covered by the TennCare program and, prior to providing the services, the provider informed the enrollee that the services were not covered. The provider is required to inform the enrollee on the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgement in writing prior to rendering service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills a BHO for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or

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

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

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

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

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

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

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

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

(c) The provider submits a claim for service to the appropriate BHO and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. Then and thereafter, within the remainder of the period applicable to that benefit limit, the provider may continue to bill the enrollee for services within that same exhausted benefit category without having to submit, for repeated BHO denial, claims for those subsequent services.

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

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

3.2.3 Continuity of Care

The **Contractor** must provide a smooth transition of **Enrollees** in the **TennCare Partners Program** from one provider to another when there are changes in providers. The **Contractor** shall have in place transition policies that have been approved by **TDMHDD**. At a minimum, the following items will be included:

3.2.3.1 A schedule which assures transfer does not create a lapse in service;

3.2.3.2 A mechanism for timely information exchange (including transfer of the **Enrollee** record);

3.2.3.3 A mechanism for assuring confidentiality;

3.2.3.4 A mechanism for allowing an **Enrollee** to request and be granted a change of provider;

3.2.3.5 The Contractor must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each **Enrollee** who received his or her primary care from, or was seen on a regular basis by, the terminated provider. This written notification shall include an explanation of why the current provider is no longer available, a listing of new providers and how to contact them, the procedure the **Enrollee** needs to follow in order to change providers, and the effective date of change;

3.2.3.6 Proper and timely notice will be given to the current provider so proper termination can occur between the **Enrollee** and provider.

3.2.3.7 The policies and procedures must reflect an appropriate schedule as approved by **TDMHDD** for transitioning **Enrollees** from one provider to another when there is medical necessity for ongoing care. The policies and procedures must address the following special populations:

3.2.3.7.1 Children in State custody;

3.2.3.7.2 Children at risk of State custody;

3.2.3.7.3 Children who are seriously emotionally disturbed;

3.2.3.7.4 Adults who are severely and/or persistently mentally ill;

3.2.3.7.5 Persons who have addictive disorders;

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

3.2.3.7.7 Persons with mental health disorders who are also developmentally disabled and/or mentally retarded (dually diagnosed), are allowed to remain with their providers of the services listed below for the minimum timeframes set out below as long as the services continue to be medically necessary. As an example, for an inpatient stay, this subsection is applicable only if the person continues to require inpatient psychiatric facility care six (6) months after the execution of this CONTRACT.

Minimum time required before a transition in providers is permitted:

Mental Health Case Management	3 months
Psychiatrist	3 months
Outpatient therapy	3 months
Psychosocial rehabilitation; supported employment	3 months
Inpatient or residential treatment; supportive housing	6 months

The **Contractor** may shorten these transition timeframes only when the provider of services is no longer available to serve the **Enrollee** or when a change in providers is agreed to in writing by the **Enrollee**.

3.2.4 Out of Service Area and Out of Plan Use

The **Contractor** must notify and advise all **TennCare Partners Program Enrollees** of the provisions governing out of plan use, including the use of providers outside the State or service area. The following criteria shall apply:

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

3.2.4.2 The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Attachment A of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency medical services does not meet the definition herein and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTORS process and timeframes for reconsideration. In the event a provider disagrees with the CONTRACTORS decision to disapprove a claim for emergency medical services, the provider may pursue the independent review process for disputed claims as provided by T.C.A. Section 56-32-226, including but not limited to, BHO reconsideration.

3.2.4.3 Should the **Contractor** not be able to provide necessary services covered under the contract to a particular enrollee, the **Contractor** must adequately and timely

cover these services out of network for the enrollee for as long as the **Contractor** is unable to provide them. The **Contractor** must require the out-of-plan provider to seek authorization for services and accept the **Contractor** payment as payment in full for the service(s) in accordance with **TennCare** Rule 1200-13-12-.08(1) of TDFA. The **Contractor** may deny payment for non-authorized services provided by out-of-plan providers.

3.2.4.4 When an **Enrollee** has used non-emergency covered services available under this CONTRACT from a provider who was not enrolled as a participating provider in the **Contractor's** provider network and the **Contractor** has not authorized such use in advance, the **Contractor** may choose to pay or not pay for the service(s) received. The **Contractor** must require the out-of-plan provider to accept the **Contractor** payment as payment in full for the service(s) in accordance with **TennCare** Rule 1200-13-13-.08(1) and 1200-14-14-.08(1).

3.2.4.5 When an **Enrollee** is dually eligible for Medicare and Medicaid and requires services covered by the **TennCare Partners Program** but not covered by Medicare, and the services are ordered by a physician who accepts Medicare payment and is a non-CONTRACT provider with the **Contractor,** the plan must provide reimbursement for the ordered service if the service is provided by a CONTRACT provider. Reimbursement must be at the same rate paid had the service been ordered by a CONTRACT provider.

The **CONTRACTOR** is responsible for coordinating **TennCare** covered benefits with benefits offered by other insurance, including Medicare, which the enrollee may have. For Medicaid eligible enrollees, such coordination must ensure that TennCare covered services are delivered without charge to the enrollee.

3.2.4.6 The **Contractor** is not liable for the cost of non-covered services or the cost of non-emergency services ordered and obtained from non-CONTRACT providers.

3.2.4.7 Any non-CONTRACT provider "regularly" providing non-emergency services must be credentialed and re-credentialed by the **Contractor** in accordance with Section 3.6.4 within thirty (30) calendar days after the

event occurs requiring such approval. The term "regularly" means no more than ten (10) such payments to any non-CONTRACT provider for non-emergency services over any continuous twelve (12) month period.

3.2.5 Advance Directives

The **Contractor** shall comply with federal requirements concerning advance directives as described in 42 CFR 422.128 and 489 Subpart I, and as described in Tennessee Code Annotated, §§32-11-105, 34-6-201 through 34-6-215, and 68-11-201 through 68-11-224, and 33-6, Part 10 and as stipulated by the **Enrollee**. Any written information provided by the **Contractor,** must reflect changes in state law as soon as possible, but no later that ninety (90) calendar days after the effective date of the change.

3.2.6 Compliance with the Clinical Laboratory Improvement Act (CLIA) of 1988

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

The **Contractor** shall require all laboratory testing sites providing services under this CONTRACT to have either a 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 certificates of registration may perform a full range of laboratory tests. The **Contractor** shall comply with the provisions of CLIA 1988 at such time that CMS mandates the enforcement of the provisions of CLIA.

3.2.7 Interpreter Services

The **Contractor** shall make oral interpretation services free of charge to **Enrollees**. This applies to all non-English languages, not just those identified as prevalent. Interpreter services shall be available 24 hours a day, seven (7) days a week. Interpreter services should be available in the form of in-person interpreters, sign language or access to telephonic translation assistance, such as the ATT universal line. In-person interpreters shall be provided for language spoken by five percent (5%) or more of the population. The **Contractor** shall develop a written procedure for the provision of language interpretation and translation services for **Enrollees**.

The **Contractor** shall provide instruction for its staff and all direct service subcontractors regarding the procedure.

3.3 Appeals and Complaints

(i) 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.

(ii) 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 3.4.2.1 The CONTRACTOR shall have internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare Waiver, consent decrees, or court orders governing the appeals process.

The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI meetings, to the review of member complaints and appeals that have been received

The CONTRACTOR shall ensure that punitive action is not taken against a provider who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

3.3.1 Appeals

The CONTRACTORS appeal process shall include, at a minimum, the following:

3.3.1.1 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 an enrollee choose to appeal in writing, the enrollee will be instructed to file via mail or fax to the designated TENNCARE P. O. Box for medical appeals.

3.3.1.2 The CONTRACTOR shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The CONTRACTOR shall notify TENNCARE and TDMHDD of the names of appointed staff members and their telephone 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.

3.3.1.3 The CONTRACTOR shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action must be taken by the CONTRACTOR regarding the handling and disposition of an appeal.

3.3.1.4 The CONTRACTOR shall identify the appropriate individual or body within the plan having decision-making authority as part of the appeal procedure.

3.3.1.5 The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, members shall not be required to use a TENNCARE approved appeal form in order to file an appeal;

3.3.1.6 Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form(s);

3.3.1.7 The CONTRACTOR shall provide reasonable assistance to all appellants during the appeal process.

3.3.1.8 At any point in the appeal process, TENNCARE shall have the authority to remove a member from the CONTRACTORS plan when it is determined that such removal is in the best interest of the member and TENNCARE;

3.3.1.9 The CONTRACTOR shall require providers to display notices of member's right to appeal adverse actions affecting

services in public areas of each facility in accordance with TennCare rules and regulations. The CONTRACTOR shall ensure that providers have accurate and adequate supply of public notices.

3.3.1.10 Neither the CONTRACTOR nor TENNCARE shall prohibit or discourage any individual from testifying on behalf of a member.

3.3.1.11 The CONTRACTOR shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures as they become effective.

3.3.1.12 TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which shall be followed by the CONTRACTOR. However, the CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, the CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.

3.3.1.13 The CONTRACTOR shall provide general and targeted education to providers regarding expedited appeals, (described in Tenncare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof

3.3.1.14 The CONTRACTOR shall require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the CONTRACTOR when requested by TENNCARE.

3.3.1.15 The CONTRACTOR shall provide notice to contract providers regarding providers' responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation.

3.3.1.16 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 (i.e., therapeutic duplication, etc.)

3.3.1.17 Member eligibility and eligibility related grievance and appeals, including termination of eligibility, effective date of coverage, and the determination of premium and co-payment responsibilities shall be directed to the Department of Human Services.

If it is determined by TENNCARE that violations of the appeal guidelines have occurred by the CONTRACTOR, TENNCARE shall require the CONTRACTOR to submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by TENNCARE, including an acceptable corrective action plan, shall result in the CONTRACTOR being subject to liquidated damages as described in Section 5.3 of this Agreement.

3.4 Marketing & Enrollee Materials

3.4.1 Marketing

Enrollment into BHOs is conducted by **TDMHDD** and **TennCare**. Therefore, the **Contractor** shall not conduct any marketing activities for the purpose of seeking to influence enrollment into its plan.

3.4.2 Enrollee Materials

The **CONTRACTOR** shall distribute various types of **Enrollee** materials to its entire service area as required by this CONTRACT. These materials include, but are not limited to, member handbooks, provider directories, identification cards, fact sheets, notices, or any other material necessary to provide information to **Enrollees** as described herein. The **CONTRACTOR** may distribute additional materials and information, other than those required by this Section, to **Enrollees** in order to promote health and/or educate **Enrollees**. These materials include, but are not limited to, newsletters, form letters, etc. The **CONTRACTOR** may make **Enrollee** and provider materials available via the Internet with the

prior written approval of **TDMHDD**. However, all **Enrollee** materials must be approved by **TennCare** prior to distribution.

3.4.2.1 Member Handbooks

3.4.2.1.1 The **Contractor** shall update or develop their member handbook annually unless a longer period of time is approved by **TennCare and TDMHDD.** As described by **TennCare and TDMHDD,** the annual requirement to update and/or develop a member handbook may be delayed as a result of major modifications and/or reform efforts being implemented in the **TennCare** program. The **Contractor** must submit member handbooks for review and approval by **TennCare, TDMHDD and TDCI** at least thirty (30) calendar days prior to distribution. The **Contractor** must submit both English and Spanish language translations. A paper copy of the member handbook must be distributed to Enrollees within thirty calendar days of enrollment in the Contractors plan. A member handbook must be distributed to all contracted providers upon initial credentialing and annually thereafter as handbooks are updated. The handbook shall, at a minimum, be in compliance with all applicable requirements of this Agreement and any and all federal and state laws, rules and regulations and include:

3.4.2.1.2 A table of contents;

3.4.2.1.3 An explanation of how members will be notified of member specific information such as effective date of enrollment;

3.4.2.1.4 A description of services provided including limitations, exclusions, and out-of-plan use;

3.4.2.1.5 A description of **TennCare** cost sharing responsibilities for **Enrollees** must include an explanation that providers and/or the **Contractor** may utilize whatever legal actions

that are available to collect these amounts. Furthermore, the information shall indicate that the enrollee 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 they are billed;

3.4.2.1.6 Information about preventive services for adults and children, including TENNderCare for eligible individuals to include a listing of preventive services and notice that preventive services are at no cost and without **TennCare** cost share responsibilities;

3.4.2.1.7 Procedures for obtaining required services, including direct access as appropriate for the **Enrollee's** condition and identified needs and obtaining referrals to providers outside of the plan. The handbook should advise members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan and any co-payment requirements would be the same as if this provider were in the plan;

3.4.2.1.8 An explanation of emergency services and procedures on how to obtain emergency services both in and out of the **Contractor's** service area including post-stabilization explanation, use of 911, locations of emergency settings and locations for post stabilization services;

3.4.2.1.9 Appeal procedures as described in Section 3.3 of this CONTRACT;

3.4.2.1.10 Notice to the **Enrollee** that in addition to the **Enrollee's** right to file an appeal for actions taken by the **Contractor**, the **Enrollee** shall have the right to request reassessment of eligibility related decisions directly to **TennCare**;

3.4.2.1.11 Written information concerning advance directives as described in the Code of Federal Regulations, 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128 and state law;

3.4.2.1.12 Notice to the **Enrollee** that enrollment in the **Contractor's** plan invalidates any prior authorization for services granted by another plan but not utilized by the **Enrollee** prior to the **Enrollee's** enrollment into the **Contractor's** plan and notice of continuation of care when entering the **Contractor's** plan;

3.4.2.1.13 Notice to the **Enrollee** that it is the member's responsibility to notify the **Contractor** and the **TennCare** agency each and every time the member moves to a new address;

3.4.2.1.14 Notice to the **Enrollee** of their right to disenroll from the **TennCare Program** at any time with instructions to contact **TennCare** for disenrollment forms and additional information on disenrollment;

3.4.2.1.15 The toll-free telephone number for **TennCare** with a statement that the **Enrollee** may contact the plan or **TennCare** regarding questions about **TennCare**. The **TennCare** toll-free hotline number is 1-866-311-4287;

3.4.2.1.16 Notice to **Enrollees** that they have the right to contact either the **TennCare** Partners Advocacy Line (TPAL) or the **TDMHDD** Office of Consumer Affairs without fear of retribution. This notice shall include the telephone numbers of both TPAL (1-800-758-1638) and the Office of Consumer Affairs (1-800-560-5767).

3.4.2.1.17 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;

3.4.2.1.18 Educational information for **Enrollees** of their rights and necessary steps to amend their data in accordance with HIPAA regulations; and

3.4.2.1.19 Notice to the **Enrollee** of the right to file a complaint as is provided for by Title VI or the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1975, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.E. 97-35) and a complaint form on which to do so.

The **Contractor** shall use specific language provided by **TennCare** to describe selected requirements and other requirements as identified by **TennCare**. The selected requirements may include, but not be limited to, benefits covered, exclusions, **TennCare** cost sharing responsibilities, members responsibilities to respond to requests for information (re: address, employment, third party liability, etc.), emergency services, appeal processes, appeal rights, rights to change plans and to disenroll from **TennCare**, and acceptable reasons for disenrollment.

At such time **TennCare** provides the **Contractor** with a standardized format or standardized language for a member handbook, the **Contractor** shall agree to utilize the format and make appropriate additions and/or revisions as required by **TennCare**.

3.4.2.2 Identification Card

Each enrollee shall be provided an identification card, which identifies the enrollee as a participant in the TennCare Partners Program within thirty (30) calendar days of notification of enrollment into the CONTRACTORS plan or prior to enrollee's beginning effective date. The identification card must comply with all state and federal requirements. Once the identification card has been approved by TENNCARE the CONTRACTOR shall submit five (5) printed sample cards of the final product, unless otherwise specified by TENNCARE, to the TennCare Marketing Coordinator within thirty (30) working days from the print date. Photo copies may not be submitted as a final product. Prior to modifying an approved

identification card the CONTRACTOR shall submit for approval by TENNCARE a detailed description of the proposed modification. The identification card may be issued by the CONTRACTOR, subject to prior approval of the format and content by TENNCARE, or the identification card may be issued by TENNCARE in a format and content mutually agreed upon by the CONTRACTOR and TENNCARE. Regardless of whether the identification card is issued by the CONTRACTOR or TENNCARE, all expenses associated with production and mailing of the identification card shall be the responsibility of the CONTRACTOR. Identification cards must be submitted to **TennCare, TDMHDD and TDCI** for prior approval.

3.4.2.3 Explanation of Benefits

The **Contractor** shall give a full written explanation of the **Contractor's** plan to the **Enrollee** within thirty (30) calendar days after notification of their enrollment in the plan, including but not limited to a member handbook as described in Section 3.4.2.1 of this CONTRACT. In addition to the information described above, this written explanation shall, at a minimum, also include:

3.4.2.3.1 Effective date of enrollment;

3.4.2.3.2 Names, locations, telephone numbers, office hours and non-English languages spoken by current network providers and identification of providers accepting new patients. The provider listing shall be updated at least quarterly to reflect changes in the provider network. The **Contractor** must assure that, at least one month prior to and throughout the open enrollment period, all communication and/or materials representing the **Contractor's** provider network accurately reflect the **Contractor's** provider network that will be available to **Enrollee** on the **Enrollee's** effective date.

The **Contractor** must re-distribute the provider listing to **Enrollees** who are

enrolled for at least twelve (12) consecutive months; and

3.4.2.3.3 All other information as required by CMS.

3.4.2.4 Quarterly Newsletters

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

3.4.2.4.1.1 specific articles or other specific information as described and 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;

3.4.2.4.1.2 the procedure on how to obtain information in alternative formats or how to access interpretation services, as well as a statement that interpretation and translation services are free.

3.4.2.4.1.3 A notice to **Enrollees** of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.E. 97-35), and a **Contractor** phone number for doing so. The notice in the newsletter shall be in English and in Spanish;

3.4.2.4.1.4 For TennCare enrollees, EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services;

3.4.2.4.1.5 member services toll-free telephone numbers; including the TennCare Hotline, the Contractor's customer service line as well as the service / information that may be obtained from each line; and

3.4.2.4.1.6 the following information to report fraud" "To report fraud or abuse to OIG: You can call 1-800-433-3982, OR Go online at www.state.tn.us/tenncare and click on "Report Fraud." To report provider fraud or patient abuse to MFCU, call free 1-800-433-5454."

3.4.2.4.2 Teen / Adolescent Newsletter. The Contractor shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services, etc. with an emphasis on the encouragement to utilize TENNderCare services.

The Teen / Adolescent Newsletter shall be a product of the MCC Adolescent Well-Care Collaborative. The MCCs will agree on five required topics to include in each newsletter. MCCs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved by TennCare.

The Contractor shall include the following information in each newsletter:

3.4.2.4.2.1 Five teen/adolescent specific articles as agreed upon by the MCC Adolescent Well Care Collaborative; and

3.4.2.4.2.2 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; and

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

3.4.3.4.3 In order to satisfy the requirement to distribute the quarterly newsletters to all enrollees, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the enrollee's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to enrollees, the Contractor shall also submit to TennCare, five (5) final printed originals, unless otherwise specified by TennCare, of the newsletters and documentation from the BHOs mail room or outside vendor indicating that the newsletters were mailed within the calendar quarter, the quantity and the date mailed, to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in Section 5.3.3.1 of this Agreement. The BHO must also send five (5) printed originals of the newsletter to TDMHDD.

3.4.3 Permissible Communication Activities

The **Contractor** shall not engage in any solicitation of prospective **Enrollees** and shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. The following

communication activities are permitted for purposes of educating or communicating with current **Enrollees**:

3.4.3.1 Distribution of general information through mass media;

3.4.3.2 Telephone calls, mailings and home visits to current **Enrollees** of the **Contractor** only for the sole purpose of educating current **Enrollees** about services offered by or available through the **Contractor**; and

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

3.4.4 Prior Approval Process for Enrollee Materials

3.4.4.1 The **Contractor** shall submit to **TDMHDD** a detailed description of any **Enrollee** materials it intends to use and a description of any communication or educational activities to be held prior to implementation or use. This includes but is not limited to all policies and manuals, brochures, posters, fact sheets, video tapes, story boards for the production of videos, audio tapes, newsletters, and any and all other forms of public contact such as participation in health fairs and/or telemarketing scripts.

3.4.4.2 All materials submitted by the **Contractor** shall be accompanied by a description of the **Contractor's** intent and procedure for the use of the materials. All written material submitted by the **Contractor** must be submitted on paper and electronic file media. Materials developed by a recognized entity having no association with the **Contractor** that are related to management of specific types of diseases (e.g., depression, anxiety, ADHD, etc.) or general health improvement must be submitted for approval; however, an electronic file for these materials may not be required. The electronic files, when required, must be submitted in a format acceptable to **TDMHDD**. Electronic files submitted in any other format than those approved by **TDMHDD** cannot be processed.

3.4.4.3 **TDMHDD** shall review the **Contractor's** descriptions and materials and either approve, deny or return (with written comments) within fifteen (15) calendar days from the date of submission.

3.4.4.4 Once materials have been approved by **TDMHDD**, the **Contractor** shall submit ten (10) copies of the final product to **TDMHDD**.

3.4.4.5 **TDMHDD** reserves the right to notify the **Contractor** to discontinue or modify **Enrollee** communication or education activities or materials after approval.

3.4.4.6 Prior to modifying any approved activity or material, the **Contractor** shall submit for approval by **TDMHDD** a detailed description of the proposed modification.

3.4.5 Written Material Guidelines

3.4.5.1 All materials shall be worded at or below a 6th grade reading level, unless **TennCare** approves otherwise.

3.4.5.2 All written materials shall be clearly legible with a minimum font size of 12pt (with the exception of the member identification card) unless otherwise approved by **TennCare**.

3.4.5.3 All written materials shall be printed with an assurance of non-discrimination.

3.4.5.4 The following shall not be used on communication material without the written approval of **TennCare**:

3.4.5.4.1 The Seal of the State of Tennessee;

3.4.5.4.2 The **TennCare** name unless the initials "SM" denoting a service mark, is superscripted to the right of the name; and

3.4.5.4.3 The word "free" can only be used if the service is no cost to all **Enrollees**. Only **Enrollees** who meet Medicaid eligibility requirements, as provided in the **TennCare** Rules and Regulations, are exempt from **TennCare** cost sharing responsibilities. If **Enrollees** have **TennCare** cost share responsibilities, the services are not free. Any conditions of payments must be clearly and conspicuously disclosed in close proximity to the "free" good or service offer.

3.4.5.5 All vital **Contractor** documents and the member handbook must be translated and available in English, Spanish and prevalent non-English language as specified by **TennCare**.

3.4.5.6 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 1,000 **Enrollees**, whichever is less.

3.4.5.7 All written materials shall be made available in alternative formats and in an appropriate manner that takes into consideration persons with special needs or appropriate interpretation services shall be provided by the **Contractor**, as well as a statement that interpretation services are free. Individuals with special needs could include, but not be limited to, those with limited vision or have a limited reading proficiency.

3.4.5.8 The **Contractor** shall provide written notice of any changes in policies or procedures described in written materials previously sent to the **Enrollee**. The **Contractor** shall provide written notice at least thirty (30) calendar days before the effective date of the change.

3.4.6 Failure to Comply with Enrollee Material Requirements

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

3.4.6.1 Revocation of previously authorized materials or activities;

3.4.6.2 Refusal of **TennCare** to authorize new enrollments for a period specified by **TennCare**;

3.4.6.3 Forfeiture by the **Contractor** of all or part of the capitation payments for persons enrolled as a result of marketing practices; and/or

3.4.6.4 Application of remedies and sanctions as provided in Section 5 of this CONTRACT including the imposition of liquidated damages.

3.4.7 Provider Directory

The **Contractor** shall be responsible for distributing provider directories to new **Enrollees** within thirty (30) calendar days of receipt of notification by **TennCare** of enrollment in the **Contractor's** plan or prior to enrollee's beginning effective date. The **Contractor** shall also be responsible for redistribution of updated provider information on an annual basis. The provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network providers, identification of providers accepting new patients, emergency services settings and post stabilization service locations. **Enrollee** provider directories, and any revisions thereto, shall be submitted to **TDMHDD** for approval prior to distribution to **Enrollees**. Each submission shall include a paper and an electronic copy. The text of the directory shall be in Microsoft Word or Adobe (PDF) format. In addition, the provider information used to populate the **Enrollee** provider directory shall be submitted as a TXT file or such format as otherwise approved by
TDMHDD and be produced using the same extract process as the actual **Enrollee** provider directory. 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 **Enrollee** regardless of whether or not a provider directory has been previously mailed to **Enrollees** in the existing case.

3.5 Staffing Requirements

3.5.1 Staffing Plan

3.5.1.1 The **Contractor** shall not have an employment, consulting, or any other agreement with a person who 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.

3.5.1.2 The **Contractor** must maintain a sufficiently staffed and working office within the State of Tennessee, including a full-time Tennessee-based administration specifically identified to administer the day-to-day business and programmatic activities of this CONTRACT. The staffing must be capable of fulfilling the requirements of this CONTRACT. The minimum staff requirements are as follows (not all positions listed must be maintained in Tennessee):

3.5.1.2.1 A Chief Executive Officer with clear authority over the entire operation of the BHO;

3.5.1.2.2 A Chief Financial Officer to oversee the budget and accounting system;

3.5.1.2.3 A full-time administrator (project director) specifically identified with overall responsibility for the administration of this CONTRACT. This person shall be at the **Contractor's** officer level, shall have signature authority, and must be approved by **TDMHDD**. The administrator shall be responsible for the coordination and operation of all aspects of the CONTRACT;

3.5.1.2.4 Sufficient full-time clinical and support staff to conduct daily business in an orderly manner, including such functions as administration, accounting and finance, complying with the requirements related to fraud as set forth in Section 1.9 of this Agreement, prior authorizations, medical management, marketing, appeal system resolution, and claims processing and reporting, as

determined through management and medical reviews;

3.5.1.2.5 A Medical Director who is a board certified psychiatrist licensed in the State of Tennessee who has at least five years combined experience in mental health and alcohol and substance abuse services and is a Senior Executive in the **Contractor's** organization. At a minimum, the Medical Director will be responsible for: the development of clinical practice standards, clinical policies and procedures; oversight of the **Contractor's** appeals and complaint procedure; the development, implementation, and ongoing review of the **Contractor's** internal quality improvement program; the development of utilization management programs; oversight of policies and procedures relating to confidentiality of medical records; oversight of TENNderCare policies and procedures and the oversight of case management programs;

3.5.1.2.6 A qualified mental health professional licensed in the State of Tennessee, if required for the profession, who has at least five (5) years of experience in treating children with mental health disorders who are also developmentally disabled. This person shall be responsible for authorizing services for persons with mental health disorders who are also developmentally disabled;

3.5.1.2.7 A qualified mental health professional licensed in the State of Tennessee, if required for the profession, who has at least five (5) years of experience in treating persons with substance abuse disorders. This person shall be responsible for authorizing services for persons with substance abuse disorders;

3.5.1.2.8 A staff individual who is knowledgeable of accreditation standards of NCQA, JCAHO or URAC and whose primary duties are to assist in evaluating claims for medical necessity;

3.5.1.2.9 A person who is trained and experienced in information systems, data processing and data reporting as required to provide necessary and timely reports to **TennCare and TDMHDD**;

3.5.1.2.10 A staff person who is responsible for non-discrimination compliance in accordance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1975, the Age Discrimination Act of 1975, and the Omnibus Budget Reconciliation Act of 1981 (P.E. 97-35). Non-discrimination compliance need not be the sole function of the designated staff member. The **Contractor** shall identify the designated non-discrimination compliance staff member to **TDMHDD** by name. At such time this function is redirected, the name of the staff member who assumed the duties shall be reported in writing to **TDMHDD** within five (5) business days of the change;

3.5.1.2.11 A staff person who is responsible for participating in workgroups as needed to address issues in key areas of the program. These workgroups will consist of key stakeholders including **TennCare** and **TDMHDD,** and the **Contractor's** staff;

3.5.1.2.12 A specific Department of Children's Services (DCS) liaison person or persons. The name, title, address and contact numbers (phone, fax, etc.) for each DCS liaison shall be made available to **TDMHDD**, DCS and MCO providers; and

3.5.1.2.13 The **Contractor** shall identify and assign specific staff to provide legal and technical assistance for and coordination with the legal system for court ordered services and services provided to **Judicials**.

3.5.1.2.14 The **Contractor** shall identify in writing the Chief Executive Officer, Chief Financial

Officer, Administrator, Medical Director, Title VI Compliance Officer, DCS liaisons and key contact person for Fraud Detection as set forth in Section 1.9 of this Agreement, Prior Authorizations, Marketing, Claims Processing, Information Systems, Member Services, Provider Services, Appeal System Resolution, and EPSD&T within thirty (30) calendar days of the CONTRACT execution. Notice of any changes in staff persons during the term of this CONTRACT must be made in writing within ten (10) business days.

3.5.1.2.15 The **Contractor** shall employ a Consumer Advocate in its Tennessee business office.

The **Contractor's** failure to comply with staffing requirements as described in this CONTRACT may result in the application of liquidated damages as specified in Section 5.3.3.

3.5.2 Training

The **Contractor** must participate in training to include, but not be limited to**,** crisis, mandatory prescreening, TPG and CRG assessments, substance abuse, mental health case management, and other areas specified in Standard IX of the BHO Quality Monitoring Program (QMP) Standards (see Attachment C), and as required by **TDMHDD**.

3.5.3 Telephone Access for Enrollees & Providers

3.5.3.1 The **Contractor** must provide a published toll-free telephone number that is answered promptly in the **Contractor's** Tennessee administration office by staff who are trained to respond to requests, concerns, and questions from **Enrollees**, family members, and providers. Staff must be available to answer telephone calls from 7:00am Central Time until 7:00pm Central Time seven days a week. After these peak hours, calls must be answered promptly by staff, but may be routed to other locations.

3.5.3.2 **Contractor** must provide procedures to insure that all **Enrollees** and network providers receive the above telephone number, including publishing the number in

member handbooks as specified in Section 3.4.2. and in newsletters as referenced in Section 3.4.2.4.

3.5.3.3 The **Contractor** must also participate in the implementation of a toll-free crisis line for the general Tennessee population, as described in Section 2.5.9.

3.6 Provider Requirements

3.6.1 Provider Network Composition Requirements

3.6.1.1 The **Contractor** shall recruit, credential, evaluate, and monitor providers with an appropriate combination of skills experience, and specialties to constitute a provider network capable of providing covered benefits to **Enrollees** within the access standards as specified in Attachment B. The **Contractor's** network shall be capable of providing 24-hour comprehensive behavioral health services to a minimum of 150,000 **Enrollees**.

In accordance with Section 42 CFR 438.12 (a), the **Contractor** shall not be required to contract with providers beyond the number necessary to meet the needs of its **Enrollees**. The **Contractor** shall not be precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. The **Contractor** shall not be prohibited from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to **Enrollees**.

The **Contractor** shall ensure providers within their network participate in **TDMHDD'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. The **Contractor** shall require network providers to offer hours of operation that are no less

than the hours of operation offered to commercial **Enrollees** or comparable to Medicaid fee-for-service, if the provider serves only **TennCare Enrollees**. Emergency behavioral health services shall be available twenty-four (24) hours a day, seven (7) days a week.

The **Contractor** may 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. Further, the **Contractor** shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment.

The **Contractor** shall not require service providers to accept **TennCare** reimbursement amounts for services provided under any non-**TennCare** or non-**TDMHDD** plan operated or administered by the **Contractor**.

The **Contractor**, in establishing and maintaining the network, must consider the following:

3.6.1.1.1 The anticipated **TennCare** enrollment;

3.6.1.1.2 The expected utilization of services, taking into consideration the characteristics and health care needs of specific **TennCare** populations represented in the CONTRACT;

3.6.1.1.3 The number and types (in terms of training, experience and specialization) of

providers required to furnish the contracted **TennCare** services;

3.6.1.1.4 The number of network providers who are not accepting new **TennCare Enrollees**; and

3.6.1.1.5 The geographic location of providers and **TennCare Enrollees**, considering distance, travel time, the means of transportation ordinarily used by **TennCare Enrollees**, and whether the location provides physical access for **TennCare Enrollees** with disabilities.

3.6.1.2 Minimum standards for this CONTRACT are:

3.6.1.2.1 There shall be a sufficient number of providers of behavioral health services within each geographic area of the State. Providers must be strategically located so that no **Enrollee** has to travel distances in excess of those provided in Attachment B of this CONTRACT, or in excess of the community standard when **TDMHDD**, at its sole discretion, determines that the community standard is an appropriate standard for travel distances.

3.6.1.2.1.1 In the event that the **Contractor** is unable to meet the standards specified in Attachment B for inpatient or residential care due to a lack of available resources in the State, the **Contractor** must propose alternative service(s), which may include the use of intensive home-based services, for **Enrollees** who reside in the

affected area. Once approved by **TDMHDD**, the alternative service(s) may be offered to **Enrollees**. The alternative service must be discussed and accepted by the **Enrollee** and his/her family or parent(s), legal guardian(s), or legal custodian(s), if applicable, prior to the provision of said services. A lack of available resources means that there is no resource in the State as opposed to no resource participating in the **Contractor's** network.

3.6.1.2.1.2 In the event that an **Enrollee** requires inpatient care and the **Enrollee** has refused the alternative service, or an **Enrollee** requires 24 hour residential care and the travel distance to the closest inpatient/ residential facility exceeds the travel standards specified in Attachment B, the **Contractor** shall offer transportation regardless of the **Enrollee's** access to transportation. If the **Enrollee** is a child who needs to be accompanied by an adult, transportation must be provided for both the child and adult.

3.6.1.2.2 The **Contractor** shall ensure it provides accessible and available services covered under this CONTRACT for all **Enrollees**, including special populations. Special populations include, but are not limited to, the following:

3.6.1.2.2.1 Individuals with physical disabilities such as hearing loss or vision impairment;

3.6.1.2.2.2 Individuals who are dually diagnosed with both mental health and alcohol and/or drug abuse disorders;

3.6.1.2.2.3 Individuals who are diagnosed with mental health disorders and who are also developmentally disabled;

3.6.1.2.2.4 Homeless individuals;

3.6.1.2.2.5 Persons involved with the juvenile or adult judicial system;

3.6.1.2.2.6 The geriatric population;

3.6.1.2.2.7 Preschool children from birth to age 6 years who have experienced neglect, abuse, severe environmental trauma, or other life circumstances which threaten normal child development;

3.6.1.2.2.8 Children and youth who have committed sexual offenses against others using any type of force or coercion;

3.6.1.2.2.9 Children in State custody;

3.6.1.2.2.10 Children at risk of State custody;

3.6.1.2.2.11 Children who are seriously emotionally disturbed;

3.6.1.2.2.12 Adults who are severely and/or persistently mentally ill; and

3.6.1.2.2.13 Persons who have addictive disorders.

3.6.1.3 Inpatient Facilities

The **Contractor** shall maintain a sufficient network of facility providers with the capability of providing the benefits required under this CONTRACT to all eligible individuals as described in Section 2.2 of this CONTRACT. At the direction of **TDMHDD**, the **Contractor** will divert new admissions to other inpatient facilities to ensure that the Regional Mental Health Institutes do not operate above their licensed capacity. In the event the **Contractor** terminates an arrangement with a facility provider, the **Contractor** shall continue to provide care for all eligible individuals who are receiving care from that hospital provider at the time of termination until such time as the **Contractor** can reasonably transfer the **Enrollee** to a service and/or network provider without interrupting service delivery.

The **Contractor** shall identify, develop or enhance existing mental health and/or substance abuse inpatient and residential treatment capacity for adults and adolescents dually diagnosed with a mental health and substance abuse disorder.

3.6.1.4 Residential Treatment Facilities

The **Contractor** must include appropriately licensed community based facilities that offer 24-hour residential treatment and rehabilitation services.

3.6.1.5 Outpatient Mental Health & Substance Abuse Providers

The **Contractor's** network shall include providers who can provide integrated, community-based behavioral health care. The network shall include sufficient numbers of providers to provide comprehensive mental health services for **Enrollees**, including, but not limited to: registered nurses; psychiatrists; psychologists; social workers; case managers; licensed alcohol and drug counselors; licensed social workers; and family and marital counselors

3.6.1.6 Physician Unique Identifiers

The **Contractor** shall require each physician to have a unique identifier, in accordance with federal regulations.

3.6.2 Licensure of Provider Sites

The **Contractor** must ensure each provider's service delivery site meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approval per **TDMHDD** requirements.

3.6.3 Licensure of Provider Staff

The **Contractor** must determine that all providers in its network maintain a current license or certification for the provision of those services as appropriate and must monitor the accuracy of the providers' current license or certification per **TDMHDD** requirements. The **Contractor** must further require non-participation of providers convicted of felony criminal activity, or otherwise not in good standing with **TennCare** or **TDMHDD** unless a waiver allowing for participation is provided by **TDMHDD**.

3.6.4 Credentialing

The **Contractor** must maintain a current credentialing manual per **TDMHDD** requirements as set forth in Standard VIII of the BHO QMP Standards (see Attachment C) and as further specified below. The **Contractor** shall submit the credentialing manual to **TDMHDD** for approval prior to the delivery of services and prior to modification(s).

In addition to the requirements found in Standard VIII of the BHO QMP Standards, the manual must include:

3.6.4.1 A written notice process the **Contractor** will use to inform affected individuals or groups of providers in its network of a decision not to include them in the **Contractor's** network and the reason for its decision.

3.6.4.2 A written description of its credentialing criteria to providers upon request.

3.6.4.3 The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application and signed Provider Agreement. Completely process shall mean that the CONTRACTOR shall review, approve, and load approved applicants to their provider

files in their claims processing system or deny the application and assure that provider is not included in the CONTRACTORS' network.

3.6.5 Provider Relations Plan

3.6.5.1 The **Contractor** must develop a Provider Relations Handbook for its network providers in the **TennCare Partners Program**.

3.6.5.2 The **Contractor** must implement a Provider Relations Plan, to be approved by **TDMHDD**. This plan must contain at least the following:

3.6.5.2.1 The full time employment of at least one Tennessee-based provider relations specialist available to providers at least Monday through Friday (excluding holidays), 8:00am to 5:00pm Central Time;

3.6.5.2.2 The establishment of a published 24-hour a day, seven days a week telephone number available only to network providers which offers provider assistance, including service authorization, clinical consultation, issue resolution, and information. The telephone must be answered promptly by staff on all business days in the Tennessee administrative office from 7:00am until 7:00pm (Central Time); after these peak hours, the telephone must be answered promptly by staff, but can be routed to other locations. In addition to the 24-hour phone line, the **Contractor** must establish an alternative method for obtaining service appeal (e.g., fax);

3.6.5.2.3 An educational plan for network providers which includes, at least, **Contractor** requirements and topical information and which includes **Enrollees** and family members as trainers;

3.6.5.2.4 An annual **TDMHDD** approved provider satisfaction survey conducted with any necessary incentives to insure a minimum response rate of fifty percent (50%) of the

Contractor's providers; a plan for addressing and resolving problems which are identified by the survey process; and a means for reporting survey results and related plans of correction and/or results of plans of correction to **TDMHDD** on an annual basis; and

3.6.5.2.5 A plan for networking activities for providers within the same geographic region; at a minimum, there must be quarterly network meetings for the following types of providers: mental health case managers, crisis service providers, housing/residential care service providers, psychiatric rehabilitation service providers, and substance abuse treatment providers.

3.6.6 Provider Networks

The **Contractor** shall provide the following information for **TDMHDD's** approval:

3.6.6.1 A listing of all providers enrolled in the **Contractor's** provider network including, but not limited to, agencies and individual physicians, mental health case management agencies, psychologists, licensed clinical social workers, registered nurses, nurse practitioners, certified alcohol and drug abuse counselors, other mental health or substance abuse professionals, pharmacies, hospitals, etc. This listing shall include regularly enrolled providers, specialty or referral providers, and any other provider which may be enrolled for purpose of payment for services provided out-of-plan. This information shall be reported in standardized formats as specified by **TennCare** and **TDMHDD** and transmitted accordingly to **TennCare** and **TDMHDD** on a monthly basis. The minimum data elements required by **TDMHDD** for this listing can be found in Attachment D.1 of this CONTRACT. Failure of the **Contractor** to provide monthly updates may result in the application of liquidated damages as described in Section 5.3.3 and Attachment E.

3.6.6.2 A statement documenting each facility/individual listed in response to Section 3.6.6.1 is properly licensed, certified, accredited, designated, approved, and/or meets required

standards for the provision of those services that require certain licensure, certification, accreditation, approval, and/or compliance with standards.

3.6.6.3 The policies and procedures the **Contractor** will follow for monitoring the accuracy of the provider listing required pursuant to Section 3.6.6.1. Included in the policies and procedures are:

3.6.6.3.1 Identification of which providers are required to be licensed, certified, accredited, approved, and/or meet **TDMHDD** standards;

3.6.6.3.2 A requirement for all providers to maintain their license, certification, accreditation, and/or approval verification on-site and at the **Contractor's** central office;

3.6.6.3.3 A description of the **Contractor's** related monitoring activities which includes at least monthly reviews of provider licensure and certification by the **Contractor**; and

3.6.6.3.4 A requirement that **TDMHDD** be notified of changes, using the format prescribed by **TDMHDD**.

3.6.7 Payment Requirements

The **CONTRACTOR** shall assure that payments are not issued to providers that have not obtained a Tennessee Medicaid Provider number or for which disclosure requirements have not been obtained by the **CONTRACTOR** in accordance with 42 CFR 455.100 through 106 and Section 3.7.2 of this Agreement.

The **Contractor** shall agree to report all provider related data required pursuant to this Agreement to **TennCare** using uniform provider numbers. The uniform numbers are to be reported for all providers except pharmacy will be the National Provider Identifier (NPI) Number issued by CMS where applicable and the traditional "Medicaid" provider number issued by **TennCare**. Prior to payment of a claim, the BHO shall require that providers that have not been enrolled in the TennCare program previously as a Medicaid provider or as a provider who currently receives direct

payment from TennCare (i.e. Medicare cost sharing) contact the Medicaid / TennCare Provider Enrollment Unit and obtain a "Medicaid" provider number. The issuance of a "Medicaid" provider number by TennCare is simply for the purpose of establishing a common provider number for reporting purposes as required by this Section and does not imply that TennCare has credentialed the provider or convey any other contractual relationship or any other responsibility with the provider. Pharmacy providers shall use the National Association Board of Pharmacy (NABP) number that has been assigned as well as the NPI number issued by CMS where applicable. The **Contractor** agrees to utilize CMS's newly established NPI number for all provider reporting purposes in accordance with timeframes established by CMS including but not limited to the development of contingency plans beginning May 23, 2007 and the implementation of final plans thereafter.

3.7 Requirements Regarding Contracts & Subcontracts

3.7.1 Subcontracts

The **Contractor** shall be responsible for the administration and management of all aspects of this CONTRACT and the health plan covered there under including all subcontracts. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the **Contractor** to **TDMHDD** to assure that all activities under this CONTRACT are carried out in conformity with the terms and conditions of this CONTRACT.

3.7.1.1 All subcontracts and revisions thereto, as defined in Attachment A of this CONTRACT, shall be approved in advance by **TDMHDD** and the TDCI TennCare Oversight Division. All subcontracts shall be in writing and fulfill the requirements of 42 CFR 434.6 and 42 CFR 438.6 that are appropriate to the service or activity delegated under the subcontract. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to **TDMHDD** within thirty (30) calendar days of execution.

3.7.1.2 The **Contractor** shall assure that the subcontractor shall not enter into any subsequent contracts or subcontracts for any of the work contemplated under the subcontractor for purposes of this CONTRACT, without approval of the **Contractor**.

3.7.1.3 If the subcontract is for the purpose of securing the provision of covered benefits, the subcontract must specify that the subcontractor adhere to the Quality Monitoring Plan included in the CONTRACT as Attachment C. The Quality Monitoring Plan shall be included as part of the subcontract between the **Contractor** and the subcontractor, or referenced in the agreement and provided separately at the time the subcontract is executed.

3.7.1.4 The **Contractor** must include in its subcontracts and agreements with providers a statement prohibiting subcontractors and providers from encouraging or suggesting, in writing or verbally, that **TennCare** children be placed into State custody in order to receive medical or behavioral services covered by **TennCare**.

3.7.1.5 Approval of subcontracts shall not be considered granted unless **TDHMDD** issues its approval in writing.

3.7.1.6 HIPAA Requirements. The **Contractor** shall require all its subcontractors to adhere to the HIPAA regulation requirements.

3.7.1.7 Individual Encounter Data. The **Contractor** shall require all subcontractors to submit individual encounter data to support the **Contractor's** responsibility to verify services delivered.

3.7.1.8 The **Contractor** must ensure **TDMHDD** that it evaluates the prospective subcontractor's ability to perform the activities to be delegated.

3.7.1.9 Written agreements with subcontractors must 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.

3.7.1.10 The **Contractor** must assure **TDMHDD** the subcontractor's performance will be monitored at least annually and subject it to formal review, consistent with industry standards or State laws and regulations. The **Contractor** may include provisions that allow **Contractor** to assess liquidated damages against subcontractors, with approval by **TDMHDD**, where that subcontractor is

responsible for assessment of liquidated damages against the **Contractor** by the State.

3.7.1.11 The **Contractor** shall provide appeal procedures and timeframes to subcontractors upon the execution of all subcontracts.

