AMENDMENT NUMBER 10
WEST GRAND REGION
CONTRACTOR RISK AGREEMENT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.,
d.b.a. BLUECARE
CONTRACT NUMBER: FA- 08-24978-00

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

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

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

Advance Determination- A decision made by the Bureau in accordance with the process and requirements described in Rule 1200-13-01-.05(6) that an Applicant would not qualify to enroll in CHOICES Group 3 (including Interim CHOICES Group 3) when enrollment into CHOICES Group 3 has not actually been denied or terminated, and which may impact the person's NF LOC eligibility.

Chronic Condition – as defined by Population Health (and AHRQ) is a condition that lasts 12 months or longer and meets one of both of the following tests: (a) it places limitation on self-care, independent living, and social interactions; (b) it results in the need for ongoing intervention with medical products, services, and special equipment (see Perrin et al., 1993)

Engaged – When a member consents to participate in a Population Health program, the member can be determined to be engaged.

Health Coaching – A method of guiding and motivating members participating in Population Health programs to address their health by engaging in self-care and, if needed, make behavioral changes to improve their health. Health coaching operates on the premise that increasing a member's confidence in managing their health and achieving their own goals will have a more lasting effect on outcomes.

Interactive Intervention (Touch) – As it pertains to Population Health it is a two way interaction in which the member receives self management support or health education by one of the following modes: an interactive mail-based communication (i.e. mail-based support or education requested by the member, communication in the form of a member survey, quiz or assessment of member knowledge gained from reading the communication); an interactive telephone contact; including an interactive voice response (IVR)module; an in person contact; and online contact including contact by an interactive web-based module; live chat and secure e-mail. Interactive contacts do not include completion of a health risk appraisal or contacts made only to make an appointment, leave a message, or acknowledge receipt of materials.

Medical Home – As defined by Population Health and per NCQA, the Medical Home is a model for care provided by physician practices aimed at strengthening the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship.

Medical Home Lock-in Project – As referred to in CRA 2.8, the project combines the Patient Centered Medical Home with an incentive program based upon quality care. In this project members will only be allowed to see their assigned PCP or another participating PCP within their group /same TIN, because no other provider will be paid for providing services to them. The providers must agree with the health plan to meet specific annual quality of care metrics in their practice. Member outcomes and utilization patterns will be analyzed by the MCO to assess the effectiveness of the project. The primary care providers that meet all specifications and improve quality of care and member outcomes are rewarded by the health plan.

Medical Necessity - Medical Necessity and Medically Necessary as used in this Agreement shall have the meaning contained in Tenn. Code Ann. 71-5-144 and TennCare Rule 1200-13-16.

Non-Interactive Intervention (Touch) – As it pertains to Population Health it is a one way attempt to interact or communicate with members. There is no confirmation of receipt. This does not include completion of a health appraisal.

Plan of Care – As it pertains to Population Health it is a personalized plan to meet a member's specific needs and contains the following elements: prioritized goals that consider member and care giver needs which are documented; a time frame for re-evaluation; the resources to be utilized; a plan for continuity of care, including transition of care and transfers; and uses a collaborative approach including family participation. The plan of care is built upon the information collected from the health assessment to actively engage the member in developing goals and identifying a course of action to respond to the members' needs. The goals and actions in the plan of care must address medical, social, educational, and other services needed by the member. Providing educational materials alone does not meet the intent of this factor.

Population Health Care Coordination Program – The program addresses acute health needs or risks which need immediate attention. Assistance provided to enrollees is short-term and time limited in nature. Activities may include, but are not limited to, assistance with making appointments, transportation, social services, etc. and should not be confused with activities provided through the CHOICES Care Coordination Program.

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

Area Agency on Aging and Disability (AAAD) – Agencies designated by the Commission on Aging and Disability or its successor organization to plan for and provide services to the elderly and disabled within a defined geographic area as provided by T.C.A. Title 71, Chapter 2.