3.7.1.12 Written agreements with subcontractors must specify that the subcontractor agreements shall be assignable from the **Contractor** to the State, or its designee at the State's discretion upon written notice to the **Contractor** and the affected subcontractor or upon the **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**.

3.7.1.13 Written agreements with subcontractors must include language that all applicable federal and state laws, rules, and executive orders in Section 6 of this CONTRACT are adhered to and that specifically include language conforming with subsections 6.5, 6.13, and 6.15.

3.7.1.14 Written agreements with subcontractors must provide for monitoring, whether announced or unannounced, of services rendered to **Enrollees**, **State-Onlys** and **Judicials** sponsored by the **Contractor**.

3.7.1.15 Written agreements with subcontractors must specify that the **Contractor** shall monitor the quality of services delivered under the CONTRACT and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by **TDMHDD**.

3.7.1.16 Written agreements with subcontractors must require that the provider comply with corrective action plans initiated by the **Contractor**.

3.7.1.17 Written agreements with subcontractors specify the functions and/or services to be furnished by the provider and determine that the functions and/or services to be

furnished are within the scope of his/her professional/technical practice.

3.7.1.18 Should the **Contractor** have a subcontract arrangement for utilization management activities, the **Contractor** shall assure, consistent with 42 CFR 438.6(h) and 42 CFR 422.208, that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any **Enrollee**, as provided by the Balanced Budget Act of 1997 and the provisions of 42 CFR 438.210(e).

3.7.1.19 The **Contractor** must include in its subcontracts a statement prohibiting Physician Incentive Plans.

3.7.2 Provider Agreements

All provider agreements and revisions thereto, as defined in Attachment A of this Contract, shall be approved in advance by the TDCI TennCare Oversight Division. All provider agreements executed by the **Contractor**, and all provider agreements executed by subcontracting entities or organizations, pursuant to this Section shall, at a minimum, meet the following requirements. No other terms or conditions agreed to by the **Contractor** and provider shall negate or supersede the following requirements.

3.7.2.1 Agreements will be in writing and shall contain provisions satisfying applicable statutory requirements. All new provider agreements and existing provider agreements as they are renewed, must include a signature page that contains **Contractor** and provider names that are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties;

3.7.2.2 Specify the effective dates of the provider agreement with a term of no less than one (1) year and renewal options (cancellation clauses must be no less than sixty (60) calendar days);

3.7.2.3 Specify in the provider agreement that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;

3.7.2.4 Require that the provider not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without approval of the **Contractor**;

3.7.2.5 Identify the population covered by the provider agreement;

3.7.2.6 Specify that the provider may not refuse to provide medically necessary or covered preventive services to a **TennCare Enrollee** under this CONTRACT for non-medical reasons, including, but not limited to, failure to pay applicable **TennCare** cost sharing responsibilities. In accordance with Section 3.2.2.5, the provider may not charge **Enrollees** for missed appointments unless otherwise approved by **TennCare** or **TDMHDD**. The provider shall not be required to accept or continue treatment of an **Enrollee** with whom the provider feels he/she cannot establish and/or maintain a professional relationship, however, the provider shall adhere to the nondiscrimination requirements of Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990;

3.7.2.7 Specify the functions and/or services to be furnished by the provider and determine that the functions and/or services to be furnished are within the scope of his/her professional/technical practice;

3.7.2.8 Specify the amount, duration and scope of services to be furnished by the provider;

3.7.2.9 Provide that emergency services be rendered without the requirement of prior authorization of any kind;

3.7.2.10 If the provider performs laboratory services, the provider must meet all applicable requirements of the Clinical Laboratory Improvement Act (CLIA) of 1988 at such time that CMS mandates the enforcement of the provisions of CLIA;

3.7.2.11 Require that an adequate record system be maintained and that all records be maintained for no less than five (5) years from the close of the Agreement or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other

commonly accepted information elements for services rendered to enrollees pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions).

All agreements shall include a statement that as a condition of participation in TennCare, enrollees shall give the TENNCARE Bureau, TENNCARE, TDMHDD, the Office of the Comptroller, and any health oversight agency, such as OIG, TBI MFCU, HHS OIG, and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE, TDMHDD, or authorized federal, state and Comptroller personnel, including, but not limited to, the OIG, the TBI MFCU, the HHS OIG and the DOJ.

Require that medical records requirements found in Section 3.10.16 be included in provider agreements and that medical records are maintained at site where medical services are rendered. Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records.

The provider agreement must contain the language described in Sections 3.10.15 and 3.11.6 of this Agreement;

3.7.2.12 Require that any and all records be maintained for a period not less than five (5) years from the close of the CONTRACT and retained further if the records are under review or audit until the review or audit is complete. Said records shall be made available and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of authorized representative of the **Contractor, TDMHDD,** TDCI, CMS or **TennCare**;

3.7.2.13 Provide that TENNCARE, TDMHDD, TDCI, HHS, HHS OIG ,Comptroller, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means, any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of PHI to health oversight agencies, including, but not limited to, OIG, TBI MFCU, HHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, TDMHDD, TDCI, OIG, TBI MFCU, HHS OIG, DOJ, Office of the Comptroller, may use these records and information for administrative, civil or criminal investigations and prosecutions;

3.7.2.14 No less than on an annual basis provide for monitoring, whether announced or unannounced, of services rendered to **Enrollees**, **State-Onlys** and **Judicials** sponsored by the **Contractor**. The **Contractor** may include provisions that allow **Contractor** to assess liquidated damages against providers, with approval by **TDMHDD**, where that provider is responsible for

assessment of liquidated damages against the **Contractor** by the State;

3.7.2.15 Whether announced or unannounced, provide for the participation and cooperation in any internal and external Quality Management/Quality Improvement, utilization review, peer review and appeal procedures established by the **Contractor** and/or **TDMHDD**;

3.7.2.16 Specify that the **Contractor** shall monitor the quality of services delivered under the CONTRACT and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by **TDMHDD**;

3.7.2.17 Require that the provider comply with corrective action plans initiated by the **Contractor**;

3.7.2.18 Provide for submission of all reports and clinical information required by the **Contractor**;

3.7.2.19 Require safeguarding of information about **Enrollees** according to applicable state and federal laws and regulations and as described in Section 6.1 of this CONTRACT;

3.7.2.20 Provide the name and address of the official payee to whom payment shall be made;

3.7.2.21 Make full disclosure of the method and amount of compensation or other consideration to be received from the **Contractor**;

3.7.2.22 Provide for prompt submission of information needed to make payment;

3.7.2.23 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 Tennessee Code Annotated, 56-32-226 and Section 3.11.2 of this CONTRACT;

3.7.2.24 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), legal guardian(s), or legal custodian(s), conservator, spouse or any other legally responsible person of the patient being served;

3.7.2.25 Specify that at all times during the term of the CONTRACT, the provider shall indemnify and hold **TDMHDD, TennCare,** and TDCI harmless from all claims, losses, or suits relating to activities undertaken pursuant to the CONTRACT between **TDMHDD** and the **Contractor**. This indemnification may be accomplished by incorporating Section 6.12 of this CONTRACT in its entirety in the provider agreement or by use of other language developed by the **Contractor** and approved by **TDMHDD**;

3.7.2.26 Require the provider to secure all necessary liability (including general liability, professional liability, and workers compensation insurance) and malpractice insurance coverage as is necessary to adequately protect the Plan's **Enrollees** and the **Contractor** under this CONTRACT. The provider shall provide such insurance coverage throughout the term of the provider agreement and upon execution of the provider agreement furnish the **Contractor** with written verification of the existence of such coverage. The amount of the insurance shall be in accordance with Section 3.1.10;

3.7.2.27 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** plan;

3.7.2.28 Provide that the CONTRACT incorporates by reference all applicable federal and state laws, **TennCare** Rules and Regulations or court orders, and revisions of such laws or regulations shall automatically be incorporated into the CONTRACT, as they become effective. In the event that changes in the CONTRACT as a result of revisions and applicable federal or state law materially

affect the position of either party, the **Contractor** and provider agree to negotiate such further amendments as may be necessary to correct any inequities;

3.7.2.29 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the CONTRACT termination date, or early termination of the CONTRACT. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the CONTRACT, 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);

3.7.2.30 Specify that both parties recognize that in the event of termination of this CONTRACT between the **Contractor** and **TDMHDD** for any of the reasons described in Section 5.1.6 of this CONTRACT, the provider shall immediately make available to **TDMHDD**, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the MCO/provider agreement. The provision of such records shall be at no expense to **TDMHDD**;

3.7.2.31 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 T.C.A. 56-32-226(b);

3.7.2.32 Include a conflict of interest clause as stated in subsections (1) and (2) of Section 6.5, Gratuities clause as stated in Section 6.6 and Lobbying clause as stated in Section 6.7 of this Agreement between the **CONTRACTOR, TennCare and TDMHDD.**

3.7.2.33 Specify the extent to which any savings or loss realized by the plan shall be shared with the providers;

3.7.2.34 Specify that the provider shall be required to accept **TennCare** reimbursement amounts for services provided under the CONTRACT between the provider and **Contractor** to **TennCare Partners Enrollees** and shall not be required to accept **TennCare** reimbursement

amounts for services provided to persons who are covered under another health plan operated or administered by the **Contractor**;

3.7.2.35 Specify that the provider must adhere to the Quality Monitoring Plan included in this CONTRACT as Attachment C;

3.7.2.36 Specify that a provider shall have one hundred and twenty (120) calendar days from the date of rendering a service to file an initial claim with the **Contractor** except in situations regarding coordination of benefits or subrogation, in which case the provider is pursuing payment from a third party or if an **Enrollee** is enrolled in the plan with a retroactive eligibility date. In situations of enrollment in the plan with a retroactive eligibility date, the time frame for filing a claim shall begin on the date that the **Contractor** receives notification from **TennCare** of the **Enrollee's** eligibility;

3.7.2.37 Specify the provider agreement shall include a signature page that contains the **Contractor** and provider typed names, provider company with titles, and dated signatures of all appropriate parties;

3.7.2.38 Specify attachments and/or exhibits to the provider agreement contain language and definitions consistent with this CONTRACT;

3.7.2.39 Specify the provider agreement must number CONTRACT pages in sequential order;

3.7.2.40 Specify the provider submit to the **Contractor** the necessary information so the **Contractor** can determine the average unit costs pursuant to Section 3.10.10.4;

3.7.2.41 Specify that the CONTRACT is not exclusive with respect to any service or geographic area;

3.7.2.42 No agreement executed between the **Contractor** and a provider shall require the provider to assume financial risk for the provision of services, which are not directly or indirectly furnished, by that provider to an **Enrollee** in the **TennCare Partners Program**. The term indirectly means the provider retains ultimate management and

control over the services furnished to **Enrollees** in the **TennCare Partners Program**. The **Contractor** may request the TDCI TennCare Oversight Division to provide, in advance, a written opinion whether a proposed CONTRACT provision is in compliance with this Section, and the TDCI TennCare Oversight Division must respond to any such request within thirty (30) calendar days after receipt of the request by the TDCI TennCare Oversight Division. **TDMHDD**, in addition to any and all remedies set forth in this CONTRACT, may also commence an action against the **Contractor** in accordance with Section 6.11 of this CONTRACT to recover from the **Contractor** any losses incurred by a provider as a result of the **Contractor's** breach of this Section. Any amounts recovered by **TDMHDD** which are for losses incurred by a provider as a result of the **Contractor's** breach of this Section shall be returned without interest to the provider;

3.7.2.43 All provider agreements must include language which informs providers of the package of benefits TENNderCare offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs.

3.7.2.44 Specify that the provider will comply with the appeal process including but not limited to assisting an **Enrollee** by providing appeal forms and contact information including the appropriate address for submitting appeals for State level review;

3.7.2.45 Require that the provider display notices of the **Enrollee's** right to appeal any adverse action affecting services in public areas of their facility(ies) in accordance with **TennCare** rules, subsequent amendments, or any and all court orders. The **Contractor** shall ensure that providers have correct and adequate supply of public notices;

3.7.2.46 Require that if any requirement in the provider agreement is determined by **TDMHDD** to conflict with the CONTRACT between **TDMHDD** and the **Contractor**, such requirement shall be null and void and all other provisions shall remain in full force and effect;

3.7.2.47 Include a statement prohibiting providers from encouraging or suggesting, in writing or verbally, that **TennCare** children be placed into State custody in order to receive medical or behavioral services covered by **TennCare**; and

3.7.2.48 Specify that in the event that **TDMHDD** deems the **Contractor** unable to timely process and reimburse claims and requires the **Contractor** to submit provider claims to an alternate claims processor, the provider shall agree to accept reimbursement at the **Contractor's** contracted reimbursement rate or the rate established by **TDMHDD**, whichever is greater.

3.7.2.49 Specify that all assessments detailed in Section 2.5.3 are completed by **TDMHDD**-certified raters and that the assessments are completed within the specified timeframes. The rater certification process shall include

completing the CRG/TPG assessments' training and passing the **TDMHDD** rater competency examination, scored only by **TDMHDD**-certified trainers.

3.7.2.50 The **Contractor** must include in its agreements with providers a statement prohibiting Physician Incentive Plans

3.7.2.51 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.

3.7.2.52 Require the provider to comply with fraud and abuse requirements described in Section 3.1.12of this Agreement;

3.7.2.53 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 CONTRACTORS request for information, the request to provide medical records, credentialing information, etc., at the CONTRACTORS discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

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

Failure to comply with notice requirements described herein may result in liquidated damages as described in Section 5.3.3 of this Contract.

3.7.4 The CONTRACTOR shall notify TennCare of any provider termination and submit a copy of one of the actual member notices mailed as well as an electronic listing identifying each member to whom a notice was sent within five (5) business days of the date the member notice was sent as required in Section 3.7.3. In addition to the member notice and electronic listing, documentation from the CONTRACTORS' mail room or outside vendor indicating the quantity and date member notices were mailed shall be sent to TENNCARE as proof of compliance with the member notification requirements. The CONTRACTOR shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request by TENNCARE. If the termination was initiated by the provider, said notice shall include a copy of the provider's notification to the Contractor.

Furthermore, if termination of the CONTRACTORS' provider agreement with any provider group, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Sections 3.1.3 and 3.6.1.2 of this Contract, such termination shall be reported by the CONTRACTOR to TENNCARE and TDMHDD in the standard format used to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

3.8 Enrollee Involvement

3.8.1 The **Contractor** must submit for **TDMHDD** approval its policies and procedures with respect to **Enrollee,** or parent(s), legal guardian(s) or legal custodian(s) of minor, involvement. These policies and procedures must include, at a minimum, the following elements:

3.8.1.1 The requirement that mental health case management service plans and other relevant treatment plans document **Enrollee** involvement. This includes **Enrollee**/family member signature on the plan and upon each subsequent plan review, where appropriate, and a description of how this requirement will be met;

3.8.1.2 The requirement that **Enrollee** education materials include statements regarding the **Enrollee's,** or parent(s), legal guardian(s), or legal custodian(s), right to involvement in treatment decisions, their ability to choose and change service providers, and a description of how this requirement will be met;

3.8.1.3 The requirement that provider education include materials regarding the rights of **Enrollees**, or parent(s), legal guardian(s), or legal custodian(s), to be involved in treatment decisions and a description of how this requirement will be met and;

3.8.1.4 A description of the quality monitoring activities to be used to measure provider compliance with the requirement for **Enrollee's**, or parent(s), legal guardian(s), or legal custodian(s)'s, involvement in treatment planning;

3.8.2 The **Contractor** shall provide an education plan for all **Enrollees** regarding behavioral health issues; education must occur on a regular basis. At a minimum, educational materials must include information on medications and their side effects; mental disorders and treatment options; self-help groups and other community support services available for **Enrollees** and families.

3.8.3 The **Contractor** shall establish an Advisory Committee that is accountable to the **Contractor's** governing body to provide input and advice, according to the following requirements:

3.8.3.1 The **Contractor's** 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 and families of children with Serious Emotional Disturbance;

3.8.3.2 There must be geographic diversity;

3.8.3.3 There must be cultural and racial diversity;

3.8.3.4 There must be representation by providers and consumers (or family members of consumers) of substance abuse services;

3.8.3.5 At a minimum, the **Contractor's** Advisory Committee must have input into policy development, planning for services, service evaluation, and **Enrollee**, family member and provider education;

3.8.3.6 Meetings must be held at least quarterly;

3.8.3.7 Travel costs must be paid by the **Contractor**;

3.8.3.8 The **Contractor** must submit two semi-annual reports to **TDMHDD** regarding the activities of the **Contractor's** Advisory Committee; and

3.8.3.9 The **Contractor**, as BHO Advisory Committee membership changes, must submit current membership lists to **TDMHDD**.

3.8.4 The **Contractor** shall require providers to inform children and adolescents for whom residential treatment is being considered and their parent(s), legal guardian(s), or legal custodian(s), 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.

3.8.5 The **Contractor** shall require providers to inform all **Enrollees** being considered for prescription of psychotropic medications of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

3.9 Quality Improvement and Utilization Management

3.9.1 Quality Improvement

3.9.1.1 The **Contractor** must implement a Quality Monitoring Plan (QMP) in accordance with **TDMHDD** requirements as referenced in Attachment C. The **Contractor** shall use as a guideline the Standards for Internal Quality

Monitoring in Attachment C of this CONTRACT and the Quality Monitoring Plan shall be approved by **TDMHDD** prior to the enrollment of any **TennCare Enrollees**. Any changes to the quality monitoring program structure shall require prior written approval from **TDMHDD**. The Quality Monitoring Plan shall be submitted to **TDMHDD** annually for reconsideration for approval along with the annual Quality Monitoring Plan (QMP) report described in Attachment C of this CONTRACT.

3.9.1.2 The **Contractor** must disseminate the **TDMHDD** Clinical Best Practice Guidelines to providers for their use and, upon request, to **Enrollees** and potential **Enrollees**.

3.9.1.3 The **Contractor** must provide the **TDMHDD** Office of Managed Care (OMC) with ten (10) business days advance notice of all regularly scheduled meetings of the Quality Assurance/Quality Improvement Committee and Peer Review Committee. To the extent allowed by law, the **TDMHDD** Office of Managed Care, or OMC designee, may attend the Quality Assurance/Quality Improvement Committee and/or Peer Review Committee meetings at OMC option. In addition, written minutes shall be kept of all meetings of the Quality Assurance/Quality Improvement Committee. A copy of the 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. The **Contractor** is subject to annual, external independent reviews of the quality outcomes, timeliness of, and access to, the services covered under this CONTRACT.

The Contractor shall notify TDMHDD within three (3) business days of any decision to suspend new admissions to a provider or terminate a provider from their network. The notification shall include the name of the provider, the reason(s) for the action to discontinue admissions or terminate the provider from the network, and the effective date of the action.

3.9.2 Focused Clinical Studies

The **Contractor** must conduct at least three (3) continuous focused clinical studies per calendar year for the purpose of identifying areas for service development, procedural change and improvement. At least two clinical areas of concern and one of the health services delivery areas of concern are required for evaluation and study. Clinical areas of concern for study shall be identified from: high-volume diagnosis or services; or high-risk diagnoses, services, or special populations (e.g., persons with serious and persistent mental illnesses, persons with dual diagnoses, persons with addictive disorders, children in State custody). The health services delivery area of concern for study shall be inpatient facility services; partial facility services; or ambulatory services, unless otherwise specified by **TDMHDD**.

3.9.2.1 No later than April 1st of each calendar year, the **CONTRACTOR** shall submit to the **TDMHDD** Office of Managed Care, a written plan that identifies each of the proposed focused clinical study topics. On a quarterly basis, the **CONTRACTOR** shall provide progress reports on each focused clinical study and shall report annually on the results of each study no later than April 1st. Each study topic and its written plan must be submitted at least 3 months prior to the proposed implementation date for the study to the **TDMHDD** Office of Managed Care for review and approval. The written plans must include the following information:

3.9.2.1.1 Study topic;

3.9.2.1.2 Target Population;

3.9.2.1.3 Study Design;

3.9.2.1.4 Timeline for data collection;

3.9.2.1.5 Sampling methodology, if appropriate (including description of the target population and breakdown of special populations);

3.9.2.1.6 Instruments/tools to be used;

3.9.2.1.7 Performance measures, relevant benchmarks and source documentation,

expected baselines, and anticipated findings;

3.9.2.1.8 Analytic plans and assumptions;

3.9.2.1.9 Reporting plan (e.g., elements, audience) and timetable; and

3.9.2.1.10 Timetable for implementation in order to submit a final report during the last month of the calendar year.

3.9.2.2 The **Contractor** shall make all data-sets used for analysis available to **TDMHDD**, including record layouts, data dictionaries, and computer programming code used for each analysis.

3.9.3 Utilization Management

3.9.3.1 The **Contractor** shall operate a system for managing service utilization that both ensures adequate control over high cost and high-risk services and procedures and promotes timely access to needed treatment and rehabilitation services in accordance with standards of practice approved by **TDMHDD**. These procedures shall have the flexibility to efficiently authorize services for complex treatment plans. The **Contractor** shall submit all policies, guidelines, and utilization management criteria, including time standards for authorization decisions to **TDMHDD** for approval.

The **Contractor's** utilization management policies and procedures shall meet the requirements set forth in Standard XIV in the Standards for BHO Quality Monitoring Programs (Attachment C). In addition, the utilization management policies and procedures shall include:

3.9.3.1.1 Mechanisms to ensure consistent application criteria for authorization decisions and provide for consultation with the requesting provider when appropriate;

3.9.3.1.2 Mechanisms to ensure that services are authorized based on assessment information and treatment plans submitted by providers;

3.9.3.1.3 A prohibition against any requirement that a lower level of care be shown to be unsuccessful prior to authorization or approval of a higher level of care;

3.9.3.1.4 Mechanisms 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;

3.9.3.1.5 A prohibition against incentives for the denial, limitation, or discontinuation of medically necessary services to any **Enrollee**; and

3.9.3.1.6 Mechanisms to ensure direct access to specialists for required services, including those requiring multiple encounters, is not restricted and is based on the **Enrollee's** condition and identified needs.

3.9.3.2 The **Contractor** shall instruct and assist network providers to verify an individual's eligibility prior to providing any service other than crisis. The only exception to this requirement is when a person requests services for an emergency situation. In the event of an emergency medical condition, network providers shall provide immediate medical services.

3.9.3.3 The **Contractor** shall ensure twenty-four (24) hour access to a qualified health professional who is able to assess patient need and authorize services.

3.9.3.4 Authorization decisions shall be communicated to the provider within forty-eight (48) hours of the decision. It is not required that the notice be in writing, but the **Contractor** must be able to produce proof or documentation of notice to the requesting provider. Qualified mental health professionals rendering authorization decisions for the **Contractor** shall consult with the requesting providers when medically necessary.

3.9.3.5 The **Contractor** shall provide the medical necessity criteria specified in this CONTRACT and any Best Practice Guidelines identified by **TDMHDD** to its network physicians and utilization reviewers.

3.9.3.6 The **Contractor** shall not deny any covered service based upon cost criteria.

3.10 Records and Reporting Requirements

3.10.1 General Requirements

The **Contractor** is responsible for complying with all the reporting requirements established by **TDMHDD**, including certifications or additional certifications of documents or data as required by **TDMHDD** set out in Section 4.7.7 of this CONTRACT and consistent with federal regulations Title 42, Subpart H. **TDMHDD** shall provide the **Contractor** with the appropriate reporting format, instructions, submission timetables, and technical assistance when required. **TDMHDD** may, at its discretion, require the **Contractor** to submit new reports, to recreate, reconstruct or re-sort reports using the same or different reporting formats, instructions and submission timetables as specified by **TDMHDD**. Requests to submit new reports, recreate, reconstruct or re-sort said reports may be considered Ad Hoc reports. Failure to report information, as specified by **TDMHDD**, may result in the assessment of liquidated damages as described in Section 5.3.3 of this CONTRACT.

3.10.1.1 Time Tables

For the purposes of determining liquidated damages in accordance with this Section, reports are due in accordance with the following schedule, unless otherwise specified elsewhere in this CONTRACT.

Report Frequency	***Due Date***
Daily Report	Within two (2) working days
Weekly Reports	Wednesday of the following week
Monthly Reports	20th of the following month
Quarterly Reports	30th of the following month
Semi-Annual Reports	January 31 and July 31
Annual Reports	Ninety (90) calendar days after the end of the year
On Request Reports	Within three (3) working days from the date of request when reasonable unless otherwise specified by **TDMHDD**
Ad Hoc Reports	Within ten (10) working days from the date of the request when reasonable unless otherwise specified by **TDMHDD**

Failure to report information as specified by **TDMHDD** may result in the application of liquidated damages as described in Section 5.3.3 of this CONTRACT. If the due date is on a weekend or holiday, the report shall be due on the next business day.

3.10.1.2 Submission Standards

3.10.1.2.1 The **Contractor** must submit to **TennCare** all required transaction files utilizing an interface specified by **TennCare**. The

Contractor will be responsible for all costs involved.

3.10.1.2.2 Upon request by **TennCare,** the **Contractor** must provide **TennCare** with files for comparisons between **TennCare** databases and the **Contractor's** database. The **Contractor** shall reconcile any discrepancies.

3.10.1.2.3 The **Contractor** shall be responsible for its Information Systems concerning all aspects for:

3.10.1.2.3.1 System backups,

3.10.1.2.3.2 Off-site security storage of same system backups,

3.10.1.2.3.3 System restores,

3.10.1.2.3.4 Disaster Recovery Plan and Procedures, and

3.10.1.2.3.5 all security needs and considerations.

The **Contractor** is responsible for all documentation and procedures concerning all five (5) of these items, insuring they are kept up-to-date, accurate, and accessible.

3.10.1.2.4 At any point in the CONTRACT, **TennCare** has the right to obtain from the **Contractor** materials, systems, or other items developed, refined, or enhanced in the course of or under the CONTRACT, subject to software licensing limitations. The **Contractor** agrees that **TennCare** shall have royalty-free, nonexclusive and irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for government purposes. This includes the right to obtain a free, legal, licensed copy(s) of the **Contractor's** software, physical data base structure(s),

and ongoing upgrades as available relating to admissions/intake, patient tracking, all components of billing, and any other aspect of the **Contractor's** system software.

3.10.2 Provider Enrollment Reporting

The **Contractor** shall furnish to **TennCare** and **TDMHDD** listings of all providers enrolled in the **Contractor's** provider network. These listings shall include regularly enrolled providers, specialty or referral providers, and any other provider which may be enrolled for purpose of payment for services provided out-of-plan. This information shall be reported in a standardized formats as specified by **TennCare** and **TDMHDD** and transmitted electronically to **TennCare** and **TDMHDD** on a monthly basis. The minimum data elements required by **TDMHDD** for this listing may be found in Attachment D.1 of this CONTRACT.

Each provider shall be identified by a Tennessee Medicaid I.D. number (i.e. each servicing provider in a group or clinic practice must be identified by a separate provider number) as well as the National Provider Identifier (NPI) number, effective May 23, 2007. These unique identifiers shall appear on all encounter data transmittals.

3.10.3 Enrollee Assessment Reporting

The **Contractor** shall furnish to **TennCare** and **TDMHDD** information regarding the CRG assessment or TPG assessment of **Enrollees** who have presented for mental health or substance abuse services or who have been referred for assessments prior to obtaining such services. This information shall be reported in a standardized format as specified by **TDMHDD** and transmitted electronically to the **TDMHDD** on a basis specified by **TDMHDD**. The minimum data elements required to be provided are identified in Attachment D.2 and D.3 of this CONTRACT.

3.10.4 Enrollee Encounter Reporting

The **Contractor** shall furnish to **TennCare** information regarding individual encounters (individual units of service provided to **Enrollees**). Encounter information will be submitted for each covered service as listed in Section 2.5 provided, regardless of provider reimbursement methodology. In the event that services are bundled for the purpose of payment, the Contractor shall require the provider to submit unbundled services in the necessary

format to support the Contractor's obligation to submit encounter data for each individual unit of service. This information shall be reported in a standardized format as specified by **TDMHDD** and transmitted electronically to **TennCare** on a monthly basis**.** The minimum data elements required to be provided are identified in Attachment D.4 of this CONTRACT.

If a national standardized encounter reporting format is developed, the **Contractor** agrees to implement this format if directed to do so by **TDMHDD**.

3.10.5 Case Management Reporting

The **Contractor** shall submit a report of the utilization of case management services to **TDMHDD** on a quarterly basis. The methodology for reporting shall be prior approved by **TDMHDD** and the minimum data elements required to be provided are identified in Attachment D.5.

3.10.6 Crisis Response Reporting

In accordance with Section 2.5.9.4, the **Contractor** shall monitor crisis service providers and report information to **TDMHDD** on a quarterly basis for those indicators listed in Attachment D.6 and Attachment E. All measures shall be reported separately for adults ages eighteen (18) years and over and children under eighteen (18) years. All information shall be reported for each individual crisis service provider in a standardized format as specified by **TDMHDD**.

3.10.7 Cost and Utilization Reports

The Contractor shall submit quarterly Cost and Utilization Reports. These reports shall be submitted using the format provided in Attachments J, K, L, M, and N. These reports shall be in an Excel spreadsheet format and submitted with a ninety (90) day lag and shall be due to TennCare one hundred five (105) calendar days following the quarter for which the Contractor is reporting. These reports shall be submitted on both a cumulative year basis and on a rolling twelve (12) month basis.

3.10.8 Enrollee Information, Weekly Reporting

The **Contractor** shall submit weekly reports in an electronic format, unless otherwise specified or approved by **TennCare** in writing, which shall serve as the source of information for a change in the **Enrollee's TennCare** information. This report shall include

Enrollees who move outside the **Contractor's** service area as well as **Enrollees** who move to a new address within the **Contractor's** service area. The **Contractor** agrees to work with the State to devise a methodology to use returned mail to identify **Enrollees** who have moved and whose whereabouts are unknown.

Within 90 days of notification from **TennCare**, the **Contractor** shall also be required to include in this report, any information which is known by the **Contractor** that may affect an **Enrollee's TennCare** eligibility and/or **TennCare** cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of un-insurability including limited coverage and exclusionary riders to policies, whether or not the **Enrollee** is incarcerated, or resides outside the State of Tennessee. The minimum data elements required for this report can be found in

Attachment D of this CONTRACT. This notice may be accomplished through a written form or as an electronic media update, as mutually agreed upon by the **Contractor** and **TennCare**.

The CONTRACTOR shall gather, store and update a minimum of the following health insurance information:

- Recipient SSN
- Type of coverage (Inpatient, outpatient, pharmacy, dental, vision, etc.)
- Policyholder name
- Policyholder SSN, if available
- Policyholder's relationship to the recipient
- TennCare carrier number, carrier name and address, if available
- Policy number
- Begin and end date of policy

Health insurance data provided by the CONTRACTOR that does not include the above required fields will be returned to the CONTRACTOR.

3.10.9 Enrollee Verification Information on Request

TennCare may provide the **Contractor** with a report in electronic format containing **Enrollees** for whom **TennCare** has been unable

to locate or verify various types of pertinent information. Upon receipt of this report, the **Contractor** shall provide **TennCare** with any information known by the **Contractor** that may affect an **Enrollee's TennCare** eligibility and/or **TennCare** cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of uninsurability, including limited coverage and exclusionary riders to policies, information regarding an **Enrollee** who has been incarcerated, change of residence or residence outside the State of Tennessee, within the timeframes specified by **TennCare**. **TennCare** shall not specify timeframes less than thirty (30) calendar days from the **Contractor's** receipt of such report. The minimum data elements required for this report can be found in Attachment D.7 of this CONTRACT.

3.10.10 Enrollee Cost-Sharing Liabilities

In accordance with Section 3.2.2.4, the **Contractor** shall track and report to **TennCare** the amount of **Enrollee** cost-sharing liabilities. This information shall be reported in a standardized format as specified by **TennCare** on a monthly basis.

3.10.11 Financial Reporting

3.10.11.1 The **Contractor** shall file with the TDCI TennCare Oversight Division, with a copy to **TDMHDD**, an annual report on the form prescribed by the National Association of Insurance Commissioners (NAIC) for health maintenance organizations, on or before March 1 of each calendar year, as required by Tennessee Code Annotated, §56-32-208. The **Contractor** shall comply with any and all rules and regulations of TDCI related to the preparation and filing of this report. This annual report shall also contain an income statement detailing the **Contractor's** fourth quarter and year- to-date revenues earned and expenses incurred as a result of the **Contractor's** participation in the State of Tennessee's **TennCare Partners Program**. Furthermore, in accordance with Section 3.10.14 the medical loss ratio report must be filed with and reconciled to the NAIC annual statement.

3.10.11.2 The **Contractor** shall file with the TDCI TennCare Oversight Division, with a copy to **TDMHDD**, a quarterly financial report on the form prescribed by the National Association of Insurance Commissioners for

health maintenance organizations. These quarterly reports shall be filed on or before June 1 (covering first quarter of the current year), September 1 (covering second quarter of current year), and December 1 (covering third quarter of current year) of each calendar year. Each quarterly report shall also contain an income statement detailing the **Contractor's** quarterly and year-to-date revenues earned and expenses incurred as a result of the **Contractor's** participation in the State of Tennessee's **TennCare Partners Program**. The medical loss ratio report required in Section 3.10.14 must be filed with and reconciled to the September NAIC quarterly report. The actuarial certification shall be prepared in accordance with the NAIC guidelines.

3.10.11.3 The **Contractor** shall, when determining liabilities on its annual report and quarterly financial reports, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, or unpaid, or for which the **Contractor** is or may be liable, and to provide for the expense of adjustment or settlement of such claims. Such liabilities shall be computed in accordance with procedures to be established by the TDCI TennCare Oversight Division upon reasonable consideration of the ascertained experience and character of the **Contractor**.

3.10.11.4 The **Contractor** shall report monthly to **TDMHDD** summary reports of cost for providing each definable unit of service reported in accordance with Section 3.10.4 for two dual eligible categories (Medicare/ **TennCare** Medicaid and Medicare/ **TennCare** Standard). These reports shall be due by the 21st of the month <u>two</u> months following the period being reported. The State shall be responsible for providing the **Contractor** with information needed to identify these dual eligible **Enrollees**. The **Contractor** is not relieved from this obligation because the **Contractor** has any subcontracts for the provision of any such unit of service, regardless of the method of payment to the subcontractor(s). Cost data for dual eligible **Enrollees** shall be reported electronically using the report format provided in Attachment D.8 or as later revised.

3.10.11.5 The **Contractor** shall disclose to **TDMHDD**, the Comptroller General and/or CMS full and complete information regarding ownership, financial transactions and persons convicted of any criminal activity as specified in Section 3.1.11.

3.10.12 Performance Measurement Reporting

Performance measurements for the performance measures specified in Attachment E shall be submitted to **TDMHDD** in accordance with Attachment E and as specified therein.

3.10.13 Focused Studies

In accordance with Section 3.9.2, the **Contractor** is required to conduct at least three focused clinical studies. The **Contractor** shall submit a hard copy report of the study design, analysis and results, for each continuous focused study to **TDMHDD** on an annual basis.

3.10.14 Assessments Reporting

On a quarterly basis, the **Contractor** shall conduct audits of CRG/TPG assessments for accuracy and conformity to **TDMHDD** policies and procedures. The **Contractor** shall audit all providers conducting these assessments on at least an annual basis. The methodology for these audits must be submitted to **TDMHDD** for approval no later than March 1st of each year and the results of these audits shall be reported on an annual basis to **TDMHDD** no later than the last day of the calendar year.

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 TDMHDD.

3.10.15 Medical Loss Ratio Report

The medical loss ratio report shall be reported monthly with cumulative year to date calculation using the forms in Attachment

D.9. The **Contractor** shall report all medical expenses and capitation payments received from **TennCare** and complete the supporting claims lag tables. Monthly expenditures shall be reported on a rolling basis by provider groupings including but not limited to:

3.10.15.1 direct payment to providers for covered medical services and

3.10.15.2 capitated payments to providers and subcontractors for covered medical services.

The **Contractor** will submit these reports monthly, due by the 21st of the following month. The **Contractor** will also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report must reconcile to NAIC filings.

3.10.16 Availability of Records

3.10.16.1 The CONTRACTOR shall insure within its own organization and pursuant to any agreement the CONTRACTOR may have with any other providers of service, including, but not limited to providers, sub-contractor's or any person or entity receiving monies directly or indirectly by or through TennCare, that TENNCARE representatives and authorized federal, state and Comptroller personnel, including, but not limited to TENNCARE, the Office of the Inspector General (OIG), the Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU), the Department of Health and Human Services, Office of Inspector General (HHS OIG) and the Department of Justice (DOJ), and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to the medical care or services provided to TennCare enrollees.

3.10.16.2 The CONTRACTOR and its subcontractor's 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 CONTRACTORS, the sub-contractor's and/or the provider's expense for administrative, civil and/or criminal review, audit, evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Comptroller of Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the HHS OIG, TENNCARE or any duly authorized state or federal agency. Access will be either through on-site review of records or through the mail at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. All records to be sent by mail will be sent to TENNCARE within twenty (20) working days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE, TDMHDD, authorized federal, state, and Comptroller of Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the HHS OIG, or any duly authorized state or federal agency. Records related to appeals shall be forwarded within the time frames specified in the appeal process portion of this Agreement. Such requests made by TENNCARE shall not be unreasonable.

The CONTRACTOR and any of its subcontractor's, providers any entity or person directly or indirectly receiving monies originating from TennCare, shall make all records, including, but not limited to, financial, administrative and medical records available to any duly authorized government agency, including but not limited to TENNCARE, OIG, TBI MFCU, HHS OIG and DOJ, upon any authorized government agency's request. Any authorized government agency, including but not limited to OIG, TBI MFCU, HHS OIG and DOJ, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.

3.10.16.3 The CONTRACTOR, any CONTRACTORS management company and any CONTRACTORS claims processing sub-contractor shall cooperate with the State, or any of the State's Contractors and agents, including, but not limited to TENNCARE, OIG, TBI MFCU, DOJ and the HHS OIG, and the Office of the Comptroller, and any duly authorized governmental agency, during the course of any claims processing, financial or operational examinations or during any administrative, civil or criminal investigation, hearing or prosecution. This cooperation shall include, but shall not be limited to the following:

3.10.16.3a Providing full cooperation and direct and unrestricted access to facilities, information, and staff, including facilities, information and staff of any management company or sub-contractor, to the State or any of the State's Contractors and agents, which includes, but is not limited to TennCare, OIG, TBI MFCU, DOJ and the HHS OIG, and the Office of the Comptroller and any duly authorized governmental agency.

3.10.16.3.b 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.

3.10.16.3.c The CONTRACTOR shall cooperate fully with audits the State may conduct of medical management to include clinical processes and outcomes, internal audits, provider networks, and any other aspect of the program the State deems appropriate. The State may select any qualified persons, or organization to conduct the audits.

3.10.17 Medical Records Requirements

The CONTRACTOR shall maintain, and shall require contracted providers and sub-contractor's to maintain medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. Medical records are to be maintained at the site where medical

services are provided for each member enrolled under this Agreement. The CONTRACTOR shall have policies and distribute policies to practice sites that address:

3.10.17.1. Confidentiality of medical records;

3.10.17.2 Medical record documentation standards;

3.10.17.3 An organized medical record keeping system and standards for the availability of medical records, including but not limited to:

(a) Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and subject to reasonable charges, be given copies thereof upon request;

(b) When a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records.

3.10.17.4 Performance goals to assess the quality of medical record keeping; and

3.10.17.5 CONTRACTOR medical record keeping policies and practices must be consistent with 42 CFR 456 and NCQA Standards for medical record documentation.

3.10.17.6 CONTRACTOR must implement a Quality Monitoring Program Plan in accordance with TDMHDD requirements as referenced in Attachment C. The Quality Monitoring Program Plan must have prior written approval from TDMHDD.

3.10.18 IMD Out-of-State Report

The **CONTRACTOR** shall report monthly by the 5th day of the following month to **TDMHDD** on the use of Institutions for Mental Diseases (IMD) utilized outside of the state of Tennessee. The report shall be in a format prescribed by **TDMHDD**.

3.10.19 RESERVED

3.10.20 Business Continuity and Disaster Recovery Reports

The **CONTRACTOR** shall submit a high level summary of their baseline *Business Continuity and Recovery (BC-DR) Plan* or make it available at **CONTRACTOR's** local Tennessee site for review and approval as specified by **TENNCARE.** The CONTRACTOR shall communicate a high level summary of

proposed modifications to the BC_DR plan or make it available at CONTRACTOR's local Tennessee site at least fifteen (15) calendar days prior to their proposed incorporation. Such modifications shall be subject to review and approval by TENNCARE.

3.10.21 Cost Avoidance Value Reporting

Cost Avoidance Value Reporting. The CONTRACTOR shall report all claim adjusted amounts due to TPL coverage or Medicare coverage on a frequency and in a format and media described by TENNCARE. The CONTRACTOR shall calculate cost savings in categories described by TENNCARE.

3.11 Accounting Requirements

3.11.1 General Requirements

The **Contractor** shall establish and maintain an accounting system as prescribed or permitted by the State of Tennessee Department of Commerce and Insurance. The accounting system shall maintain records pertaining to the tasks defined in this CONTRACT and any other costs and expenditures made under the CONTRACT.

Specific accounting records and procedures are subject to **TDMHDD** and federal approval. Accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the CONTRACT period and for five (5) years thereafter.

3.11.2 Claims Processing

3.11.2.1 Claims Processing Requirements

The **Contractor** shall have in place an automated claims processing system capable of accepting and processing claims submitted electronically. To the

extent that the **Contractor** compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the **Contractor** shall process, as described herein, the provider's claims for covered benefits provided to **Enrollees** or **Judicials** consistent with applicable **Contractor** policies and procedures and the terms of this CONTRACT.

The **Contractor** shall ensure that ninety percent (90%) of claims for payment for services delivered to an **Enrollee** or a **Judicial** (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 such claims. 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 services delivered to an **Enrollee** or a **Judicial.** "Pay" means that the **Contractor** shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the **Contractor**. "Process" means the **Contractor** must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial.

If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Should the **Contractor** deny, reduce, terminate, suspend or delay payment, the **Contractor** shall give notice on the date of action when the action is a denial of payment. 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. If requested by the provider, 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 capitation

payments generated and paid by the **Contractor**. The status report shall contain appropriate explanatory remarks related to payment or denial of the claim.

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:

3.11.2.1.1 the time period specified in the CONTRACT between the provider and the **Contractor** or subcontractor, or if a time period is not specified in the CONTRACT,

3.11.2.1.2 the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or

3.11.2.1.3 If the **Contractor** is required to compensate the provider directly, within five (5) calendar days after receipt of the capitation payment and supporting Remittance Advice information from **TennCare.**

The **Contractor** shall CONTRACT with independent reviewers to review disputed claims as provided by T.C.A., Section 56-32-226.

Failure to meet claims processing requirements may result in the application of liquidated damages and other remedies as described in Section 5 of this CONTRACT and in Section 3.11.3 below.

3.11.3 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. **TennCare** shall provide a notice of deficiency and request corrective action. The **Contractor** may also be subject to the application of liquidated

damages specified in Section 5.3.3 and the retention of withholds as specified in Section 4.7.4. 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 require the **Contractor** to:

3.11.3.1 Subcontract for the provision of claims processing services; or

3.11.3.2 Submit claims to an alternate claims processor designated by the State at the **Contractor's** expense. In this event, claims shall be processed at the contracted rate or at a rate to be determined by **TennCare.**

3.11.4 Audit Guidelines

The State may develop comprehensive audit guidelines for the monitoring of **Contractor's** claims processing performance. These claims processing audit guidelines may consist of specified performance criteria and liquidated or other damages for **Contractor's** failure to meet the specified performance criteria.

3.11.5 Monitoring and Audit Requirements

3.11.5.1 Audit Requirements

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 CONTRACT. The Audit Requirements include the following:

3.11.5.1.1 The audit shall be performed in accordance with the requirements set forth in the NAIC Annual Statement Instructions for Annual Audited Financial Reports covering the previous calendar year except that the Audited Financial Report shall be submitted to TDCI and **TDMHDD** on or before May 1 of each calendar year rather than June 1 of the calendar year,

3.11.5.1.2 The audited financial statements, prepared in accordance with the accounting practices prescribed or permitted by the State of Tennessee Department of Commerce and Insurance, shall include an income statement addressing the **TennCare Partners Program** operations of the **Contractor**,

3.11.5.1.3 Any extensions for filing the audited financial statements must be approved by the Comptroller of the Treasury rather than by the TDCI Commissioner, and

3.11.5.1.4 The **Contractor** shall ensure that all reports, letters and notifications required by the NAIC Annual Statement Instructions for Annual Audited Financial Reports are submitted to TDCI within the time frames set out in the NAIC Annual Statement Instructions.

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 CONTRACT, this CONTRACT takes precedence. These financial reporting requirements shall supersede any other reporting requirements required of the **Contractor** by the TDCI, and the TDCI shall enact any necessary rule or regulation to conform with this provision of the CONTRACT.

3.11.6 Records Maintenance

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 3.1.12 of this Agreement. Records other than medical

records may be kept in an original paper state or preserved on micro media 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, TDMHDD, OIG, TBI MFCU, DOJ and the HHS OIG, and Comptroller personnel during the Agreement period and five (5) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the Agreement period, these records shall be available at the CONTRACTORS chosen location in Tennessee subject to the approval of TENNCARE and/or TDMHDD. If the records need to be sent to TENNCARE and/or TDMHDD, 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 TDMHDD.

3.11.7 Accessibility of Records for Monitoring

For purposes of monitoring under this CONTRACT, the **Contractor** shall make available to federal, state, and Comptroller of the Treasury personnel authorized by law or otherwise all records, books, documents, and other evidence pertaining to this CONTRACT, as well as appropriate administrative and/or management personnel who administer the plan. The monitoring shall occur periodically during the CONTRACT period and may include announced or unannounced visits, or both.

3.11.8 Changes Resulting from Monitoring and Audit

The **Contractor** shall, as soon as is practical and no later than sixty (60) calendar days after a notice of deficiencies is received, unless justified and agreed upon by **TDMHDD**, comply with all recommendations made in writing by **TDMHDD** consistent with the terms of this CONTRACT, pursuant to CONTRACT items found not in compliance as a result of any day to day monitoring activities or any other authorized monitoring report or audit. A written plan to correct cited deficiencies and a time frame for completion must be submitted to **TDMHDD** by the **Contractor** within thirty (30) working days after receipt of notice of deficiencies. **TDMHDD** may extend or reduce the time frame for corrective action where, in its opinion, it is reasonable and

advisable to do so. The **Contractor** shall be responsible for assuring corrective action when a subcontractor's or provider's quality of care is inadequate**.** **TDMHDD** reserves the right to suspend enrollment in the plan if it is determined that quality of care is inadequate.

In the event the **Contractor** fails to complete the actions required by the corrective action plan within the time frame specified, **TennCare** shall assess the liquidated damages and/or remedies as specified in Section 5 of this CONTRACT. If the deficiencies are severe, **TDMHDD** may terminate the CONTRACT for cause as described in Section 5.1.2 of this CONTRACT.

Any liquidated damages assessed by **TDMHDD** shall be due and payable to **TennCare** within thirty (30) calendar days of notice of damages and if payment is not made by the due date, said liquidated damages may be withheld from future capitation payments by **TennCare** without further notice.

This Section shall apply to any corrective action requirements not otherwise specifically addressed.

3.12 Fiscal Management

3.12.1 General Requirements

The **Contractor** shall be responsible for sound fiscal management of the plan developed under this CONTRACT. The **Contractor** must adhere to the minimum guidelines described below.

3.12.2 Capitation Payments

The **Contractor** agrees to accept the capitation payments remitted by **TennCare** in accordance with Section 4.7 of this CONTRACT. These capitation payments are payment in full for all services provided pursuant to this CONTRACT and for all administrative and management fees and profits of the **Contractor** in providing or arranging for covered services.

3.12.3 Return of Funds

The **Contractor** must return to **TennCare** any overpayments due or funds disallowed under this CONTRACT. Such funds shall be considered **TennCare** funds and shall be refunded to **TennCare**.

The refund shall be due within thirty (30) calendar days after notification to the **Contractor** by **TennCare** unless this deadline is extended by **TennCare** in writing.

3.12.4 Interest

Interest generated through investments made by the **Contractor** of funds paid to the **Contractor** under this CONTRACT shall be the property of the **Contractor** and shall be used at the **Contractor's** discretion.

3.12.5 Third Party Resources

The CONTRACTOR shall be required to seek and collect third party subrogation amounts regardless of the amount available or believed to be available as required by federal guidelines. The amount of provider payments shall be net of third party recoveries captured on the CONTRACTOR'S claims processing system prior to notification of TennCare of the amount paid. The CONTRACTOR shall post all third party payments to claim level detail by enrollee. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall also be retained by the CONTRACTOR. On a monthly basis, the CONTRACTOR shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. Further, the CONTRACTOR shall provide any information necessary in a format and media described by TennCare and shall cooperate as requested by TennCare, with TennCare and/or a Cost Recovery Vendor at such time that TennCare acquires said services.

Failure to seek, make reasonable effort to collect and report third party recoveries shall result in liquidated damages as described in Section 5.3.3 of this Agreement. It shall be the CONTRACTOR'S responsibility to demonstrate, upon request, to TennCare that reasonable effort has been made to seek, collect and/or report third party recoveries. TennCare shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated.

3.12.6 Limitation on Payments to Providers and Subcontractors Related to the Contractor

The **Contractor** shall not pay more for services rendered by any provider or subcontractor related to the **Contractor** than the **Contractor** pays to unrelated providers and subcontractors for similar services. A provider or subcontractor is considered "related" to the **Contractor** if the provider or subcontractor has an "ownership or control interest" or an "indirect ownership interest" in the **Contractor**, or the **Contractor** has an "ownership or control interest" or an "indirect ownership interest" in the provider or subcontractor. The terms "indirect ownership interest," "ownership interest" and "ownership or control interest" shall have the same meaning as set forth in 42 CFR, Sections 455.101 and 455.102.

Any payments made by the **Contractor** that exceed the limitations set forth in this section shall be considered non-allowable "payments for covered services" in calculating any monetary amount required to be returned by the **Contractor** to **TDMHDD** under Section 3.12.3 of this CONTRACT. No later than July 15 of each calendar year, the **Contractor** shall submit (with the information required in Section 3.12.3 of this CONTRACT):

3.12.6.1 a list of all related providers and subcontractors with which the **Contractor** has contracted during the preceding calendar year, and

3.12.6.2 detailed explanation verifying that the payments made to such related providers and subcontractors are not in excess of the amounts allowed by this Section.

3.12.7 Subrogation (Casualty) Recovery

The CONTRACTOR shall conduct diagnosis and trauma code editing to identify potential subrogation related claims. TENNCARE approved questionnaires or other type TENNCARE approved forms shall be used to gather data and information pertinent to potential subrogation cases. TENNCARE shall determine a threshold amount for which a subrogation case should be pursued. The CONTRACTOR shall develop and utilize guidelines which have been approved by TENNCARE to settle subrogation cases. The CONTRACTOR shall submit subrogation recovery guidelines to TENNCARE for review and approval by January 15th each year and prior to subsequent changes thereafter. TENNCARE shall respond to the CONTRACTOR's

request within fifteen (15) calendar days of the CONTRACTOR's submission of the subrogation recovery guidelines.

3.13 Notification of Legal Action Against the Contractor

The **Contractor** shall provide to the Commissioner of **TDMHDD** and to the Deputy Commissioner of the TDCI TennCare Oversight Division, notice in writing by Certified Mail (or other means such as overnight delivery reasonably designed to document delivery) within five (5) business days of the CONTRACTOR being served with any administrative or legal action or complaint filed regarding any claim in law or equity made against the **Contractor** or an affiliate of the CONTRACTOR (including but not limited to a parent company) that would materially impact either such affiliate's ability to operate its business or the CONTRACTOR's performance of duties hereunder. The CONTRACTOR shall also provide similar notice of any arbitration proceedings instituted between a provider and the **Contractor**. It is the intent of the provision that the CONTRACTOR notify TENNCARE of any and all actions described herein that may affect the CONTRACTOR's financial viability and/or program, operations or integrity. Records of persons with serious emotional disturbance or mental illness must be maintained in conformity with Tennessee Code Annotated, §33-3-101.

Records of persons whose confidentiality is protected by 42 CFR Part 2 must be maintained in conformity with that rule or Tennessee Code Annotated, §33-3-103, whichever is more stringent. The **Contractor** shall ensure all tasks related to the provider agreement are performed in accordance with the terms of this CONTRACT.

3.14 Non-Discrimination Compliance

The **Contractor** shall provide instruction on non-discrimination compliance for its staff including, but not limited to, the designated staff person for civil rights, and all direct service subcontractors regarding the procedure. The **Contractor** shall further submit the following to **TDMHDD**:

3.14.1 On an annual basis, a copy of the **Contractor's** personnel policies and other operational policies that, at a minimum, emphasize non-discrimination in hiring, promotional, contracting processes and participation on advisory/planning boards or committees.

3.14.2 On an annual basis, a summary listing totaling the number of supervisory personnel by race/national origin and gender. The **Contractor** is required to request this information from all

Contractor staff. **Contractor** staff response is voluntary. The **Contractor** is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts. Such listing shall separate categories for total supervisory personnel by gender and race/national origin. The race/national origin categories are following: White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin, and other race/national origin.

3.14.3 On an annual basis, a summary listing by Community Services Area of servicing providers which includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race/ethnic origin and shall be sorted by Community Services Area. Each provider type (e.g. physician, dentist, etc.) shall be reported separately within the Community Services Area. Primary care providers shall be reported separately from other physician specialties. The **Contractor** is required to request this information from all providers. Provider response is voluntary. The **Contractor** is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding participation in the **Contractor's** provider network or in determination of compensation amounts.

3.14.4 On a quarterly basis, a listing of all complaints/appeals filed by employees, (when the complaint is related to **TennCare** benefits provided by the **Contractor**) **Enrollees**, providers, and subcontractors in which discrimination is alleged in the **Contractor's TDMHDD** Plan. Such listing shall include, at a minimum, the identity of the complainant, the circumstances of the complaint/appeal, date complaint/appeal filed, the complainant's relationship to the **Contractor**, **Contractor's** resolution, if resolved, and name of **Contractor** staff person responsible for adjudication of complaint/appeal.

3.14.5 On an annual basis, a copy of the **Contractor's** policy, that demonstrates non-discrimination in provision of services to persons with Limited English Proficiency.

3.14.6 On an annual basis, a listing of the interpreter/translator services utilized by the **Contractor** in services to **Enrollees**. The listing shall provide the full name of interpreter/translator services, address of services, phone number of services, hours services are available and be sorted by CSA.

3.14.7 On an annual basis, the **Contractor's** Title VI Compliance Plan and Assurance of Non-discrimination. The signature date of the **Contractors'** Title VI Compliance Plan is to coordinate with the signature date of the **Contractors'** Assurance of Non-Discrimination Compliance.

3.15 Management Information Systems (MIS) Requirements

3.15.1 The **Contractor** shall have comprehensive automated management information systems (MIS) capable of supporting the requirements of this CONTRACT, including, but not limited to the following functions:

3.15.1.1 Eligibility and enrollment;

3.15.1.2 Claims processing;

3.15.1.3 Encounter data submissions;

3.15.1.4 Service authorization and care coordination;

3.15.1.5 Utilization management;

3.15.1.6 Provider network information;

3.15.1.7 TENNderCare tracking;

3.15.1.8 Performance and outcome reporting;

3.15.1.9 Financial reporting;

3.15.1.10 Appeals and complaint processing; and

3.15.1.11 Provider profiling.

3.15.2 The eligibility subsystem must have the capability to receive and process eligibility data from **TennCare** on a daily basis. Eligibility updates shall be loaded within twenty-four (24) hours of receipt from **TennCare.**

3.15.3 The claims processing subsystem must have the capability to process claims in accordance with the requirements specified in Section 3.11.2.

3.15.4 The system must be capable of documenting administrative and clinical procedures while maintaining confidentiality of individual medical information.

3.15.5 The encounter data reporting system should be designed to capture and report individual encounter records, and report all data elements in the form and format specified by **TennCare**, regardless of type of reimbursement arrangement in place with the provider delivering the service.

3.15.6 The **Contractor** shall have internal procedures to ensure that data reported to the **TDMHDD** are valid and to test validity and consistency on a regular basis. The **Contractor** shall also agree to cooperate in data validation activities that may be conducted by **TDMHDD**, at its discretion, by making available medical records, claims records, and a sample of other data according to specifications developed by the **TDMHDD**.

3.15.7 The **Contractor** shall operate a system that tracks TENNderCare activities for each enrolled child by name and identification number and allows the **Contractor** to track the status of the child with respect to behavioral health services.

3.15.8 The system shall include all data necessary to coordinate care, including, but not limited to: client ID number, provider number, treatment plan and treatment goals, progress toward goals, referrals made, services requested and services authorized, period of service authorization, number of units authorized, diagnosis – all axes, any applicable assessment information, eligibility and legal status, reviewer ID, date of request and date of review.

3.15.9 The system shall support care coordination functions, including, but not limited to, TENNderCare compliance, treatment planning, comments from service providers, and resources available from the provider.

3.15.10 The **Contractor's** provider database shall include but not be limited to, licensure status, hospital admitting privileges, if applicable, languages spoken, education and training and board eligibility/certification. Basic demographic information, hours of operations, office locations, telephone numbers, facsimile numbers, and email addresses (if applicable), languages spoken by office staff, status of panel (open,closed0, and malpractice coverage shall also be available.

3.15.11 The **Contractor's** MIS shall have the capacity to produce all reports required pursuant to this CONTRACT.

3.15.12 The **Contractor** shall complete all data mapping necessary to submit information to **TennCare** and respond to information provided by **TennCare**. This will consist of a cross-reference map of required **TennCare** MIS (TCMIS) data and **Contractor** system data elements and data structures. **TennCare** will make any necessary data formats available to the **Contractor.**

3.15.13 The **Contractor's** MIS shall comply with **TennCare** interface standards.

3.15.14 To ensure the security and confidentiality of all transmitted files, the **Contractor** shall establish a dedicated communication line connecting TCMIS to the **Contractor's** processing site. The cost of this communication line is to be borne solely by the **Contractor**. This dedicated communication line must meet the following specifications:

3.15.14.1 All circuits, circuit terminations and supported network options are to be coordinated through Director of Information Services, **TennCare**, 729 Church Street, Nashville, Tennessee 37247-6501.

3.15.14.2 **TennCare** Director of Information Services shall be contacted before placing all line orders.

3.15.14.3 **Contractor** is responsible for providing compatible mode table definitions and NCP configurations for all non-standard system transmissions.

3.15.14.4 **Contractor** is responsible for supplying both host and remote modems for all non-state initiated circuits.

3.15.14.5 Dial-up access into production regions is prohibited.

3.15.15 The **Contractor** shall assist **TennCare** with the analysis and testing of **Contractor's** information systems prior to the delivery of services. The **Contractor** shall respond promptly to all requests from TCMIS during readiness review**.** The **Contractor** must provide system access to allow **TennCare** to test the **Contractor's** system through the **TennCare** network. Any software or additional communications network required for access will be provided by the **Contractor**.

3.15.16 The **Contractor's** claims processing system must perform the following validation edits and audits:

3.15.16.1 Prior Approval – The system must determine whether a covered service requires prior approval, and if so, whether approval was granted by the **Contractor**.

3.15.16.2 Valid Dates of Service – The system must assure that dates of services are valid dates, are no older than one hundred and eighty (180) days from the date of the service and are not in the future.

3.15.16.3 Duplicate Claims – The system must automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate.

3.15.16.4 Covered Service – The system must verify that a service is a valid covered service and is eligible for payment under the **TennCare** benefit package for the **Enrollee's** eligibility group.

3.15.16.5 Provider Validation – The system must approve for payment only those claims received from providers eligible to provide services.

3.15.16.6 Eligibility Validation – The system must confirm the **Enrollee** or **Judicial** for whom a service was provided was eligible on the date the service was incurred and approve for payment only those claims for eligible **Enrollees** and **Judicials**.

3.15.16.7 Quantity of Service – The system must evaluate claims for services provided to **Enrollees** to assure that any applicable maximum lifetime limitations as specified in Section 2.5.1/Table 1 have not been exceeded. The system must deny payment for any services in excess of the maximum lifetime limitations.

3.15.16.8 Rejected Claims – The system must determine whether a claim is acceptable for adjudication and reject claims that are not.

3.15.16.9 Managed Care Organizations (MCOs)– The system must reject claims that should rightly be processed and

paid by an **Enrollee's** MCO for any and all physical health treatments.

3.15.17 The system must assign a unique number to each prior approval request processed. The prior approval number shall be maintained in a database designed by the **Contractor** that will contain all pertinent information about the request and be available to staff responding to provider inquiries. This information will include, but not be limited to: provider, recipient, begin and end dates of service, covered service, and request disposition (i.e., approved or denied).

3.15.18 The **Contractor** must comply with recognized industry standards governing security of state and federal Automated Data Processing systems and information processing. At a minimum, the State requires the **Contractor** to conduct a security risk analysis and to communicate the results in an Information Security Plan provided prior to the delivery of services. The risk analysis will also be made available to appropriate federal agencies.

3.15.19 The system must comply with the following specific security measures:

3.15.19.1 Computer hardware controls that ensure acceptance of data from authorized networks only.

3.15.19.2 At the **Contractor's** central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes.

3.15.19.3 Manual procedures that provide secure access to the system with minimal risk.

3.15.19.4 Multilevel passwords, identification codes or other security procedures that must be used by state agency or **Contractor** personnel.

3.15.19.5 All **Contractor** MIS software changes are subject to **TennCare** approval prior to implementation.

3.15.19.6 System operation functions must be segregated from systems development duties.

3.15.20 The **Contractor** must submit evidence that they have a Business Continuity/Disaster Recovery Plan for their central processing site

for prior approval with the execution of this CONTRACT. **TennCare** has thirty (30) calendar days to respond. If requested, test results of the plan must be made available to **TennCare**. The plan must be able to meet the requirements of any applicable state and federal regulations, the **TennCare** Bureau and Tennessee's Office of Information Resources (OIR).

3.15.21 The **Contractor's** Business Continuity/Disaster Recovery Plan must be submitted to **TennCare** and must include sufficient information to show that the **Contractor** meets the following requirements:

3.15.21.1 Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation must be in the form of a formal Disaster Recovery Plan. The **Contractor** will apply recognized industry standards governing Disaster Preparedness and Recovery including the ability to continue processing in the event that the central site is rendered inoperable.

3.15.21.2 Employees at the site must be familiar with the emergency procedures.

3.15.21.3 Smoking must be prohibited at the site.

3.15.21.4 Heat and smoke detectors must be installed at the site both in the ceiling and under raised floors (if applicable). These devices must alert the local fire department as well as internal personnel.

3.15.21.5 Portable fire extinguishers must be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested.

3.15.21.6 The site must be protected by an automatic fire suppression system.

3.15.21.7 The site must be backed up by an uninterruptible power source system.

3.15.22 Business Continuity and Disaster Recovery (BC-DR) Plan

(a) Regardless of the architecture of its Systems, the CONTRACTOR shall develop and be continually ready to invoke a BC-DR plan

that is reviewed and prior approved by TENNCARE. TENNCARE shall provide guidance to the CONTRACTOR regarding its BC-DR plan in a Standard Operating Procedure.

(b) At a minimum the CONTRACTOR's BC-DR plan shall address the following scenarios: (a) the central computer installation and resident software are destroyed or damaged, (b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (c) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, and (d) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e., causes unscheduled System unavailability.

(c) The CONTRACTOR's BC-DR plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

(d) The CONTRACTOR shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to TENNCARE that it can restore System functions.

(e) The CONTRACTOR shall submit a baseline BC-DR plan to TENNCARE and communicate proposed modifications as required in Section 3.10.20.

3.16 Compliance with Health Insurance Portability & Accountability Act (HIPAA) Requirements

The **Contractor** warrants to the State that it is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this contract. The **Contractor** warrants that it will cooperate with the State in the course of performance of this CONTRACT so that both parties will be in compliance with HIPAA, including cooperation and coordination with state privacy officials and other compliance officers required by HIPAA and its regulations. The **Contractor** will sign any documents that are reasonably necessary to keep the State and **Contractor** in compliance with HIPAA, including but not limited to business associate agreements.

3.16.1 In accordance with HIPAA regulations, the **Contractor** shall, at a minimum, comply with the following requirements:

3.16.2 As a party to this Agreement, the **Contractor** hereby acknowledges its designation as a covered entity under the HIPAA regulations;

3.16.3 The **Contractor** shall comply with the transactions and code set, privacy, and security regulations, once finalized, of the Health Insurance Portability and Accountability Act of 1996 by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations;

3.16.4 The **Contractor** shall transmit/receive from/to its provider, subcontractors, clearinghouses and **TennCare** all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by **TennCare** so long as **TennCare** direction does not conflict with the law;

3.16.5 The **Contractor** shall agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of this CONTRACT and will then take all reasonable steps to cure the breach or end the violation as applicable. If for any reason the **Contractor** cannot meet the requirements of this Section, **TennCare** may terminate this CONTRACT in accordance with Section 5.1;

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

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

3.16.8 The **Contractor** shall report to **TennCare** within five (5) calendar days of becoming aware of any use or disclosure of Protected Health Information in violation of this CONTRACT by the **Contractor**, its officers, directors, employees, subcontractors or agents or by a third party to which the **Contractor** disclosed Protected Health Information;

3.16.9 The **Contractor** shall specify in its agreements that any agent or subcontractor that will have access to Protected Health Information agrees to be bound by the same restrictions, terms and conditions that apply to the **Contractor** pursuant to this Section;

3.16.10 The **Contractor** shall make available to **TennCare Enrollees** the right to amend their Protected Health Information data in accordance with the federal HIPAA regulations. The **Contractor** shall also send information to **Enrollees** educating them of their rights and necessary steps in this regard;

3.16.11 The **Contractor** shall make an **Enrollee's** PHI data accessible to **TennCare** immediately upon request by **TennCare**;

3.16.12 The **Contractor** shall make available to **TennCare** within ten (10) calendar days of notice by **TennCare** any such information in the **Contractor's** possession that 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:

3.16.12.1 the date of disclosure;

3.16.12.2 the name of the entity or person who received the HIPAA protected information, and if known, the address of such entity or person;

3.16.12.3 a brief description of the Protected Health Information disclosed; and

3.16.12.4 a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

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

3.16.13 The **Contractor** shall make its internal policies and procedures, records and other documentation related to the use and disclosure of Protected Health Information available to the Secretary of the Centers for Medicare and Medicaid Services for the purposes of determining compliance with the HIPAA regulations upon request;

3.16.14 The **Contractor** shall create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations;

3.16.15 The **Contractor** shall agree to the return or destruction of all Protected Health Information created or received by the **Contractor**;

3.16.16 The **Contractor** shall implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this CONTRACT;

3.16.17 The **Contractor** shall create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; patients rights to amend, access, request restrictions, and right to file a complaint;

3.16.18 The **Contractor** shall provide an appropriate level of training to its staff and **Enrollees** regarding HIPAA related policies, procedures, **Enrollee** rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter;

3.16.19 The **Contractor** shall be allowed to use and receive information from **TennCare** where necessary for the management and administration of this CONTRACT and to carry out business operations;

3.16.20 The **Contractor** shall be permitted to use and disclose PHI for the **Contractor's** own legal responsibilities;

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

3.16.22 The **Contractor** will continue to protect personally identifiable information relating to individuals who are deceased;

3.16.23 The **Contractor** will be responsible for informing its **Enrollees** of their privacy rights in the manner specified under the regulations;

3.16.24 The **Contractor** must make available protected health information in accordance with 45 CFR § 164.524;

3.16.25 The **Contractor** must make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR §164.526; and

3.16.26 In accordance with HIPAA regulations, **TennCare** shall, at a minimum, adhere to the following guidelines:

3.16.26.1 **TennCare** shall make its individually identifiable health information available to **Enrollees** for amendment and access as specified and restricted under the federal HIPAA regulations.

3.16.26.2 **TennCare** shall set up policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding plan administration and oversight.

3.16.26.3 **TennCare** shall adopt a mechanism for resolving any issues of non-compliance as required by law.

3.16.26.4 **TennCare** shall establish similar HIPAA data partner agreements with its subcontractors and other business associates.

3.17 Confidentiality of Records

Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the **Contractor** by the State or acquired by the **Contractor** on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and

federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information 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 applicable state and federal law, state and federal rules and regulations, **TDMHDD** departmental policy, and ethical standards.

The **Contractor's** obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the **Contractor** of this CONTRACT; previously possessed by the **Contractor** without written obligations to the State to protect it; acquired by the **Contractor** without written restrictions against disclosure from a third party which, to the **Contractor's** knowledge, is free to disclose the information; independently developed by the **Contractor** without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit **Contractor** to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the **Contractor** due to intentional or negligent actions or inactions of agents of the State or third parties. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this CONTRACT.

3.18 Transition to the Contractor

3.18.1 Implementation

The **Contractor** shall:

3.18.1.1 Develop and submit to **TDMHDD** for approval, immediately after notification of the CONTRACT award, a detailed work plan and timeline for performing the obligations set forth in the CONTRACT.

3.18.1.2 On a weekly basis after notification of the CONTRACT award and until the service start date, provide **TDMHDD** with updates to the initial work plan and timeline, identifying adjustments that have been made to either, and describing the **Contractor's** current state of readiness to perform all CONTRACT obligations.

3.18.1.3 Submit to **TDMHDD** all deliverables that must be in place by the times specified in this CONTRACT.

3.18.1.4 Ensure that all workplace requirements specified in the CONTRACT and deemed necessary by **TDMHDD** to perform the requirements in the CONTRACT, are in place and operative as of the service start date.

3.18.1.5 Establish its provider network and execute provider agreements with such providers, all in accordance with the provisions set forth in the CONTRACT prior to the service start date.

3.18.2 Provide Adequate Assurances

After notification of the CONTRACT award, from time to time at the request of **TDMHDD**, **Contractor's** Executive Officers shall provide adequate written assurances concerning preparation to perform the CONTRACT obligations, completion of the elements of the transition plan, or completion of the elements of the work plan.

SECTION 4. TDMHDD RESPONSIBILITIES

4.1 General Responsibilities

TDMHDD shall be responsible for monitoring and oversight of this CONTRACT. Such monitoring and oversight shall be conducted in good faith with the best interests of all **Enrollees**, the State and the citizens it serves being the prime consideration.

TDMHDD may delegate or authorize other parties in writing to perform any of the services or functions specified in this CONTRACT as being the responsibility of **TDMHDD**. **TDMHDD** may, upon written notice to the **Contractor**, delegate or authorize the services or functions to be performed by another party.

4.2 Interpretations

Any dispute between the **Contractor** and **TDMHDD** concerning the clarification, interpretation and application of any provision of this CONTRACT or any federal and state laws and regulations governing, or in any way affecting, this CONTRACT shall be resolved by **TDMHDD**. When a clarification, interpretation and application is required, the **Contractor** will submit written requests to **TDMHDD**. **TDMHDD** will contact the appropriate agencies in responding to the request. Any clarifications received pursuant to requests for clarification or interpretation shall be forwarded upon receipt to the **Contractor**. Nothing in this Section shall be construed as a waiver by the **Contractor** of any legal right it may have to contest the findings of either the state or federal governments or both as they relate to the clarification, interpretation and application of this CONTRACT or of any statute, regulation, and/or policy.

4.3 Eligibility and Enrollment

TDMHDD and **TennCare** shall be responsible for verifying the eligibility, enrollment and, disenrollment of **Enrollees** from the **Contractor's** plan.

4.3.1 TennCare Enrollees

TennCare shall be responsible for verifying the eligibility of all **TennCare Medicaid** and **TennCare Standard Enrollees** and for assigning them to and disenrolling them from the **Contractor's** Plan.

TDMHDD shall be responsible for determining the eligibility of all non-**Enrollees** in the **TennCare Partners Program.** All such persons must first have applied for **TennCare** benefits and been denied or not yet approved for enrollment by **TennCare** on the basis of eligibility for **TennCare Medicaid** or **TennCare Standard**. **TDMHDD** shall be responsible for enrolling these persons in the **TennCare Partners Program**. **TennCare** shall be responsible for assigning these persons to a BHO.

4.3.2 Judicials

TDMHDD shall be responsible for temporarily assigning all **Judicials** to the **Contractor's** plan. In the event a **Judicial** is referred by a court of competent jurisdiction, the referral shall be construed as if the referral was a temporary assignment by **TDMHDD**. The **Contractor** shall be responsible only for the services as prescribed under the terms of this CONTRACT or as required by the statute or court order under which the **Judicial** was referred. The preceding sentence notwithstanding, the **Judicial** shall not be considered as an **Enrollee** in the **Contractor's** plan.

Except for **Judicials**, **TennCare** shall arrange for the **Contractor** to have daily updated eligibility information in the form of on-line computer access. **TennCare** shall also arrange for the **Contractor** to receive a daily list of all the **Enrollees** who become ineligible or disenrolled from the **Contractor's** plan or who have been determined to have moved out of the State of Tennessee.

4.4 Approval Process

At any time that approval of **TDMHDD** is required in this CONTRACT, such approval shall not be considered granted unless **TDMHDD** issues its approval in writing. Should **TDMHDD** not respond in the required amount of time, as set forth in Attachment F, 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 **TDMHDD** to assess liquidated damages or withholds shall not preclude **TDMHDD** from requiring the **Contractor** to rescind or modify the "item" if it is determined

by **TDMHDD** to be in the best interest of the **TennCare Partners Program**. Material requiring **TDMHDD** approval includes, at a minimum, the following:

4.4.1 The **Contractor's** provider network and any additions and deletions;

4.4.2 In accordance with Section 3.4, all materials to be used in educating or communicating with existing **Enrollees**;

4.4.3 The **Contractor's** *pro forma* agreement(s) with providers and any amendments thereto;

4.4.4 Any subcontracts which may be proposed for any services other than the services and benefits provided to **Enrollees**;

4.4.5 Appeal procedures;

4.4.8 Reporting templates and procedures;

4.4.9 Indemnity language in provider agreements if different from the standard indemnity language found in Section 6.12 of this CONTRACT or the *pro forma* agreements which are reviewed in accordance with Section 4.4.3 above;

4.4.10 Quality Assurance/Quality Improvement procedures, including utilization management criteria and credentialing criteria;

4.4.11 Focused clinical study topics;

4.4.12 Fraud and Abuse Compliance Plan;

4.4.13 Insurance and bonding plans;

4.4.14 Disaster Recovery Plan;

4.4.15 Transition Plan in accordance with Section 5.1.3.1.

4.5 Inspections and Monitoring

4.5.1 Facility Inspection

TDMHDD, **TennCare**, TDCI, CMS, or any agents of these agencies 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 CONTRACT. Inspections may be made at any time during the term of this CONTRACT and without prior notice.

4.5.2 Monitoring

TDMHDD, in its daily activities, shall monitor the **Contractor's** health plan for compliance with the provisions of this CONTRACT. Further, **TDMHDD**, CMS, or their agents shall at least annually monitor the operation of the **Contractor** for compliance with the provisions of this CONTRACT and applicable federal and state laws and regulations. Such monitoring activities shall include, but are not limited to, inspection of **Contractor's** facilities, auditing and/or review of all records developed under this CONTRACT including periodic medical audits, appeals, enrollments, disenrollments, termination, utilization and financial records, reviewing management systems and procedures developed under this CONTRACT and review of any other areas or materials relevant to or pertaining to this CONTRACT. The State, at its discretion, may contract with an independent evaluator to determine the accuracy and conformity to **TDMHDD** policies and procedures of CRG/TPG assessments. Because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes, emphasis will be placed on case record validation during periodic monitoring visits to project sites. The monitoring agency shall prepare a report of its findings and recommendations and require the **Contractor** to develop corrective action plans as appropriate.

4.6 Responses to Enrollees

4.6.1 Appeals

TennCare shall establish and maintain an informal review process and formal appeal procedures whereby, any **Enrollee** or anyone authorized to act on their behalf may grieve or appeal an adverse action by the **Contractor** in accordance with Section 3.3. The **Contractor** specifically acknowledges, in accordance with 1200-13-13-.11 AND 1200-13-14-.11 of the **TennCare** Rules of TDFA, it is bound by the decision of **TennCare**, whether as the result of an informal review or formal appeal, and shall not appeal any decision rendered by **TennCare**.

4.6.2 Consumer Affairs

TDMHDD shall maintain an Office of Consumer Affairs in order to respond to **Enrollee** inquiries and complaints.

4.7 Payment Terms and Conditions

4.7.1 Maximum Liability and Allocation of Funds to this Contract

This CONTRACT is subject to appropriation and availability of State and federal funds. In no event shall the maximum liability of the State for the T**ennCare Partners Program** in the East Grand Region exceed One Hundred Fifty Million Dollars ($150,000,000.00) for the contract period of July 1, 2007 through June 30, 2008. In the event the participant enrollment is greater than the projected enrollment used to develop the maximum liability, TDMHDD will pay the Contractor for each Enrollee at per member per month rate in Section 4.7.2. The State reserves the right in its sole, absolute and unfettered discretion to equitably allocate the total available funds for payment for services under this CONTRACT from the total State and federal sums available for the payment for services in the entire State. The State shall notify Contractor of any changes in funding or any changes in the allocation of funding as soon as possible. If the CONTRACT 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 determined by the independent actuarial analysis under contract with the State pursuant to Section 4.7.2, or there is a reduction in the total available funds for the payment of services under this CONTRACT, the State and the **Contractor** shall negotiate in good faith to reduce CONTRACT expenditures to the CONTRACT maximum level or the State shall adjust the CONTRACT maximum liability to accommodate the aforementioned circumstances in consultation with the independent actuary. In the event of a reduction in available funds or increase in expected costs due to enrollment growth or shift, the State and the Contractor shall negotiate in good faith to adjust the range of covered services in lieu of an increase in funding. Such required benefit adjustments will be developed in consultation with the independent actuary. This CONTRACT 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 otherwise available but not allocated by the State to this CONTRACT. In no event shall the maximum liability of the State

under this CONTRACT exceed the **Contractor's** allocated portion of the total available State and federal funds as determined by the State.

The **Contractor** is not entitled to be paid the maximum liability for any period under the CONTRACT or any extensions of the CONTRACT. The maximum liability represents available funds for payment to the **Contractor** and does not guarantee payment of any such funds to the **Contractor** under this CONTRACT. The **Contractor** shall be paid in accordance with the rates detailed herein.

The payments as calculated under Section 4.7.2 section shall constitute the entire compensation due the **Contractor** for the service and all of the **Contractor's** obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, profit, and all other direct and indirect costs incurred or to be incurred by the **Contractor**.

The payments specified in Section 4.7 of this Agreement, as amended, shall represent payment in full. TennCare shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as a Prepaid Limited Health Service Organization in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at Tennessee Code Annotated *§ 56-32-201* et seq. or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at Tennessee Code Annotated § 56-51-101 et seq. or any subsequent amendments thereto.

4.7.2 Payment Methodology

The **Contractor** shall be compensated based on the rates herein for the payment rate categories authorized by the State. Payments shall be subject to withholds as set forth in the Agreement. The rates in Table 3 shall be applicable from January 1, 2006 through June 30, 2006.

The rates in the Table 1 shall be applicable from July 1, 2004 through June 30, 2005. They shall also be applicable for the period July 1 – 31, 2005.

Table 1: Rates

PAYMENT RATE CATEGORY	PER MEMBER/ PER MONTH RATE
Priority Population age 0-12	$319.35
Priority Population age 13-17	$437.07
Priority Population age 18 and above	$228.15
Non-Priority Population age 0-12	$4.72
Non-Priority Population age 13-17	$22.55
Non-Priority Population age 18 and above	$6.09

The Rates in Table 2 shall be applicable from August 1, 2005 through December 31, 2005.

Table 2: Rates

PAYMENT RATE CATEGORY	PER MEMBER / PER MONTH RATE
Priority Population age 0-12	$296.41
Priority Population age 13-17	$403.47
Priority Population age 18 and above	$226.63
Non-Priority Population age 0-12	$3.05
Non-Priority Population age 13-17	$20.35
Non-Priority Population age 18 and above	$6.06

These rates include the nine- percent (9%) administrative fees and the two- percent (2%) premium taxes.

Table 3: Rates

PAYMENT RATE CATEGORY	PER MEMBER/ PER MONTH RATE
Priority Population age 0-12	$301.84
Priority Population age 13-17	$411.78
Priority Population age 18 and above	$232.86
Non-Priority Population age 0-12	$3.11
Non-Priority Population age 13-17	$20.85
Non-Priority Population age 18 and above	$6.45

The Contractor shall be compensated based on the rates herein for the payment rate categories authorized by the State. Payments shall be subject to withholds as set forth in the CONTRACT. The rates in the Table 4 shall be applicable from July 1, 2006 through June 30, 2007.

Table 4: Rates:

PAYMENT RATE CATEGORY	PER MEMBER/ PER MONTH RATE
Priority Population age 0-12	302.57
Priority Population age 13-17	430.61
Priority Population age 18 and above	243.26
Non-Priority Population age 0-12	2.84
Non-Priority Population age 13-17	17.47

Non-Priority Population age 18 and above	4.94
State Only & Judicials	285.73

The Contractor shall be compensated based on the rates herein for the payment rate categories authorized by the State. Payments shall be subject to withholds as set forth in the CONTRACT. The rates in Table 5 shall be applicable from September 1, 2006 through July 31, 2007.

Table 5: Rates:

PAYMENT RATE CATEGORY	**PER MEMBER/ PER MONTH RATE**
Priority Population age 0-12	$304.82
Priority Population age 13-17	$434.19
Priority Population age 18 and above	$244.96
Non-Priority Population age 0-12	$2.86
Non-Priority Population age 13-17	$17.63
Non-Priority Population age 18 and above	$4.98
State Only & Judicials	$287.41

The Contractor shall be compensated based on the rates herein for the payment rate categories authorized by the State. Payments shall be subject to withholds as set forth in the CONTRACT. The rates in Table 6 shall be applicable from August 1, 2007 through October 31, 2007.

Table 6: Rates:

BHO Rate Ceiling PMPM August 1, 2007 – October 31, 2007

Age Group	*Priority*	*Non-Priority*	*State Only & Judicials*
0 – 13	***$259.84***	***$3.88***	***$56.79***
14 – 18	***$322.93***	***$18.52***	***$293.22***
19 – 20	***$164.10***	***$6.42***	***$209.67***
21 and over	***$248.55***	***$6.31***	***$266.85***

If the CONTRACT is extended for an additional period or periods in accordance with Section 6.18 of this CONTRACT, the **Contractor** shall be compensated based upon the payment rate categories detailed above subject to adjustment as determined by annual independent actuarial analysis and subject to State appropriations.

TennCare shall make monthly payments to the **Contractor** for its satisfactory performance and provision of covered services under this CONTRACT. Each payment shall be paid on or before the fifth (5th) business day of each month. Each monthly payment to the **Contractor** shall be equal to the number of **Enrollees** residing in the **Contractor's** plan as assigned to six (6) categories, multiplied by the appropriate rates for the **Enrollee** categories as set out below. These payments shall be less any adjustments which may include set-offs, withholds for penalties, damages, liquidated damages, or adjustments based upon a change of **Enrollee** status or partial takeover as provided under any section of this CONTRACT. Payment adjustments shall be accomplished through the monthly payment reconciliation process. Each payment shall be calculated as follows:

4.7.2.1 Counting Enrollees

For the period beginning with the service start date, and each month thereafter, **TennCare** will calculate the number of **Enrollees** in the **Contractor's** Grand Region. For assignment to a **Contractor's** plan for payment purposes only, an **Enrollee's** residence shall be conclusively

determined to be the region of residence recorded in the **TennCare** eligibility system at the time the capitation payment is calculated and the capitation payment shall not be retroactively adjusted to reflect a different region of residence. This provision is applicable only for determination of applicable rate payment and is not applicable to any other consideration, such as applicable plan or duration of enrollment in any plan.

4.7.2.2 Payment Rate Category

TennCare will determine the appropriate capitation payment rate category to which each **Enrollee** is assigned for payment purposes under this CONTRACT.

The payment amount owed the **Contractor** for each **Enrollee** shall be determined by dividing the appropriate capitation rate category by the number of days in the month and then multiplying the quotient of this transaction by the number of days the enrollee was enrolled in the plan.

4.7.2.2.1 Payment Rate Category Assignment

TennCare's assignment of an **Enrollee** to a capitation payment rate category is for payment purposes under this CONTRACT, only, and is not an "adverse action" or determination of the benefits to which an **Enrollee** is entitled under **the TennCare Partners Program**, **TennCare** Rules, policies and procedures, the **TennCare** Waiver or relevant court orders.

4.7.2.2.2 Payment Rate Category Adjustment For Non-Utilizers of Services

Enrollees who are priority participants as defined in this CONTRACT, who have not received behavioral health services as reported pursuant to Section 3.10.4 and Attachment D of this CONTRACT (excluding a CRG/TPG Assessment), within the preceding twelve (12) months from the date of the calculation of the monthly payment, or who have not had a CRG/TPG assessment within the preceding twelve (12) months from the date of the

calculation of the monthly payment, shall be assigned to a non-priority population rate category for payment purposes under this CONTRACT.

4.7.2.3 Retroactive Adjustments Due to Enrollee Status

Except as set forth in Section 4.7.2.1, 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** or to accurately reflect payments that should have been made.

4.7.2.3.1 Should **TennCare** determine after the capitation payment is made that an **Enrollee's** capitation rate category had changed or the **Enrollee** was deceased, **TennCare** shall retroactively adjust the payment to the **Contractor** to accurately reflect the **Enrollee's** capitation rate category for the period. **TennCare** shall retroactively adjust the payment to the **Contractor**, not to exceed twelve (12) months. **TennCare** and the **Contractor** agree that the twelve (12) month limitation described in this paragraph is applicable only to retroactive capitation rate payment adjustments and shall in no way be construed as a determination of the effective date of eligibility or enrollment in the **Contractor's** plan.

4.7.2.4 With respect to any **Enrollee** with a retroactive effective date of enrollment that precedes the start date of **Contractor's** obligation to provide services under this agreement **TennCare** shall not include in any calculation to determine a payment due to **Contractor** or any adjustment, any time or condition that precedes the start date of **Contractor's** obligation to provide services under this CONTRACT. **Contractor** shall not be at risk for the payment of behavioral health services incurred by an enrollee during a retroactive eligibility period prior to the service start of this CONTRACT; however, the **Contractor** agrees to process claims and reimburse providers for services incurred during said retroactive period in accordance with the requirements of this CONTRACT. The **Contractor** shall be entitled to an administrative fee equal to six percent (6%) of the value of claims paid as reimbursement for administrative expenses associated with this function. The **Contractor** agrees to

reconcile capitation payments made for retroactive periods of eligibility prior to the service start date under this CONTRACT, reduced by the amount of the allowed administrative expenses and applicable taxes, to actual expenditures for behavioral health services incurred prior to the service start date under this CONTRACT within ninety (90) days of the end of each calendar year. Actual expenditures for behavioral health services and the allowed amount for administrative expenses are subject to Tennessee Code Annotated 56-51-152. The **Contractor** is responsible for any payments required pursuant to Tennessee Code Annotated 56-51-152. The **Contractor** and **TennCare** shall mutually agree upon the form and format of the reconciliation. To the extent that actual expenditures for behavioral health services exceed total capitation payments reduced by the allowed amount for administrative expenses and applicable taxes for the retroactive period, **TennCare** will pay the difference to the **Contractor** within thirty (30) days of receipt of the reconciliation. To the extent that actual expenditures for behavioral health services were less than the total capitation payments reduced by the allowed amount for administrative expenses and applicable taxes for the retroactive period, the **Contractor** agrees to pay the difference to **TennCare** within thirty (30) days of completion of the reconciliation.

4.7.2.5 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 appropriate cost-sharing schedules in effect on the date of service for which reimbursement is sought.

4.7.3 Performance Incentives

Performance incentives may be paid to the **Contractor**, dependent on state appropriations and at the discretion of **TennCare** and **TDMHDD**. The three (3) areas in which performance incentives may be available are as follows:

4.7.3.1 increase in community tenure with a focus on adults discharged from inpatient psychiatric facilities who are identified as SPMI;

4.7.3.2 a reduction in re-hospitalization rates for adults identified as SPMI; and

4.7.3.3 an increase in the rate of mental health assessments for children at risk of serious emotional disturbance.

4.7.4 Cash Flow Withholds, Retention of Cash Flow Withholds and Permanent Withholds

As an additional incentive for compliance with the terms and conditions of this CONTRACT, there is established this system of cash flow withholds and retention. The amount due for the first monthly payment, and for each month thereafter, calculated pursuant to Section 4.7.2 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. 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 CONTRACT.

4.7.4.1 Except as further provided below, the applicable cash flow withhold percentage amount shall be ten percent (10%) (which shall be the maximum cash flow withhold percentage amount) for the first six months following the service start date, and for any consecutive six-month period following **Contractor's** receipt of a notice of compliance deficiency correction as described in Section 4.7.4.5. If, during any consecutive six (6) month period following the service start date, the **Contractor** shall not have received a notice of compliance deficiency as described in Section 4.7.4.5, the cash flow withhold percentage amount shall be reduced to five percent (5%). If, during any consecutive six (6) month period following a reduction of the monthly cash flow withhold amount to five percent (5%), the **Contractor** shall not have received a notice of compliance deficiency as described in Section 4.7.4.5, and shall not have been assessed any liquidated damages, the cash flow withhold percentage amount shall be reduced to two and one-half percent (2.5%).

4.7.4.2 **Contractor** shall receive a notice of compliance deficiency as described in Section 4.7.4.5, below, the applicable cash flow withhold percentage amount shall not be decreased and it shall be the maximum cash flow withhold percentage amount.

4.7.4.3 The State may retain monthly cash flow withhold amounts

attributed to the month following **Contractor's** receipt of the notice of compliance deficiency and shall not distribute such sums retained for so long as the compliance deficiencies described in any notice of compliance deficiency for that month shall continue and shall not have been corrected and acknowledged in a notice of compliance deficiency correction.

4.7.4.4 Except as provided below, upon receipt of a notice of compliance deficiency correction as described in Section 4.7.4.5, retained cash flow withhold amounts attributed to one or more notices of compliance deficiency referred to in the notice of correction shall be distributed to the **Contractor** in the next following regular monthly payment, provided there are no other outstanding notices of compliance deficiency that have not been corrected, except for the regular cash flow withhold amount at the appropriate withhold percentage amount as calculated in Section 4.7.4.2.

4.7.4.4.1 The monthly cash flow withhold amount shall be the maximum monthly cash flow withhold amount, following any notice of compliance deficiency set out in Section 4.7.4.5 and may not be reduced until the **Contractor** shall have maintained six (6) consecutive months without a notice of compliance deficiency as described in Section 4.7.4.5.