CHOICES At-Risk Demonstration Group – Individuals who are age 65 and older and adults age 21 and older with physical disabilities who (1) meet nursing home financial eligibility for TennCare-reimbursed long term services and supports, (2) meet the nursing facility level of care in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TENNCARE CHOICES HCBS available through CHOICES Group 3, are At Risk for Institutionalization as defined in TennCare Rules. The CHOICES At-Risk Demonstration Group is open only between July 1, 2012, through December 31, 2013. Individuals enrolled in the CHOICES At-Risk Demonstration Group as of December 31, 2013, may continue to qualify in this group after December 31, 2013, so long as they

(1) continue to meet Nursing Facility financial eligibility and the LOC criteria in place when they enrolled; and (2) remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES 3.

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

Group 1
Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility.

Group 2
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving CHOICES HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

Group 3
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are "at-risk" for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group as described in TennCare rules and regulations.

Interim Group 3 (open for new enrollment only between July 1, 2012, through December 31, 2013)
Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of CHOICES At-Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. There is no enrollment target on Interim Group 3.

All requirements set forth is this agreement regarding Group 3 members are applicable to Interim Group 3 members, except as explicitly stated otherwise. Interim Group 3 members are not subject to an enrollment target.

Risk Agreement – An agreement signed by a CHOICES Group 2 or 3 member who will receive CHOICES HCBS (or his/her representative) that includes, at a minimum, identified risks to the member of residing in the community and receiving HCBS, the possible consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk. For members electing to participate in consumer direction, the risk agreement must include any additional risks associated with the member's decision to act as the employer of record, or to have a representative act as the employer of record on his/her behalf. See Section 2.9.6 of this Agreement for related requirements.

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

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) – The state agency having the authority to provide care for persons with mental illness, and /or substance abuse needs

Transition Allowance– A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of the CONTRACTOR, be provided as a cost-effective alternative to continued institutional care for a CHOICES Group 1 member in order to facilitate transition from a nursing facility to the community when such member will, upon transition to CHOICES Group 2 or Group 3, receive more cost-effective non-residential home and community based services or companion care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain and that are essential in order to establish a community residence when such residence is not already established and to facilitate the member's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

3. Section 2.2 shall be amended by adding a new Section 2.2.3 as follows:

2.2.3 If the CONTRACTOR is part of a health maintenance organization holding company system as defined by TCA 56-11-101(b)(5), the CONTRACTOR agrees to comply with the Insurance Holding Company System Act of 1986 as set forth in TCA 56-11-101 et seq. The CONTRACTOR agrees to comply with the requirements of TCA 56-11-101 et seq. whether the CONTRACTOR is domiciled in Tennessee or is a foreign insurer or health maintenance organization subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to this contained in TCA 56-11-101 et seq.

4. Section 2.4.6.1 shall be deleted and replaced as follows:

2.4.6.1 The CONTRACTOR shall receive, process, and update outbound 834 enrollment files from TENNCARE. Enrollment data shall be updated or uploaded systematically to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. The CONTRACTOR shall report to TENNCARE, in a form and format to be provided by TENNCARE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from TENNCARE and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance.

5. Section 2.4.10 shall be deleted and replaced as follows:

2.4.10 Information Requirements Upon Enrollment

As described in Section 2.17 of this Agreement, the CONTRACTOR shall provide the following information to new members: a member handbook, an identification card, and information regarding how to access and/or request a general provider directory and/or a CHOICES provider directory. In addition, the CONTRACTOR shall provide CHOICES members with CHOICES member education materials (see Section 2.17.7).

6. Section 2.6.1.2.4 and 2.6.1.2.5 shall be deleted and replaced as follows:

2.6.1.2.4 Each of the CONTRACTOR's Population Health programs (see Section 2.8) shall address the needs of members who have co-morbid physical health and behavioral health conditions.

2.6.1.2.5 As required in Section 2.9.5.2.2, the CONTRACTOR shall provide the appropriate level of Population Health services (see Section 2.8.4 of this Agreement) to non-CHOICES members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide Population Health services to enrollees with co-morbid physical and behavioral health conditions. If a member with co-morbid physical and behavioral conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member's Population Health Care Manager collaborates on an ongoing basis with both the member and other individuals involved in the member's care. As required in Section 2.9.6.1.9 of this Agreement, the CONTRACTOR shall ensure that upon enrollment into CHOICES, the appropriate level of Population Health activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health and long-term care needs. The member's care coordinator may use resources and staff from the CONTRACTOR's Population Health program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team. The CONTRACTOR shall report on its Population Health activities per requirements in Section 2.30.6.1.