4.7.4.4.2 Any monthly retained cash flow withhold amount that is retained for six (6) months, counting the first month after the **Contractor** shall have received a notice of compliance deficiency as cause for retention of the next monthly cash flow withhold amount as the first month, may, in the discretion of the State, be declared a permanent withhold ineligible for future distribution and shall not be paid to the **Contractor**, in addition to any other remedies available to the State.

4.7.4.5 Notices

4.7.4.5.1 Notice of Compliance Deficiency

No monthly cash flow withhold amount may be

retained by the State unless the **Contractor** shall receive a written notice in advance, as stipulated by Section 4.7.4.4.2, of the payment day. The notice shall be titled "notice of compliance deficiency and cause for retention of monthly cash flow withhold amount" and shall specify compliance deficiencies that must be corrected before the State will distribute the monthly cash flow withhold amount as set out in Section 4.7.4.

4.7.4.5.2 Notice of Compliance Deficiency Correction

Upon acceptance of **Contractor's** correction of the deficiency or deficiencies subject of a notice of compliance deficiency described above, the State shall provide to **Contractor** a notice to acknowledge its acceptance of the **Contractor's** action, and authorization of distribution of any retained monthly cash flow withhold amount associated with the notice of compliance deficiency. If there are no other outstanding notices of compliance deficiency, the next monthly regular payment to **Contractor** following the date of this notice shall be counted as the first month for purposes of determining the six (6) month periods described in Section 4.7.4.1.

4.7.4.6 Compliance deficiencies that may cause the State to retain a monthly cash flow withhold may be based upon **Contractor's** non-compliance with any provision of this CONTRACT including but not limited to deficient performance of the following terms and conditions:

4.7.4.6.1 The requirements of Section 2.5, as they relate to provision of covered services;

4.7.4.6.2 The requirements of Sections 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.8, 3.15 and 5.1.2.10;

4.7.4.6.3 The Quality Monitoring and Quality Improvement Program, as referenced in Section 3.9 and Attachment C;

4.7.4.6.4 The Records and Reporting Requirements, specified in Section 3.10;

4.7.4.6.5 The **TennCare** Waiver, any applicable amendments thereto, and any Special Terms and Conditions imposed upon the **TennCare** Waiver or any amendments thereto.

4.7.5 Other Payment Adjustments

The failure of **TennCare** to make any of the following payment adjustments, which are in addition to the amount(s) withheld in accordance with Section 4.7.2, shall not prejudice **TDMHDD's** right or in any way prevent **TennCare** from making the adjustment(s) at any future date.

4.7.5.2 Liquidated Damages

TennCare may reduce payments to the **Contractor** by the amount of any liquidated damages not received from the **Contractor** by **TennCare** on or before the date the liquidated damages are to be paid. **TennCare**, at its discretion, may withhold from any later payments due the **Contractor** any subsequent liquidated damages payable to **TennCare**. (See Section 5 of this CONTRACT.)

4.7.5.3 Actual Damages

TennCare may reduce payments to the **Contractor** by the amount of actual damages, including incidental and consequential damages, resulting from any breach of this CONTRACT by the **Contractor**. (See Section 5 of this CONTRACT.)

4.7.5.4 Cost of Partial Breach

TennCare may reduce payments to the **Contractor** by the amounts determined in accordance with Section 5.2.3.7 of this CONTRACT.

4.7.5.5 Amounts Due State

TennCare may withhold from any payment due the **Contractor** any other amounts due the State by the

Contractor, including but not limited to, any amount due **TDMHDD** or **TennCare** as the result of any state or federal audit or examination of the **Contractor**.

Any adjustments made pursuant to Section 4.7.5 and amounts owed to **TDMHDD** or **TennCare** as damages or as cost to cure a breach or provide any defaulted services shall not be counted in determining the percentage of the capitation payments paid for the provision of covered services and payment of premiums tax in accordance with Section 3.12.2.

4.7.6 Changes in Scope of Services

If significant changes are made in the scope of services, including but not limited to both covered services and administrative requirements, under the **TennCare Partners Program**, as mandated by court orders or actions of the Congress, the State, the State Legislature, CMS, DHHS or any agency of the State government, **TDMHDD** shall review and adjust the capitation amount accordingly as determined by an independent actuarial analysis under contract with the State, subject to the availability of State appropriations for the mandate. In the event that the proposed adjustment as determined by the independent actuarial analysis would cause the CONTRACT maximum to be exceeded, **TDMHDD** and the **Contractor** shall negotiate in good faith changes in the scope of services to offset the additional costs incurred as a result of these changes. The State shall notify **Contractor** as soon as possible in advance of any such changes and shall seek the prior approval of CMS.

4.7.7 Required Certification of Data and Documents

Documents and data submitted to the State under Section 3.10 of this CONTRACT must be certified in accordance with federal requirements of 42 CFR 438.602, et seq. and this section as follows*:*

4.7.7.1 Any documents or data that are required to be submitted to the State by the **Contractor** under this CONTRACT, including but not limited to data which contains or consists of enrollment information or encounter data must be certified in conformity with this subsection;

4.7.7.2 Each time a required document or data is submitted it must be accompanied by a concurrent, original written certificate, unless an appropriate alternate electronic certification procedure is agreed upon in advance; and

4.7.7.3 The data must be certified by any one of the following: the **Contractor's** Chief Executive Officer, the Chief Financial Officer, or an individual who reports directly to either of those officers and who has been identified in a prior written notice to **TDMHDD**, as a person possessing delegated authority to sign for either of those officers; and

4.7.7.4 The certificate must be in substantially the following form: "I, _____, do hereby attest that, based upon the best of my knowledge, information and belief, the _____ [document/data] submitted herewith is accurate, complete and truthful.

4.7.8 Crisis Toll Free Number

The Contractor shall operate a statewide toll free number for adult crisis services. The toll free number service shall include the Middle Tennessee Grand Region and the Contractor shall be reimbursed $25,000 for the period April 1, 2007 through June 30, 2007. In the event the Middle Tennessee Grand Region census increases above 2,300,000 citizens, based on the United States Census Bureau reports, the Contractor shall receive an additional five-percent (5%) payment for each additional 100,000 individuals. In the event the Middle Tennessee Grand Region census decreases below 2,200,000 citizens, based on the United States Census Bureau reports, the Contractor's payment shall be reduced by five-percent (5%) for each reduction of 100,000 individuals.

4.8 TDMHDD Financial Responsibility

Notwithstanding any provision in this CONTRACT to the contrary, **TDMHDD** and **TennCare** shall be solely responsible to the

Contractor for the amount described herein and in no event shall **TDMHDD** or **TennCare** be responsible, either directly or indirectly, to any subcontractor, provider or any other party who may provide the services described herein or otherwise.

SECTION 5. REMEDIES

5.1 Termination

In the event of the termination of this CONTRACT, either at the expiration and non-renewal of this CONTRACT or as an early termination prior to the expiration of this CONTRACT, neither party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred under this CONTRACT prior to the effective date of such early termination. The **Contractor** shall also not be relieved of its responsibilities for payment or appropriate denial of payment for all services provided to **Enrollees** in accordance with this CONTRACT and the provider agreements. **TDMHDD** or **TennCare** shall have no responsibilities for any liabilities incurred by the **Contractor** which arise as a result of its performance under this CONTRACT.

5.1.1 Termination Procedure

Written notice may be given in the case of the expiration and non-renewal of this CONTRACT and shall be given in the case of the early termination of this CONTRACT. The notice shall be to the person designated in accordance with Section 1.2. In the event the notice does not comply with the terms of this CONTRACT, the notice shall still be effective in all respects; however, **Contractor** may request clarification of the notice, and such request shall not affect the effectiveness or date of the notice.

5.1.1.1 Notice of Expiration and Non-Renewal

In the event of the expiration and non-renewal of this CONTRACT, **TDMHDD** may cause to be delivered to the **Contractor** a written Notice of Expiration and Non-Renewal. The Notice of Expiration and Non-Renewal shall include the last date of operations and may specify or otherwise include any requirements, consistent with Section 5.1.3, which are or are not to be imposed. The Notice of Expiration may be utilized if in the judgment of **TDMHDD** Sections 5.1.3.1.1 through 5.1.3.1.3 should be

exercised or Section 5.1.3.2 is deemed applicable.

5.1.1.2 Notice of Termination

In the event of an early termination of this CONTRACT, including the non-renewal of this CONTRACT, 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 or otherwise include the date of the Notice of Termination, the effective date of the early termination, cite the provision of this CONTRACT giving the right to terminate, the circumstances giving rise to termination, and any conditions of the termination, not inconsistent with the terms of this CONTRACT. In the event of termination for any reason, **TDMHDD** shall have the option of requiring the performance of the requirements of Section 5.1.2 (or their written waiver) or imposing any conditions of early termination not inconsistent with this CONTRACT.

5.1.2 Requirements of Termination

Upon receipt of notice of termination or non-renewal, and subject to the provisions of this Section, on the date and to the extent specified in the notice of termination and as directed by the State in the event of non-renewal, the **Contractor** shall:

5.1.2.1 Stop work under this CONTRACT in whole, or in part, immediately or in stages, but not until the date specified in the Notice of Termination;

5.1.2.2 Enter into no further subcontracts or provider agreements, except as necessary for the **Contractor** to fulfill its obligations under this CONTRACT as of the effective date of the termination;

5.1.2.3 At the request of **TDMHDD**, assign to **TDMHDD** or its designee, in the manner and to the extent required by **TDMHDD**, all rights, title and interest of the **Contractor** for the performance of the subcontracts to be determined at need, in which case **TDMHDD** or its designee shall have the right, at its discretion, to settle or pay any of the claims arising out of the continuation of and the termination of

such subcontracts and provider agreements;

5.1.2.4 If not otherwise required under Section 5.1.3, complete performance under this CONTRACT, or in the case of an early termination, to the extent required under the Notice of Termination;

5.1.2.5 Prior to the submission of a final invoice, settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts and provider agreements;

5.1.2.6 In the event the CONTRACT is terminated by **TDMHDD**, the **Contractor** shall continue to serve or arrange for provision of services to all **Enrollees** in the plan for up to sixty (60) calendar days from the CONTRACT termination date or until the **Enrollees** can be transferred to another contractor, whichever is longer. During this transition period, **TennCare** shall continue to pay the applicable capitation rate(s) as described in Section 4.7 of this CONTRACT;

5.1.2.7 Take such action as may be necessary, or as **TDMHDD** may direct, for the protection of property related to this CONTRACT which is in possession of the **Contractor** and in which **TDMHDD** has or may acquire an interest;

5.1.2.8 Promptly make available to **TDMHDD**, or to such other party as **TDMHDD** shall designate, any and all records, whether medical or financial, related to the provision of services to or on behalf of the **Enrollee**; such records shall be in a form which, at the sole discretion of **TDMHDD**, is usable by the party to whom the records are sent; such records shall be provided at no expense to **TDMHDD**;

5.1.2.9 Promptly provide all information necessary to **TDMHDD** or another **Contractor** acting on behalf of **TDMHDD** for reimbursement of any outstanding claims at the time of termination; such records shall be provided at no expense to **TDMHDD**;

5.1.2.10 Submit a termination plan to **TennCare** for review, which is subject to **TennCare** approval. This plan must, at a minimum, contain the provisions in Sections 5.1.3 and 6.16, as appropriate. The **Contractor** shall agree to make

revisions to the plan as necessary in order to obtain approval by **TennCare;** and

5.1.2.11 In order for a terminated or partially terminated **Contractor** to resume providing terminated services, said terminated **Contractor** shall execute an entirely new application to participate in the **TennCare Program** and shall execute a new CONTRACT.

5.1.3 Continuity of Services

The **Contractor** expressly acknowledges the services provided under this CONTRACT must be continued without interruption and, upon expiration or the early termination of this CONTRACT, a successor, either an agency of the State of Tennessee or another **Contractor**, may continue such services. The **Contractor** agrees to cooperate with any successor to effect an orderly and efficient transition to a successor.

5.1.3.1 Unless written notice to the contrary is received from **TDMHDD**, the **Contractor** agrees to the following:

5.1.3.1.1 The **Contractor** shall negotiate in good faith a Transition Plan with a successor to determine the nature and extent of the services to be provided by the successor and the **Contractor**. The Transition Plan shall be subject to the approval of **TDMHDD**. If **TDMHDD** does not approve the Transition Plan, or if the parties cannot agree to the terms and conditions of the Transition Plan within fifteen (15) calendar days following the date of the Notice of Termination or the Notice of Expiration, or any other time period specified in writing by **TDMHDD**, **TDMHDD** shall determine the terms and conditions of the Transition Plan. The **Contractor** and the successor, as affirmed under this CONTRACT, expressly agree to abide by the terms and conditions of the Transition Plan as determined by **TDMHDD**.

5.1.3.1.2 The **Contractor** shall retain and make available sufficient qualified and experienced personnel during the transition period to ensure the terms and conditions of this CONTRACT and of the

Transition Plan are met.

5.1.3.1.3 The **Contractor** shall provide and continue to perform such services which are not inconsistent with the terms of this CONTRACT and which can reasonably be expected to be provided or performed in order to effect an orderly and efficient transition to a successor.

5.1.3.2 The **Contractor** agrees to the following only if written notice is received from **TDMHDD**:

The **Contractor** shall continue to serve or arrange for the provision of services to **Enrollees** for a transition period of sixty (60) calendar days from the CONTRACT termination date or until all the **Enrollees** can be transferred to another **Contractor's** plan. During this transition period, **TennCare** shall continue to make payments to the **Contractor** in accordance with Section 4.7 of this CONTRACT.

5.1.4 Final Invoice

The **Contractor** shall submit the final invoice for payment, for all services rendered prior to the effective date of termination, to **TennCare** no more than one hundred and fifty (150) calendar days after the effective date of any termination. If the **Contractor** fails to do so, all rights to payment are waived. **TennCare** will not honor any requests submitted after the one hundred and fifty (150) calendar day period.

5.1.5 Final Payment

The final payment due the **Contractor** under the terms of this CONTRACT shall be paid within thirty (30) calendar days after the final approvable invoice is submitted within the one hundred and fifty (150) calendar day period specified in accordance with Section 5.1.4, subject to the following limitations:

5.1.5.1 The final payment may be withheld until **TDMHDD** receives from the **Contractor** all reports and information required pursuant to this CONTRACT and all written and properly executed documents as reasonably required by **TDMHDD** as the result of the termination.

5.1.5.2 The amount of the final payment may be reduced by the following:

5.1.5.2.1 Any other adjustment payable to **TennCare** in accordance with Section 4.7.4;

5.1.5.2.2 Any amounts owed to any subcontractors or service providers and not paid or appropriately denied by the **Contractor** as of the date of the final payment;

5.1.5.2.3 Any amounts paid to subcontractors or service providers in accordance with Section 5.1.2.4 to settle or pay any of the claims arising out of the termination of such subcontracts and provider agreements;

5.1.5.2.4 Any payment by **TDMHDD** or **TennCare** determined to have been erroneously paid;

5.1.5.2.5 Any financial liability payable to **TDMHDD** or **TennCare** as the result of audits completed after the effective date of the termination of this CONTRACT;

5.1.5.2.6 Except for termination due to the expiration and non-renewal of this CONTRACT and early termination in accordance with Sections 5.1.6.3 through 5.1.6.5, any damages sustained by **TDMHDD** as the result of the early termination; and

5.1.5.2.7 In the case of any default, any cost incurred by **TDMHDD**, including legal fees and court cost incurred by the Office of the Attorney General, to enforce any provision of this CONTRACT or to collect any amount owed **TDMHDD**.

5.1.5.3 **TDMHDD** or **TennCare** shall give the **Contractor** prior written notification, stating the reasons for and the amount and the anticipated date of any such deduction from the final payment made under Section 5.1.5.2, and shall give the **Contractor** the right to object to the basis or amount of the deduction.

5.1.5.4 If the **Contractor** and **TDMHDD** or **TennCare** fail to agree on the amount of the final payment, **TDMHDD** or **TennCare** shall determine on the basis of the information available, the amount, if any, due the **Contractor**.

5.1.6 Reasons Supporting Termination

The CONTRACT may be terminated for any of the following reasons:

5.1.6.1 Termination by Expiration and Non-Renewal

In the event this CONTRACT expires and is not renewed with the **Contractor**, this CONTRACT shall terminate in accordance with Section 5.1.1.1.

5.1.6.2 Termination by Mutual Consent

TDMHDD and the **Contractor** may terminate this CONTRACT at any time by written mutual consent. Both parties shall sign the Notice of Termination which shall include, inter alia, the date of termination. **TDMHDD** shall inform all affected **Enrollees** of their disenrollment from the plan provided by the **Contractor** and their reassignment to another plan.

5.1.6.3 Termination for Convenience

Either party may terminate this CONTRACT immediately or in stages at any time by written notice given to the other party at least sixty (60) calendar days before the effective date of such early termination. Said termination shall not be a breach of contract by either party and the **Contractor** and **TennCare** shall not be responsible to each other or any other party for any costs, expenses, or damages occasioned by said termination. **TennCare** shall inform all affected **Enrollees** of their disenrollment from the plan provided by the **Contractor** and their reassignment to another plan.

Termination for convenience by **TDMHDD** shall include, but not be limited to, a material change in ownership of the **Contractor**. For purposes of this section, “material change in ownership” means a change in ownership prohibited under Tennessee Code Annotated §56-32-222

for an HMO licensed in Tennessee. Termination for convenience by the **Contractor** shall not limit **TDMHDD's** ability to exercise exigency in accordance with Section 6.19 of this CONTRACT.

5.1.6.4 Termination by TDMHDD for the Unavailability of Funds

This CONTRACT is subject to appropriation and availability of state and federal funds. In the event funds are not appropriated or are otherwise unavailable, **TDMHDD** reserves the right to immediately terminate this CONTRACT without penalty upon written notice given to the **Contractor**. Availability of funds shall be determined solely by **TennCare. TennCare** shall inform all affected **Enrollees** of their disenrollment from the plan and the reasons for their not being reassigned to another plan. 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. The termination shall not be a breach of

this CONTRACT by **TDMHDD** and **TDMHDD** shall not be responsible to the **Contractor** or any other party for any costs, expenses, or damages occasioned by the termination.

5.1.6.5 Termination by TDMHDD due to the Expiration, Suspension or Termination of the TennCare Waiver

This CONTRACT is subject to the continuation of the **TennCare** Waiver, Section 1115(a) Demonstration Project. In the event the **TennCare** Waiver expires or is suspended or terminated for whatever reason, **TDMHDD** reserves the right to immediately terminate this CONTRACT upon written notice to the **Contractor**. The termination shall not be a breach of this CONTRACT by **TDMHDD** and **TDMHDD** shall not be responsible to the **Contractor** or any other party for any costs, expenses, or damages occasioned by the termination. **TennCare** shall inform all affected **Enrollees** of their disenrollment from the plan provided by the **Contractor** and the reasons for their not being reassigned to another plan.

5.1.6.6 Termination due to the Contractor's Insolvency

5.1.6.6.1 The **Contractor** must, during the term of this CONTRACT, demonstrate sufficient financial capital to perform its obligations under this CONTRACT. If **TDMHDD** reasonably determines the **Contractor's** financial condition is not sufficient to allow the **Contractor** to provide the services as described, **TDMHDD** may terminate this CONTRACT in whole or in part, immediately or in stages. Said termination shall not be deemed a breach by either party.

5.1.6.6.2 For the purposes of this Section, the **Contractor** shall be presumed to be insolvent and in a condition hazardous financially to **Enrollees**, creditors and the public, under any of the following circumstances:

5.1.6.6.2.1 The **Contractor** cannot demonstrate to the satisfaction of **TDMHDD** the **Contractor** has established and maintained the financial requirements set forth in Section 3.1.8 of this CONTRACT; or

5.1.6.6.2.2 A trustee, receiver, or liquidator for all or a substantial part of the **Contractor's** property is appointed, or proceedings for bankruptcy, reorganization, arrangement or liquidation are instituted by or against the **Contractor**.

5.1.6.6.2.3 In the event the **Contractor** meets any of the above circumstances of insolvency or enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the **Contractor** shall notify **TDMHDD** by the quickest means possible, with written notification of the insolvency or bankruptcy being given within five (5) calendar days of the

Contractor's meeting the circumstances of insolvency or the initiation of the proceedings relating to the bankruptcy filing. In the case of insolvency, the notification shall include the circumstance of insolvency and the date the **Contractor** met the circumstance of insolvency. In the case of bankruptcy, the notification shall include the date on which the bankruptcy petition was filed and the identity of the court in which the bankruptcy petition was filed.

The **Contractor's** insolvency or the filing of a petition in bankruptcy by or against the **Contractor** shall constitute grounds for termination for cause in accordance with Section 5.1.6.7, except the Notice of Breach and any cure periods as specified in Section 5.2.2 shall not be available to the **Contractor**.

This provision is not intended to imply the State consents to the **Contractor** filing a bankruptcy petition under federal bankruptcy laws.

5.1.6.6.3 **Enrollees** shall not be held liable for the **Contractor's** debt in the event of the **Contractor's** insolvency nor shall any **Enrollee** be held liable for any bill, charge, or reimbursement owed to any provider for services provided to an **Enrollee** or than applicable **TennCare** cost sharing responsibilities.

5.1.6.7 Termination by TDMHDD for Cause

TDMHDD may also terminate this CONTRACT for cause if it is determined the **Contractor** has breached the CONTRACT, as described in Section 5.2.

5.1.6.8 Notice of Intention Respecting Non-Renewal by

CONTRACTOR

This CONTRACT shall be valid for the period specified in Section 6.18 of the CONTRACT unless earlier terminated under terms of this CONTRACT. For the benefit of the State and **TDMHDD** and to assure proper continuity of services, the **CONTRACTOR** shall provide to **TDMHDD** a notice to be received by a date not later than one hundred and eighty (180) calendar days prior to the expiration of this CONTRACT written notice of its intention respecting non-renewal of this CONTRACT. The written notice shall specify the last date of intended operations. Upon **TDMHDD'S** receipt of the **Contractor's** notice of intention not to renew, regardless of the date of receipt, **TDMHDD** shall have the rights set out in section 5.1.1.1. and 5.1.3. The **Contractor** shall comply with all terms and conditions in this CONTRACT during the close-out period.

5.2 Breach By Contractor

5.2.1 General Requirements

The **Contractor** shall be deemed to have breached this CONTRACT if any of the following occurs:

5.2.1.1 The **Contractor** submitted incorrect, misleading or falsified information as part of or in addition to its BHO Proposal or in response to questions concerning the **Contractor's** BHO Application or any such additional information. **TDMHDD** shall, at its own discretion, determine whether or not the incorrect, misleading or falsified information would have altered the selection of the **Contractor** as a **Contractor** under this CONTRACT;

5.2.1.2 The **Contractor** no longer meets the applicable conditions or qualifications which were submitted under this CONTRACT;

5.2.1.3 The **Contractor** fails to perform in accordance with any term or provision of this CONTRACT or any applicable law or regulation;

5.2.1.4 The **Contractor** renders only partial performance of any term or provision of this CONTRACT;

5.2.1.5 The **Contractor** engages in any act prohibited or restricted by this CONTRACT or by state or federal statute, rule or regulation; or

5.2.1.6 The **Contractor** fails to qualify for, or has had revoked, a license required to operate in the State of Tennessee or is suspended, debarred or otherwise becomes ineligible or excluded from participation in any covered service in accordance with Title 45, Code of Federal Regulations, Part 76, or any statute or rule of the State of Tennessee or in any other State, which in the opinion of **TDMHDD,** would result in the **Contractor** having its license suspended or revoked or failing to become licensed or being suspended, debarred or ineligible or excluded from entering into this CONTRACT if the cause for such action had occurred in Tennessee.

5.2.2 Notice of Breach

In the event of breach by the **Contractor**, **TDMHDD** shall provide the **Contractor** written Notice of Breach. The State shall have available the remedy of Actual Damages and any other remedy available at law or equity. The Notice of Breach shall specify the date of the notice, each specific breach of term of this CONTRACT with which the **Contractor** has not complied, and any corrective action which must be taken by the **Contractor** to cure each breach. The **Contractor** shall be allowed twenty (20) calendar days from the date of the Notice of Breach to cure each breach, unless the breach is one of those specified in Section 5.3.3; in which case **TDMHDD** shall provide **Contractor** a Notice of Breach but no cure period shall be applicable unless expressly provided in Section 5.3.3. Notwithstanding any provision herein to the contrary, in the event the Notice of Breach does not comply with the terms of this CONTRACT, the notice shall still be effective in all respects; however, the **Contractor** may request a clarification of such notice. Any such defect, request or clarification shall not affect the effectiveness or date of the Notice of Breach.

If the **Contractor** disagrees with the determination of breach or designated corrective action described in the notice, the **Contractor** shall nevertheless implement the corrective action, without prejudice to any rights the **Contractor** may have to later dispute the finding of breach or designated corrective action.

The requirement for a Notice of Breach and any cure periods shall be available to the **Contractor** only for the initial event of breach

under Section 5.2.1. In the event of repeated breaches of the same general nature, no subsequent Notice of Breach or opportunity to cure is required.

5.2.3 Remedies for Breach

In the event the **Contractor** fails to cure the breach within the time period provided, **TDMHDD** 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 CONTRACT or otherwise available at law or equity. Failure to comply with these remedies may result in the immediate termination of this CONTRACT by **TDMHDD**, and the Notice of Breach and the cure periods as specified in Section 5.2.2 shall not be available to the **Contractor**.

5.2.3.1 **TDMHDD** may initiate recovery of actual damages, including incidental and consequential damages, and any other remedy available by law or equity.

5.2.3.2 **TDMHDD** may require the **Contractor** to prepare a plan to correct cited deficiencies and to immediately, or within the time frames specified by **TDMHDD**, implement such plan.

5.2.3.3 **TDMHDD** may recover any and all liquidated damages provided for in this CONTRACT.

5.2.3.4 **TDMHDD** may require the **Contractor** to obtain a performance bond in the amount of the average of one (1) month's capitation payment, excluding any adjustments made in accordance with Section 4.7.4, as determined by **TDMHDD**, and any liquidated damages assessed against the **Contractor** and not paid as of the effective date of the performance bond.

5.2.3.5 **TDMHDD** may require the **Contractor** to obtain a payment bond in the amount of ninety percent (90%) of the average of one (1) month's capitation payment, excluding any adjustments made in accordance with Section 4.7.4, as determined by **TDMHDD**, and any liquidated damages assessed against the **Contractor** and not paid as the effective date of the payment bond.

5.2.3.6 Each bond which may be required under Sections 5.2.3.4 or 5.2.3.5 must be issued by one or more corporate sureties, licensed in Tennessee by the TDCI, be on a

form prescribed by **TDMHDD**, have attached a certified and current power of attorney appointing an attorney-in-fact who is licensed in and a resident of the State of Tennessee, and name **TDMHDD** as obligee or owner.

5.2.3.7 Breach—Declaration of Partial Default

In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the **Contractor** written notice of: (1) the date which **Contractor** shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the **Contractor.**

In the event the State declares a Partial Default, which is not cured in accordance with the same procedures specified in Section 5.2.2, the State may withhold, together with any other damages associated with the Breach, from the amounts due the **Contractor** the greater of: (1) amounts which would be paid the **Contractor** to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the **Contractor** is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material from **Contractor**. The State shall make the final and binding determination of said amount.

5.2.3.7.1 The State may assess Liquidated Damages against the **Contractor** for any failure to perform, which ultimately results in a Partial Default with said Liquidated Damages to cease when said Partial Default is effective. Upon Partial Default, the **Contractor** shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. **Contractor** agrees to cooperate fully with the State in the event a Partial Default is taken.

5.2.4 Failure to Enforce

The failure of **TDMHDD** to insist, in one or more instances, upon the performance of any term of this CONTRACT is not a waiver of **TDMHDD's** right to future performance of such term, and the **Contractor's** obligation for future performance of such term shall continue in effect.

5.3 Liquidated Damages

TDMHDD shall notify the Contractor of amounts to be assessed as Liquidated Damages. It is acknowledged by **TDMHDD** and the **Contractor** that in the event of failure to meet the requirements provided in this CONTRACT and all documents incorporated herein, **TDMHDD** will be harmed. The actual damages which **TDMHDD** 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 the **Contractor** shall be subject to damages and/or sanctions as described below. It is further agreed the **Contractor** shall pay **TDMHDD** liquidated damages as directed by **TDMHDD** and not to exceed the fixed amount as stated below; provided however, if it is finally determined the **Contractor** would have been able to meet the CONTRACT requirements listed below but for **TDMHDD's** failure to perform as provided in this CONTRACT, the **Contractor** shall not be liable for damages resulting directly there from.

Deleted: therefrom

The State may continue to withhold the Liquidated Damages or a portion thereof until the **Contractor** cures the Breach, the State exercises its option to declare a Partial Default, or the State terminates the CONTRACT. The State is not obligated to assess Liquidated Damages before availing itself of any other remedy. The State may choose to discontinue Liquidated Damages and avail itself of any other remedy available under this CONTRACT or at law or equity; provided, however, **Contractor** shall receive a credit for said Liquidated Damages previously withheld except in the event of a Partial Default.

The liquidated damages for reports, records, and deliverables are detailed in Section 5.3.3 below. The liquidated damages for performance measures are detailed separately, in Attachment E of this CONTRACT.

5.3.1.1 Specific Acknowledgments

The **Contractor** represents and covenants the **Contractor** has carefully reviewed each specified liquidated damage described in this CONTRACT and agrees each liquidated

damage is reasonable and represents probable actual damages which **TDMHDD** would sustain in the event of a breach.

5.3.1.2 Exclusion

The **Contractor** agrees the liquidated damages do not include any injury or damages sustained by a third party and the liquidated damages are in addition to any other amounts the **Contractor** may owe **TDMHDD**, including, but not limited to, amounts owed as overpayments, including excess administrative and management fees and profits in accordance with Section 3.12.3, amounts owed as actual damages, amounts owed to cure a partial default in accordance with Section 5.2.3.7, and amounts owed as indemnification in accordance with Section 6.12.

5.3.1.3 Date of Accrual

The **Contractor** agrees liquidated damages shall accrue on the date following the date the report or deliverable was due or the breach occurred subject to the cure period in Section 5.2.2, if any. With respect to reports and other deliverables, the submission of an incorrect report or a deficient deliverable shall be the same as if the report or deliverable had not been provided.

5.3.1.4 Failure to Enforce

The **Contractor** agrees **TDMHDD** is not obligated to assess liquidated damages before availing itself of any other remedy. **TDMHDD** may, at any time after liquidated damages have been assessed, choose to terminate one or more of the assessments of liquidated damages and avail itself of any other remedy available under this CONTRACT or by law or equity. The failure of **TDMHDD** to assess a liquidated damage or **TDMHDD's** termination of one or more assessments of liquidated damages shall not prejudice **TDMHDD's** right to or in any way prevent **TDMHDD** from assessing or re-assessing liquidated damages at any future date.

5.3.2 Payment

Liquidated damages shall begin to accrue in accordance with Section 5.3.1.2 and be payable on the first day of each month.

5.3.2.1 Interest

If the liquidated damages are not received by the due date, interest shall accrue as of the date determined in accordance with Subsection 5.3.1.2.

5.3.2.2 Withholding Liquidated Damages

TennCare may, with the consent of **TDMHDD**, withhold any due and payable liquidated damages, including interest, from any amounts owed the **Contractor** and/or

pursue collection of such amounts from the **Contractor**. These liquidated damages plus interest shall belong to the State.

5.3.2.3 Applicability to Capitation Payments

Assessed liquidated damages, whether paid or due, and any interest charged thereon shall be counted against the percentage for administrative and management cost and profits, and not against the percentage of the capitation payments paid for the provision of covered services and premium taxes in accordance with Section 3.12.2.

5.3.3 Schedule of Liquidated Damages

Liquidated damages shall accrue in accordance with the following schedule. In the event a cure period is authorized in accordance with Section 5.2.2 or elsewhere in this Section, and the reason for which the liquidated damage was assessed is not cured, or otherwise remains uncorrected or deficient at the end of the cure period, then actions may be pursued by the State in accordance with Sections 5.1.6.7 and 5.2.3. All records and reports with due dates that fall on a weekend day or a holiday shall be submitted on the next business day.

5.3.3.1 Records and Reports

Liquidated damages for late reports shall begin on the first day the report is late. If the report allows for a cure period, liquidated damages shall begin on the first day following the cure period. Liquidated damages for incorrect reports (except ad hoc reports involving

provider network information), or deficient deliverables shall begin on the sixteenth day after notice is provided from **TennCare** to the **Contractor** that the report remains incorrect or the deliverables remain deficient; provided, however, that it is reasonable to correct the report or deliverable within fifteen (15) calendar days. For the purposes of ad hoc reports involving provider network information, liquidated damages for incorrect reports shall begin on the first day the report is determined by **TennCare** to be incorrect.

5.3.3.1.1	Enrollee Records	Frequency or	Amount Per Record	Cure
	5.3.3.1.1.1	Daily	$100 per calendar day	None
	5.3.3.1.1.2	Weekly	$200 per calendar day	None
	5.3.3.1.1.3	Semi-Monthly	$300 per calendar day	5 calendar days
	5.3.3.1.1.4	Monthly	$500 per calendar day	5 calendar days
	5.3.3.1.1.5	Bi-Monthly	$500 per calendar day	10 calendar days
	5.3.3.1.1.6	Semi-Annual	$500 per calendar day	20 calendar days
	5.3.3.1.1.7	Annual	$500 per calendar day	20 calendar days

5.3.3.1.2	Summary Reports	Frequency or Referenced Sections	Per Report	
	5.3.3.1.2.1	ad hoc	$100 per calendar day	None
	5.3.3.1.2.2	Daily	$200 per calendar day	None
	5.3.3.1.2.3	Weekly	$400 per calendar day	None
	5.3.3.1.2.4	Semi-Monthly	$600 per calendar day	None
	5.3.3.1.2.5	Monthly	$600 per calendar day	5 calendar days
	5.3.3.1.2.6	Bi-Monthly	$600 per calendar day	10 calendar days
	5.3.3.1.2.7	Quarterly	$600 per calendar day	15 calendar days
	5.3.3.1.2.8	Semi-Annual	$600 per calendar day	20 calendar days
	5.3.3.1.2.9	Annual	$600 per calendar day	20 calendar days

5.3.3.1.3	Financial Reports	Referenced Section(s) or Attachment	Per Report	
	5.3.3.1.3.1	3.10.10.1	$600 per calendar day	5 calendar days
	5.3.3.1.3.2	3.10.10.2	$600 per calendar day	5 calendar days
	5.3.3.1.3.3	3.10.10.4	$600 per calendar day	5 calendar days
	5.3.3.1.3.4	3.11.5.1	$600 per calendar day	5 calendar days

5.3.3.2 Deliverables

		Referenced Section(s)	Amount	Cure Period
5.3.3.2.1	Crisis Services	2.5.9 3.10.6	$500 per calendar day	5 calendar days
5.3.3.2.2	Financial Disclosure in Providers	3.1.11.1	Amount Paid to the Provider	5 calendar days
5.3.3.2.3	Reserved			
5.3.3.2.4	Maintain Fidelity Bond	3.1.9	$500 per calendar day	10 calendar days
5.3.3.2.5	Proof of Coverage	3.1.9	$500 per calendar day	10 calendar days
5.3.3.2.6	Reserved			
5.3.3.2.7	Ownership and Financial Disclosure	3.1.11	$500 per calendar day	5 calendar days
5.3.3.2.8	Identification Card	3.4.2.2	$10 per calendar day per **Enrollee**	15 calendar days after assignment
5.3.3.2.9	Member Handbooks and Explanation of Benefits	3.4.2.1 3.4.2.3	$50 per calendar day per **Enrollee**	15 calendar days after assignment
5.3.3.2.10	Quarterly Newsletter	3.4.2.4	$500 per calendar day	5 calendar days
5.3.3.2.11	Reserved			
5.3.3.2.12	Telephone Access	3.5.3	See Performance Measures	None
5.3.3.2.13	Provider Site License	3.6.2	$5,000 per calendar day that a site is not licensed as required by applicable state law plus the amount paid to that provider site during that period	None
5.3.3.2.14	Provider Staff License	3.6.3	$5,000 per calendar day that staff/provider/agent/su	None

			bcontractor is not licensed as required by applicable state law plus the amount paid to the staff/provider/agent/subcontractor during that period.	
5.3.3.2.15	Credentialing Manual	3.6.4	$500 per calendar day	5 calendar days
5.3.3.2.16	Provider Relations Plan	3.6.5	$500 per calendar day	20 calendar days
5.3.3.2.17	Performance Measure Standards	Attachment E	See Attachment E	None
5.3.3.2.18	Failure to process and pay claims in a timely manner	3.11.3	$10,000 per month for each month that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of this Agreement.	None
5.3.3.2.19	Reserved			
5.3.3.2.20	Failure to provide a written notice or provision of defective notice of denial, reduction, termination, suspension, or delay of covered services	3.3	$500 per occurrence per case	None
5.3.3.2.21	Failure to provide a written discharge plan or provision of a defective discharge plan	3.2.1.2.3.2	$1,000 per occurrence per case	None
5.3.3.2.22	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable	3.3	$500 per day beginning on the next calendar day after default by the plan in addition to the cost of	None

	and appropriate directive from **TennCare** to do so or upon approval of the service or payment by the CONTRACTOR during the appeal process or within a longer period of time which has been approved by **TennCare** upon a plan's demonstration of good cause		the services not provided.	
5.3.3.2.23	Failure to provide proof of compliance to the Bureau Office of Contract Compliance and Performance within five (5) calendar days of a reasonable and appropriate directive from **TennCare** or within a longer period of time which has been approved by **TennCare** upon a plan's demonstration of good cause	3.3	$500 per day beginning on the next calendar day after default by the plan	None
5.3.3.2.24	Imposing arbitrary utilization guidelines or other quantitative coverage limits	3.9.3	$500 per occurrence	None
5.3.3.2.25	Services wrongfully withheld where the **Enrollee** was not receiving the service and the **Enrollee** went without coverage of the disputed service while an appeal on the service was pending	3.3	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	None

			Enrollee's expense	
5.3.3.2.26	Reserved			
5.3.3.2.27	Failure to comply with the notice requirements of the **TennCare** Rules and regulations or any subsequent amendments thereto, and court orders governing appeal procedures as they become effective	3.3	$500 per occurrence in addition to $500. per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this CONTRACT or required by **TennCare**	None
5.3.3.2.28	Failure to provide continuation or restoration of services where an **Enrollee** was receiving the service as required by **TennCare** Rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective	3.3	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 after an On Request Report regarding a member's request for continuation of benefits is sent by TENNCARE.	None
5.3.3.2.29	Failure to provide	2.5.3	$500 per month per	None

	CRG/TPG assessments within the specified timeframes		**Enrollee**	
5.3.3.2.30	Failure to provide CRG/TPG assessments by **TDMHDD**-certified raters or in accordance with **TDMHDD** policies and procedures	2.5.3	$500 per occurrence per case	None
5.3.3.2.31	Failure to comply with Conflict of Interest, Lobbying and Gratuities requirements described in Sections 6.5, 6.6 & 6.7.	6.5 6.6 6.7	110% of the total amount of compensation paid by **Contractor** to inappropriate individuals as described in Sections 6.5, 6.6, & 6.7 and possible termination of the Agreement as described in Sections 6.5, 6.6, & 6.7 of this Agreement.	None
5.3.3.2.32	Failure to submit TennCare and TDMHDD Disclosure of Lobbying Activities Form by **Contractor**.	6.7	$1,000.00 per day that disclosure is late.	None
5.3.3.2.33	Failure to comply with Offer of Gratuities constraints described in Section 6.6	6.6	110% of the total benefits provided by the CONTRACTOR to inappropriate individuals and possible termination of the Agreement for breach as described in Section 6.6 of this Agreement.	None
5.3.3.2.34	Failure to seek, collect and/or report third party recoveries to TennCare.	3.12.5	$500. per day for each calendar day that TennCare determines the CONTRACTOR is not making reasonable effort to seek and	None

			collect third party recoveries.	
5.3.3.2.35	Failure to obtain approval of enrollee materials.	3.4	For Deliverables due on or after January 1, 2006: $500. for each day that TennCare determines the CONTRACTOR has provided enrollee material that has not been approved by TennCare.	None
5.3.3.2.36	Failure to comply with marketing timeframes for providing Member Handbooks, I.D. cards, Provider Directories and Newsletters.	Marketing Materials, 3.4	For Deliverables due on or after January 1, 2006: $5000. for each occurrence. . For purposes of this Agreement, occurrence means each instance in which Member materials are provided or should have been provided regardless of the number of Members affected at that time.	None
5.3.3.2.37	Failure to achieve and/or maintain financial reserves in accordance with TCA	Financial Requirements, 3.1.8	$500. per calendar day for each day that financial requirements have not been met.	None
5.3.3.2.38	Failure to comply with fraud and abuse provisions as described in Section 3.1.12 of this Agreement	Fraud and Abuse, 3.1.12	$500. per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions described in Section 3.1.12 of this Agreement.	None
5.3.3.2.39	Failure to require and assure compliance with Ownership and Disclosure requirements	Provider Contracts, 3.7.2	$5000. per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain	None

			complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B.	
5.3.3.2.40	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child at risk of entering DCS custody as described in this Agreement.	2.5	The actual amount paid by DCS and/or TENNCARE for necessary services or $1000. whichever is greater, to be deducted from monthly payments	None
5.3.3.2.41	Failure to comply with obligations and timeframes in the delivery of EPSD&T screens and related services as per this Agreement.	2.5.4	The actual amount paid by DCS and/or TENNCARE for necessary services or $1000. whichever is greater, to be deducted from monthly payments.	None
5.3.3.2.42	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	2.5	The actual amount paid by DCS and/or TENNCARE for necessary services or $1000. whichever is greater, to be deducted from monthly payments.	None
5.3.3.2.43	Failure to forward an expedited appeal to TennCare in twenty four (24) hours or a standard appeal in five (5) days.	3.3	$500. per calendar day	None
5.3.3.2.44	Failure to provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare	3.3	$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	None

	rules and regulations and all court orders and consent decrees governing appeals procedures as they become effective.		the provisions set forth by this Agreement or required by TennCare	
5.3.3.2.45	Failure to submit a timely corrected notice of adverse action to TENNCARE for review and approval prior to issuance to the member.	3.3	$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.	None
5.3.3.2.46	Per the Revised Grier Consent Decree, "Systemic problems or violations of the law" (e.g. a failure in 20% or more of appealed cases over a 60 day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures as they become effective.	3.3	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"	None

			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.)	
5.3.3.2.47	Systemic violations regarding any aspect of the requirements in accordance with this Agreement and the TennCare rules and regulations	3.3	First occurrence: $500 per instance of such systemic violations, even if damages regarding one or more particular instances have been assessed. Damages per instance shall increase in $500 increments for each subsequent systemic violation ($500 per instance the first time a systemic violation relating to a particular requirement is identified; $1,000 per instance for the 2nd time a systemic violation relating to the same requirement is identified; etc.)	None
5.3.3.2.48	Failure to complete or comply with corrective action plans as required by TENNCARE and/or TDMHDD	3.11.8 3.10.1	$500. per calendar day for each day the corrective action is not completed or complied with as required.	None
5.3.3.2.49	Failure to 1) provide an approved service timely, i.e., in accordance with timelines specified in the Special Terms and	2.5 3.3 Attachment B	The cost of services not provided plus $500 per day, per occurrence, for each day 1) that approved care is not provided	None

	Conditions for Access in the TennCare Waiver or Attachment B, or when not specified therein, with reasonable promptness; or 2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service.		timely; or 2) notice of delay is not provided and/or the MCC fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service.	
5.3.3.2.50	Failure to submit the CONTRACTORS' annual NAIC filing as described in Section 3.10.10 of this Agreement.	3.10.10	$500. per calendar day	None
5.3.3.2.51	Failure to submit the CONTRACTORS' quarterly NAIC filing as described in Section 3.10.10	3.10.10	$500. per calendar day	None
5.3.3.2.52	Failure to submit audited financial statements as described in Section 3.11.5	3.11.5	$500. per calendar day	None
5.3.3.2.53	Failure to maintain a complaint and appeal system as required in Section 3.3 of this Agreement.	3.3	$500. per calendar day	None
5.3.3.2.54	Failure to maintain required insurance as required in Section 4.4.13 of this Agreement.	4.4.13 3.1.10	$500. per calendar day	None
5.3.3.2.55	Reserved			
5.3.3.2.56	Failure to completely process a credentialing	3.6.4 Attachment C	$5000 per application that has not been approved and loaded	None

	application within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application and signed Provider Agreement as required in Section 3.6.4 of this Agreement.		into the CONTRACTORS' system or denied within thirty (30) calendar days of receipt of a completed credentialing application. And/Or $1000 per application per day for each day beyond thirty (30) calendar days that a completed credentialing application has not been completed as described in Section 3.6.4 of this Agreement.	
5.3.3.2.57	Failure to maintain provider agreements in accordance with this Agreement.	3.7.2	$5000 per provider agreement found to be non-compliant with the requirements outlined in Section 3.7.2 of this Agreement.	None
5.3.3.2.58	Failure to comply in any way with staffing requirements as described in this Agreement.	3.5	$250. per calendar day for each day that staffing requirements as described in this Agreement are not met.	None
5.3.3.2.59	Failure to report provider notice of termination of participation in the CONTRACTORS' plan.	3.7.4	$200. per day	None
5.3.3.2.60	Failure to address or resolve problems with individual encounter records in a timely	3.10.4	An amount equal to the paid amount of the individual encounter record(s) that was	None

	manner as required by TENNCARE.		rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TENNCARE.	

5.4 Other Remedies

5.4.1 Partial Takeover

The State may, at its convenience and without cause, exercise a partial takeover of any service, which the **Contractor** is obligated to perform under this CONTRACT, including but not limited to any service which is the subject of a subcontract between **Contractor** and a third party, although the **Contractor** is not in Breach (hereinafter referred to as "Partial Takeover"). Said Partial Takeover shall not be deemed a Breach of CONTRACT by the State. **Contractor** shall be given at least thirty (30) days prior written notice of said Partial Takeover with said notice to specify the area(s) of service the State will assume and the date of said assumption. Any Partial Takeover by the State shall not alter in any way **Contractor's** other obligations under this CONTRACT. The State may withhold from amounts due the **Contractor** the amount the **Contractor** would have been paid to deliver the service as determined by the State. Section 4.7.6 shall apply in the event the Partial Takeover results in a change in the scope of services. The amounts shall be withheld effective as of the date the State assumes the service. Upon Partial Takeover, the **Contractor** shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

5.4.2 The parties shall also have any other remedies set forth in other Sections of this CONTRACT.

SECTION 6. MISCELLANEOUS TERMS AND CONDITIONS

6.1 Applicable Laws, Rules and Policies

The **Contractor** agrees to comply with all applicable federal and state laws, rules, and executive orders, which include, but are not limited to:

6.1.1 Title 42, Code of Federal Regulations, Chapter IV, Subchapter C,

excepting those parts waived under the **TennCare** Waiver, Section 1115(a) Demonstration Project the Amendment to the **TennCare** Waiver, known as the "**The TennCare Partners Program**", and any Special Terms and Conditions imposed on the **TennCare** Waiver and the Amendment thereto;

6.1.2 The Amendment to the **TennCare** Waiver, known as "**The TennCare Partners Program**" and any Special Terms and Conditions imposed thereon;

6.1.3 The **TennCare** Waiver, Section 1115(a) Demonstration Project, having the reference number 11-W-00151/4, and the Special Terms and Conditions imposed thereon, which are not in conflict with the documents specified in Sections 5.1.1 and 5.1.2;

6.1.4 Title 45, Code of Federal Regulations, Part 74, General Grants Administration Requirements;

6.1.5 Titles 4, 33, 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.

6.1.6 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 *et seq*.) and the Federal Water Pollution Control Act, as amended (33 U.S.C. 1251 *et seq*.);

6.1.7 Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d) and regulations issued pursuant thereto, Title 45, Code of Federal Regulations, Part 80;

6.1.8 Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e) in regard to employees or applicants for employment;

6.1.9 Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, Title 45, Code of Federal Regulations, Part 84;

6.1.10 The Age Discrimination Act of 1975, as amended, (42 U.S.C. 6101 *et seq*.), which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, Title 45, Code of Federal Regulations, Parts 90 and 91;

6.1.11 The Omnibus Budget Reconciliation Act of 1981, (PL 97-35), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;

6.1.12 Americans with Disabilities Act, (42 U.S.C. Section 12101 *et seq*.), and regulations issued pursuant thereto, Title 28, Code of Federal Regulations, Parts 35 and 36;

6.1.13 Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare and/or Medicaid program;

6.1.14 Confidentiality of Alcohol and Drug Abuse Patient Records, Title 42, Code of Federal Regulations, Part 2;

6.1.15 Federal Executive Order 11246, "Equal Employment Opportunity", as amended by Federal Executive Order 11375, and as supplemented by Title 41, Code of Federal Regulations, Part 60, Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor;

6.1.16 Tennessee Consumer Protection Act, (Section 47-18-101 *et seq.*) Tennessee Code Annotated;

6.1.17 Rules of the Tennessee Department of Health, (and as superseded by the **TennCare** Rules of the Tennessee Department of Finance and Administration); Chapter 1200-13-13 and 1200-13-14;

6.1.18 Rules of the Department of Mental Health and Developmental Disabilities, Rule 0940, *et seq*.;

6.1.19 Gubernatorial Executive Orders; including Executive Order 1 effective January 26, 1995 and Executive Order 3 effective February 3, 2003;

6.1.20 The Clinical Laboratory Improvement Act (CLIA) of 1988;

6.1.21 Requests for approval of material modification as provided at TCA 56-32-201 *et. seq*.;

6.1.22 Health Insurance Portability and Accountability Act (HIPAA) requirements;

6.1.23 Title IX of the Education Amendments of 1972 (regarding

education programs and activities);

6.1.24 Copeland Anti-Kickback Act (all contracts in excess of $2,000);

6.1.25 Davis-Bacon Act (all contracts in excess of $2,000);

6.1.26 Contract Work Hours and Safety Standards (all contracts in excess of $2,000 for construction and $2,500 employing mechanics or laborers);

6.1.27 Rights to Inventions Made Under a Contract or Agreement (all contracts containing experimental, developmental, or research work);

6.1.28 Byrd Anti-Lobbying Amendment;

6.1.29 Contracts, subcontracts, and subgrants of amounts in excess of $100,000 shall contain a provision which requires 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.);

6.1.30 Contracts shall recognize mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165);

6.1.31 Contracts shall contain a statement that federal funds have not been used for lobbying;

6.1.32 Pro-Children Act of 1994 and the Tennessee Children's Act for Clean Indoor Air of 1995; and

6.1.33 All references in this CONTRACT or any attachment thereto to the Tennessee Department of Mental Health and Developmental Disabilities **(TDMHDD)** shall be deemed to also be references to the Tennessee Department of Finance and Administration.

6.2 Use of Data

TDMHDD 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 CONTRACT. **TDMHDD** shall not disclose proprietary

information to the extent such information is conferred confidential status by state or federal law, except as permitted under these laws.

6.3 Waiver

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this CONTRACT may be waived except by written amendment to this CONTRACT signed by all signatories to this CONTRACT or in the event the signatory is no longer empowered to sign this CONTRACT, the signatory's replacement, and forbearance, forgiveness, or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings has occurred, the other party shall have the right to invoke any remedy available under law or equity notwithstanding any such forbearance, forgiveness or indulgence.

6.4 Severability

If any provision of this CONTRACT is determined by a court of competent jurisdiction or agreed by the parties hereto to be overly broad in duration or substantive scope, such provision shall be deemed narrowed to the broadest term or extent permitted by applicable law. If any provision of this CONTRACT or the applicability thereof to any person or circumstance is determined by a court of competent jurisdiction or agreed by the parties hereto to be unlawful, void or, for any reason, unenforceable, such determination shall not affect other provisions or applications of this CONTRACT which can be given effect without the invalid provision(s) or application; and, to that end, the provisions of this CONTRACT are held to be severable.

In addition, if the laws or rules governing this CONTRACT should be amended or judicially interpreted as to render the fulfillment of this CONTRACT impossible or economically unfeasible, both **TDMHDD** and the **Contractor** will be discharged from further obligations created under the terms of this CONTRACT.

6.5 Conflicts of Interest

6.5.1 The CONTRACTOR warrants that no part of the total Agreement amount provided herein shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state or federal officer or employee of the State of Tennessee or any immediate family member of a state or federal officer or

employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the CONTRACTOR in connection with any work contemplated or performed relative to this Agreement unless disclosed to the Commissioner, Tennessee Department of Finance and Administration. For purposes of Section 6.13 and its subparts of this contract, "immediate family member" shall mean a spouse or minor child(ren) living in the household.

6.5.1.1 Quarterly, by January 30, April 30, July 30, and October 30 each year, or at other times or intervals as designated by the Deputy Commissioner of the Bureau of TennCare, disclosure shall be made by the CONTRACTOR to the Deputy Commissioner of the Bureau of TennCare, Department of Finance and Administration in writing. The disclosure shall include, but not be limited to, the following:

6.5.1.1.1 A list of any state or federal officer or employee of the State of Tennessee as well as any immediate family member of a state or federal officer or employee of the State of Tennessee who receives wages or compensation from the CONTRACTOR; and

6.5.1.1.2 A statement of the reason or purpose for the wages or compensation. The disclosures shall be made by the CONTRACTOR and reviewed by TENNCARE in accordance with Standard Operating Procedures and the disclosures shall be distributed to, amongst other persons, entities and organizations, the Commissioner, Tennessee Department of Finance and Administration, the Tennessee Ethics Commission, the TennCare Oversight Committee and the Fiscal Review Committee.

6.5.1.2 This Agreement may be terminated by TENNCARE and/or the CONTRACTOR may be subject to sanctions, including liquidated damages, under this Agreement if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any state or federal officials or employees of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee if the offering or giving of said

gratuity is in contravention or violation of state or federal law. It is understood by and between the parties that the failure to disclose information as required under Section 6.13 of this Agreement may result in termination of this Agreement and the CONTRACTOR may be subject to sanctions, including liquidated damages in accordance with Section 5.3 of this Agreement. The CONTRACTOR certifies that no member of or delegate of Congress, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially from this Agreement.

6.5.2 The CONTRACTOR shall include language in all subcontracts and provider agreements and any and all agreements that result from this Agreement between CONTRACTOR and TENNCARE to ensure that it is maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization. Said language may make applicable the provisions of Section 6.13 to all subcontracts, provider agreements and all agreements that result from the Agreement between the CONTRACTOR and TENNCARE.

6.6 Offer of Gratuities

By signing this CONTRACT, the **Contractor** signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially from this procurement. This CONTRACT may be terminated by **TDMHDD** if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the **Contractor**, his agent, or employees and may result in termination of the CONTRACT and/or liquidated damages as provided in Section 5.3.3.2 of this CONTRACT.

6.7 Lobbying

The CONTRACTOR certifies by signing this Agreement, to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352 (See also TCA 3-6-101 *et. Seq., .* 3-6-201 *et Seq.,* 3-6-301 *et. Seq.,* and 8-50-505.).

The CONTRACTOR shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

Failure by the CONTRACTOR to comply with the provisions herein shall result in termination of the Contractor and/or liquidated damages as provided in 5.3.3.2 of this Agreement.

6.8 Accessibility

TDMHDD or its authorized representative shall have access to the **Contractor's** premises, or such other places where services are performed under this CONTRACT, and to all financial, medical and other records to ensure compliance with the terms and conditions of this CONTRACT and to investigate any complaints or appeals reported or made to **TDMHDD**. The **Contractor** shall include a clause to this effect in all subcontracts and provider agreements.

6.9 Attorney's Fees

In the event either party deems it necessary to take legal action to enforce any provision of this CONTRACT, and **TDMHDD** prevails, the **Contractor** agrees to pay all costs and expenses of such action, including attorney's fees of the State.

6.10 Assignment

This CONTRACT and the monies that may become due hereunder are not assignable by the **Contractor** except with the prior written approval of **TDMHDD**.

6.11 Independent Contractor

It is expressly agreed 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 CONTRACT shall act in an independent capacity and not as agents, officers and employees of **TDMHDD** or the State of Tennessee. It is further expressly agreed this

CONTRACT shall not be construed as a partnership or joint venture between the **Contractor** or any subcontractor or provider and **TDMHDD** and the State of Tennessee.

6.12 Force Majeure

TDMHDD shall not be liable for any excess cost to the **Contractor** for **TDMHDD**'s failure to perform the duties required by this CONTRACT if such failure arises out of causes beyond the control of **TDMHDD** or is not the result of fault or negligence on the part of **TDMHDD**.

The **Contractor** shall not be liable for performance of the duties and responsibilities of this CONTRACT when its ability to perform is prevented by causes beyond its control. These acts must occur without the fault or negligence of the **Contractor**. Such acts include destruction of the facilities due to hurricanes, fires, war, riots, and other similar acts. However, in the event of damage to its facilities, the **Contractor** will be responsible for insuring swift correction of the problem so as to enable it to continue its responsibility for the delivery of health care. The failure of the **Contractor**'s fiscal intermediary, subcontractors or providers to perform any requirements of this CONTRACT shall not be considered a 'force majeure'.

6.13 Disputes and Venue

The **Contractor** specifically acknowledges the sole and exclusive remedy for any claim by the **Contractor** against **TDMHDD** arising out of the breach of this CONTRACT shall be handled in accordance with Section 9-8-301, *et seq*., Tennessee Code Annotated. The **Contractor** shall give notice to **TDMHDD** of the substance and basis of its claim thirty (30) calendar days prior to filing the claim in accordance with Section 9-8-301, *et seq*., Tennessee Code Annotated. The **Contractor** shall comply with all terms and conditions contained within this CONTRACT pending the final resolution of the contested action. The venue for any cause of action concerning any provisions of this CONTRACT or the applicability thereof shall be in Davidson County, Tennessee.

6.14 Indemnification

The **Contractor** agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which

may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the **Contractor**, its employees, or any person acting for or on its or their behalf relating to this Contract or the **Contractor's** failure to comply with the terms of this CONTRACT. The **Contractor** further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the **Contractor** to the State.

In the event of any such suit or claim, the **Contractor** shall give the State immediate notice thereof and shall provide all assistance required by the State in the State's defense. The State shall give the **Contractor** written notice of any such claim or suit, and the **Contractor** shall have full right and obligation to conduct the **Contractor**'s own defense thereof.

Nothing contained herein shall be deemed to accord to the **Contractor**, through its attorney(s), the right to represent the State of Tennessee in any legal matter, such rights being governed by Tennessee Code Annotated, Section 8-6-106.

The **Contractor** agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims or suits which may be brought against the State for infringement of any laws regarding patents or copyrights which may arise from the **Contractor's** performance of this Contract. In any such action brought against the State, the **Contractor** shall satisfy and indemnify the State for the amount of any final judgment for infringement. The **Contractor** further agrees it shall be liable for the reasonable fees of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the **Contractor** to the State. The State shall give the **Contractor** written notice of any such claim or suit and full right and opportunity to conduct the **Contractor's** own defense thereof 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 Section 8-6-106, Tennessee Code Annotated.

6.15 Non-Discrimination

The **Contractor** hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this CONTRACT or in the employment practices of the **Contractor** on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by federal, Tennessee State constitutional,

or statutory law. The **Contractor** shall, upon request, show proof of such non-discrimination and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.

6.16 Confidentiality of Information

The **Contractor** shall assure all materials and information directly or indirectly identifying any current or former **Enrollee** or potential **Enrollee**, which is provided to or obtained by or through the **Contractor's** performance under this CONTRACT, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, Title 42, Part 2, Code of Federal Regulations, and Title 45, Part 160 and 164, Code of Federal Regulations and shall not be disclosed except in accordance with those Titles or to **TDMHDD** and CMS of the United States Department of Health and Human Services, or their designees, as necessary to administrated this CONTRACT. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former **Enrollee** or potential **Enrollee**.

6.17 Debarment and Suspension

6.17.1 The **Contractor** certifies, to the best of its knowledge and belief, that it and its principals comply with the regulations found in Title 45, Part 76, Code of Federal Regulations, including:

6.17.1.1 are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;

6.17.1.2 have not within a three (3) year period preceding this CONTRACT 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 contract 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;

6.17.1.3 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 6.15.1.2 of this certification; and

6.17.1.4 have not within a three (3) year period preceding this CONTRACT had one or more public transactions (federal, State, or local) terminated for cause or default.

6.18 Passing Withholds or Liquidated Damages to Providers or Subcontractors

This CONTRACT shall be in effect from July 1, 2004 through June 30, 2006, subject to approval by the United States Department of Health and Human Services. The State shall have no obligations for services rendered by the **Contractor** which are not performed within the specified period. The **Contractor** shall be allowed to assess liquidated damages, or all or any portion of a withhold retained by **TDMHDD** under Section 4.7.4 of this CONTRACT against any subcontractor or provider, in accordance with previously approved contract provisions and with written permission of **TDMHDD**.

6.19 Duties of Contractor upon Expiration, Non-Renewal or Termination of the CONTRACT

6.19.1 The **Contractor**, upon expiration, non-renewal or termination of the CONTRACT, shall perform the obligations set forth in Section 5.1 as well as the following obligations (hereinafter referred to as "continuing obligations"), for a period to extend to twelve (12) months after the effective date of termination.

6.19.1.1 The **Contractor** shall complete the processing of all claims incurred during the term of the CONTRACT in the manner described in Sections 3.11.2 and 3.11.3.

6.19.1.2 The **Contractor** shall file all reports concerning the **Contractor's** operations during the term of the CONTRACT in the manner described in Section 3.10.

6.19.1.3 The **Contractor** shall process all appeals that occurred during the term of the CONTRACT in the manner set forth in Section 3.3.

6.19.1.4 The **Contractor** shall take whatever other actions are necessary in order to ensure the efficient and orderly transition of **Enrollees** from coverage under this CONTRACT to coverage under any new arrangement developed by **TDMHDD** in the manner set forth in Section 5.1.3.

6.19.2 During the time period following expiration or termination of the CONTRACT during which the **Contractor** is completing its continuing obligations, the **Contractor** shall maintain the fidelity bonds and insurance as set forth in Section 3.1.9 and 3.1.10. The **Contractor** shall also obtain a written and binding guarantee from a financially viable entity (which can be an owner of the **Contractor**) of all debts incurred by the **Contractor** up to a maximum amount of seven million dollars ($7,000,000) or the **Contractor**'s minimum net worth as defined at Section 3.1.8.1, whichever is greater. This guarantee must be approved by the **TennCare** Division of the TDCI; must be submitted by the **Contractor** to the TDCI **TennCare** Division within thirty (30) calendar days after sending any written notice of termination or non-renewal; and must be approved or disapproved by the TDCI **TennCare** Division within fifteen (15) calendar days after receipt. Approval of this guarantee by the TDCI **TennCare** Division relieves the **Contractor** from compliance with all financial requirements defined at Section 3.1.8. Failure to timely submit this guarantee, or to obtain approval of this guarantee by the TDCI **TennCare** Division, shall result in the automatic retention by **TennCare** of the ten percent (10%) withhold defined in Section 4.7.4, which shall be returned upon approval of the guarantee. Execution of any such guarantee does not relieve the **Contractor** from any and all legal debts and obligations incurred by the **Contractor**. The requirements of the **Contractor** described above shall cease upon **TDMHDD** approval of the final report described in Section 6.17.3.

6.19.3 Upon the expiration or termination of this CONTRACT, the **Contractor** shall submit reports to **TDMHDD** every thirty (30) calendar days detailing the **Contractor's** progress in completing its continuing obligations under this CONTRACT. The **Contractor**, upon completion of these continuing obligations, shall submit a final report to **TDMHDD** describing how the **Contractor** has completed its continuing obligations. **TDMHDD** shall within twenty (20) calendar days of receipt of this report advise in writing whether **TDMHDD** agrees the **Contractor** has fulfilled its continuing obligations. If **TDMHDD** determines the

final report does not provide evidence the **Contractor** has fulfilled its continuing obligations, then **TDMHDD** shall require the **Contractor** to submit a revised final report. **TDMHDD** shall in writing notify the **Contractor** once the **Contractor** has submitted a revised final report evidencing to the satisfaction of **TDMHDD** that the **Contractor** has fulfilled its continuing obligations.

6.20 Term of the Contract

This CONTRACT shall remain in effect from July 1, 2004 through June 30, 2008, subject to receipt of necessary State approvals and receipt of approval from the United States Department of Health and Human Services.

At its option, the State may extend this CONTRACT for an additional period or periods of time representing increments of no more than one (1) year and a total CONTRACT term of no more than five (5) years, under the same terms and conditions as detailed herein, unless the **Contractor** shall notify the State of the **Contractor's** intent to terminate this CONTRACT pursuant to the terms of Section 5.1.6.8 of this CONTRACT.

6.21 Exigency

At the option of the State, the **Contractor** agrees to continue services under this CONTRACT when **TDMHDD** determines in **TDMHDD's** sole discretion that there is a public exigency that requires the contracted services to continue. Continuation of services pursuant to this section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) calendar days notice shall be given by **TDMHDD** before the option is exercised. The **Contractor** reimbursement during exigency periods shall be the established capitation rate in effect during the last three (3) months of this CONTRACT.

6.22 Tennessee Consolidated Retirement System

The **Contractor** acknowledges and understands that, subject to statutory exceptions contained in Tennessee Code Annotated, (Section 8-36-801, *et. seq*.), the law governing the Tennessee Consolidated Retirement System, provides that if a retired member returns to State employment, the member's retirement allowance is suspended during the period of employment. Accordingly and notwithstanding any provision of this CONTRACT 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 CONTRACT is that of "employee/employer" and not that of an independent contractor, the **Contractor** may be required to repay to the Tennessee Consolidated Retirement System the amount of retirement benefits the **Contractor** received from the Retirement System during the period of this CONTRACT.

6.23 Prohibition of Illegal Immigrants

The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document as Attachment II, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the contractor and made available to state officials upon request.

b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the contractor and made available to state officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this contract.

e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is

authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.

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

CONTRACTOR:

_____
Russell C. Petrella, Ph.D.
President
TENNESSEE BEHAVIORAL HEALTH, INC.
_____DATE

TENNESSEE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES:

_____
Virginia Trotter Betts, MSN, JD, RN, FAAN
Commissioner
_____DATE

APPROVED:

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION:

_____
M. D. Goetz, Jr.
Commissioner
_____DATE

COMPTROLLER OF TREASURY:

_____
John G. Morgan
Comptroller of Treasury
_____DATE

Attachment A: Definitions

DEFINITIONS

The terms used in this CONTRACT shall be given the meaning used in the Rules and Regulations of **TennCare** applicable to the **TennCare Partners Program**. However, the following terms when used in this CONTRACT, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between the Definitions, Addendum, Attachments, and other Sections of this CONTRACT, the language in Sections 1 through 6 of this CONTRACT shall govern.

1. **Abuse (as adapted from definition in 42 CFR 455.2)** – Provider practices inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the **TennCare** program or in reimbursement for services not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the **TennCare** program.

2. **Administrative Costs** – All costs associated with the administration of this CONTRACT. 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 **TDMHDD** under the terms of this CONTRACT (e.g., claims processing, marketing) are considered to be an "administrative cost".

3. **Adults - Continuous Treatment Team (CTT)** – A coordinated team comprised of staff that provide a range of intensive, integrated case management, treatment, and rehabilitation services in order to maximize the consumer's level of independence, life functioning, and quality of life. Components include psychiatric services; assessment, evaluation and service planning services; medication and medication management; supporting counseling; vocational referral and linkage; social support services; and advocacy and linkage services.

4. **Adverse Action** – Any action which results in a delay, denial, reduction, suspension, or termination of TennCare Partners benefits, as well as any other acts or omissions of the Contractor which impairs the quality, timeliness, or availability of such benefits. Specific examples include, but are not limited to:

   - The denial or limited authorization of a requested service, including the type or level of service;
   - The reduction, suspension, or termination of a previously authorized service;
   - The denial, in whole or in part, of payment for a service;
   - The failure to provide services in a timely manner, as defined by the State;
   - The failure of the **Contractor** to act to dispose of grievances within the timeframes established by the State; or
   - For a resident in a rural area with only one **Contractor**, the denial of a Medicaid **Enrollee's** request to exercise his or her right to obtain services outside the network under the following circumstances:

- The service or type of provider (in terms of training, experience, and specialization) is not available within the **Contractor's** network.
- The provider is not part of the network, but is the main source of service to an **Enrollee**, provided that –
  - The provider is given the opportunity to become a participating provider under the same requirements for participation in the **Contractor's** network as other network providers of that type.
  - If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the **Enrollee** will be transitioned to a participating provider within 60 days (after being given an opportunity to select a provider who participates).
  - The only plan or provider available to the **Enrollee** does not, because of moral or religious objections, provide the service the **Enrollee** seeks.
  - The **Enrollee's** primary care provider or other provider determines that the **Enrollee** needs related services that would subject the **Enrollee** to unnecessary risk if received separately and not all the related services are available in the network.
  - The State determines that other circumstances warrant out-of-network treatment.

5. **Alcohol Abuse** – A condition characterized by the continuous or episodic use of alcohol resulting in social impairment, vocational impairment, psychological dependence or pathological patterns of use.

6. **Alcohol Dependence** – Alcohol abuse which results in the development of tolerance or manifestations of alcohol abstinence syndrome upon cessation of use.

7. **Appeal Procedure** – The process for resolving an **Enrollee's** right to contest verbally or in writing any adverse action which was taken by the **Contractor** to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the **Contractor** which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by **TennCare** Rules 1200-13-13-.11, 1200-13-14-.11 and any and all applicable court orders.

8. **BHO Application** – The application including all supporting material submitted by the **Contractor** to demonstrate its ability to participate in the **TennCare Partners Program.**

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

10. **Behavioral Health Care** – Generally recognized and accepted mental health and substance abuse services.

11. **Behavioral Health Organization (BHO)** – An entity that organizes and assures the delivery of behavioral health services.

12. **Behavioral Health Organization Advisory Council** - A culturally and racially diverse group of individuals comprised of at least fifty-one percent

(51%) consumers and/or family members of consumers who advise and provide input to the **Contractor** regarding contractual obligations and the provision of behavioral health services. This Council also provides oversight and stakeholder perspective into the **Contractor's** overall operation of the **TennCare Partners Program**.

13. **Benefits** – A schedule of behavioral health care services to be delivered to all **Enrollees** covered in the **Contractor's** plan developed pursuant to Section 2.6 of the CONTRACT.

14. **Best Practice Guidelines** – A set of patient care strategies to assist providers in clinical decision making which are developed by **TDMHDD**.

15. **CFR (Code of Federal Regulations)** – Regulations of the Center for Medicare and Medicaid of the U.S. Department of Health and Human Services.

16. **CMS (Centers for Medicare and Medicaid Services)** – The federal agency responsible for oversight of the Medicaid and Medicare programs.

17. **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

18. **Capitation Rate** – When used to describe payments to the provider: the fee which is paid by **TennCare** to a **Contractor** for each **Enrollee** covered under a plan for the provision of behavioral health services, whether or not the **Enrollee** utilizes services during the payment period. Also used to reference a method of payment in which the organization delivering care provides a defined set of services to persons in a defined group for a single rate, usually calculated and paid on a per person per month basis.

19. **Children/Adolescents – Continuous Treatment Team (CTT)** – A coordinated team of staff who provide a range of intensive, integrated case management, treatment, and rehabilitation services. The general intent is to provide intensive treatment to families of children/adolescents with acute psychiatric problems in an effort to prevent the child's 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.

20. **Children At Risk of State Custody** – Children who are determined to belong in one of the following two groups:

    a. Children at imminent risk of entering custody - Children who are at risk of entering State custody as identified pursuant to T.C.A. 37-5-103 (10).

    b. Children at serious risk of entering custody: Children whom DCS has identified as a result of a Children's Protective Services (CPS) referral; or children whose parents or guardians are considering voluntary surrender (who come to the attention of DCS); and who are highly likely to come into custody.

21. **Center of Excellence (COE) for Children** – Tertiary care academic medical center designated by the State as possessing, or being in a position to quickly develop, expertise in pediatrics, child behavioral health issues (including aggression, depression, attachment disorders and sexualized behaviors), and the unique health care needs of children in State custody.

22. **Claim** – A bill for services, a line item of service or all services for one recipient within a bill.

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

24. **Clean Claim** – A claim received by the BHO for processing or adjudication which requires no further information, adjustment, or alteration by the provider of the services or from a third party in order to be processed and paid or appropriately denied by the BHO. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

25. **Clinical Inquiry** – Contact regarding the status of, or information regarding, the direct care or treatment needs of an individual.

26. **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.

    b. **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.

    c. **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.

    d. **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.

    e. **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.

27. **Cold Call Marketing** – Any unsolicited personal contact by the **Contractor** with a **Potential Enrollee** for the purpose of marketing.

28. **Community Services Agency** – A quasi-governmental entity that provides coordination of funds or programs designed for the care of children and other citizens in Tennessee.

29. **Community Services Area (CSA)** – One or more counties in a defined geographical area in which a BHO is authorized to enroll and serve **TennCare Enrollees** in exchange for a monthly capitation fee. There are

12 CSAs in Tennessee, eight are in rural areas and four are located in metropolitan areas.

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

1. Northwest CSA: Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll and Benton Counties

2. Southwest CSA: Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester and McNairy Counties

3. Shelby CSA: Shelby County

4. Mid-Cumberland CSA: Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson and Rutherford Counties

5. Davidson CSA: Davidson County

6. South Central CSA: Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore Counties

7. Upper Cumberland CSA: Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, DeKalb, Putnam, Cumberland, White, Cannon, Warren and Van Buren Counties

8. Southeast CSA: Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley and Marion Counties

9. Hamilton CSA: Hamilton County

10. East Tennessee CSA: Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon and Roane Counties

11. Knox CSA: Knox County

12. First Tennessee CSA: Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter and Johnson Counties

30. **Comprehensive Child & Family Treatment (CCFT)** – A high intensity, time limited service designed to provide stabilization and to deter the “imminent” risk of State custody for the member. The primary goal of CCFT is to reach an appropriate point of stabilization so the

member can be transitioned to CTT or other clinically appropriate services.

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

32. **Contract** – The **TennCare Partners Behavioral Health Contractor Agreement** is the contract entered into by **TDMHDD** on behalf of the State of Tennessee with one or more entities (referred to as BHOs) that have been issued certificates of authority by the Tennessee Department of Commerce and Insurance, under Tennessee law, to act as pre-paid limited health services organizations for the purpose of delivering mental health and substance abuse services covered by the **TennCare Partners Program** as well as certain services for specified non-participants. The Contract is also referred to in the Operational Protocol New TennCare Waiver 2002-2007 or other predecessor documents as the Contractor Risk Agreement, Provider Risk Agreement, managed care contractor, or TennCare/BHO contract.

33. **Covered Service** – See Benefits.

34. **DHHS** – United States Department of Health and Human Services.

35. **Department of Children's Services (DCS)** – The State agency having the statutory authority to provide a system of services for children in the custody of the State, or at risk of State custody.

36. **Department of Children's Services (DCS) Custody Children (Children in State Custody)** – Children in State custody who have been identified by DCS as belonging in one of the following groups:

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

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

37. **Developmental Disability** – A condition based on having either a chronic disability or mental retardation.

38. **Disenrollment** – The discontinuance of an **Enrollee's** entitlement to receive covered services under the terms of this CONTRACT, and deletion from the approved list of **Enrollees** furnished by **TDMHDD** to the **Contractor**.

39. **EPSDT (Early Periodic Screening, Diagnosis and Treatment)** – Screening in accordance with professional standards, interperiodic screening and diagnostic services to determine the existence of physical

or mental illness or conditions in recipients under age 21; and healthcare, treatment, and other measures to correct, ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered.

40. **Eligible Person** – Any person certified by **TennCare** as eligible to receive services and benefits under the **TennCare Program**.

41. **Emergency Medical Condition (as related to mental health and substance abuse treatment services)** – A mental health or substance abuse condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or to result in placing another individual at immediate substantial likelihood of serious harm.

42. **Emergency Services** – means covered inpatient and outpatient services that are: furnished by a provider that is qualified to furnish these services under this title and that are needed to evaluate or stabilize an emergency medical condition.

43. **Enrollee** – Any eligible person who has enrolled in the **Contractor's** plan in accordance with the provisions of this CONTRACT.

44. **Enrollee Month** – A month of health care coverage for a **TennCare** eligible enrolled in a BHO plan.

45. **Enrollee with Special Health Care Needs** – **Enrollees** in institutional eligibility categories, including those who are enrolled in home and community based programs as an alternative to institutional placement (except that dually eligible **Enrollees** shall be exempt from this category); and **Enrollees** in foster care.

46. **Enrollment** – The process by which a person becomes an **Enrollee** of the **Contractor's** plan.

47. **Executive Oversight Committee** – The Committee designed by the State to have primary oversight responsibility for the implementation of a health service system for children in State custody, in accordance with the Revised Remedial Plan/Remedial Plan and the EPSDT Consent Decree.

48. **FPL** – Federal Poverty Level.

49. **FTE** – Full time equivalent position.

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

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

52. **Fiscal Agent** – Any agency who processes claims for payment and performs certain other related functions.

53. **Forensics** – As generally defined by **TDMHDD** - Court ordered evaluation (competency to stand trial and mental condition at the time of the crime) and treatment for pre-trial defendants and evaluation and treatment for individuals found not guilty by reason of insanity. For purposes of this CONTRACT, "Forensics" is defined as court ordered outpatient services for individuals found not guilty by reason of insanity or incompetent to stand trial.

54. **Fraud** – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

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

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

56. **Health Care Financing Administration** – The former name of CMS, the federal agency responsible for oversight of the Medicaid and Medicare programs.

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

58. **Implementation Team** – A team of medical professionals under the direction of the Commissioner of Health who is charged with staffing the

59. Executive Oversight Committee and overseeing the operational details of the Remedial Plan. The Implementation Team can determine if services which have been ordered for children at risk of custody and denied by the BHO are to be implemented while awaiting the results of an appeal.

59. **IRS** – Drugs that are Identical, Related or Similar to Less than Effective drugs.

60. **Interperiodic Screening** – A screening service for a child under age twenty-one (21) to determine the existence of physical and mental illness or conditions that occurs in between the times designated in the periodicity schedule for providing screens.

61. **Judicial** – An individual who requires **Judicial Services** as specified in Section 2.2.2 of this CONTRACT, but does not meet eligibility requirements for enrollment in the **TennCare Partners Program**. A **Judicial** is not an **Enrollee** of **TennCare** or an **Enrollee** in the BHO plan and is entitled to BHO coverage of only those mental health evaluation and treatment services required by the statute or court order under which the individual was referred.

62. **Judicial Services** – Evaluation and treatment services required by statute as specified in Section 2.5.7 of this CONTRACT. Judicial services are provided by BHOs under the **TennCare** Partners Program to persons who require them by statute (specified in Section 2.5.8 of this CONTRACT), whether they are **TennCare Partners Program Enrollees** or enter the **TennCare Partners Program** as **Judicials**.

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

64. **Letter of Referral** – A document developed by a BHO and a mental health or substance abuse provider which is not in the BHO's network, but which has responsibility for service to persons in the **TennCare Partners Program**.

65. **MCO** – Managed Care Organization (includes HMOs and PPOs).

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

67.

67. **Mandatory Outpatient Treatment (MOT)** – Process whereby a person who was hospitalized and who requires outpatient treatment can be required to participate in that outpatient treatment in order to prevent deterioration in his/her mental condition.

68. **Market Area** – One (1) or more community service areas in which the **Contractor** is authorized, by terms of this CONTRACT, to market eligible persons for enrollment in the **Contractor's** plan.

69. **Marketing** – Any activity conducted by or on behalf of the **Contractor** where information regarding the services offered by the **Contractor** is disseminated in order to persuade eligible persons to enroll or accept any application for enrollment in the **Contractor**'s prepaid health plan operated pursuant to this CONTRACT.

70. **Medical Assistance or Medical Care Services** – Covered services provided to **Enrollees** of **TennCare**, including physical health, behavioral health services as permitted by CMS Medicaid Demonstration Project # 11-W-00002/4 **TennCare** Program.

71. **Medical Expenses (sometimes referred to as "Covered Medical Services")** – Consist of the following:

    a. Medical Expenses
    b. Covered Services (as specified in Section 2.5 and Attachment B)
    c. Services provided pursuant to EPSDT for the **TennCare** Medicaid population only
    d. Case Management
    e. Covered services directed by **TennCare** or an administrative law judge
    f. Net impact of reinsurance coverage purchased by the BHO

    For the purposes of determining the Medical Loss Ratio, Medical Expenses do not include:
    a. Services Not Covered (Section 2.6.6)
    b. Services eligible for reimbursement by Medicare
    c. The activities described in or required to be conducted in Section 3 and Attachments B, C, D, E, F, G, (including, but not limited to, utilization management, utilization review activities) which are administrative costs.
    d. This definition does not apply to NAIC filings.

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

73. **Medical Necessity** – Services or supplies provided by an institution, physician, or other provider that are required to identify or treat an **Enrollee's** illness, disease, or injury and which are:

a. Consistent with the symptoms or diagnosis and treatment of the **Enrollee's** illness, disease, or injury;

b. Appropriate with regard to standards of good medical practice;

c. Not solely for the convenience of an **Enrollee**, physician, institution or other provider;

d. The most appropriate supply or level of services that can safely be provided to the **Enrollee**. When applied to the care of an inpatient, **Medically Necessary** further means services for the **Enrollee's** medical symptoms or condition require the services and cannot be safely provided to the **Enrollee** as an outpatient; and

e. When applied to **TennCare Enrollees** under 21 years of age, services shall be provided in accordance with Early, Periodic Screening, Diagnosis and Treatment requirements including federal regulations as described in 42 CRF Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

74. **Medical Records** – A single complete record kept at the site of the **Enrollee's** treatment(s), which documents all of the treatment plans developed, medical services ordered for the member and medical services received by the member. All medical histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical documentation in written or electronic format; and analyses of such information.

75. **Member** – A person who enrolls in the **Contractor's** plan under the provisions of this CONTRACT with **TennCare**.

76. **Mental Health Facility** – Such facilities include an institution, treatment resource group, residence boarding home, sheltered workshop, activity center, rehabilitation center, hospital, community mental health center, counseling center, clinic, halfway house or other entity by these or other names providing mental health services.

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

78. **Mental Health and Substance Abuse Treatment Services (or Emergency Services)** – Covered inpatient and outpatient mental health and substance abuse treatment services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition

that is found to exist using the prudent layperson standard and emergency ambulance transport.

79. **Mental Illness** – A psychiatric disorder, alcohol dependence, or drug dependence, but does not include mental retardation or other developmental disabilities.

80. **NAIC** – National Association of Insurance Commissioners.

81. **Non-Clinical Inquiry** – Contact regarding the status of, or information regarding, non-treatment areas such as eligibility, provider information, BHO information.

82. **Non-Contract Provider** – Any person, organization, agency or entity not directly or indirectly employed by or through the **Contractor** or any of its subcontractors pursuant to the CONTRACT between the **Contractor** and **TDMHDD**.

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

84. **Out-of-Plan Services** – Services provided by a non-CONTRACT provider.

85. **PACT – Program of Assertive & Community Treatment** – A service delivery model for providing comprehensive community-based treatment to persons with severe and persistent mental illness. It is a disciplinary 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 that persons with severe mental illnesses need to live successfully in the community.

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

87. **Post-stabilization Care Services** – Non-emergency covered mental health or substance abuse treatment services related to an emergency medical condition provided after an **Enrollee** is stabilized in order to

maintain the stabilized condition, or, under the circumstances described in 42 CRF 438.114(e) to improve or resolve the Enrollee's condition.

88. **Potential Enrollee** – an **Enrollee** who is a Medicaid recipient, who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an **Enrollee** of a specific **Contractor**.

89. **Primary Care Physician** – A physician responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating

referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

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

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

92. **Priority Participant** – Is an individual who is enrolled in the **TennCare** Program; 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 Participant** expires twelve (12) months after the assessment as been completed. In order for an individual to remain a **Priority Participant** 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.

93. **Provider** – An institution, facility, agency, person, corporation, partnership, or association which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the **Contractor.**

94. **Provider Agreement** – A contract between a BHO and a provider of health care services which describes the conditions under which the provider agrees to furnish covered services to the BHO's members.

95. **Psychiatric Facility** – Such facilities include an institution, treatment resource group, residence boarding home, sheltered workshop, activity center, rehabilitation center, hospital, community mental health center,

counseling center, clinic, halfway house or other entity by these or other names providing mental health services.

96. **Quality Improvement (QI)** – The ongoing process of responding to data gathered through quality monitoring efforts, in such a way as to improve the quality of health care delivered to individuals. This process necessarily involves follow-up studies of the measures taken to effect change in order to demonstrate that the desired change has occurred.

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

98. **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:

a. Person under the age of 18, and

b. 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

b. 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.

99. **Service Authorization Request** – A managed care **Enrollee's** request for the provision of a service.

100. **Service Location** – Any location at which an **Enrollee** obtains any mental health/substance abuse service covered by the **Contractor** pursuant to the terms of this CONTRACT.

101. **Services** – Shall mean the benefits described in Section 2.5, Attachment B, and the Quality Monitoring Plan (Attachment C of this CONTRACT).

102. **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:

a. Age 18 and over; and

b. 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

c. 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.

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

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

105. **Subcontract** – An agreement entered into by the **Contractor** with any other person or entity which agrees to perform any administrative function or service for the **Contractor** specifically related to securing or fulfilling the **Contractor's** obligations to **TDMHDD** under the terms of this CONTRACT, (e.g., claims processing, marketing, etc.) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by the CONTRACT.

    This definition 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 **TDMHDD** under the terms of this CONTRACT. All agreements to provide covered services as described in Section 2.5 of this CONTRACT shall be considered Provider agreements and governed by Section 3.7.2 of this CONTRACT.

106. **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 **TDMHDD** under the terms of this CONTRACT.

107. **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.

108. **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.

a. **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).

b. ***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.

c. **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.

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

110. **TennCare/BHO CONTRACT** – The CONTRACT entered into between the State of Tennessee and a BHO under the **TennCare Program** by which a BHO generally receives a capitation payment in return for providing defined health care services to **TennCare Enrollees**.

111. **TennCare Medicaid Enrollee** – an **Enrollee** who qualifies and has been determined eligible for benefits in the **TennCare Program** through eligibility criteria designated as "TennCare Medicaid" as described in the February 12, 2002 TennCare Program Design and Waiver Modifications as approved by CMS and in the TennCare Rules and Regulations.

112. **TennCare Partners Program** – A component of the TennCare Program consistent with waivers granted by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, whereby the State of Tennessee has been granted the authority to pay a

monthly prepaid capitated payment amount to BHOs for rendering or arranging necessary behavioral health services to persons who are or who would have been Medicaid- eligible under the Medicaid Program as it was administered during Tennessee's fiscal year 1992-93 and non-Medicaid-eligible Tennesseans who are enrolled in the **TennCare** Program.

113. **TennCare Program** – A program established by the State of Tennessee, consistent with waivers granted by Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services, whereby the State of Tennessee has been granted the authority to pay a monthly prepaid capitated payment amount to MCOs and BHOs for rendering or arranging necessary medical services to persons who are or who would have been Medicaid-eligible under the Medicaid Program as it was administered during Tennessee's fiscal year 1992-93 and non-Medicaid-eligible Tennesseans who are uninsured or who are uninsurable and are enrolled in the **TennCare** Program.

113A. **TennCare Representatives** - The State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this Agreement. Such entity(s) may include, but are not limited to, the TennCare Bureau, the Department of Health, the Department of Finance and Administration, the Department of Mental Health and Developmental Disabilities, the Department of Mental Retardation, the TennCare Division within the Tennessee Department of Commerce and Insurance, the Office of Inspector General and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.

114. **TennCare Select** – TennCare Select is the statewide health plan operated by the State of Tennessee (and administered by an ASO contractor) to provide coverage for children in custody, SSI eligible children, and other disability groups. This plan also serves as a backup MCO for areas of the State where there is no other TennCare MCO available.

115. **TennCare Standard Enrollee** – An **Enrollee** who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as “TennCare Standard” as described in the approved TennCare waiver beginning on July 1, 2002 and as amended by CMS on March 24, 2005, and the TennCare Rules and Regulations.

116. **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.

117. **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.

118. **Tennessee Department of Health (DOH)** – The State agency having the statutory authority to provide for health care needs in Tennessee. For the purposes of this CONTRACT, DOH shall mean the State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this CONTRACT.

119. **Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD)** – Serves as the State's mental health and developmental disability authority and is responsible for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information and advocacy for persons of all ages who have mental illness, serious emotional disturbance, or developmental disabilities. For the purposes of this CONTRACT, **TDMHDD** shall mean the State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this **Contract**, such as the TennCare Bureau and TDCI.

120. **Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) clinical Best Practice Guidelines** – a set of patient care strategies developed by **TDMHDD** to assist providers in clinical decision making.

121 **Third Party** – Any entity or funding source other than the member or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical care of the **Enrollee.**

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

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

124. **Urgent** – An urgent condition is defined as an acute onset of a psychiatric condition which while not constituting an immediate substantial likelihood of harm to self or others will if left untreated deteriorate into a bona fide emergency.

125. **Vital BHO Documents** – Consent forms and notices pertaining to the reduction, denial, delay, suspension or termination of services.

126. **Vital MCO Documents** – Consent forms and notices pertaining to the reduction, denial, delay, suspension or termination of services.

ATTACHMENT B

COVERED MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Covered Mental Health and Substance Abuse Services

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Part 1: Services Available to Adults and Children and Adolescents

SERVICE	**Psychiatric Inpatient Facility**

DEFINITION
An inpatient psychiatric facility/unit that offers comprehensive diagnosis, treatment and care to individuals with a mental illness. The focus may be on acute or longer term care and rehabilitation.

ACCESS/AVAILABILITY REQUIREMENTS

Psychiatric Inpatient Facility Services

Geographic Access to the Service Type	Within 60 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Not applicable
Maximum Time for Admission to the Service Type	1 hour (emer invol)/48 hours (invol)/48 hours (vol)

SERVICE COMPONENTS

- **Intake**

The process of gathering information and assessing the need for service as defined under CPT code 90801.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including components such as completing a medical history and conducting a mental status examination.