7. Section 2.6.5.2.5 shall be deleted and replaced as follows:

2.6.5.2.5 For CHOICES Group 1 members transitioning from a nursing facility to Group 2 or Group 3, a one-time transition allowance, per member. The amount of the transition allowance shall not exceed two thousand dollars ($2,000) and may be used for items such as, but not limited to, the first month's rent and/or utility deposits, kitchen appliances, furniture, and basic household items. When the CONTRACTOR elects to provide a Transition Allowance to a member transitioning to CHOICES Group 3, the amount of the Transition Allowance shall be applied to the member's Expenditure Cap.

8. Section 2.6.5.3 shall be amended by adding the phrase "or Group 3" in the last sentence as follows:

2.6.5.3 If the CONTRACTOR chooses to provide cost effective alternative services to a CHOICES member, in no case shall the cost of CHOICES HCBS, private duty nursing and home health care for Group 2 exceed a member's cost neutrality cap nor the total cost of CHOICES

HCBS, excluding minor home modifications, for members in Group 3 exceed the expenditure cap. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care for CHOICES Group 2 members pursuant to Section 2.6.5.2 of this Agreement including, as applicable: CHOICES HCBS in excess of specified benefit limits, the one-time transition allowance for CHOICES Group 1 members who are transitioning to CHOICES Group 2 or Group 3, and NEMT for Groups 2 and 3

9. Section 2.6.6.2 shall be amended by deleting and replacing the words "disease management" with "Population Health" as follows:

2.6.6.2 The CONTRACTOR shall not offer or provide any services other than services covered by this Agreement (see Section 2.6.1) or services provided as a cost effective alternative (see Section 2.6.5) of this Agreement. However, the CONTRACTOR may provide incentives that have been specifically prior approved in writing by TENNCARE. For example, TENNCARE may approve the use of incentives given to enrollees to encourage participation in Population Health programs.

10. Section 2.7.6.4.7.2 shall be deleted and replaced as follows:

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

11. Section 2.8 shall be deleted and replaced in its entirety as follows:

2.8 POPULATION HEALTH

2.8.1 General

2.8.1.1 The CONTRACTOR shall establish and operate an integrated Population Health Program based upon risk stratification of the CONTRACTOR population. The Population Health Model touches members across the entire care continuum, promoting healthy behaviors and disease self management as well as providing care coordination and intense care management as needed and supported by evidence-based medicine and national best practices. The CONTRACTOR shall evaluate the entire enrollee population and identify enrollees for specific programs according to risk rather than disease specific categories. This approach shall include the following risk Levels and programs:

2.8.1.1.1 **Risk Level 0: Wellness Program**

2.8.1.1.2 **Risk Level 1: Low Risk Maternity, Health Risk Management** and **Care Coordination** programs; and

2.8.1.1.3 **Risk Level 2**: **Chronic Care Management**, **High Risk Pregnancy** and **Complex Case Management** programs

2.8.2 Member Identification /Stratification Strategies

2.8.2.1 The CONTRACTOR shall utilize a combination of predictive modeling utilizing claims data, pharmacy data, and laboratory results, supplemented by referrals, UM data, and/ or health risk assessment results to stratify the member population into the following risk categories:

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

2.8.2.1.2 **Level 1**- All members that do not meet the Level 0 or Level 2 criteria.

2.8.2.1.2.1 All members identified as Level 1, through predicative modeling, and not pregnant are eligible for the **Health Risk Management Program**. At a minimum, the CONTRACTOR shall enroll members with the following chronic diseases: Asthma, Bipolar, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Congestive Heart Disease, Diabetes, Major Depression, and Schizophrenia. The CONTRACTOR shall also provide this program for members they identify with other chronic diseases that are prevalent in a significant number of members, or for members with other chronic diseases utilizing significant health resources in their regional population.

2.8.2.1.2.1.1 The CONTRACTOR shall sub-stratify members identified for the Health Risk Management program into high, medium and low categories based on criteria developed by the CONTRACTOR and reported in the annual program description. The CONTRACTOR shall provide the minimum interventions for each category as outlined in Section 2.8.4.3 of this Agreement.