Social Evaluation
An evaluation to ascertain the social situation of the individual, including components such as compiling personal background, family background, family interactions, living arrangements, economy problems; and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

MOT Discharge
A plan which must be filed with the court, pre-discharge of an individual found not guilty by reason of insanity (NGRI) and not committable. May include court testimony.

48 Hour Evaluation
An evaluation, up to 48 hours, to determine need for treatment, including involuntary commitment.

DCS Transfer Evaluation
An evaluation within five (5) business days of transfer to a psychiatric inpatient facility from a DCS institution to determine if the statutory transfer standard was met.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through components such as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
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.

Medical Evaluation
A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the **Enrollee** and/or essential others. The plan should identify treatment needs necessary to achieve the **Enrollee's** stated goals as well as an explanation of the availability, intensity, and duration of each required service.

The plan must be developed in a face to face encounter with the **Enrollee** and/or face-to-face with essential others in relation to a specific **Enrollee**.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc. May include services provided under a mandatory treatment obligation.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapies with groups of families or married couples are also included if there is **more than one** family or couple in the session. May include services provided under a mandatory treatment obligation.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are in treatment together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital or committed relationship who are in treatment together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, with such interviews centering around the patient's problems without the patient himself necessarily being in direct treatment or being present in the sessions. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy Except Detoxification Purposes)
Treatment through the use of medications. May include services provided under a mandatory treatment obligation.

Education (if child)
The provision of regular and special education, by Tennessee licensed teachers, in compliance with Minimum Rules and Regulations of the Tennessee Department of Education.

ADULT STANDARDS
- meets appropriate state licensure
- JCAHO accredited
- accepts voluntary and involuntary admissions
- must comply with **TDMHDD** Rule 0940-1-1 and 0940-1-2 regarding administration of psychotropic medication
- demonstrate ability to link with other mental health providers

CHILDREN AND ADOLESCENT STANDARDS
- meets appropriate state licensure
- JCAHO accredited
- accepts voluntary and involuntary admissions
- age separated and developmental age appropriate services

- must comply with **TDMHDD** Rule 0940-1-1 and 0940-1-2 regarding administration of psychotropic medication
- demonstrate ability to link with other mental health providers

SERVICE	Outpatient Mental Health

DEFINITION
This service includes a wide array of outpatient services including, but not limited to evaluation, intervention/therapy, or day treatment. The services can either be based on site or can be delivered off-site (anywhere in the community through the Medicaid rehabilitation option).

ACCESS/AVAILABILITY REQUIREMENTS

M.D. SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours. If medication related, within 1 hour
Maximum Time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 business days.

NON-M.D. SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours. If medication related, within 1 hour
Maximum Time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 business days.

DAY TREATMENT/PARTIAL HOSPITALIZATION

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Not applicable
Maximum time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 business days.

SERVICE COMPONENTS

OUTPATIENT MENTAL HEALTH SERVICES

M.D. SERVICES/NON-M.D. SERVICES

- **Intake**

The process of gathering information needed to screen for and/or initiate service as defined under CPT code 90801.

- **Behavioral Health Assessment**

Procedures used to diagnose mental health or substance abuse conditions and determine treatment plans.

- **Interperiodic Screening**
- A screening service for a child under age 21 to determine the existence of mental illness or conditions that occurs in between the times designated in the periodicity schedule for providing screens.**EPSD&T**

Screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for **Enrollees** under age 21.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including components such as compiling a medical history and conducting mental status examination.

Social Evaluation
An evaluation to ascertain the social situation of the individual, including components such as compiling personal background, family background, family interactions, living arrangements, economy problems; to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

MOT Affidavit
A process of filing with a court if an Mandatory Outpatient Treatment (MOT) **Enrollee** is non-compliant with, or is in need of renewal, of MOT. May include court testimony.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through components such as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, and psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
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.

Medical Evaluation
A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the **Enrollee** and/or essential others. The plan should identify treatment needs necessary to achieve the **Enrollee's** stated goals, as well as an explanation of the availability, intensity, and duration of each required service.

The plan must be developed in a face-to-face encounter with the **Enrollee** and/or face-to-face with essential others in relation to a specific **Enrollee**.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc. May include services provided under a mandatory treatment obligation.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples is also included if there is **more than one** family or couple in the session. May include services provided under a mandatory treatment obligation.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are in treatment together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital or committed relationship who are in treatment together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy Except for Detoxification Purposes)
Treatment through the use of medication(s). May include services provided under a mandatory treatment obligation.

Co-occurring Treatment
Treatments and therapies specifically designed to simultaneously treat a mental illness and accompanying substance abuse issues. These therapies are intended for persons who, due to the severity of both conditions, can not be adequately treated in separate programs for these conditions.

Home and Community Treatment
These therapies are specifically designed to be delivered in the setting where the **Enrollee** is actually living. These therapies provide services that address the **Enrollee's** mental illness related functioning in these settings. Settings may include but are not limited to: **Enrollee's** home, nursing home or other non-mental health residential treatment settings.

- **Mental Health Case Monitoring**

A service provided to persons who are largely able to manage much of their own progress. The focus of mental health case monitoring is on psychosocial progress with an emphasis on monitoring stability and independence in the community; coordinating and linking to services; formation of a single point of resource and is a transitional service from more intensive to less intensive mental health case management. Case monitoring shall provide a minimum of one monthly contact with **Enrollee**/family either face-to-face or by phone.

DAY TREATMENT

- **Intake**

The process of gathering information and assessing the need for service as defined under CPT code 90801.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including components such as compiling a medical history and conducting a mental status examination.

Social Evaluation
An evaluation to ascertain the social situation of the individual, including components such as compiling personal background, family background, family interactions, living arrangements, economy problems; to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through components such as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
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.

Medical Evaluation
A medical/physical examination by a physician.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the **Enrollee** and/or essential others. The plan should identify treatment needs necessary to achieve the **Enrollee's** stated goals, as well as an explanation of the availability, intensity and duration of each required service.

The plan must be developed in a face to face encounter with the client and/or face to face with essential others in relation to a specific client.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples is also included if there is **more than one** family or couple in the session.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are in treatment together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital or committed relationship who are in treatment together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy Except for Detoxification Purposes)
Treatment through the use of medication(s).

- **Interpersonal Skill Training**

Training in communication, assertion, decision making, getting along with others, making friends and appropriate expression of feelings.

- **Daily Living Skills Training**

Training to help **Enrollees** acquire skills in shopping, budgeting, use of community resources, grooming, housekeeping, etc.

- **Leisure Skills Training**

Activities which assist **Enrollee** to meet leisure and social needs in their community in accordance with their income and their interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the general community.

- **Education Activities**

Activities aimed at providing the **Enrollee** with more information (i.e., current events, medication use and side effects, physical health and basic adult education).

- **Pre-Vocational Activities**

Activities to assist the **Enrollee** to learn job acquisition skills (i.e., filling out job applications and interviewing for the job).

PARTIAL HOSPITALIZATION

Partial hospitalization is defined as a non-residential medically directed treatment program that offers intensive, coordinated, and structured services for adults and/or children within a stable therapeutic milieu. Partial hospitalization embraces day, evening, night, and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized mental health service approaches. Partial hospitalization is designed to provide intensive treatment services for individuals who are able to be voluntarily diverted from inpatient psychiatric hospitalization or require intensive treatment after discharge from an inpatient stay. Programs are designed to serve individuals with significant impairment resulting from a psychiatric, emotional or behavioral disorder. Such programs are also intended to have a positive impact on the individual's support system.

Partial hospitalization programs may either be free standing or integrated with a broader mental health or medical program. If integrated, partial hospitalization must be a separate, identifiable, organized program representing a significant link within the continuum of comprehensive mental health services.

ADULT STANDARDS

M.D. SERVICES and NON-M.D. SERVICES

- meets appropriate State licensure
- must have 24 hour phone answering availability and referral
- on and off-site capability
- on-going staff training
- demonstrate ability to link with other mental health providers

DAY TREATMENT

- must meet appropriate State licensure
- on-going staff training
- demonstrate ability to link with other mental health providers

PARTIAL HOSPITALIZATION

- must meet appropriate State licensure
- on-going staff training
- demonstrate ability to link with other mental health providers

CHILDREN AND ADOLESCENT STANDARDS

M.D. SERVICES and NON-M.D. SERVICES

- meets appropriate State licensure
- must have 24 hour phone answering availability and referral
- on and off-site capability
- age and developmental age appropriate
- on-going staff training
- demonstrate ability to link with other mental health providers

DAY TREATMENT

- must meet appropriate State licensure
- on-going staff training
- demonstrate ability to link with other mental health providers
- the provision of regular and special education, by TN licensed teachers, in compliance with Minimum Rules and Regulations of the Tennessee Department of Education

PARTIAL HOSPITALIZATION

- must meet appropriate State licensure
- on-going staff training
- demonstrate ability to link with other mental health providers

SERVICE	Crisis Services

DEFINITION

Crisis Services

When there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others, crisis services are available to anyone living in Tennessee regardless of insurance type or coverage. Crisis Services are available twenty-four (24) hours a day seven (7) days a week for anyone experiencing a mental health crisis, an urgent condition, or a psychiatric emergency. A mental health crisis is defined as any mental health issue perceived to be a crisis by the above mentioned individuals. An urgent condition is defined as an acute onset of a psychiatric condition, not constituting an immediate substantial likelihood of harm to self or others, but if left untreated it may deteriorate into a psychiatric emergency. A psychiatric emergency is defined as an acute onset of a psychiatric condition that manifests itself by an immediate substantial likelihood of serious harm to self or others. These services will include twenty-four (24) hour telephone lines, triage, intervention, and evaluation for additional services/treatment and follow-up services. For admission to Regional Mental Health Institutes (RMHIs), Crisis Teams are capable of performing the functions of mandatory prescreening in accordance with Title 33, Chapter 6 of Tennessee Code Annotated, to ensure an effective inpatient diversion system and maintain the individual in the least restrictive environment as appropriate. Private hospitals that have been approved by **TDMHDD** will also accept mandatory pre-screening from the crisis team. Crisis services shall not be responsible for pre-authorizing involuntary hospitalization.

ACCESS/AVAILABILITY REQUIREMENTS

Crisis Services

Geographic Access to the Service Type	Within 30 miles of an Individual's Home
Response Time to Contact an Individual in an Urgent Situation	N/A
Maximum Time for a Face-to-Face Contact for an Individual	Within 1 hour in an emergency and within 4 hours in an urgent situation.

SERVICE COMPONENTS

Activating Crisis Services

Telephone and Walk-in Triage

Crisis services can be activated by a telephone or by a walk-in center. A triage screening determines what type of crisis is occurring, medical, mental health, a community safety concern or an issue that can be effectively addressed by an active case manager. The triage screening also determines the appropriate intervention needed to alleviate the crisis. The triage screening can be completed via telephone or in the case of a walk-in, via face-to-face.

Crisis Services Intervention

The triage screening determines the needs of the individual, the nature of the mental health crisis, the availability of an active case manager, or if the crisis team would be the appropriate response. An intervention may be completed via telephone or, as needed face-to-face. At the time of intervention, an assessment is completed to determine the substantial likelihood of harm to self or others and/or the need for referral(s) to additional services/treatment. The intervention is intended to involve the appropriate resources necessary to stabilize the individual and prevent the crisis from escalating.

Telephone Intervention
A telephone intervention is between crisis staff and the individual and/or the family. The intervention is intended to assess the need for mobile crisis services or a referral to the appropriate resource(s) in order to stabilize the individual and to prevent the crisis from escalating.

Mobile Crisis Intervention
Crisis staff are dispatched to the location of the individual in crisis to complete a face-to-face assessment to determine the risk or substantial likelihood of harm to self or others and/or the need for referral(s) to additional services/treatment, or intervene to stabilize the individual and prevent the crisis from escalating.

Walk-In
Crisis staff completes an assessment of the individual, who has walked in to the center, to determine the risk of substantial likelihood of harm to self or others and/or the need for referral(s) to additional services/treatment, or intervene to stabilize the individual and prevent the crisis from escalating.

Referral

Linking the individual with the appropriate resources to provide care, following stabilization.

Psychiatric Hospitalization and Mandatory Pre-Screening to the RMHI

A face-to-face assessment is completed to determine if inpatient psychiatric hospitalization is the least restrictive option to alleviate the crisis. All RMHIs require a mandatory pre-screening be completed before admission. Private hospitals that have been approved by **TDMHDD** may also accept mandatory pre-screening from the crisis team.

Follow-Up

Telephone call(s) or a face-to-face assessment(s) between crisis staff and the individual following the crisis intervention session, to ensure the safety of the individual until treatment is scheduled or treatment begins and/or the crisis is alleviated. Follow-up services could be once a day for several days or several times a day, as deemed necessary by crisis staff.

Crisis Respite

Crisis respite services are intended to provide immediate shelter to those individuals with emotional/behavioral problems who are in need of emergency respite. These services involve short-term respite with overnight capacity for room and board, while meeting the crisis need and is provided by trained crisis respite staff. For children/adolescents, parental, guardian, or court authorization must be given for the use of crisis respite services. Crisis respite is in an approved community location, which can be facility-based, home-based or hospital-based, depending on the need and availability.

Facility-based Crisis Respite Services
Crisis respite services that utilize a placement in a facility with direct care from trained crisis respite staff in direct response to the assessment of risk.

Home-based Crisis Respite Services
Crisis respite services that utilize a placement in an approved home or the home of the individual, with direct care from trained crisis respite staff or family members in direct response to the assessment of the risk.

Hospital-based Crisis Respite Services
Crisis respite services, that utilize hospital emergency rooms or other acute psychiatric services based on the assessment of risk to the individual and/or the need for a medically supervised setting.

ACCESS/AVAILABILITY REQUIREMENTS

Crisis Respite

Geographic Access to the Service Type	Within 30 miles of an Individual's Home
Response Time to Contact an Individual in an Urgent Situation	Within 1 hour
Maximum Time for Admission to the Service Type	Within 2 hours

SERVICE	Psychiatric Rehabilitation

DEFINITION

Psychiatric Rehabilitation

An array of consumer-centered services designed to assist the individual to attain or maintain his or her optimal level of functioning. These services involve assessing the individual's readiness and or interest in the development of a rehabilitation plan followed by either a plan to develop readiness or a specific rehabilitation plan. These services are to assist the individual to develop or improve the skills and supports needed in order to perform as successfully and independently as possible in the living, working, learning, or socializing roles and environments of their choice.

Supported Employment

This consists of a range of services to assist consumers to prepare for, obtain, and maintain employment. This service also includes a variety of support services to the consumer, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Supported Housing – This service refers to facilities staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff support. These facilities are for persons with serious and persistent mental illnesses 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. Supported Housing does not include the payment of room and board.

Peer Support

These services are consumer-family based and operated providing self-help skills. Services are often provided during the evening and weekend hours.

Psychosocial Rehabilitation

A consumer-centered group of services for consumers to enhance and support the process of recovery. Service recipients, in partnership with staff, form goals for skill development in the areas of vocational, educational, and interpersonal growth that serve to maximize opportunities for successful community integration. Service recipients proceed with the goal development at their own pace and may continue in the program with varying intensity for an indefinite period of time

ACCESS/AVAILABILITY REQUIREMENTS

PSYCHIATRIC REHABILITATION

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	N/A
Maximum Time for Admission to the Service Type	Within 14 calendar days

SERVICE COMPONENTS

SUPPORTED EMPLOYMENT (SITE-BASED/SERVICE-BASED)

- **Programmatic Admissions Screening**

The process of gathering information and assessing the need for service.

- **Assessment**

Educational Evaluation
An evaluation to determine academic interest aptitudes and achievements.

Vocational and Work Evaluation
An evaluation to determine vocational interests, aptitudes and achievements.

Rehabilitation Readiness Assessment
An assessment to determine the individual's current interest and skills needed to develop and attain rehabilitation goals.

- **Service Plan**

An individualized comprehensive plan which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify services and assistance necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

The plan must be developed in a face-to-face encounter with the consumer and/or face-to-face with essential others in relation to a specific consumer.

- **Enclave**

A work unit provided by a licensed vocational program consisting of two (2) or more individuals with a severe and/or persistent mental illness working in a normal, competitive work setting. The setting focuses on assessment, training and work experience with pay.

- **Social Support Services**

Group and individual activities or programs provided in a supportive environment. The service is non-clinical and is not meant to provide a treatment intervention. The service promotes peer support and socialization. The service might also provide an individual

client with assistance in the use of community resources and might refer and link the client to the appropriate service.

- **Pre-vocational Work Units**

A structured work environment or program provided by the agency that focuses on assessment, training and work experience. The setting is located at the agency.

- **Interpersonal Skills Training**

Training in communication, decision making, problem solving, relationship building, peer support, self-responsibility and self advocacy.

- **Daily Living Skills Training**

Teaching the skills at the location where the skills are to be used as opposed to teaching the skills at the program site. Skills taught include budgeting, nutrition, safety, banking, self medication, shopping, use of transportation, etc.

- **Leisure Skills Training**

Assisting clients to meet their leisure and social needs in their community in accordance with their income and interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the community at large.

- **Educational Development**

Linking the client to basic adult education opportunities, GED opportunities in the community.

- **Self Help Groups**

Consumer run groups conducted for the purpose of providing companionship, mutual support and self-advocacy.

- **Family Involvement**

Reinforcement and encouragement of family members as natural support systems. Family education in crisis management, psychopharmocology and community resources. Skills are learned via staff and consumer participating together and mutually sharing the activity. The staff serves in the role model function by working on a task side by side with the consumer.

- **Pre-vocational Job Readiness**

Supportive employment sessions are initial contacts between the job coach and the consumer to help the consumer develop choices about employment and select the types of jobs preferred.

- **Job Coaching**

Assistance provided to a consumer by the staff member or “job coach” for the purpose of modifying behaviors that represent barriers for the consumer to become/maintain gainful employment.

- **Development of Job Sites**

Activities related to the initiation and development of new employment resources, utilizing private, local, state, and/or federal resources. Emphasis is on the resource development which parallels the community at large.

- **Job Placement**

Activities which match employer and employee needs to a particular job.

- **Employer Support**

Contact with the Employer/Supervisor is made in relation to a specific consumer's job performance from the employer's perspective. May also include educating the employer in providing job coaching assistance to the consumer, restricted to activities directly related to the consumer's job and performed by a staff member whose major responsibilities are supported employment work functions.

- **Community Education/Advocacy**

Community educational and advocacy activities related to identifying service needs.

- **Rehabilitation Plan**

A plan developed by the consumer, in partnership with staff, to change or improve his or her role in one of the specific life domains of living, working, learning, and socializing. The plan should include the specific goal, services and supports needed to achieve the goal as well as the method to be used to achieve the goal.

- **Rehabilitation Readiness Development Plan**

A plan to develop the skills needed in order to set and pursue a rehabilitation goal.

ADULT STANDARDS

PSYCHIATRIC REHABILITATION

- must meet appropriate state licensure
- at least 85% of jobs are jobs which exist normally in the community
- consumers must have reliable transportation plans
- on-going staff training
- demonstrate ability to link with other mental health providers

SERVICE	***Pharmacy Services for Psychotropic Medication***

DEFINITION
Psychotropic medication and pharmacy services related to dispensing this medication.

ACCESS/AVAILABILITY REQUIREMENTS

Pharmacy Services for Psychotropic Medication

Geographic Access to the Service Type	Access that transportation time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours
Maximum Time for Admission to the Service Type	Within 7 calendar days

STANDARDS
- must meet appropriate state licensure

REMINDER: THE COST OF THIS BENEFIT IS COVERED BY THE STATE

SERVICE	Lab Services Related to Psychiatric Needs

DEFINITION
Lab services related to psychiatric treatment.

ACCESS/AVAILABILITY REQUIREMENTS

Lab Services Related to Psychiatric Needs

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours
Maximum Time for Admission to the Service Type	Within 7 calendar days

STANDARDS
- must meet appropriate state licensure

SERVICE	**Transportation to Covered Benefits**

DEFINITION
The BHO will, except as otherwise provided in **Standards** below, assure the provision of necessary transportation for eligible recipients to and from providers in order for the eligible recipients to obtain **TennCare** covered services.

ACCESS/AVAILABILITY REQUIREMENTS

Transportation to Covered Mental Health Services

Geographic Access to the Service Type	Within 30 miles of the Enrollee
Response Time to Contact an Active Consumer in an Urgent Situation	Within 2 hours
Maximum Time for Admission to the Service Type	While a maximum time is not specified for non-emergency transportation, the BHO may recommend the recipient give the provider a 5 working day notice of their transportation needs whenever possible. Such notice, however, cannot be required.

STANDARDS

Transportation services must meet current **TennCare** standards.

SERVICE	Inpatient/Residential Substance Abuse Treatment and Detoxification

DEFINITIONS

TREATMENT
A hospital inpatient or residential facility that offers comprehensive substance abuse treatment, detoxification and care.

DETOXIFICATION
Inpatient hospital services for consumers who are experiencing or at risk of experiencing a severe withdrawal syndrome or whose treatment needs are complicated by other physical or psychiatric conditions. The goals of this service are to minimize the consumer's discomfort and other potential adverse consequences of withdrawal; encouraging the patient to complete detoxification and enter into a rehabilitation program; and, to the extent the consumer's physical and cognitive condition permits, beginning the rehabilitation process.

ACCESS/AVAILABILITY REQUIREMENTS

INPATIENT & RESIDENTIAL TREATMENT

Geographic Access to the Service Type	Within 60 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Not applicable
Maximum Time for Admission to the Service Type	2 calendar days for all inpatient services/residential services.

DETOXIFICATION

Geographic Access to the Service Type	Within 60 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Not applicable
Maximum Time for Admission to the Service Type	Within 24 hours or 1 hour if an emergency

SERVICE COMPONENTS

TREATMENT

- **Intake**

The process of gathering information and assessing the need for service as defined under CPT code 90801.

- **Evaluation**

- **Treatment Plan**

An individualized comprehensive treatment plan developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

The plan must be developed in a face-to-face encounter with the client and/or face with essential others in relation to a specific consumer.

- **Intervention/Therapy**

DETOXIFICATION

- **Intake**

The process of gathering information needed to screen and initiate service as defined under CPT code 90801.

- **Evaluation**

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

The plan must be developed in a face-to-face encounter with the consumer and/or face to face with essential others in relation to a specific consumer.

- **Intervention/Therapy**

STANDARDS

TREATMENT

- must meet appropriate state licensure

DETOXIFICATION

- must meet appropriate state licensure

SERVICE	Outpatient Substance Abuse Treatment and Detoxification

DEFINITION

TREATMENT
This service includes an array of outpatient substance abuse treatment and detoxification services.

DETOXIFICATION
An outpatient service for consumers withdrawing from psychoactive substances who are not at risk of a severe withdrawal syndrome or psychiatric destabilization and who live in environments that will not undermine their treatment. The goals of this service are to minimize the consumer's discomfort and other potential adverse consequences of withdrawal; encouraging the consumer to complete detoxification and enter into a rehabilitation program; and, to the extent the consumer's physical and cognitive condition permits, beginning the rehabilitation process.

ACCESS/AVAILABILITY REQUIREMENTS

OUTPATIENT TREATMENT

Geographic Access to Service Type	Within 30 miles of an individual's home.
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours
Maximum Time for Admission to Service Type	Within 3 calendar days for all other outpatient services

DETOXIFICATION

Geographic Access to Service Type	With 30 miles of individual's home.
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 Hours
Maximum Time for Admission to Service Type	Within 24 Hours

SERVICE COMPONENTS
TREATMENT

- **Intake**

The process of gathering information and assessing the need for service as defined under CPT code 90801.

- **Evaluation**

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity and duration of each required service.

The plan must be developed in a face-to-face encounter with the consumer and/or face-to-face with essential others in relation to a specific client.

- **Intervention/Therapy**

Therapy may consist of outpatient services, intensive outpatient rehabilitation, or other outpatient services as needed

DETOXIFICATION

- **Intake**

The process of gathering information and assessing the need for service as defined under CPT code 90801.

- **Evaluation**

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

The plan must be developed in a face-to-face encounter with the consumer and/or face-to-face with essential others in relation to a specific client.

- **Intervention/Therapy**

STANDARDS

TREATMENT

- Must meet appropriate state licensure.

DETOXIFICATION

- Must meet appropriate state licensure.
- Consumer cannot have major psychiatric treatment needs.
- Consumer must not be at risk of severe withdrawal syndrome or psychiatric destabilization.
- Consumer must live in environments that will not undermine treatment.
- A Tennessee licensed physician must supervise the detoxification process.
- A minimum of daily re-evaluations by a Tennessee licensed physician or registered nurse.
- Consumer must participate in an outpatient service while he/she is in the detoxification process.

Part 2: Definitions of Services Available to Adults

SERVICE	**Mental Health Case Management - ADULT**

DEFINITION
A series 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 consumer/family access to services. Mental health case management requires the mental health case manager and the consumer and/or family have a strong productive relationship which includes viewing the consumer/family as a responsible partner in identifying and obtaining the necessary services and resources. Mental health case management is provided in community settings which are accessible and comfortable to the consumer/family. The service is available 24 hours a day, 7 days a week. The service is not time limited and provides the consumer/family the opportunity to improve their quality of life.

ACCESS/AVAILABILITY REQUIREMENTS

Mental Health Case Management - Adult

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours
Maximum Time for Admission to the Service Type	Within 7 calendar days

SERVICE COMPONENTS

- **Programmatic Admissions Screening**

The process of gathering information and assessing the need for service.

- **Assessment**

Mental Health Case Management Assessment
An assessment includes, but is not limited to: the ongoing determination of an individual's current and potential strengths, resources, and basic needs through formal and informal evaluation. Assessment components include: intake, mental status, medication, general health, self-care, support network, living situation, employment capabilities and status, educational needs, training needs and consultation with the family. Assessing the consumer's progress with goals and choices on an on-going basis is also considered an assessment.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

- **Service Plan**

An individualized comprehensive plan which is developed, negotiated and agreed upon by the consumer and mental health case manager and/or essential others. Mental health case managers coordinate the development of the service plan. The plan should identify services and assistance necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service. Intensity of case management should be determined by the results of the case management assessment.

The plan must be developed in a face-to-face encounter with the consumer and/or face-to-face with essential others in relation to a specific consumer.

- **Crisis Facilitation**

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific consumer or other person(s) in relation to a specific consumer. It is the process of accessing and coordinating services for a consumer 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 consumer.

- **Assessment of Daily Functioning**

The on-going monitoring of how a consumer 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 consumer in their natural environment..

- **Assessment/Referral/Coordination**

Assessing the needs of the consumer for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the consumer's natural environment.

- **Liaison**

Mental health case management is an activity 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.

RECOMMENDED GUIDELINES

There should be two levels of mental health case management for eligible adults age 18 years and older.

1. Level 1 mental health case management is the most intensive level of service. Frequent and comprehensive support is to be provided to the most severely disabled adults 24 hours per day, 7 days per week. Individuals are at high risk of future hospitalization or placement, and who need both community support and treatment interventions. Level 1 may include such models as CTT, PACT, etc.

2. Level 2 mental health case management is a less intensive level of service which is recovery-oriented and available 24 hours per day, 7 days per week. Symptoms are at least partially stabilized or reduced in order to allow rehabilitation efforts.

   A mental health case manager who is assigned to both a parent(s) and child in the same family, should have the skills and experience needed for both ages.

Focus of the service:

The focus of Level 1 mental health case management is symptom stabilization and addressing basic needs, with an emphasis on the following:

- Obtaining basic human supports;
- Decreasing symptoms and side effects;
- Increasing periods of independence;
- Building support networks; and
- Decreasing period of crisis or severe dysfunction.

The focus of Level 2 mental health case management is psychosocial progress, with an emphasis on:

- Maximizing strengths and recovery outcomes;
- Obtaining and coordinating services and resources;
- Skills Training; and
- Provision of consistent direct support.

Service delivery:

1. Caseload size will be determined based on an average number of consumers per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1 and 2.
   - For Levels 1 and 2, no case manager will have a caseload of over 35 consumers
   - Case load sizes for Adult CTT will be 1:20 with no CTT Case Manager having a caseload of over 20 CTT consumers.

2. Frequency and type of contact will be as follows:
   - For Level 1, a minimum of one face-to-face contact per week , with 80% of these contacts being out of the office.
   - For Level 2, a minimum of two face-to-face contacts per month, with 80% of these contacts being out of the office.
   - For Adult CTT, a minimum of one face-to-face contact (encounter) per week, with 80% of those contacts (encounters) being out of the office.

3. The minimum qualifications for a mental health case manager will be a bachelor's degree. Supervisors should maintain a 1:30 supervisory ratio with mental health case managers.

Expected outcomes:

1. Level 1.

   An increase in:
   - Community tenure
   - Housing stability
   - Social integration
   - Satisfaction

   A decrease in:
   - Frequency or length of hospitalization
   - Medication
   - Symptoms and side effects
   - Impairment from substance abuse
   - Level of care needed and/or desired

2. Level 2.

   An increase in:
   - Community tenure
   - Time spent working or in school
   - Social contacts
   - Personal satisfaction and independence
   - Independent or semi-independent housing

   A decrease in:
   - Crisis episodes
   - Impairment from substance abuse

SERVICE	24 Hour Residential Treatment - ADULT

DEFINITION
Community based facility that offers 24 hour residential care as well as treatment and rehabilitation. The focus may be on short-term crisis stabilization or on long-term rehabilitation.

ACCESS/AVAILABILITY REQUIREMENTS

24 Hour Residential Treatment - ADULT

Geographic Access to the Service Type	Within 70 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 48 hours
Maximum Time for Admission to the Service Type	Within 30 calendar days

SERVICE COMPONENTS

- **Programmatic Admissions Screening**

The process of gathering information and assessing the need for service.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including components such as compiling a medical history and conducting a mental status examination.

Social Evaluation
An evaluation to ascertain the level of social functioning of an individual, including elements such as personal history, family history, family interactions, living arrangements, financial problems; legal history, and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through indicators such as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work Evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

The plan must be developed in a face-to-face encounter with the consumer and/or face-to-face with essential others in relation to a specific consumer.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples is also included if there is **more than one** family or couple in the session.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are in treatment together as a unit. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital or committed relationship who are in treatment together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy Except for Detoxification Purposes)
Treatment provided through the use of medications.

- **Interpersonal Skill Training**

Training in communication, assertion, decision making, relating well to others, making friends and appropriate expression of feelings.

- **Daily Living Skills Training**

Training to help clients acquire skills in shopping, budgeting, use of community resources, grooming, housekeeping, etc.

- **Leisure Skills Training**

Activities which assist clients to meet leisure and social needs in their community in accordance with their income and their interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the community at large.

- **Education Activities**

Activities aimed at providing the client with more information (i.e., current events, medication use and side effects, physical health and basic adult education).

- **Pre-Vocational Activities**

Activities to assist the consumer to learn job acquisition skills (i.e., filling out job applications and interviewing for the job).

ADULT STANDARDS

- meets appropriate state licensure and local housing codes
- meets accreditation standards as required by 42 CFR 441.151
- on-going staff training required

Part 3: Definitions of Covered Services Available Children & Adolescents

SERVICE	Mental Health Case Management
CHILDREN AND ADOLESCENTS	

DEFINITION

A series of actions taken by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the consumer/family access to services. Mental health case management requires the mental health case manager and consumer/family to have a strong productive relationship which includes viewing the consumer/family as a responsible partner in identifying and obtaining the necessary services and resources. Service is focused on the child and the natural or surrogate family. Service may work with multiple systems, e.g., education, child welfare, juvenile justice, etc. The service is available 24 hours a day, 7 days a week. The service is not time limited and provides the consumer/family the opportunity to improve their quality of life.

ACCESS/AVAILABILITY REQUIREMENTS

Mental Health Case Management - Children and Adolescents

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours
Maximum Time for Admission to the Service Type	Within 7 calendar days

SERVICE COMPONENTS

- **Programmatic Admissions Screening**

The process of gathering information and assessing the need for service.

- **Assessment**

Mental Health Case Management Assessment

An assessment including but not limited to: the ongoing determination of an individual's current and potential strengths, resources, and basic needs through formal and informal evaluation. Assessment activities include: intake, mental status, medication, general health, self-care, support network, living situation, employment capabilities and status, educational needs, training needs and consultation with the family. Assessing the consumer's progress with goals and choices on an on-going basis is also considered an assessment activity. Assessment, therefore, is not limited to a formal process.

Target Population Group (TPG) Assessment

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.

- **Service Plan**

An individualized, comprehensive plan developed, negotiated and agreed upon by the consumer and mental health case manager and/or essential others. Mental health case managers coordinate the development of the service plan. The plan should identify services and assistance necessary to achieve the consumer's stated goals, as well as an explanation of the availability, intensity, and duration of each required service.

The plan must be developed in a face-to-face encounter with the consumer and/or face-to-face with essential others in relation to a specific consumer.

- **Crisis Facilitation**

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific consumer or other person(s) in relation to a specific consumer. It is the process of accessing and coordinating services for a consumer 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 consumer.

- **Assessment of Daily Functioning**

The on-going monitoring of how a consumer 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 consumer in their natural environment..

- **Assessment/Referral/Coordination**

Assessing the needs of the consumer for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the consumer's natural environment.

- **Liaison**

Mental health case management activity which offers to persons who are not yet assigned but who are eligible, for mental health case management, short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

RECOMMENDED GUIDELINES

There should be two levels of mental health case management for children and youth.

Level 1 mental health case management is the most intensive level of service. Frequent and comprehensive support is to be provided and available 24 hours per day, 7 days per week. Children may be at imminent risk of out-of-home placement, including psychiatric hospitalization, and/or exhibiting multiple needs requiring services from multiple agencies. Intensive case management may include such models as CTT, CCFT, etc.

Level 2 mental health case management is a less intensive level for children with multiple needs requiring services from one or more agencies.

-

Mental health case management to both a parent(s) and child in the same family, should include skills and experience needed for both ages.

SERVICE DELIVERY:

1. Caseload size will be determined based on an average number of consumers per case manager, with the expectation that case manager will have mixed caseloads of Level 1 and Level 2 cases.

    - For Levels 1 and 2 the average will be 1:18 with no case manager having a caseload of over 30.

2. Frequency of contacts:

- Level 1 will provide an average of 1 face-to-face contact per week with child/family and one weekly contact with systems such as school, probation, and therapist.

- Level 2 will provide an average of 2 face-to-face contacts per month with the child/family and 2 per month with other systems.

- Each C & A CTT consumer will receive a minimum of 12 contacts (encounters) per month.

- In the event an extended contact (encounter) is delivered based on medical necessity, the first hour (and up to 1 hour and 29 minutes) will be regarded as one contact hour, the second contact hour commences at 1 hour and 30 minutes and (up to 2 hours and 29 minutes), the third contact hour commences at 2 hours and 30 minutes (and up to 3 hours and 29 minutes), etc.

3. Eighty percent of all case management services should take place outside the case manager's office.

4. The intervention plan for children in Level 1 and 2 mental health case management must have clear outcome objectives.

5. The C&A case management model should be strengths-based and outcome driven and should adhere to the CAASP principles described in *A System of Care for Children & Youth with Severe Emotional Disturbances*, Stroul and Friedman, 1986; Stroul and Pires, 1997.

6. The C&A case management model provides a transition from C&A services into adult services, including adult case management services. The decision to serve an 18-year old youth via the children's case management system versus the adult system should be a provider's clinical decision. In general, a youth would be maintained in the youth system if current active case management began before the age of 18 and the youth would be expected to be discharged before the 19th birthday. Conversely, if the entry level point occurred after the age of 18 years, the youth would usually be served by adult case management. Transition from children's services, including case management, should be incorporated into the child's service plan.

7. All case management services must be documented in a service plan. Case management activities are correlated to expected outcomes. Outcome achievement is monitored, with progress being noted periodically in a written record.

EXPECTED OUTCOMES

1. Level 1

   An increase in:

   - in-home care
   - social integration
   - family satisfaction
   - other agency/system support
   - regular school attendance

   A decrease in:

   - out-of-house care or hospitalization
   - symptoms and side effects
   - level of care needed

2. Level 2

   An increase in:

   - social contacts
   - time in school
   - child and family satisfaction

   A decrease in:

   - crisis episodes
   - family stress
   - number of services required

SERVICE	24 Hour Residential Treatment CHILDREN AND ADOLESCENT

DEFINITION
Community based facility that offers 24-hour residential care, as well as treatment and rehabilitation. The focus may be on short-term crisis stabilization or on long-term rehabilitation.

ACCESS/AVAILABILITY REQUIREMENTS

24 Hour Residential Treatment - Children and Adolescents

Geographic Access to the Service Type	Within 70 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	48 hours
Maximum Time for Admission to the Service Type	Within 30 calendar days

SERVICE COMPONENTS

- **Programmatic Admissions Screening**

The process of gathering information and assessing the need for service.

- Evaluation

Psychiatric Evaluation
A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation
An evaluation to ascertain the level of social functioning of an individual, including such things as personal history, family history, family interactions, living arrangements, financial problems; legal history, and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
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.

Medical Evaluation
A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work Evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

The plan must be developed in a face-to-face encounter with the consumer and/or face-to-face with essential others in relation to a specific consumer.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is more than one family or couple in the session.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy Except for Detoxification Purposes)
Treatment through the use of medications or drugs.

Interpersonal Skill Training
Training in communication, assertion, decision making, getting along with others, making friends and appropriate expression of feelings.

- **Daily Living Skills Training**

Training to help clients acquire skills in shopping, budgeting, use of community resources, grooming, housekeeping, etc.

- **Leisure Skills Training**

Activities which assist clients to meet leisure and social needs in their community in accordance with their income and their interests. Teaching consumer in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the community at large.

- **Education Activities**

Activities aimed at providing the consumer with more information (i.e., current events, medication use and side effects, physical health and basic adult education).

- **Pre-Vocational Activities**

Activities to assist the consumer to learn job acquisition skills (i.e., filling out job applications and interviewing for the job).

CHILDREN AND ADOLESCENT STANDARDS

- meets appropriate state licensure and local housing codes
- meets accreditation standards as required by 42 CFR 441.151
- age separated and developmental age appropriate services
- on-going staff training required
- the provision of regular and special education, by Tennessee licensed teachers, in compliance with Minimum Rules and Regulations of the Tennessee Department of Education.

ATTACHMENT C

STANDARDS FOR BHO QUALITY MONITORING PROGRAMS

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STANDARDS FOR INTERNAL QUALITY MONITORING PROGRAMS OF BEHAVIORAL HEALTH ORGANIZATIONS CONTRACTING WITH THE TENNESSEE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

A Behavioral Health Organization (BHO) which contracts with the Tennessee Department of Mental Health and Developmental Disabilities (**TDMHDD**) to provide **TennCare** funded mental health services will have in place an internal quality monitoring program. The internal quality monitoring program (QMP) will consist of systematic activities undertaken by the BHO to monitor and evaluate the services delivered to its **Enrollees**. The evaluation will be based on predetermined, objective standards. The primary purpose is to assure and to continually improve the quality of behavioral health services provided.

The BHO will submit a written description of the QMP to **TDMHDD** for approval that shall address each standard specified in Attachment C. The QMP shall be submitted for approval prior to the delivery of services and annually thereafter.

The guidelines provided in this Attachment were developed using standards of **TDMHDD,** Tennessee Department of Health and the Bureau of Alcohol and Drug Abuse Services. The standards were patterned after **TennCare's** requirements for an internal quality monitoring program.

TDMHDD will monitor the BHO's compliance with the standards governing the organization's QMP. The BHO's quality monitoring program is to be evaluated using the following standards.

QMP STANDARDS

STANDARD I: **THE ORGANIZATION HAS A CLEARLY WRITTEN DESCRIPTION OF ITS QMP THAT ASSIGNS RESPONSIBILITY TO APPROPRIATE INDIVIDUALS. THE WRITTEN DESCRIPTION INCLUDES:**

A. Goals and Objectives: The written description contains comprehensive quality assurance/improvement goals and objectives which are developed initially, reviewed annually, and revised as needed. Included is a timetable for implementation and accomplishment of objectives and goals. Objectives must be specific and measurable.

B. Scope:

1. The scope of the QMP is comprehensive, addressing both the quality of behavioral health services provided and the quality of non-clinical aspects of care such as competency of care, awareness, availability, accessibility, consumer family involvement, coordination, continuity of care, basic rights, confidentiality and cultural sensitivity.

2. The QMP methodology provides for a review of the entire range of behavioral health services provided by assuring that all demographic groups, clinically related/target population groups, non-target population groups, service settings (e.g., inpatient, clinic, off-site/home, etc.), and types of services (e.g., mental health case management, residential treatment, partial hospitalization, housing/ residential care, outpatient, and symptom management, specialized crisis services, and psychiatric rehabilitation and support services) are involved in the scope of the review.

C. Specific Activities: The written description specifies the quality of services studies and other activities to be undertaken over a prescribed period of time and the methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities are clearly identified and are appropriate.

D. Continuous Activity: The written description provides for continuous performance of quality assurance/improvement activities, including tracking of issues over time.

E. Provider Review: The QMP provides for:

1. Peer review by appropriate types of behavioral health care professionals of the processes followed in the provision of each different type of behavioral health service [e.g., reviewers of psychosocial services should include a provider(s) of psychosocial services]; and

2. Feedback to provider organizations, to mental health care and substance abuse professionals, and to BHO staff regarding performance, consumer outcomes, and activities of the quality-monitoring program.

3. Network provider participation in quality monitoring program activities.

F. Focus on Outcomes: The QMP methodology addresses the behavioral health outcomes identified by **TDMHDD** and any other outcomes identified by the BHO.

G. Systematic Process of Quality Assurance and Improvement: The QMP objectively and systematically monitors and evaluates the quality and appropriateness of services provided to its **Enrollees** and pursues opportunities for improvement on an ongoing basis.

1. The QMP has written descriptions of the processes for monitoring and evaluating the following, which include the data to be collected and how the data will be analyzed and trended. For *f.* through *h.* below, the BHO reports its findings to **TDMHDD** in accordance with the reporting requirements specified in Attachment E.

   a. Utilization management based on criteria set forth by **TDMHDD**.

   b. Compliance with standards set by **TDMHDD** (including those set forth in this document, those referenced by this document, those referenced by the CONTRACT, and licensure standards);

   c. Measurement of performance as prescribed by **TDMHDD**;

   d. Use of clinical care standards/Best Practice Guidelines which have been approved by **TDMHDD**;

e. Service denials by the BHO;

f. Inpatient psychiatric hospital admissions and readmissions;

g. Satisfaction of consumers and families with the service provided through calendar year 2004. **TDMHDD** shall be responsible for these satisfaction surveys after 2004; and

h. Network provider satisfaction.

2. The BHO improves quality by addressing opportunities identified through clinical quality improvement activities, as appropriate. The BHO also assesses the effectiveness of these interventions through systematic follow-up. As part of the quality assurance and improvement process, cross-functional teams should be established. The team's purpose would be to identify areas where improvements are needed, establish the cause of the problem, develop and implement an improved process, assess its impact and, if needed, adjust or modify the process. This approach follows the Plan-Do-Check-Act (PDCA) cycle and is presented in condensed form below.

   a. Identify and analyze the problem: The problem statement should clearly reveal the discrepancy between what is expected and what is actually happening. Some examples of sources that could be used to identify areas that need improvement are: deficiencies in complying with standards, data that indicate unmet outcomes, failure to consistently use best practice guidelines, consumer/family dissatisfaction as indicated by surveys, and complaints and appeals. In identifying areas that need improvement, under-utilization and over-utilization patterns should be considered.

   b. Design and implement the intervention of new or modified process: After careful analysis of the problem, the team designs or redesigns a process that is expected to improve the process. The change is implemented either system-wide or on a pilot basis. If the problem is isolated, the BHO takes appropriate actions when it identifies individual occurrences of poor quality.

   c. Measure and Assess: Data are systematically collected and analyzed to assess the effectiveness of an intervention or new process. These data are compared to baseline data when available.

d. Evaluate: If the data indicate that the new or modified process has improved the process, the process is kept in place. If the process was implemented on a pilot basis and data indicates improvement, the process is implemented system-wide. If the new or modified process is determined to be ineffective, the team reconvenes to design and implement another process.

e. Inform Senior Management: Senior management should be kept abreast of the team's progress. The results should then be carefully documented and made a part of the organization's record.

3. The scope and content of the QMP reflect the BHO's delivery system and the relevant clinical issues that affect members of its covered population.

   a. The BHO assesses and evaluates at least three clinical issues relevant to its membership on an annual basis. The study topic and methodology are submitted to **TDMHDD** for prior approval.

      1. At least two clinical issues are selected from:

         - high-volume diagnoses or services; or
         - high-risk diagnoses, services, or special populations, such as:
           persons with serious and persistent mental illnesses, persons with dual diagnoses, children in State custody.

      2. At least one clinical issue is also selected from:

         - inpatient facility services;
         - partial facility services; or
         - ambulatory services

   b. The BHO identifies at least two clinical issues for **TDMHDD** approval in collaboration with the QI Committee.

   c. The BHO monitors to detect potential under- and over-utilization of services.

4. The BHO evaluates the overall effectiveness of the QMP and demonstrates improvements in quality of clinical care and service provided to its members.

a. The BHO must complete quarterly QMP Progress Reports which describe actions taken, progress made toward meeting quality assurance/improvement objectives, and improvements made.

b. The BHO must conduct an annual written evaluation that includes:

1. a description of Quality Improvement (QI) activities and studies that have been completed or are ongoing;

2. trended quality-of-clinical care and service performance measures and desired outcomes and progress toward achieving desired outcomes, including performance measures specified in Attachment E;

3. an analysis of demonstrated improvements in the quality of clinical care and service;

4. current areas of deficiencies and recommendations for corrective action;

5. an evaluation of the overall effectiveness of the QMP;

6. utilization data; and

7. an assessment of provider accessibility and availability.

c. The BHO documents how QI activities have improved clinical care, preventive behavioral health services and member services.

d. The BHO makes available to its members, practitioners and Advisory Board information about its QI program, and its quarterly QMP reports and annual evaluation.

e. Upon completion of the quarterly QMP reports and the annual evaluation, the BHO submits their full report to **TDMHDD**.

f. The BHO makes available the results of the quarterly QMP reports and annual written evaluation to their Advisory Board, providers and relevant stakeholders.

g. In addition, the BHO submits to **TDMHDD** revised quality management and improvement plan(s) for the next contract year.

5. The findings, conclusions, recommendations, actions taken and results of the actions taken as a result of the quality assurance/improvement activities are documented and reported to appropriate individuals within the BHO and through the established quality assurance/ improvement channels.

   a. Quality assurance/improvement information is used in recredentialing, reconstructing, and/or annual performance evaluations.

   b. Quality assurance/improvement activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of **Enrollee** complaints and appeals.

   c. There is a linkage between quality assurance/improvement and other management functions of the BHO such as network changes, service redesigns, benefits changes, and medical management system.

6. The BHO develops an annual QI work plan or schedule of activities that includes:

   a. the objectives, scope, and planned projects or activities for the year;

   b. planned monitoring of previously identified issues, including issues to be tracked over time; and

   c. a planned evaluation of the QI program.

H. Evaluation of the Continuity and Effectiveness of the QMP:

1. The BHO must conduct an annual evaluation of the scope and content of the written QMP to ensure it covers all types of services provided in all settings to all categories of enrolled individuals.

2. On an annual basis, the BHO must collect, analyze, and report data to **TDMHDD** regarding the number of individuals who have had more than one mental health case manager during the previous year. This will include a breakdown of how many

Enrollees have had two mental health case managers, three mental health case managers, and so forth. Also included with these data, should be a compilation of the reasons for changes in mental health case managers and how many individuals changed mental health case managers for each of the identified reasons.

3. At the close of each contract year, the BHO submits to **TDMHDD** a written report on the QMP which addresses: quality improvement studies and other activities completed; trending of data related to desired outcomes; quality improvements made during the previous year; current areas of deficiencies and recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP. In addition, the BHO submits to **TDMHDD** its revised QMP plan for the next contract year.

STANDARD II: **THE GOVERNING BODY OF THE BHO IS THE BOARD OF DIRECTORS OR, WHERE THE BOARD'S PARTICIPATION WITH QUALITY IMPROVEMENT ISSUES IS NOT DIRECT, A DESIGNATED COMMITTEE OF THE SENIOR MANAGEMENT OF THE BHO. RESPONSIBILITIES OF THE GOVERNING BODY FOR MONITORING, EVALUATING, AND MAKING IMPROVEMENTS TO SERVICES INCLUDE:**

A. Oversight of the QMP: There is documentation that the Governing Body has approved the overall QMP plan and all subsequent revisions.

B. Oversight Entity: The Governing Body has formally designated an accountable entity or entities within the BHO to provide oversight of the organization's quality assurance/ improvement efforts.

C. Constituting an Advisory Board: The Governing Body has the responsibility for constituting an Advisory Board as required by **TDMHDD**. The primary purposes of the advisory board are to assist the BHO with its internal quality monitoring and to advise the Governing Body regarding issues around the provision of services.

D. QMP Progress Reports: The Governing Body and the Advisory Board receive, at least quarterly, written reports from the QMP which describe actions taken, progress made toward meeting quality assurance/improvement objectives, and improvements made.

E. Annual QMP Evaluation: The Governing Body and the Advisory Board formally review on a periodic basis (but no less frequently than annually) a written report on the QMP which includes, at a minimum, studies undertaken, results, and subsequent actions; aggregate data on utilization; the quality of services provided; progress toward achieving desired outcomes; and an assessment of provider accessibility.

STANDARD III: **THE QMP IDENTIFIES A COMMITTEE WHICH IS RESPONSIBLE FOR PERFORMING QUALITY ASSURANCE/ IMPROVEMENT FUNCTIONS WITHIN THE BHO AND IS ACTIVELY INVOLVED IN THE REVIEW, ANALYSIS AND ENHANCEMENT OF THE QUALITY ASSURANCE AND IMPROVEMENT PROGRAM. THE COMMITTEE HAS:**

A. Regular Meetings: The committee meets on a regular basis with specified frequency to oversee QMP activities. The frequency must be sufficient to demonstrate that the committee is following up on all findings and required actions. The committee must meet at least quarterly.

B. Established Parameters for Operating: The role, structure, and functions of the committee itself are specified in writing. At a minimum, the role of the QMP Committee must include recommending policy decisions, reviewing and evaluating quality assurance/improvement activities, instituting needed actions, and ensuring appropriate follow-up.

C. Documentation: There is written documentation of the committee's activities, findings, recommendations, and actions.

D. Accountability: The QMP committee is accountable to the Governing Body and reports to it (or its designee) and the Advisory Board on at least a quarterly basis. Included in the report are the committee's activities, findings, recommendations, and actions.

E. Membership: In addition to staff identified by the BHO, members include provider representatives, a representative from the **TDMHDD's** Office of the Medical Director, a representative from the **TDMHDD's** Office of Managed Care, and a representative from the Department of Health's Bureau of Alcohol and Drug Abuse Services.

STANDARD IV: **THERE IS A DESIGNATED BHO MEDICAL DIRECTOR, WHO IS A SENIOR EXECUTIVE AND IS RESPONSIBLE FOR IMPLEMENTATION AND OVERSIGHT OF THE QMP.**

STANDARD V: **THE QMP HAS SUFFICIENT MATERIAL RESOURCES AND STAFF (WHO HAVE THE NECESSARY EDUCATION, EXPERIENCE, AND/OR TRAINING) TO CARRY OUT ITS FUNCTIONS.**

STANDARD VI: **THERE IS PROVIDER PARTICIPATION IN THE QMP.**

A. Participating providers are kept informed about the written QMP plan.

B. The BHO includes a requirement for complying with the QMP plan standards in all its provider agreements and employment agreements.

C. Further, all provider agreements specify

1. the BHO has access to the treatment records of its **Enrollees** as permitted by state and federal confidentiality laws; and

2. the BHO allows open provider-patient communication regarding appropriate treatment alternatives without penalizing providers discussing medically necessary or appropriate care for the **Enrollee**.

STANDARD VII: **THE BHO REMAINS ACCOUNTABLE FOR ALL QMP FUNCTIONS, EVEN IF CERTAIN FUNCTIONS ARE DELEGATED TO OTHER ENTITIES. IF THE BHO DELEGATES ANY QUALITY ASSURANCE/IMPROVEMENT ACTIVITIES TO PROVIDERS:**

A. There is a written description of the delegated activities, the delegate's accountability for these activities, the frequency of reporting to the BHO, the BHO's process for evaluating the delegate's performance, and the remedies, including revoking the delegation agreement, if the delegate does not fulfill its obligations.

B. The BHO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of services being provided.

C. There is documented evidence of continuous and ongoing evaluation of delegated activities, including annual approval of quality assurance/improvement plans, evaluation of regular specified reports, documentation that verifies the BHO evaluates the delegates capacity to perform the delegated activities prior to delegation, and an annual evaluation of whether the delegate's activities are being conducted in accordance with the BHO's expectations and standards.

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STANDARD VIII: **THE BHO CREDENTIALS AND RECREDENTIALS ALL LICENSED AND/OR CERTIFIED PROFESSIONAL STAFF.**

A. The BHO must have written policies and procedures in place which direct the credentialing, recredentialing and reappointment of behavioral healthcare professionals with whom it contracts or employs, who render services to **Enrollees**. Credentialing and recredentialing policies and procedures must be submitted to the **TDMHDD** Office of Managed Care for approval. Included in these are:

1. The requirement that the Governing Body or the group to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.

2. The designation of a credentialing or other peer review body which makes recommendations regarding credentialing decisions.

3. The criteria and primary source to be used to verify criteria.

4. The process used to make decisions.

5. The extent of any delegated credentialing or recredentialing arrangements.

6. The right of practitioners to review the information submitted in support of their credentialing applications.

7. The process for notification to a practitioner of any information obtained during the BHOs credentialing/recredentialing process that varies substantially from the information provided to the BHO by the practitioner.

8. The practitioner’s right to correct erroneous information.

9. The medical director or other designated health care practitioner's direct responsibility and participation in the credentialing program.

10. The process used to ensure confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.

11. Alterations of the conditions of the practitioner's participation with the BHO based on issues of quality of care and service. These policies and procedures define the range of actions that the BHO may take to improve performance prior to termination.

    a. The BHO has procedures for, and evidence of the implementation of, as appropriate, reporting serious quality deficiencies that could result in a practitioner's suspension or termination to appropriate authorities.

    b. The BHO has an appeal process for instances in which the BHO chooses to alter the condition of the practitioner's participation based on issues of quality of care and/or service or imposes sanctions. The BHO informs practitioners of the appeal process.

12. The formal selection and retention criteria that assure that providers who serve high-risk populations or who specialize in the treatment of costly conditions are not discriminated against by the BHO.

13. Identification of those practitioners who fall under its scope of authority and actions. At a minimum this includes: physicians and other licensed and/or certified practitioners who provide behavioral health treatment (including, but not limited to, clinical and counseling psychologists, psychological examiners, registered nurses, practical nurses, social workers, alcohol and other drug abuse counselors, professional counselors, and marital and family counselors).

14. The requirements that identified practitioners are credentialed prior to providing services to **TennCare Partners Program Enrollees** and that these practitioners are recredentialed at least every three years thereafter.

15. The requirement that an identified practitioner meet the following criteria in order to be credentialed or recredentialed:

a. is appropriately licensed and/or certified, in good standing, and is not excluded from participation in federal health care programs under either Sections 1128 or 1128A of the Social Security Act;

b. is appropriately trained and/or has the necessary experience to occupy the identified position within the organization;

c. has demonstrated competencies needed for adequate job performance (for recredentialling, an annual performance evaluation by the supervisor and, possibly, peer reviews will be used as well as other information such as any complaints made about the practitioner, malpractice suits filed, practitioner to practitioner or practitioner performance to benchmark comparison data, etc.); and

d. is free from health problems which could affect his/her practice.

e. In addition, in order to credential or recredential a practitioner, the organization must have adequate facilities, equipment, number and types of support personnel and any other necessary support services required for the professional in the identified position.

16. The **Contractor** is required to offer an appeals process to individual clinicians who are denied credentialing/recredentialing or for whom sanctions are imposed. The **Contractor** is required to provide affected providers written notice of the reason(s) for its decision.

17. When individuals providing mental health treatment services are not required to be licensed or certified, it is the responsibility of the BHO to assure that, based on the following applicable **TDMHDD** and Department of Health licensure rules and/or programs standards, that individuals are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

    a. Mental health and substance abuse providers, excluding licensed and/or certified practitioners, who provide the following behavioral health services in the programs listed below are to be reviewed according to the appropriate state program licensure:

Programs licensed by the Department of Mental Health and Developmental Disabilities, the Department of Health, and Department of Children's Services, as appropriate, which include but are not limited to: Mental Health Day Program (including day treatment and partial hospitalization), Outpatient Mental Health Services (including rehabilitation/ symptom management, crisis services, and regional intervention program), Mental Health Hospital Facilities, Mental Health Residential Treatment Facilities, Mental Health Crisis Stabilization Units, Psychosocial Rehabilitation, Diagnostic and Evaluation Centers, Wilderness Programs (day treatment component), Mental Health Case Management, Substance Abuse Residential, Substance Abuse Outpatient, and all general surgical hospitals operating a unit or program to provide mental health and/or substance abuse services.

Mental health providers, excluding licensed and or certified practitioners, who provide the following mental health services are to be reviewed according to **TDMHDD** Program Standards: Crisis Respite, Housing Developer, Supported Employment, Therapeutic Foster Care, Planned Respite, Emergency Respite, and Infant Stimulation.

Substance abuse providers who provide the following services are to be reviewed according to the appropriate state program licensure: Medical Detoxification, Social Detoxification, Residential Rehabilitation, Adolescent and Residential Rehabilitation, Partial Hospitalization, Halfway House, Youth Day Treatment, Women's Intensive Outpatient, Outpatient, Pregnant Substance Abusers Residential Treatment, Pregnant Substance Abusers Intensive Outpatient, AIDS Outreach, Family Intervention and Referral Services, Methadone Maintenance, Life Development Center (Wilderness Program), and Dual Diagnosis Programs.

B. Practitioners are credentialed initially (prior to delivering services) and are recredentialed at least every three years.

C. The BHO verifies at least the following information from primary sources for the initial credentialing process:

1. A current valid license to practice as an independent behavioral healthcare practitioner at the highest level certified or approved by the State;

2. Good standing of clinical privileges at the institution designated by the behavioral healthcare practitioner as the primary admitting facility, as applicable.

3. A valid Drug Enforcement Agency (DEA) certificate (or copy);

4. Graduation from an accredited professional school or highest training program applicable to the academic degree, discipline and licensure of the behavioral healthcare practitioner;

5. Board certification, if designated by the practitioner on the application,

6. Current, adequate malpractice insurance; and

7. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

D. The recredentialing process includes verification of at least the following information:

1. A current valid license to practice as an independent behavioral healthcare practitioner at the highest level certified or approved by the State;

2. Good standing of clinical privileges at the institution designated by the behavioral healthcare practitioner as the primary admitting facility, as applicable;

3. A valid DEA certificate (or copy);

4. Board certification, if designated by the practitioner on the application (only if board certification has expired or is new since last credentialing);

5. Current, adequate malpractice insurance; and

6. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

E. The BHO's records indicate that prior to making a credentialing or recredentialing decision, the BHO receives the following information:

1. the National Practitioner Data Bank;

2. sanctions or limitations on licensure from the appropriate state agency, State Board of Medical Examiners, State Board of Licensure or Certification, or the Federation of State Medical Boards; and

3. previous sanction activity by regional Medicare and Medicaid offices and any exclusions from participation in federal programs as contained in the Excluded Provider Listing System (EPLS) maintained by the General Accounting Office (GAO) and accessible at www.epls.gov.

F. The applicant completes a written application at credentialing and recredentialing that includes a statement regarding:

1. the reasons for any inability to perform the essential functions of the position, with or without accommodation;

2. lack of present illegal drug use;

3. history of loss of license and felony convictions;

4. history of loss or limitations of privileges or disciplinary activity; and

5. an attestation as to the correctness and completeness of the application.

G. The recredentialing process also includes a review of data regarding member complaints, results of quality reviews, utilization management, consumer satisfaction surveys, and reverification, where required, of current licensure.

H. At the time of recredentialing, the BHO conducts site visits to the offices of its high volume practitioners.

1. The BHO uses objective criteria to identify and evaluate high volume practitioners.

2. The BHO conducts a structured review of the site to ensure conformity with the BHO's standards.

3. The BHO documents an evaluation of treatment record keeping practices and standards of care documented at each site to ensure conformity with the BHO's standards.

I. If the BHO delegates credentialing (and recredentialing) activities to provider organizations, there is a written description of the delegated activities and the delegate's accountability for these activities. There is also evidence the delegate has accomplished the credentialing activities. The BHO must monitor the effectiveness of the delegate's credentialing and recredentialing process.

J. The BHO retains the right to approve providers and sites and to terminate or suspend individual providers. The BHO has policies and procedures for the suspension, reduction, or termination of practitioner privileges.

K. There is a mechanism for, and evidence of the implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner to the appropriate authorities.

L. There is a provider appellate process for instances where the BHO chooses to reduce, suspend, or terminate a practitioner's privileges with the organization.

M. In accordance with **TDMHDD** requirements, the BHO has a mechanism for notifying **TDMHDD** at the time of network provider additions and deletions

N. Annually, the BHO reassesses its provider network to assure that all providers are licensed and certified as required by state law and to assure that the composition of the provider network is such that the BHO is in compliance with its access and availability standards relating to geographic coverage of service sites, response time to contact an active **Enrollee** in an urgent situation, and maximum time for an admission to a service. (NOTE: The BHO's standards must meet or exceed those set forth by **TDMHDD**.) The BHO will report reassessment findings to **TDMHDD** at the mid-point of each contract year and at the end of each contract year.

O. The BHO shall provide input to **TDMHDD** on an as-needed basis on the rater validity of individuals who administer Target Population Group (TPG) and Clinically Related Group (CRG) assessments.

P. The BHO must have written policies and procedures in place which direct the credentialing, recredentialing and reappointment of organizational providers with whom it contracts or employs who treat **Enrollees** and who fall within its scope of authority and action. Behavioral health care practitioners who are under contract with a specific facility and have no independent relationship with the BHO do not have to be individually credentialed or recredentialed by the BHO. Included in these are:

1. Organizational providers include, but are not limited to, entities providing mental health and/or substance abuse services in an inpatient, residential or outpatient setting.

2. The organization confirms the entire organization and their providers are in good standing with state and federal regulatory bodies and are compliant with relevant federal and state laws.

3. The organization confirms they have adequate facilities, equipment, number and type of support personnel and any other necessary support services needed to support the professionals in their organization.

4. The organization confirms the provider has been reviewed and approved by an accrediting body <u>or</u>

5. If the provider has not been approved by an accrediting body, the organization develops and implements standards of participation that include an on-site quality assessment.

6. At least every three (3) years, the organization confirms all providers within their organization remain in good standing with state and federal regulatory bodies and are reviewed and approved by an accrediting body if applicable.

7. Documentation of the formal selection and retention criteria assure organizational providers who serve high-risk populations or who specialize in the treatment of costly conditions are not discriminated against.

Q. All credentialing and recredentialing decisions are made within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application and signed Provider Agreement. The organization must track the amount of time from receipt of a completed application to date of provider notification of the credentialing decision.

STANDARD IX**: THE BHO MUST ENSURE THE PROVISION OF APPROPRIATE, SPECIALIZED TRAINING OF PRACTITIONERS.**

A. In order to improve upon the skills of practitioners delivering community behavioral health services, the BHO provides or requires provider organizations to provide appropriate specialized training relative only to the areas directly related to their area of responsibility which is designed for each service setting.

1. There is a written plan which directs staff training and requires that training be made available, as appropriate, in the following areas:

   a. crisis intervention and resolution, including safety procedures;

   b. medications, medication management, and medication facilitation;

   c. entitlements and procurement of entitlements;

   d. families as a system, including strengths, stressors, dynamics, intervention techniques, and family/professional collaboration;

   e. accessing and using natural support systems;

   f. legal issues and mandates regarding mental illness and substance abuse (e.g., forensics, mandatory outpatient treatment, mental health codes, custody, educational rights);

   g. community support systems, community-based services, community resources and linkages with these resources;

   h. cultural diversity;

   i. etiology, treatment, and diagnostic categories of mental illness and substance abuse;

   j. etiology and treatment of alcohol and drug abuse, physical and sexual abuse, suicidal ideation, developmental disabilities, and mental retardation;

   k. mental health case management principles, practices, and philosophy;

l. mental health case management assessment and mental health case management intervention techniques;

m. service planning and monitoring;

n. screening for inpatient hospitalization;

o. general health care practices and medical conditions which may be associated with mental illness and substance abuse;

p. age appropriate developmental principles for the consumer populations;

q. CPR and First Aid;

r. consumer rights and consumer advocacy;

s. stress management skills for mental health case managers and other mental health service providers;

t. data management and record keeping;

u. organization policies and procedures;

v. rules, regulations, standards, policies and procedures governing the provision of **TennCare** funded mental health services;

w. diagnosis and treatment of individuals with dual diagnoses; and

x. **TDMHDD** Best Practice Guidelines.

y. CRG assessment and/or TPG assessment.

B. Documentation of training and results of pre-tests and post-tests are maintained by the organizations with whom the individuals trained are employed;

C. Application of knowledge gained through the training is tied to the assessment of staff competency.

STANDARD X: **THE BHO DEMONSTRATES A COMMITMENT TO TREATING** ENROLLEES **IN A MANNER THAT ACKNOWLEDGES THEIR RIGHTS AND RESPONSIBILITIES.**

A. The BHO has a written policy that recognizes the following rights of **Enrollees**:

1. to be treated with respect, dignity, and compassion regardless of state of mind or condition;

2. to be provided treatment without regard to age, race, sex, religion, ethnic background, handicap, or ability to pay;

3. to privacy and confidentiality related to all aspects of care including, but not limited to, the unwarranted disclosure of medical records, whole or in part;

4. to be protected from neglect; to be protected from physical, emotional, or verbal abuse, and from all manner of exploitation;

5. to be informed of any proposed and/or alternative treatment methods; to be informed of the risks, benefits, consequences of treatment or non-treatment; to be informed of the side effects of his/her medication or proposed medication;

6. to participate in the development of his/her individual service plan; to participate in all decision-making regarding his/her behavioral health care; to be involved in his/her discharge or aftercare planning;

7. to be provided quality treatment by competent staff members; to be afforded continuity of care from one service provider to another;

8. to refuse to participate partially or fully in treatment or therapeutic activities (unless participation is so ordered by the court);

9. to be provided treatment in the least restrictive setting feasible;

10. to refuse the use of any audio and/or visual techniques to record or observe the individual's activities during treatment unless written and signed consent is given;

11. to participate in cultural, educational, religious, community service, vocational, and/ or recreational activities;

12. to be provided with information about the BHO, its services, its providers, to be provided with the basic rights and responsibilities of BHO members in a way which is easily understood;

13. to be able to choose providers within the limits of the network; to be able to refuse care from specific providers;

14. to voice complaints or initiate appeals about the BHO or services provided without fear of restraint, interference, coercion, discrimination, or reprisal;

15. to formulate advance directives;

16. to have access to his/her records and request that they be amended or corrected;

17. to make recommendations regarding the **Contractor's** member's rights, responsibilities and policies; and

18. to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

B. The BHO has a written policy that addresses consumers' responsibility for cooperating with those providing behavioral health services. The written policy addresses members' responsibility for:

1. providing, to the extent possible, information needed by professional staff providing services to the consumer; and

2. following instructions and guidelines given by those providing behavioral health services.

3. to participate, to the degree possible, in understanding their behavioral health problems and developing mutually agreed upon treatment goals.

C. Upon enrollment with the BHO, **Enrollees** are provided with a written statement in the form of a written member handbook approved by **TDMHDD** that includes information on the following:

1. rights and responsibilities of consumers;

2. benefits and services included and excluded as a condition of enrollment/membership, and how to obtain them, including a description of:

    a. any special benefit provision (e.g., co-payment, higher deductibles, rejection of claim) that may apply to services obtained outside the system; and

    b. the procedures for obtaining out-of-area coverage;

3. provisions for after-hours and emergency coverage;

4. the BHO's policy on referrals/coordination with physical health care providers;

5. charges to **Enrollees**, if applicable, including:

    a. policy on payment of charges; and

    b. co-payment and fees for which the **Enrollee** is responsible;

6. procedures for formally appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization;

7. procedures for changing providers;

8. procedures for disenrollment; and

9. procedures for voicing complaints and/or appeals and for recommending changes in policies and services.

D. The BHO has a system documented in written policies and procedures, linked to the QMP, for the timely resolution, as specified by **TennCare**, of member's complaints and for formal appeals**.** This system includes:

1. written procedures for registering and responding to complaints and appeals in a timely manner (timeframes for registering and responding must comply with **TennCare** requirements);

2. documentation of the substance of complaints or appeals and actions taken;

3. written procedures to ensure a resolution of the complaint or appeal;

4. quarterly aggregation and analysis of complaint and appeal data and use of the data for quality improvement; submission of findings to **TDMHDD** on quarterly basis;

5. an appeals process for appeals; and

6. a mechanism for reporting all unresolved complaints and concerns to **TDMHDD** on a monthly basis.

E. Opportunity is provided for **Enrollees** and their family members to offer suggestions for changes in BHO policies and procedures.

F. The BHO takes steps to promote accessibility of services offered to enrolled consumers. These steps include:

1. identification of the points of access to the comprehensive array of mental health services are identified for consumers; and

2. at a minimum, consumers are given information about:

   a. how to obtain services during regular hours of operations;

   b. how to obtain emergency and after-hours care; and

   c. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for the delivery of mental health services.

G. The BHO will provide written information, only after receipt of prior approval from **TDMHDD**, to **Enrollees** which is:

1. Written in prose easily readable and easily understood;

2. Available, as needed, in the languages of the major population groups served. A “major” population group is one representing at least 10% of the **Enrollees**, or 3,000 **Enrollees**, whichever is less. All vital BHO documents are also available to Limited English Proficiency groups identified by **TennCare** that constitute five percent (5%) of the **TennCare** population, or 1,000 **Enrollees**, whichever is less; and

3. Explained to individual **Enrollees**, or to a **Enrollee’s** parent, guardian, or other appropriate person responsible for protecting the rights of the **Enrollee** who are unable to read or understand easily.

H. The BHO acts to ensure the confidentiality of specified consumer information and records is protected.

1. The BHO has established in writing and enforces policies and procedures on confidentiality, including confidentiality of consumer records.

2. The BHO ensures all providers have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the provider's organization.

3. The BHO will hold confidential all information obtained by its personnel about **Enrollees** related to their examination, care, and treatment and will not divulge it without the **Enrollee's** authorization unless:

   a. it is required by law,

   b. it is necessary to coordinate the **Enrollee's** care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or

   c. it is necessary in compelling circumstances to protect the health or safety of an individual.

4. The written consent of the **Enrollee** or his/her legal representative is considered valid only if the following conditions are met:

   a. The **Enrollee** or representative is informed, in a manner understood by the consumer or his/her representative, of the specific type of information that has been requested;

   b. The **Enrollee** or representative is informed that the provision of services is not contingent on his/her decision concerning the release of information to other internal or external services; and

   c. The consent of the consumer or representative is acquired in accordance with applicable laws and regulations.

5. Any release of information in response to a court order is reported to the consumer in a timely manner.

6. **Enrollee** records may be disclosed, whether or not authorized by the **Enrollee**, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual **Enrollee** in any report of the research or otherwise disclose **Enrollee** identity.

I. The BHO has written policies regarding the appropriate treatment of minors.

J. The organization conducts periodic surveys of consumer and family member satisfaction with its services.

1. The surveys include content on perceived problems with the quality, availability, and accessibility of care. At minimum, the survey includes all items specified in Attachment E. **Enrollees** and family members are also surveyed regarding their perceptions of how they have been treated by service providers.

2. The surveys assess at least a sample of:

   a. each of the clinically related groups, target populations, and non-target populations;

   b. family members of individuals in each of the clinically related group, target population, and non-target populations;

   c. consumers who have filed complaints about services or providers or who have requested a change of provider; and

   d. members of behavioral health consumer advocacy groups.

3. As a result of the surveys, the BHO:

   a. identifies and investigates sources of dissatisfaction;

   b. outlines action steps to follow-up on the findings; and

   c. informs providers of assessment results.

4. Annually, survey findings and information regarding follow-up actions are submitted to **TDMHDD**.

5. The BHO reevaluates the effects of the activities described in 1 through 4. above.

STANDARD XI: **THE BHO HAS ESTABLISHED WRITTEN STANDARDS FOR ACCESS (I.E., TO ROUTINE, URGENT, EMERGENCY CARE) WHICH MEET OR EXCEED STANDARDS OUTLINED IN ATTACHMENT B AND ANY OTHER STANDARDS SET BY THE BHO AND COMPLIES WITH THESE STANDARDS.**

A. Standards for access meet the following requirements:

1. Standards for timeliness of access to member services (e.g., customer service line) meet or exceed such standards as specified in Attachment B. The BHO continuously monitors its compliance with these standards and takes corrective action as necessary.

2. Standards for timeliness of access to care meet or exceed such standards as specified in Attachment B. The BHO continuously monitors its compliance with these standards and takes corrective action as necessary.

3. Standards for geographic access to care meet or exceed such standards as specified in Attachment B. The BHO continuously monitors its compliance with these standards and takes corrective action as necessary.

4. Quarterly reports documenting the BHO's monitoring and corrective action activities must be submitted to **TDMHDD** upon completion.

B. The BHO has written capacity standards to ensure the availability of behavioral healthcare providers based on the assessed needs of its Enrollee population. To this end, the BHO:

1. Defines the number and types of behavioral healthcare providers and providers within its delivery system, taking into consideration assessed linguistic and cultural needs and preferences. Specific goals must be developed for at least each category listed:

   a. Psychiatrists;
   b. Registered Nurses;
   c. Mental health case managers;
   d. Psychologists;
   e. Licensed alcohol and drug counselors; and
   f. Licensed social workers, family and marital counselors

2. Provides documentation for establishing the goals to **TDMHDD** and the Advisory Board.

3. Provides comparison information from similar public behavioral health care programs to **TDMHDD** and the Advisory Board.

4. Collects and analyzes data to measure its performance against the standards.

   a. identifies opportunities for improvement and decides which opportunities to pursue;
   b. implements interventions to improve its performance;
   c. measures the effectiveness of the interventions; and
   *d. documents and reports conclusions, recommendations, actions taken, and results to its administrators, providers, Advisory Board and members and **TDMHDD**.*

C. The BHO ensures all services, both clinical and non-clinical, are accessible to all **Enrollees**, including those with who are non-English speaking, have limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, homelessness and individuals with physical and mental disabilities.

D. The BHO ensures the hours of operation of its providers are convenient to and do not discriminate against **Enrollees**.

E. The BHO instructs **Enrollees** they have the right to access emergency health care without prior authorization, consistent with the enrollee's determination of the need for such services as a prudent layperson.

F. The BHO maintains and monitors a network of appropriate providers, supported by written arrangements, sufficient to provide adequate access to covered services and to meet the needs of the population served, including special populations.

G. The BHO has written standards to ensure its referral and triage functions are appropriately implemented, monitored, and professionally managed. To this end, the BHO:

1. makes referral and triage decisions according to protocols that define the level of urgency and appropriate setting of care;

2. adopts referral and triage protocols that are based on sound clinical evidence and currently accepted practices within the industry (and approved by **TDMHDD** Office of the Medical Director):

    a. the BHO uses protocols to specifically address mental health and substance abuse referral and triage.

    b. the BHO provides up-to-date protocols and guidelines to its referral and triage staff.

3. ensures referral and triage decisions not requiring clinical judgment are determined by staff who have relevant knowledge, skills, and professional experience;

4. ensures referral and triage decisions requiring clinical judgment are determined by a licensed behavioral healthcare provider (an RN or at minimum a master's level practitioner) with appropriate qualified experience;

5. ensures referral and triage decisions for persons with dual diagnosis are determined by licensed behavioral health practitioners with experience treating persons with dual diagnosis.

6. ensures referral and triage staff are supervised by a licensed behavioral healthcare provider with a minimum of a master's degree and five years of post-master's clinical experience; and

7. ensures referral and triage decisions are reviewed and supervised by licensed behavioral healthcare providers who are experienced in clinical risk management.

    a. Inpatient referral and triage decisions are overseen by a board-certified psychiatrist with appropriate qualified experience.

    b Outpatient referral and triage decisions are overseen by a licensed, doctoral level clinical psychologist with appropriate qualified experience.

STANDARD XII: **THE BHO MAINTAINS STANDARDS FOR FACILITIES IN WHICH CONSUMERS ARE SERVED.**

A. This includes compliance with existing state and local laws regarding safety and accessibility (including the requirement that hospitals providing inpatient services are JCAHO accredited);

B. A requirement for adherence to these standards is contained in all of the BHO's provider agreements.

STANDARD XIII: **THE BHO IS IN COMPLIANCE WITH ALL STANDARDS FOR** ENROLLEE **RECORDS.**

A. The BHO will include provisions in provider agreements for appropriate access to records of its **Enrollees** for purposes of quality reviews conducted by the BHO, by **TDMHDD**, by **TennCare**, or agents thereof.

B. Records are available to providers at each encounter.

C. Records may be on paper or electronic media. The BHO takes steps to promote maintenance of consumer records in a legible, current, detailed, organized, and comprehensive manner which permits effective service provision and quality reviews as follows:

1. The BHO sets standards for consumer records. These standards will, at a minimum, include requirements that:

    a. Information related to the provision of appropriate services to a consumer is to be included in his/her record. For individuals in the target populations, a description of the consumer's physical and mental health status at the time of enrollment. This comprehensive assessment covers:

        1. a psychiatric assessment which includes: description of the presenting problem, psychiatric history and history of consumer's response to crisis situations, psychiatric symptoms, five axis diagnosis of mental illness using the most current edition of DSM, mental status exam, and history of alcohol and drug abuse;

        2. a medical assessment which includes: screening for medical problems, medical history, and present medications, and medication history;

3. Target Population Group (TPG) and Clinically Related Group (CRG) assessments are performed by persons designated by **TDMHDD**, have been trained by a **TDMHDD** approved trainer, and have passed the **TDMHDD** competency tests; these persons must use the CRG and TPG assessment forms prescribed by and in accordance with the policies of **TDMHDD**; these assessments are subject to the review and approval of **TDMHDD**.

4. a community functioning assessment or an assessment of the consumer's functioning in the following domains: living arrangements, daily activities (vocational/educational), social support, financial, leisure/ recreational, physical health and emotional/behavioral health;

5. an assessment of: consumer strengths, current life status, personal goals, and needs; and

6. a reassessment of these areas which is performed annually or sooner if warranted by a significant change in psychiatric symptoms, medical conditions, or community functioning level.

2. The services to be provided/the individualized treatment plan which is based on the psychiatric, medical, and community functioning assessments listed above and which includes (this is applicable for members of the target population and for all others who are in receipt of mental health services for thirty calendar days or longer):

   a. documentation of medical necessity;

   b. provision of either mental health case management or continuous treatment team services;

   c. goals;

   d. objectives and target dates;

   e. action steps and responsible parties for each objective;

   f. the specialized behavioral health services to be delivered (provider, location, frequency of contact, planned start date, and period of authorized services);

g. progress notes related to goals and objectives;

h. plan for prevention and/or resolution of crisis; and

i. documentation that the service plan is reviewed and revised if needed every three months by individuals responsible for its development.

3. Documentation that the rights of the consumer have been explained and are protected.

4. Documentation that the consumer and, as appropriate, his/her family members participated in the development and subsequent review of the treatment/service plan.

5. The following identifying data recorded on a standardized form:

a. Full legal name;

b. Home address;

c. Home telephone number;

d. Date of birth;

e. Sex;

f. Race or ethnic origin;

g. Conservator or guardian;

h. Education;

i. Marital status;

j. Type and place of employment;

k. Date of initial contact or enrollment with BHO;

l. Legal status, including relevant legal documents;

m. Other identifying data as indicated;

n. Date the information was gathered; and

o. Signature of staff member gathering the information.

6. Occurrence reports and information on any unusual occurrences such as the following: (NOTE: On a monthly basis, the BHO must submit to **TDMHDD** all occurrence reports and their dispositions.)

   a. Treatment complications (including medication errors and adverse medication reactions);

   b. Accidents or injuries to the consumer;

   c. Morbidity;

   d. Death of the consumer;

   e. Allegations of physical abuse, sexual abuse, and/or verbal abuse;

   f. Use of physical, mechanical, and/or chemical restraints; and

   g. Incidents of absence without leave.

7. Documentation, as necessary, of consumer/legal representative/family member consent for admission, treatment, evaluation, continuing care, release of records for information, or research.

8. Documentation of physical and mental diagnoses that have been made using a recognized diagnostic system.

9. Reports of laboratory, radiological, or other diagnostic procedures and reports of medical/surgical services when performed.

10. Hospital discharge summaries for all hospital admissions which occur while the consumer is enrolled with the BHO and for all previous admissions related to the consumer's mental illness or substance abuse.

11. Correspondence concerning the consumer's treatment and signed and dated notations of telephone calls concerning the consumer's treatment.

12. Documentation when information about the consumer is released to an individual or organization.

13. A copy of the individual's advance directive or notation that the consumer has not executed one.

14. A discharge summary or summation summary (if the consumer dies) within fifteen calendar days following disenrollment or death.

D. All entries in records are signed by the author and dated.

E. Records are kept for a minimum of five years after disenrollment or death of an individual.

F. There is a record review process to assess the content of the consumer records for legibility, organization, completion, and conformance to its standards listed above.

G. The BHO has policies and procedures that address HIPAA requirements.

STANDARD XIV: **THE BHO IMPLEMENTS A STRUCTURED UTILIZATION REVIEW PROCESS.**

A. The BHO has a written utilization management program description which includes, at a minimum, plans for compliance with utilization management criteria set by **TDMHDD**, procedures to evaluate medical necessity (including evaluation criteria and sources of information), and the process for reviewing and approving the provision of medical services.

B. The BHO ensures authorization decisions are based on all relevant medical information available about the individual **Enrollee** and in accordance with standards of care approved by **TDMHDD**. The BHO does not impose 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 **Enrollee** and his/her medical history. The BHO's utilization management activities are not structured so as to provide incentives to deny, limit, or discontinue medically necessary services to any **Enrollee**.

C. Written utilization management policies and procedures clearly specify:

1. services that are available upon direct request;
2. services that require prior authorization;

3. services that require additional review;
4. services that require concurrent review;
5. circumstances that warrant retrospective review; and
6. special procedures for management of high cost and high-risk cases.

D. The program has mechanisms to detect under utilization as well as over utilization.

E. For preauthorization and concurrent review programs:

1. Preauthorization and concurrent review decisions are supervised by qualified mental health or substance abuse professionals.

2. Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating mental health or substance abuse professional as appropriate.

3. The reasons for decisions are clearly documented and available to the **Enrollee**.

4. There are well-publicized and readily available appeals mechanisms for both providers and consumers.

5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.

6. There are mechanisms to evaluate the effects of the program using data on consumer and family satisfaction, provider satisfaction, and other appropriate measures.

7. If the BHO delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

F. The program has mechanisms and plans for provider profiling using provider utilization data.

G. Licensed experienced behavioral healthcare practitioners assess the clinical information used to support utilization management decisions.

1. Appropriately licensed and experienced behavioral healthcare providers supervise all review decisions.

2. A psychiatrist, doctoral level clinical psychologist, or certified addiction medicine specialist reviews any denial that is based on medical necessity.

3. The BHO has licensed behavioral healthcare practitioners from appropriate specialty areas to assist in making determinations of clinical appropriateness.

H. The BHO makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.

The BHO establishes standards for the timeliness of UM decision-making. These standards must be submitted to **TDMHDD** for their review and approval.

Utilization decisions are communicated to the provider of care being authorized within 48 hours of the decision.

I. The UM program is annually evaluated, approved, and revised as necessary by senior management or the QI committee.

STANDARD XV: **THE BHO HAS POLICIES AND PROCEDURES TO PROMOTE AND ASSURE CONTINUITY AND COORDINATION OF BEHAVIORAL HEALTHCARE SERVICES AND COORDINATION WITH PRIMARY CARE SERVICES FOR ITS MEMBERS.**

A. Policies and procedures should specify the following:

1. The individual formally designated as having primary responsibility for coordinating the **Enrollee's** care.

2. Programs for coordination of care that include coordination of plan services with community and social services generally available through contracting or non-contracting providers in the area served by the BHO.

3. Procedures for timely communication of clinical information among providers.

4. Measures to ensure **Enrollees** are informed of specific behavioral health care needs that require follow up; receive, as appropriate, training in self-care and other measures they may take to promote their own health.

B. The BHO facilitates continuity and coordination throughout its continuum of behavioral health services. To this end, the BHO:

1. *Exchanges information in an effective, timely and confidential manner across all levels of care and all behavioral health providers and other providers.*

2. *Ensures **Enrollees** with behavioral health disorders receive timely access and follow up to appropriate behavioral providers, including a psychiatrist for medication evaluation and psychiatric assessment.*

3. *Collects and analyzes data to evaluate continuity and coordination of care within its continuum of services.*

4. Implements interventions when appropriate to improve continuity and coordination of care within its continuum of services.

C. The BHO facilitates continuity and coordination of behavioral health services with general medical care. To this end, the BHO collaborates with relevant medical delivery systems or primary care physicians to:

1. *Exchange information in an effective, timely and confidential manner, including **Enrollee** approved communications between behavioral health providers and PCPs.*

2. *Promote the appropriate diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care.*

3. *Coordinate timely access for appropriate treatment and follow up for individuals with coexisting medical and behavioral disorders.*

4. Collect and analyze data to evaluate continuity and coordination of behavioral health care with medical care.

5. Implement interventions when appropriate to improve continuity and coordination of behavioral health care with medical care.

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STANDARD XVI: **THERE IS WRITTEN DOCUMENTATION OF QMP IMPLEMENTATION.**

A. The BHO will document that, in accordance with its written QMP plan, it is monitoring and evaluating the quality of care across all services and all treatment modalities and to all population groups.

B. The BHO must maintain and make available to **TDMHDD** and to **TennCare** all studies, reports, protocols, standards, worksheets, minutes, or such documentation as may be appropriate, concerning its quality assurance/improvement activities and corrective actions.

STANDARD XVII: **THE FINDINGS, CONCLUSIONS, RECOMMENDATIONS, ACTIONS TAKEN AND RESULTS OF THE ACTIONS TAKEN AS A RESULT OF THE QUALITY ASSURANCE/IMPROVEMENT ACTIVITIES ARE DOCUMENTED AND REPORTED TO APPROPRIATE INDIVIDUALS WITHIN THE ORGANIZATION AND THROUGH THE ESTABLISHED QUALITY ASSURANCE/ IMPROVEMENT CHANNELS.**

A. Quality assurance/improvement information is used in recredentialing, reconstructing, and/or annual performance evaluations.

B. Quality assurance/improvement activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of **Enrollee** complaints and appeals.

C. There is a linkage between quality assurance/improvement and other management functions of the BHO such as network changes, service redesigns, benefits changes, and medical management system.

ATTACHMENT D

REPORTING REQUIREMENTS

Attachment D.1

Provider Enrollment Reporting

Required Data Elements for Provider Enrollment Reporting

At a minimum, the following data elements shall be collected for each provider in the BHO's network. Monthly Updates to the Provider Network file, as follows:

Provider Network File

National Provider Identification (NPI) number
BHO Indicator
Service County
Credential Indicator
Provider DEA Number
Provider Discipline Degree
Provider Education Level
Contract Effective Date
First Name
Middle Name
Last Name
Group/Organization Name
In Plan Indicator
License Number
Type of License
Medicaid/Medicare ID Number
New Member Indicator
Phone Number
Facsimile Number
Type of Provider
Provider Specialty
Provider SSN
Provider Tax ID Number
Contract Termination Date
Provider UPIN
Service Site Address 1
Service Site Address 2
Service Site City
Service Site State
Location Code
Zip Code
Email Address
TennCare Provider Identification Number
Group Name

Service Code
Adult/Child (A/C)
License2
License3
TennCare Identification Number

Attachment D

Attachment D.2

Clinically Related Group Assessment Reporting

Required Data Elements For Clinically Related Group Assessment Of Enrollees Age 18 Years or Older

This listing shall include, at a minimum, the following data elements:

Behavioral Health Organization's ID Number
Enrollee's Last Name
Enrollee's First Name
Enrollee's Birth Date
Enrollee's Social Security Number (SSN)
Principal Diagnosis
Dual Principal/Secondary Diagnosis
Measure of **Enrollee's** Level of Functioning in Activities of Daily Living
Measure of **Enrollee's** Level of Functioning in Interpersonal Functioning
Measure of **Enrollee's** Level of Functioning in Concentration, Task Performance, and Pace
Measure of **Enrollee's** Level of Functioning in Adaptation to Change
Measure of **Enrollee's** Severity of Impairment
Measure of **Enrollee's** Duration of Mental Illness
Indicator of **Enrollee's** Former Severe Impairment
Enrollee's Need for Services to Prevent Relapse
Enrollee's Clinically Related Group (CRG)
Reason for Assessment
Date of Request for Assessment
Date of CRG Assessment
Measure of Rater's Adequacy of Information in Order to Complete Assessment
Enrollee's Current Global Assessment of Functioning (GAF) Scale Score
Enrollee's Highest GAF Scale Score (Past Year)
Enrollee's Lowest GAF Scale Score (Past Year)
Program Code
Rater's TennCare Provider ID Number

Attachment D.3

Target Population Group Assessment Reporting

Required Data Elements For Target Population Group Assessment Of Enrollees Under Age 18

This listing shall include, at a minimum, the following data elements:

Behavioral Health Organization's ID Number
Enrollee's Last Name
Enrollee's First Name
Enrollee's Date of Birth
Enrollee's Social Security Number
Principal Diagnosis
Dual Principal/Secondary Diagnosis
Enrollee's Current Global Assessment of Functioning (GAF) Scale Score
Enrollee's Highest GAF Scale Score (Past Year)
Enrollee's Lowest GAF Scale Score (Past Year)
Severity of Impairment
Serious Emotional Disturbance (SED) Status
Environmental Issues
Family Issues
Trauma Issues
Social Skills Issues
Abuse/Neglect Issues
Child at Risk of SED
Enrollee's Target Population Group (TPG)
Reason for Assessment
Date of Request for Assessment
Date of TPG Assessment
Measure of Rater's Adequacy of Information in Order to Complete Assessment
Program Code
Rater's TennCare Provider ID Number

Attachment D.4

Required Data Elements for Encounter Information Base

At a minimum, the following data elements shall be collected for Encounter Data.