2.8.2.1.2.2 The CONTRACTOR shall identify members for the Level 1, **Care Coordination Program** through referrals, hospital and ED face sheets, and any other means of identifying members with acute health needs or risks which need immediate attention. Members are identified for Care Coordination because their needs do not meet the requirements for complex case management. Members, who have declined participation in Complex Case Management, may also be enrolled in Care Coordination.

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

2.8.2.1.3.1 The CONTRACTOR shall identify members for the **Chronic Care Management** Program from those Level 2 members that are not pregnant but have complex chronic conditions with multiple identified health risks and or needs. This may include those members with co-occurring mental illness and substance abuse and/or co-morbid physical and behavioral health conditions. Members may also be identified for Chronic Care Management by referrals and health risk assessments.

2.8.2.1.3.2 The CONTRACTOR shall identify members for **Complex Case Management** from those Level 2 members that are not pregnant and have high risk, unique or complex needs. These may include members with co-occurring mental illness and substance abuse and/or co-morbid physical and behavioral health conditions. Members identified by

utilization reports as high pharmacy user or those members which exceed the ED threshold, as defined by TENNCARE shall be reviewed for need for case management. Members may also be identified for Complex Case Management by referrals and health risk assessments.

2.8.2.1.4 The CONTRACTOR shall systematically stratify newly enrolled members on a monthly basis.

2.8.2.1.5 The CONTRACTOR shall systematically re-stratify the entire CONTRACTOR's population to identify the top 3% as defined in section 2.8.2.1.3 of this agreement at a minimum of quarterly intervals to insure members with increasing health risks and needs are identified for level 2 programs.

2.8.2.1.6 The CONTRACTOR shall systematically re-stratify the entire CONTRACTOR's population at a minimum annually.

2.8.2.2 The CONTRACTOR shall identify **pregnant members** through claims, referrals, and the 834 nightly feed, as well as through any other method identified by health plan.

2.8.2.2.1 The CONTRACTOR will stratify pregnant members into either **low or high risk maternity programs** based on the CONTRACTOR's obstetrical assessment. Pregnant members identified as substance abusers, including tobacco users, or who meet other high risk indicators shall be stratified as high risk. Pregnant members who, through the OB assessment, do not meet high risk needs and members who are identified for high risk maternity but choose not to participate, shall be enrolled in the low risk maternity program.

2.8.3 Member Assessment/Identification

2.8.3.1 At time of enrollment the CONTRACTOR shall make a reasonable attempt to assess the member's health.

2.8.3.2 For the Level 2 Population Health programs with a required Health Risk Assessment (HRA), such HRA shall include screening for mental health and substance abuse, physical health conditions, behavioral health conditions, recommended preventive health status and co-morbid physical and behavioral health conditions.

2.8.3.3 For members considered high risk, the assessment shall include documenting the individual health history, determining each member's health literacy status, identifying substance abuse and behavioral issues/problems, identifying needs and gathering information, when appropriate, from other sources (e.g., family members, medical providers, and educators).

2.8.3.4 For the voluntary programs of Chronic Care Management, Complex Case Management, or High Risk Maternity Programs, for members considered to have high health risks, shall include assessing the need for a face to face visit. If needed, such a visit shall be conducted following consent of the member.

2.8.4 Program Content and Minimum Interventions

The CONTRACTOR shall establish and implement program content and interventions, based on program objectives, member assessments and risk stratification, for the seven (7) Population Health Programs listed in Section 2.8.1 of this Agreement. Activities, interventions, and education objectives appropriate for members will vary for each program with increasing engagement and intensity as level of risk increases. Each program will have a minimum standard set of interventions and frequency of touches but utilize varying modes of communication to attain the program objective.

2.8.4.1 **Wellness program**

For all eligible **Level 0** members not pregnant the CONTRACTOR shall provide a **Wellness Program** with the objective of keeping members healthy as long as possible.

2.8.4.1.1 The Wellness Program shall utilize educational materials and or activities that emphasize primary and secondary prevention.