Monthly Updates to the Encounter Files, as follows:

UB92 Claims File
Provider ID
Provider specialty
Last name
First name
Middle initial
Date of birth
Recipient's social security number
Diagnosis code 1
Diagnosis code 2
Diagnosis code 3
Diagnosis code 4
Diagnosis code 5
Resubmission code
Claim number
Service from date
Service through date
Place of service
Service type
CPT/HCPCS procedure code
Procedure modifier 1
Procedure modifier 2
Procedure modifier 3
Amount paid
Date paid
Pricing level
Amount allowed
Deductible amount
Co-Insurance amount
Liability amount
Claim type
Claim received date
Co-payment amount
Withhold amount
Bill type
Admitting diagnosis
Admit date
Covered days
Non-Covered days
Patient discharge status
Revenue code

Rate
Service units
Total charge amount billed
Non-Covered charge
Attending physician ID
COB savings amount
Prepaid amount
Discount amount
Discharge date
Provider tax ID
Payment Status
Payment code 1
Payment code 2
Payment code 3
Payment code 4
Payment code 5
Former claim number
Former payment date
Provider name
BHO Indicator
Rendering provider ID

HCFA1500 Claims File

Provider ID
Provider specialty
Last name
First name
Middle initial
Date of birth
Recipient's social security number
Diagnosis code 1
Diagnosis code 2
Diagnosis code 3
Diagnosis code 4
Diagnosis code 5
Resubmission code
Former claim number
Former payment date
Claim number
Service from date
Service through date
Place of service
Service type
CPT/HCPCS procedure code
Procedure modifier 1
Procedure modifier 2
Procedure modifier 3
Amount billed

Service units
Amount paid
Date paid
Pricing level
Amount allowed
Deductible amount
Co-Insurance amount
Treatment place
Liability amount
Claim type
Claim received date
Co-payment amount
Withhold amount
Payment code 1
Payment code 2
Payment code 3
Payment code 4
Payment code 5
Provider name
Rendering provider ID
Payment status
BHO Indicator

Attachment D.5

Required Data Elements for Case Management Reporting

Quarterly updates to the Case Management File, as follows:

Appointment kept date
BHO indicator
CM agency
Case management code
Case manager name
CRG/TPG assessment code
Discharge date
Date of birth
Facility
First name
Last name
Referral code
Social Security Number
DCS Status

Attachment D.6

Required Data Elements for Mobile Crisis Response Reporting

Response time for face to face interventions

Payor source
Type of call
Number of consumers who have active case management
Number of consumers whose case manager was involved in inpatient admission
Number of consumers whose case manager was involved in diversion from inpatient admission
Number of face to face interventions off-site
Final disposition
Barriers to diversion from inpatient admission

Attachment D.7

Required Data Elements for Reporting Enrollee Information

This report shall include, at a minimum, the following data elements;

Attachment D

1. **Enrollee's** name;
2. **Enrollee's** social security number;
3. **Enrollee's** date of birth;
4. **Enrollee's** sex;
5. **Enrollee's** previous address;
6. **Enrollee's** new address; or to the extent possible, a statement or indicator that the **Enrollee**'s new address is unknown due to mail being returned for insufficient address (e.g., undeliverable, no forwarding address, etc.) if the **Enrollee's** new address is unknown;
7. Date **Enrollee** moved;
8. A statement or indicator whether the **Enrollee's** new address is within the same community service area as the former address or is in a different community service area;
9. Identity of the new BHO plan, if known, if the **Enrollee** has moved outside the former grand region service area and desires to change BHO plans;
10. The identity of the BHO providing notice; and
11. Other pertinent information which is known by the BHO, which may have an affect on an **Enrollee's** eligibility or cost sharing status.

REQUIRED ELEMENTS FOR ENROLLEE VERIFICATION REPORTING

In response to receipt of a file from **TennCare** that identifies individuals whom **TennCare** has not been successful at contacting to verify eligibility, the **Contractor** will provide a response file that will include, at a minimum, the following data elements:

1. **Enrollee's** social security number;
2. **Enrollee's** date of birth;
3. **Enrollee's** sex;
4. **Enrollee's** name; and
5. **Enrollee's** address

Attachment D.8

Dual Eligible Cost Report

Report Template

Attachment D.8.1, Sample Dual Eligible (Medicare/TennCare Medicaid) Cost Report:

Attachment D

Enrollment													
Payments for MH/SA Services for the Month													
UB 92 Payments by the Claims Processing System													0
HCFA1500 Payments by the Claims Processing System													0
CMHC Capitation Payments													0
Other Capitation Payments													0
Grant Payments													0
Pharmacy Payments													0
Subcontractor Payments for MH/SA Services													0
Reinsurance Payment													0
Other Payments/Adjustments to MH/SA Costs													0
Less:													
Pharmacy Rebates													0
Recoveries not Reflected in Payments by the Claims System													0
Total Payments for the month		0	0	0	0	0	0	0	0	0	0	0	0	0
Remaining IBNR for the month														0
Payments and Remaining IBNR for the month		0	0	0	0	0	0	0	0	0	0	0	0	0

Attachment D.8.2, Sample Dual Eligible (Medicare/TennCare Standard) Cost Report:

Enrollment	Enrollment																											
Payments for MH/SA Services for the Month	**Paymen**		**vices for the Month**																									
UB 92 Payments by the Claims Processing System	UB 92 Pay		s Processing System																				0					0
HCFA1500 Payments by the Claims Processing System	HCFA1500		Claims Processing System																				0					0
CMHC Capitation Payments	CMHC Cap																						0					0
Other Capitation Payments	Other Capi																						0					0
Grant Payments	Grant Paym																						0					0
Pharmacy Payments	Pharmacy P																						0					0
Subcontractor Payments for MH/SA Services	Subcontrac		H/SA Services																				0					0
Reinsurance Payment	Reinsuranc																						0					0
Other Payments/Adjustments to MH/SA Costs	Other Paym		o MH/SA Costs																				0					0
Less:	Less:																											
Pharmacy Rebates	Pharmacy R																						0					0
Recoveries not Reflected in Payments by the Claims System	Recoveries		yments by the Claims System																				0					0
Total Payments for the month	Total Pa		nth 0	0	0		0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Remaining IBNR for the month	Remaining IBNR for the month																						0					0
Payments and Remaining IBNR for the month	**Paymen**		**IBNR for the month** 0	0	0		0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Attachment D.9

Medical Loss Ratio Report and Claims Lag Tables

Report Template

Attachment D.9-1, Sample Medical Loss Report:

MEDICAL LOSS RATIO REPORT
ALL REGIONS

MCO

BHO Name:

Reporting Month	Total Remaining IBNR Prior to January 1, 2003	Year: Incurred Month Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	For the Year Ended 12/31 12/31/2003
Enrollment														
TennCare Capitation Payment														0
Payments for MH/SA Services for the Month														
UB 92 Payments by the Claims Processing System														0
HCFA1500 Payments by the Claims Processing System														0
CMHC Capitation Payments														0
Other Capitation Payments														0
Grant Payments														0
Pharmacy Payments														0
Subcontractor Payments for MH/SA Services														0
Reinsurance Payment														0
Other Payments/Adjustments to MH/SA Costs														0
Less:														
Pharmacy Rebates														0
Recoveries not Reflected in Payments by the Claims System														0
Total Payments for the month		0	0	0	0	0	0	0	0	0	0	0	0	0
Remaining IBNR for the month														0
Payments and Remaining IBNR for the month		0	0	0	0	0	0	0	0	0	0	0	0	0

Medical Loss Ratio													

Attachment D.9-2, Sample Claims Lag Tables:

HCFA 1500 Payments by the Claims Processing System

Month Paid by Claim System	Total	Pre 1-1-03	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03
		Incurred Month/Year of Service												
Jan-03	0													
Feb-03	0													
Mar-03	0													
Apr-03	0													
May-03	0													
Jun-03	0													
Jul-03	0													
Aug-03	0													
Sep-03	0													
Oct-03	0													
Nov-03	0													
Dec-03	0													
Total	0		0	0	0	0	0	0	0	0	0	0	0	0

UB92 Payments by the Claims Processing System

Month Paid by the Claims System	Total	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03
		Incurred Month of Service											
Jan-03	0												
Feb-03	0												
Mar-03	0												
Apr-03	0												
May-03	0												
Jun-03	0												
Jul-03	0												
Aug-03	0												
Sep-03	0												
Oct-03	0												
Nov-03	0												
Dec-03	0												
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0

ATTACHMENT E

LIQUIDATED DAMAGES FOR PERFORMANCE MEASURES

PERFORMANCE MEASURES

The goal of **TennCare Partners** is to manage the proper utilization of available resources to assist **Enrollees** in achieving and maintaining the highest degree of behavioral health and functional capability possible. In the achievement of these goals, the opportunity to compromise the quality, availability and accessibility of services must be avoided. Especially important is the aspect of under-utilization of medically necessary services in order to reduce cost and increase the profitability of the provider. There are a number of parameters that can and should be continually monitored to assure the provision of timely quality behavioral health care to every **Enrollee**. This section specifies performance objectives to be used by **TDMHDD** to monitor administrative capabilities, service delivery, service utilization, satisfaction and outcomes. The purpose of these measures is to:

- **Administrative**: Measure the BHO's ability to perform administrative functions in a timely and accurate fashion.
- **Service Delivery**: Measure the BHO's ability to arrange or provide appropriate services in a timely fashion, where timely is consistent with the terms and conditions of the **TennCare Partners Program** waiver.
- **Service Utilization**: Measure the BHO's ability to arrange or provide for appropriate utilization of services.
- **Outcome/Satisfaction**: Measure the success of the BHO in providing services that result in desired outcomes.

TDMHDD will monitor the **Contractor's** performance relative to the benchmark specified for each performance measure. The **Contractor** shall report all data required to monitor performance in accordance with the timeframes

specified in this Section. All performance measures are to be reported to **TDMHDD**. Performance Measures I.1 and I.2 are also to be reported to TDCI and **TennCare**. Failure to meet the benchmark may result in the application of liquidated damages as specified below and/or result in a request for corrective action. Liquidated damages are grouped into five categories:

DEFICIENCY TYPE	DEFINITION	LIQUIDATED DAMAGES
I	A performance standard which, if not met, threatens the continued viability of the **TennCare Partners Program**	$10,000 will be assessed for each Type I deficiency found at the time of review
II	A performance standard which, if not met, denotes that the BHO's provider network is not adequate in a limited area	$2,000 will be assessed for each Type II deficiency found at the time of review
III	A performance standard which, if not met, is likely to result in physical or psychological harm to a **TennCare Partner's Program Enrollee**	$1,000 will be assessed for each Type III deficiency found at the time of review

DEFICIENCY TYPE	DEFINITION	LIQUIDATED DAMAGES
IV	A performance standard which, if not met, is likely to cause undue distress to a **TennCare Partner's Program Enrollee**	$500 will be assessed for each Type IV deficiency found at the time of review
V	A performance standard which, if not met, will prevent ongoing monitoring of BHO service delivery	$500 will be assessed for each Type V deficiency found at the time of review

I. ADMINISTRATIVE MEASURES

Administrative measures will be monitored to measure the BHO's ability to perform administrative functions, including member and provider services, credentialing and recredentialling, claims processing and appeals resolution, in a timely and accurate fashion.

TABLE I: ADMINISTRATIVE PERFORMANCE MEASURES

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
I.1 Timely Claims Processing	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.	A: Number of claims submitted, number of claims input, number of claims processed, number of claims paid and percentage of claims paid within 30 calendar days of receipt of claim, determined for each month in the quarter B: Number and percentage of claims processed within 60 calendar days of receipt of claim, determined for each month in the	Quarterly, within thirty (30) calendar days after the end of the quarter. Each month to be reported separately.	***I*** For each month deficient

		quarter		
I.2 Claims Payment Accuracy	97% of claims paid accurately upon initial submission	Total number of claims paid, number of claims paid accurately, and percentage of total claims paid accurately; determined for each month in the quarter	Quarterly, within thirty (30) calendar days after the end of the quarter. Each month to be reported separately	I For each deficient month.

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
I.3 Telephone Response Time	At least 95% of calls are answered by a non-recorded voice in less than 5 rings or less than 30 seconds	Number and percentage of telephone calls by length of response time (number of rings or number of seconds); determined for each month in the quarter	Quarterly, within thirty (30) calendar days after the end of the quarter. Each month to be reported separately.	**IV** For each deficient month.
I.4 Telephone call abandonment rate (unanswered calls)	No more than 5% of telephone calls are abandoned	Number and percentage of telephone calls abandoned, determined for each month in the quarter	Quarterly, within thirty (30) calendar days after the end of the quarter. Each month to be reported separately	***IV*** For each deficient month.

I.5 Credentialing Processing Time	Difference between date of notification of credentialing decision and date of submission of a complete application does not exceed one hundred and twenty (120) calendar days in routine situations, does not exceed (60) calendar days in areas with a network deficiency	Audit of credentialing file sample **NOTE:** Sampling methodology must be approved by **TDMHDD**	Quarterly, within (30) calendar days after the end of the quarter. Each month to be reported separately.	III For each deficient month.

II. SERVICE DELIVERY

Service delivery measures are to be used to monitor the BHO's ability to arrange or provide appropriate services in a timely fashion, where timely is consistent with the terms and conditions of the **TennCare Program** waiver.

Note 1. **TDMHDD** will monitor access to behavioral health providers by reviewing the BHO's monthly provider file that is electronically submitted to **TennCare** and compare these data with the BHO's membership to determine the numbers and distribution of providers compared to **Enrollees** and to calculate travel distances between contracted providers and **Enrollees**.

Note 2. **TDMHDD** will monitor access to Centers of Excellence by requiring the BHO to contract with COEs as they are designated by the State, and requiring a copy of the fully executed provider agreement to be submitted to **TDMHDD.**

TABLE II: SERVICE DELIVERY PERFORMANCE MEASURES

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
II.1 Distance from provider to **Enrollee**	In accordance with Attachment B "Geographic Access to the Service Type".	A. Electronic provider listing of all participating providers including all data elements specified in Attachment D.1.	A. Quarterly within thirty (30) calendar days after the end of the quarter. B. Annual; no later than the last day of April	II or I, dependent on number of deficiencies

II.2 Timely access to all initial appointments/ admissions	In accordance with Attachment B "Maximum Time for Admission to the Service Type" post intake assessment 90% of **Enrollees** clinically determined to need an appointment have the clinically indicated appointment scheduled within the access & availability time period	Average time between the intake assessment appointment and the **Enrollee's** next appointment scheduled or admission by type of service; determined for each month in the quarter	Quarterly, within (30) calendar days after the end of the quarter	II or I, dependent on number of deficiencies, if not cured after initial request for corrective action

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
II.3 Timely appointments and admissions for non-urgent care post intake assessment	In accordance with Attachment B "Maximum Time for Admission to the Service Type" post intake assessment 90% of **Enrollees** clinically determined to need a non-urgent appointment have the clinically indicated non-urgent appointment scheduled within the access & availability time period	Number of clinically determined appointments/ admissions scheduled post intake assessment within the access & availability time period for non-urgent care as numerator; total number non-urgent clinically determined appointments/ admissions required post intake assessment	Quarterly, within (30) calendar days after the end of the quarter	II or I, dependent on number of deficiencies, if not cured after initial request for corrective action
II.3 Timely appointments and admissions for non-urgent care post intake assessment (Continued)		as denominator for each month in the quarter		
II.4 Timely appointments and admissions for urgent care post intake assessment	In accordance with Attachment B "Response Time to Contact an Active Consumer in an Urgent	Number of clinically determined appointments/ admissions scheduled post	Quarterly, within (30) calendar days after the end of the quarter	II or I, dependent on number of deficiencies, if not cured after initial request for corrective action

	Situation to the Service Type" post intake assessment 90% of **Enrollees** clinically determined to need an urgent appointment have the clinically indicated urgent appointment scheduled within the access & availability time period	intake assessment within the access & availability time period for urgent care as numerator; total number of urgent clinically determined appointments/ admissions required post intake assessment as denominator; determined for each month in the quarter		
II.5 Percentage of crisis service recipients, excluding mandatory pre-screenings, hospitalized per month to RMHI and private psychiatric facilities	N/A	The number of non-mandatory pre-screening crisis recipients admitted to RMHI and private psychiatric facilities by the number of calls received per crisis service provider; determined for each month in the quarter	Quarterly, within (30) calendar days after the end of the quarter	V

III. SERVICE UTILIZATION

Service utilization performance measures will be used to evaluate the BHO's ability to arrange or provide for appropriate utilization of services.

All measures in Table III shall be reported separately for adults ages 18 years and over for SPMI and non-SPMI populations, and children under age 18 years by SED and non-SED populations. Benchmarks apply in aggregate only, unless otherwise specified.

TABLE III: SERVICE UTILIZATION PERFORMANCE MEASURES

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY

III.1 Length of time between hospital / RTF discharge and first subsequent mental health case management service	A. 90% of discharged **Enrollees** have a mental health case management service *scheduled* within seven (7) calendar days of discharge B. 90% of discharged **Enrollees** *receive* a mental health case management service within seven (7) calendar days of discharge, excluding situations involving **Enrollee** reschedules, no shows, and refusals	A.1 Number of **Enrollees** discharged by length of time between discharge and first scheduled subsequent mental health case management service, reported by inpatient facility discharging, and type of service scheduled; determined for each month A.2: Average length of time between hospital discharge and first scheduled subsequent mental health case management service; determined for each month B.1 Number of **Enrollees** discharged by length of time between discharge and first subsequent mental health case management service reported by CMHA and type of service received; determined for each month	Monthly, by the 20th of the following month	III

		B.2 Average length of time between hospital discharge and first subsequent mental health case management visit reported by CMHA and type of service received; determined for each month		

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	*PENALTY*
III.2 A. Average length of time between hospital/ RTF discharge for a mental health diagnosis and first subsequent MD or NP visit	A.1: 90% of discharged **Enrollees** have an MD or NP service *scheduled* within fourteen (14) calendar days of discharge	A.1.1: Number of **Enrollees** discharged with a mental health diagnosis by length of time between discharge and first scheduled subsequent MD or NP service, reported by inpatient facility discharging; determined for each month in the quarter A.1.2: Average length of time between hospital discharge for a mental health diagnosis and first scheduled subsequent MD or NP service; determined for each month in the quarter A.2.1: Number of **Enrollees** discharged with a mental health diagnosis by length of time between hospital discharge and first subsequent MD or NP service received;	Monthly by the 20th of the following month.	***III***

		determined for each month in the quarter A.2.2: Average length of time between hospital discharge for a mental health diagnosis and first subsequent MD or NP service received; determined for each month in the quarter	Monthly by the 20th of the following month.	
III.3 Average length of time between hospital/RTF discharge for a substance abuse diagnosis and first subsequent appropriate substance abuse outpatient service	90% of discharged **Enrollees** *are seen* by an MD or NP within fourteen (14) calendar days of discharge, excluding situations involving **Enrollee** reschedules, no shows, and refusals			

III.4 Percentage of **Enrollees** readmitted within seven (7) calendar days of discharge from inpatient	Not more than 10% of **Enrollees** discharged from an inpatient facility are readmitted within seven (7) calendar days of discharge	Number of **Enrollees** discharged from an inpatient or residential facility and number and percentage readmitted within seven (7) calendar days of discharge; determined for each month in the quarter	Quarterly, within thirty (30) calendar days after the end of the quarter	V
III.5 Percentage of **Enrollees** readmitted within thirty (30) calendar days of discharge from inpatient	Not more than 15% of **Enrollees** discharged from an inpatient or residential facility are readmitted within thirty (30) calendar days of discharge	Number of **Enrollees** discharged from an inpatient or residential facility and number and percentage readmitted within thirty (30) calendar days of discharge; determined for each month in the quarter	Quarterly, within thirty (30) calendar days after the end of the quarter	***V***

IV. SATISFACTION & OUTCOMES

The **Contractor** shall conduct a provider satisfaction survey on at least an annual basis to measure provider perception of the **Contractor's** performance. The survey should evaluate satisfaction with level of function, improvements in functioning, and satisfaction with the organization overall. Specific measures and benchmarks are provided below. **TDMHDD** must approve all questions included in the survey, sampling methods and sample sizes.

TABLE IV: SATISFACTION AND OUTCOME PERFORMANCE MEASURES

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
IV.1 Network providers have a satisfactory working relationship with the BHO	85% of respondents rate their experience with the BHO to be fair or better and 80% rate it as good or better	Distribution of providers by satisfaction score, reported by type of provider	Annual; no later than the last day of June	***IV***
IV.2 Network providers are satisfied with the BHO claims payment system	85% of respondents rate the BHO claims payment system as fair or better and 80% rate it as good or better	Distribution of providers by satisfaction score, reported by type of provider	Annual; no later than the last day of June	***IV***
IV.3 Network providers are satisfied with the BHO transportation services	85% of respondents rate the BHO transportation services as fair or better and 80% rate it as good or better	Distribution of providers by satisfaction score, reported by type of provider	Annual; no later than the last day of June	***IV***

IV.4 **Enrollees** are satisfied with the behavioral health services they receive	85% of respondents rate their experience with behavioral health services/BHO providers to be positive	Distribution of **Enrollees** by satisfaction score	Annual, no later than the last day of June	***IV***

ATTACHMENT F

DELIVERABLE REQUIREMENTS

Deliverable Requirements

The **Contractor** and **Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD)**, **TennCare** and **The Department of Commerce and Insurance (TDCI)** are responsible for complying with all the deliverable requirements established by the parties. All parties are responsible for assuring the accuracy and completeness of deliverables, as well as the timely submission of each deliverable. All parties will agree to the appropriate deliverable instructions, submission timetables, and technical assistance as required.

Items requiring prior approval by TDMHDD, TennCare and/or TDCI

Fidelity Bonds within sixty (60) calendar days of execution of this CONTRACT as required under Section 3.1.9	**TDMHDD** has fifteen (15) calendar days to respond
Certificates of insurance with execution of this CONTRACT as required under Section 3.1.10	**TDMHDD** will respond prior to issuance of CONTRACT
Fraud and Abuse Compliance Plan within ninety (90) calendar days of execution of this CONTRACT as required under Section 3.1.12.2.1	**TennCare** and/or Office of Inspector General (OIG) Unit thirty (30) calendar days to respond
Continuity of Care Transition Plan in accordance with 3.2.3	To be approved by **TDMHDD**
Appeal and complaint procedures with executed CONTRACT as required under Section 3.3.4	**TDMHDD** and **TennCare** will respond prior to executing CONTRACT
Enrollee provider directories in accordance with 3.4.7	To be approved by **TennCare** prior to distribution to enrollees, with paper and electronic copy in format approved by **TennCare**
Provider satisfaction survey in accordance with 3.6.5.2.4	To **TDMHDD**, annually
Credentialing manual in accordance with 3.6.4	To **TDMHDD** prior to delivery of services and prior to modifications as directed
Credentialing policies and procedures in accordance with 3.6.4.2	To **TDMHDD** as directed
Provider relations plan with executed CONTRACT as required under Section 3.6.5	**TDMHDD** will respond prior to issuing CONTRACT

The **Contractor's** provider network and any deletions or additions must be submitted prior to the execution of this CONTRACT as required under Section 3.6.6.1	**TDMHDD** has fifteen (15) calendar days to respond
Any subcontracts prior to execution of such contract(s) as required under Section 3.7.1	**TDMHDD** has fifteen (15) calendar days to respond
The **Contractor's** pro forma agreements with providers as required under Section 3.7.2	**TDCI** has thirty (30) calendar days to respond
Indemnity language found in provider contracts if different from the standard indemnity language found in this CONTRACT; prior to issuing such contracts as required under Section 3.7.2.25	**TDMHDD** has fifteen (15) calendar days to respond
Enrollee involvement plan must be submitted prior to the execution of this CONTRACT as required under Section 3.8	**TDMHDD** will respond prior to issuing CONTRACT
Quality Monitoring/Quality Improvement procedures including, but not limited to, utilization management policies and procedures prior to the execution of this CONTRACT as required under Section 3.9	**TDMHDD** has fifteen (15) calendar days to respond
Written plan for Focused Clinical Studies by March 1st of each year as required in Section 3.9.2.1	**TDMHDD** has fifteen (15) calendar days to respond
Reporting procedures as specified in the CONTRACT as required under Section 3.10	**TDMHDD**, **TennCare** and/or **TDCI** will respond prior to issuing CONTRACT
Accounting requirements in accordance with 3.11	To **TDMHDD** and **TennCare**
Disaster Recovery Plan as required under Section 3.10.1.2.3.4	**TennCare** has thirty (30) calendar days to respond
Termination Plan as required under Section 5.1.2.11 (See also in 6.16)	**TennCare** has fifteen (15) calendar days to respond
Final invoice in accordance with 5.1.4	To **TennCare**, no more than 150 calendar days after effective date of termination

Notification of insolvency in accordance with 5.1.6.6.2.3	To **TDMHDD**, within five (5) calendar days

Deliverables which are the responsibility of the Contractor

A.	Enrollee Disenrollment Reporting in accordance with 2.4.4.2	Inform **TennCare** or **TDMHDD** within three (3) business days of discovery that enrollee may satisfy disenrollment conditions
B.	Report of number of **Enrollees** who have refused Mental Health Case Management services in accordance with Section 2.5.6.8	Monthly, to **TDMHDD**
C.	DCS Liaison Staff Changes Reporting in accordance with 3.5.1.2.12	Report in writing to **TDMHDD**, **TennCare**, DCS within ten (10) business days of change
D.	TDCI compliance reporting in accordance with 3.1.7	To TDCI, within ninety (90) calendar days of execution of this CONTRACT
E.	Ownership and Financial Disclosure in accordance with Section 3.1.11	With signed CONTRACT, and annually thereafter by March 1 of every year to **TDMHDD**, the Comptroller, or CMS
F.	TDCI compliance reporting of description of complaint and appeal system in accordance with 3.1.7	To TDCI, within ninety (90) calendar days of execution of this CONTRACT
G.	TDCI compliance reporting of material modification of information reported in accordance with 3.1.7	To TDCI as directed
H.	Financial reporting in accordance with 3.10.10	To TDCI TennCare oversight division on or before March 1st of each calendar year
I.	Proof of coverage in accordance with 3.1.10	To **TDMHDD**, within sixty (60) calendar days after execution of contract (prior to commencement of work in connection with this contract
J.	Suspected **TennCare** enrollee fraud & abuse reporting in accordance with 3.1.12.2.1.8	To **TennCare** Office of Inspector General (OIG) Unit, when discovered
K.	Reports of Appeals in accordance with Section 3.3	Quarterly, to **TennCare** and **TDMHDD**

L.	Staff reporting in accordance with 3.5.1.2.14	Within thirty (30) calendar days of execution of CONTRACT, changes must be in writing within ten (10) business days
M.	Provider network listing in accordance with 3.6.6.1	To **TDMHDD**, on a monthly basis, in standardized electronic format approved by **TDMHDD**
N.	Executed subcontracts in accordance with 3.7.1.1	To **TDMHDD**, within thirty (30) calendar days of execution
O.	Notification of termination of subcontracts in accordance with 3.7.1.6	Written notice to **TDMHDD** and TDCI at least thirty (30) calendar days prior to termination; transition plan upon request
P.	Notification of administrative or legal action or complaint filed regarding any claim against **Contractor** in accordance with 3.13	To **TDMHDD**, and TDCI immediately, by certified mail
Q.	Reports regarding the activities of the BHO Advisory Committee in accordance with Section 3.8.3.8	Semi-annually, to **TDMHDD**
R.	Membership lists in accordance with 3.8.3.9	As membership changes, at least monthly to **TDMHDD**
S.	QI and Peer Review Committee meeting schedules in accordance with 3.9.1.5	To **TDMHDD** with ten (10) calendar days advance notice of regularly scheduled meetings
T.	Focused Clinical Studies in accordance with Section 3.9.2; also in 3.10.12	Annually, to **TDMHDD** by March 1st written plan; final report during last month of calendar year
U.	Results of provider satisfaction surveys in accordance with 3.6.5.2.4	To **TDMHDD**, annually
V.	Clinical practice guidelines in accordance with 3.9.3.7	To **TDMHDD**
W.	Comparison between **TennCare** and Contractor database in accordance with 3.10.1.2.2	To **TennCare** and **TDMHDD**, quarterly
X.	Provider Enrollment Reporting in accordance with 3.10.2	Monthly, to **TDMHDD**
Y.	**Enrollee** Assessment Reporting in accordance with 3.10.3	Monthly, to **TennCare** and **TDMHDD**

Z.	**Enrollee** Encounter Reporting in accordance with 3.10.4	Monthly, to **TennCare** and **TDMHDD**
AA.	Case Management Reporting in accordance with 3.10.5	Monthly, to **TDMHDD**
BB.	Crisis Response Reporting in accordance with 3.10.6	Quarterly, to **TDMHDD**-Attachment E Monthly to **TDMHDD**- Attachment D
CC.	**Enrollee** Information, weekly reporting in accordance with 3.10.7	Weekly, to **TennCare**
DD.	**Enrollee** Verification Information in accordance with 3.10.8	Immediately, upon receipt of enrollee verification request from **TennCare**
EE.	**Enrollee** Cost-Sharing Liabilities in accordance with 3.10.9	Quarterly, to **TennCare**
FF.	Annual report – Financial Reporting submitted on a form prescribed by the National Association of Insurance commissioners in accordance with 3.10.10.1	Annually, due on or before March 1 of each calendar year to TDCI, **TennCare** Division.
GG.	Quarterly financial report – submitted on a form prescribed by the National Association of Insurance Commissioners in accordance with Section 3.10.10.2	Quarterly, to TDCI **TennCare** Division
HH.	Cost and utilization data summary report in accordance with Section 3.10.10.4	Monthly, to **TennCare** and **TDMHDD**
II.	Performance Measurement Reporting in accordance with Section 3.10.11	In accordance with Attachment E, to **TDMHDD**
JJ.	Medical Loss Ratio Report and supporting claims lag tables in accordance with Section 3.10.14	Monthly, due by the 21st of the following month to TDCI, **TennCare** Division
KK.	Audit of Business Transactions/Audited Financial Statements (including income statement) in accordance with Section 3.11.5	Due on or before May 1 of each year to TDCI, **TennCare** Division
LL.	Written plan of changes resulting from monitoring and audit in accordance with Section 3.11.5.1.4	Within fifteen (15) working days after receipt of notice of deficiencies to **TennCare**

MM.	Return of funds (overpayments) in accordance with Section 3.12.3	Thirty (30) calendar days following notification from **TennCare**
NN.	Limitation on payments to providers and subcontractors in accordance with 3.12.6	To **TDMHDD**, no later than July 15th of each calendar year
OO.	Personnel and operational policies in accordance with 3.14.1	To **TDMHDD** as directed on an annual basis
PP.	Listing of supervisory personnel by race/nationality, origin, and sex in accordance with Section 3.14.2	Annually to **TDMHDD**
QQ.	Summary listing by CSA of non-institutional providers which includes race or ethnic origin of each provider in accordance with Section 3.14.3	Annually to **TDMHDD**
RR.	Quarterly listing of complaints/ appeals filed alleging discrimination in accordance with Section 3.14.4	Quarterly, by the 30th of the following month to the **TDMHDD** Title VI compliance officer
SS.	Copy of Contractor's policy regarding non-discrimination of services to persons with Limited English Proficiency in accordance with Section 3.14.5	Annually to **TDMHDD**
TT.	Listing of interpreter/translator services in accordance with 3.14.6	Annually to **TDMHDD**
UU.	Title VI Compliance Plan in accordance with Section 3.14.7	Annually to **TDMHDD**
VV.	Disclosure of protected health information in accordance with 3.16.8 and 3.16.12	To **TennCare**, within five calendar days of becoming aware of disclosure accounting information within ten (10) calendar days of request from **TennCare**
WW.	All required QI/QM reports as specified in Attachment C	As specified, to the Office of Managed Care, **TDMHDD**
XX.	Corrective Action Plans	To **TDMHDD** as directed
YY.	Ten final copies of quarterly enrollee newsletter and date information was mailed to enrollees in accordance with 3.4.4.4	To **TDMHDD** as directed

Deliverables which are the responsibility of TDMHDD

Reports concluding findings, recommendations and requirements from monitoring activities conducted by **TDMHDD** and/or CMS

Deliverables which are the responsibility of TennCare

A. Weekly listing of persons enrolled in the **Contractor**'s plan
B. Reports listing persons disenrolled from the **Contractor**'s plan

ATTACHMENT G

OPERATING PRINCIPLES FOR MCO/BHO COORDINATION

OPERATING PRINCIPLES

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

1.1 Resolution of Requests for Authorization for non-PCPs Delivering Behavioral Health Services

The **Contractor** agrees that any dispute with an MCO regarding responsibility for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a **TennCare** member. The **Contractor** agrees that Care Coordinators will deal with issues related to requests for authorization that require coordination between BHO and MCO. The BHO and MCO shall provide the other party with a list of its Care Coordinators and their telephone number(s). When either party receives a request for authorization of care that it believes is the responsibility of the other party, the Care Coordinator for the first party will contact the respective Care Coordinator of the other party by the next business day. The BHO and MCO will establish a Coordination Committee to address all issues of care coordination. The Committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Agreement. The parties will attempt in good faith to resolve any dispute and communicate the Committee's decision to the provider requesting authorization of a service. In the event the parties cannot agree within fifteen (15) days of the provider's request for prior authorization, the party who first received the authorization request will be responsible for authorization and payment to its contracted provider within the time frames designated by the Bureau of **TennCare**. Both parties are responsible for enforcing hold harmless protection of the member. The parties agree that any response to a

request for authorization shall not exceed twenty-one (21) calendar days and shall comply with the Grier Revised Consent Decree.

1.2 Claim Resolution Authorization for non-PCPs Delivering Behavioral Health Services

The **Contractor** shall designate one or more Claim Coordinators to deal with issues related to claims and payment issues that require coordination between BHO and MCO (parties). The BHO and MCO shall provide the other party, **TDMHDD**, and **TennCare** with a list of its Claim Coordinators and telephone number(s).

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

The BHO and MCO will establish a Claim Coordination Committee made up of Claims Coordinators and other representatives from each party. The number of members serving on the Claim Coordination Committee shall be determined by the mutual agreement of the parties from time to time during the term of this Agreement, or, if the parties fail to agree within ten (10) calendar days of the execution of this Agreement, the Claim Coordination Committee shall consist of two representatives of each party. The Claim Coordination Committee shall review any disputes and negotiate responsibility among the parties. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party will reimburse and abide by the prior decisions of that party. Reimbursement will be made within ten (10) business days of the Claim Coordination Committee's decision.

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

If the meeting between the CEOs or their designee(s) does not successfully resolve the dispute within ten (10) calendar days, the parties shall, within fourteen (14) calendar days after the meeting between the CEOs(s), submit a request for resolution of the dispute to the State or the State's designee for a decision.

The process as described above shall be completed within thirty (30) calendar days of receipt of the claim for payment. In the event the parties cannot agree within thirty (30) calendar days, both parties will be responsible for enforcing hold harmless protection for the member and the party who first received the request or claim from the provider will be responsible for authorization and payment to the provider within the time frames designated by the Bureau of **TennCare**. Moreover, the party that first received the request or claim from the provider must also make written request of all requisite documentation for payment and must provide written reasons for any denial.

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

The State, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) calendar days of the receipt of the required information. ("Decision"). The "Decision", which shall be determined solely by the State or its designee, may reflect a split payment responsibility that will designate specific proportions to be shared by the MCO and the BHO. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the State, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one thousand dollars ($1000) for each request for resolution. The amount of the **Contractor's** payment responsibility shall be contained in the State's Decision. These payments may be made with reservation of rights regarding any such judicial resolution. If the **Contractor** fails to pay the State within thirty (30) calendar days of the date of the State's Decision, the State may deduct amounts of the

Contractor's payment responsibility from any current or future amount owed the party.

1.3 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 Enrollee**. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim must be approved or disapproved based on the definition of emergency medical services specified in this Agreement.

1.4 Emergencies

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

1.5 Claims Processing Requirements

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

1.6 Appeal of Decision

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

1.7 Duties and Obligations

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

1.8 Confidentiality

The **Contractor** shall cooperate with the State to develop Confidentiality Guidelines that (1) meet state, federal, and other regulatory requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both BHO and MCO standards. These standards will apply to both BHO's and MCO's providers and staff. If either party believes that the standards require updating, or operational changes are needed to enforce the standards, the parties agree to meet and resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

The BHO and MCO shall assure all materials and information directly or indirectly identifying any current or former **Enrollee** which is provided to or obtained by or through the MCO's or BHO's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, Section 4-21 of this Agreement, Title 42, Part 2, Code of Federal Regulations, and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to **TDMHDD**, the **TennCare** Bureau, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former **Enrollee** or potential **Enrollee**.

1.9 Access to Service

The **Contractor** shall establish methods of referral to assure immediate access to emergency care and the provision of urgent and routine care in accordance with **TennCare** guidelines.

ATTACHMENT G

OPERATING PRINCIPLES FOR MCO/BHO COORDINATION

OPERATING PRINCIPLES

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

1.10 Resolution of Requests for Authorization for non-PCPs Delivering Behavioral Health Services

The **Contractor** agrees that any dispute with an MCO regarding responsibility for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a **TennCare** member. The **Contractor** agrees that Care Coordinators will deal with issues related to requests for authorization that require coordination between BHO and MCO. The BHO and MCO shall provide the other party with a list of its Care Coordinators and their telephone number(s). When either party receives a request for authorization of care that it believes is the responsibility of the other party, the Care Coordinator for the first party will contact the respective Care Coordinator of the other party by the next business day. The BHO and MCO will establish a Coordination Committee to address all issues of care coordination. The Committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Agreement. The parties will attempt in good faith to resolve any dispute and communicate the Committee's decision to the provider requesting authorization of a service. In the event the parties cannot agree within fifteen (15) days of the provider's request for prior authorization, the party who first received the authorization request will be responsible for authorization and payment to its contracted provider within the time frames designated by the Bureau of **TennCare**. Both parties are responsible for enforcing hold harmless protection of the member. The parties agree that any response to a

request for authorization shall not exceed twenty-one (21) calendar days and shall comply with the Grier Revised Consent Decree.

1.11 Claim Resolution Authorization for non-PCPs Delivering Behavioral Health Services

The **Contractor** shall designate one or more Claim Coordinators to deal with issues related to claims and payment issues that require coordination between BHO and MCO (parties). The BHO and MCO shall provide the other party, **TDMHDD**, and **TennCare** with a list of its Claim Coordinators and telephone number(s).

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

The BHO and MCO will establish a Claim Coordination Committee made up of Claims Coordinators and other representatives from each party. The number of members serving on the Claim Coordination Committee shall be determined by the mutual agreement of the parties from time to time during the term of this Agreement, or, if the parties fail to agree within ten (10) calendar days of the execution of this Agreement, the Claim Coordination Committee shall consist of two representatives of each party. The Claim Coordination Committee shall review any disputes and negotiate responsibility among the parties. Unless otherwise agreed, such meeting shall take place

within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party will reimburse and abide by the prior decisions of that party. Reimbursement will be made within ten (10) business days of the Claim Coordination Committee's decision.

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

If the meeting between the CEOs or their designee(s) does not successfully resolve the dispute within ten (10) calendar days, the parties shall, within fourteen (14) calendar days after the meeting between the CEOs(s), submit a request for resolution of the dispute to the State or the State's designee for a decision.

The process as described above shall be completed within thirty (30) calendar days of receipt of the claim for payment. In the event the parties cannot agree within thirty (30) calendar days, both parties will be responsible for enforcing hold harmless protection for the member and the party who first received the request or claim from the provider will be responsible for authorization and payment to the provider within the time frames designated by the Bureau of **TennCare**. Moreover, the party that first received the request or claim from the provider must also make written request of all requisite documentation for payment and must provide written reasons for any denial.

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

The State, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) calendar days of the receipt of the required information. ("Decision"). The "Decision", which shall be determined solely by the State or its designee, may reflect a split payment responsibility that will designate specific proportions to be shared by the MCO and the BHO. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the State, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one thousand dollars ($1000) for each request for resolution. The amount of the **Contractor's** payment responsibility shall be contained in the State's Decision. These payments may be made with reservation of rights regarding any such judicial resolution. If the **Contractor** fails to pay the State within thirty (30) calendar days of the date of the State's Decision, the State may deduct amounts of the

Contractor's payment responsibility from any current or future amount owed the party.

1.12 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 Enrollee**. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim must be approved or disapproved based on the definition of emergency medical services specified in this Agreement.

1.13 Emergencies

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

1.14 Claims Processing Requirements

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

1.15 Appeal of Decision

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

1.16 Duties and Obligations

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

1.17 Confidentiality

The **Contractor** shall cooperate with the State to develop Confidentiality Guidelines that (1) meet state, federal, and other regulatory requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both BHO and MCO standards. These standards will apply to both BHO's and MCO's providers and staff. If either party believes that the standards require updating, or operational changes are needed to enforce the standards, the parties agree to meet and resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

The BHO and MCO shall assure all materials and information directly or indirectly identifying any current or former **Enrollee** which is provided to or obtained by or through the MCO's or BHO's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, Section 4-21 of this Agreement, Title 42, Part 2, Code of Federal Regulations, and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to **TDMHDD**, the **TennCare** Bureau, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former **Enrollee** or potential **Enrollee**.

1.18 Access to Service

The **Contractor** shall establish methods of referral to assure immediate access to emergency care and the provision of urgent and routine care in accordance with **TennCare** guidelines.

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 fraud — recipient name or name of individual suspected of

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 II
COST-SHARING SCHEDULES

1. Out-of-Pocket Expenditures

The TENNCARE deductible for children, individuals and families shall be $0.00. The annual TENNCARE maximum out-of-pocket expenditures described below shall apply for both uninsured and uninsurable designations. Effective August 1, 2005 (unless otherwise directed by TENNCARE), there shall be no out-of pocket maximum amounts.

Poverty Level	**Individual Maximum Annual Out-of-Pocket**	**Family Maximum Annual Out-of-Pocket**
0%-100%	$0.00	$0.00
101% - 199%	$1,000.00	$2,000.00
200% and above	$2,000.00	$4,000.00

2. Copayments prior to January 1, 2003:

The following TENNCARE copayment schedule shall apply for both Uninsured and Uninsurable designations, based on the poverty level specified in TENNCARE rule 1200-13-12-.05(1)(c):

Poverty Level	**Copayment Amounts**
0%-100%	$0.00
101% - 199%	$25.00, Hospital Emergency Room (waived if admitted) $5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $15.00, Physician Specialists $5.00, Prescription or Refill $100.00, Inpatient Hospital Admission
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $25.00, Physician Specialists $10.00, Prescription or Refill $200.00, Inpatient Hospital Admission

3. **Copayment schedules effective January 1, 2003 shall be as follows:**

Poverty Level	**Copayment Amounts**
0%-99%	$0.00
100% - 199%	$25.00, Hospital Emergency Room (waived if admitted)

	$5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $15.00, Physician Specialists (including Psychiatrists) $5.00, Prescription or Refill $100.00, Inpatient Hospital Admission
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $25.00, Physician Specialists (including Psychiatrists) $10.00, Prescription or Refill $200.00, Inpatient Hospital Admission

4. **Pharmacy Copayment schedules effective August 1, 2005 (unless otherwise directed by TENNCARE) shall be as follows:**

Pharmacy Copays shall apply to all TennCare Standard enrollees as well as non-institutionalized Medicaid adults who are eligible to receive pharmacy services in the TennCare program. For dates of service on or after July 1, 2005, these pharmacy copayment amounts shall replace the pharmacy copay amounts specified in Item 3 above. All other copay amounts specified in Item 3 shall remain in effect for TennCare Standard enrollees.

Generic	$0
Brand Name	$3

Pharmacy Copayments do not apply to family planning services, pregnant women, enrollees in long term care institutions (including HCBS) or receiving Hospice care.

The CONTRACTOR is specifically prohibited from waiving or discouraging TENNCARE enrollees from paying the amounts described in this provision.

Changes in cost share responsibilities that are due to take effect August 1, 2005 may be postponed as a result of Waiver and/or Court negotiations. Changes should be implemented August 1, 2005 unless otherwise directed by TENNCARE.

ATTACHMENT I

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

SIGNATURE & DATE:

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

ATTACHMENT J
Tennessee Behavioral Health East
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 Teams											
Crisis Stabilization											
Mental Health Case Management											

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
Total Psychiatric Rehabilitation											
Supported Housing (Supervised Residential)											
Non-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 Teams											
Crisis Stabilization											
Mental Health Case Management											
Total Psychiatric Rehabilitation											
Supported Housing (Supervised Residential)											

ATTACHMENT K

Tennessee Behavioral Health East
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											

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											
Total Psychiatric Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
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											

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
Priority Substance Abuse Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Non-Priority Substance Abuse Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
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											

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Child	Medically Eligible Child	Disabled Adult	Disabled Child	Dual Eligibles/ Medicaid	Dual Eligible/ Standard	State Only & Judicial
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Total Substance Abuse /Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Priority Substance Abuse Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Non-Priority Substance Abuse Residential											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											

ATTACHMENT L

Tennessee Behavioral Health East
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

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 M

Tennessee Behavioral Health East
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 N

Tennessee Behavioral Health East
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 Team											
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 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 Supported Housing (Supervised Residential)											
Payment PMPM											
Cost Per Unit											

Utilization per 1,000											

Non-Priority Supported Housing (Supervised Residential)											
Payment PMPM											
Cost Per Unit											
Utilization per 1,000											