2.8.4.1.2 The CONTRACTOR shall provide to members eligible for the **WELLNESS PROGRAM** the following minimum interventions:

Wellness Program Minimum Interventions	
1.	One non-interactive educational quarterly touch to address the following within one year:
	A. How to be proactive in their health **B.** How to access a primary care provider **C.** Preconception and interconception health, to include Dangers of becoming pregnant while using narcotics **D.** Age and/or gender appropriate wellness preventive health services (e.g., "knowing your numbers") **E.** Assessment of special population needs for gaps in care (e.g., recommended immunizations for *children and adolescents)* **F.** Health promotion strategies (e.g., discouraging tobacco use and/or exposure, weight management, stress management, physical activity, substance abuse prevention) **G.** Healthy nutrition **H.** Other healthy and safe life styles

2.8.4.2 **Level 1: Low Risk Maternity Program**

The CONTRACTOR shall provide a Level 1 Low Risk Maternity Program for eligible members identified as described in Sections 2.8.2.4 and 2.8.2.5 of this Agreement. The goal of the program is to engage pregnant women into timely prenatal care and to deliver a healthy, term infant without complications.

2.8.4.2.1 The CONTRACTOR shall operate its Level 1 Maternity Program using an "Opt Out" methodology. Maternity program services shall be provided to all eligible members unless they specifically ask to be excluded.

2.8.4.2.2 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into the Level 2 High Risk Maternity Program.

2.8.4.2.3 The CONTRACTOR shall provide to members eligible for the **LEVEL 1 MATERNITY PROGRAM** the following minimum standard interventions:

Maternity Program Minimum Interventions	
1.	Screening for risk factors to include screening for mental health and substance abuse. This screening shall follow the contact attempt protocol referenced in Section 2.8.4.5.2 of this Agreement.
2.	Prenatal packets (considered the one non-interactive intervention to the member for the duration of the pregnancy) to include at a minimum: **A.** Encouragement to access Text4Baby **B.** Access number to maternity nurse/social worker if member would like to engage in monthly maternity management **C.** Preterm labor education **D.** Breast feeding **E.** Secondhand smoke **F.** Safe sleep **G.** Specific trimester health information **H.** Importance of postpartum visit **I.** Importance of screening for postpartum depression **J.** HUGS information **K.** Inter-conception health, to include dangers of becoming pregnant while using narcotics
3.	Follow up as appropriate to determine the status of a prenatal visit to those members who received an initial assessment but had not scheduled or completed their first prenatal visit.
4.	Follow-up to all eligible members, to assess the status of a post-partum visit appointment and assist them with making their appointment if needed.

2.8.4.3 Health Risk Management Program

For eligible Level 1 members, who are not pregnant, identified as designated in Section 2.8.2.1.2.1 of this Agreement**,** the CONTRACTOR shall provide **a Health Risk Management** Program designed to empower members to be proactive in their health and support the provider-patient relationship. The interventions provided in this program shall address the program's goal of preventing, reducing or delaying exacerbation and complications of a condition or health risk behavior.

2.8.4.3.1 Health coaching or other interventions for health risk management shall emphasize self management strategies addressing healthy behaviors (i.e. weight management and tobacco cessation), self-monitoring, co-morbidities, cultural beliefs, depression screening, and appropriate communication with providers.

2.8.4.3.2 The CONTRACTOR shall develop and operate the "opt out" health risk management program per NCQA standard QI 8 for disease management. Program services shall be provided to eligible members unless they specifically ask to be excluded.

2.8.4.3.3 The CONTRACTOR, through a welcome letter, shall inform members how to access and use services, and how to opt in or out of the program. The welcome letter may be used as the required non-interactive intervention if it includes all the required elements as detailed in Section 2.8.4.3.7 of this Agreement.

2.8.4.3.4 The CONTRACTOR shall provide, to members identified with weight management problems, education and support to address and improve this health risk. At the CONTRACTOR's discretion the CONTRACTOR may also provide, as cost effective alternatives, weight management programs for Level 1 or 2 members identified as overweight or obese.

2.8.4.3.5 The CONTRACTOR shall provide, to members identified as users of tobacco, information on availability of tobacco cessation benefits, support and referrals to available resources such as the Tennessee Tobacco Quitline.

2.8.4.3.6 The CONTRACTOR shall sub-stratify populations within the Health Risk Management Program (low, medium, high) based upon identified risk, life style choices (tobacco or substance use), referrals, and identified needs. Interventions for each subpopulation shall be based on risk level or the identified modifiable health risk behavior.

2.8.4.3.7 The CONTRACTOR shall provide to members, who are not participating in a Medical home Lock-in project, in the lowest risk level of the Health Risk Management Program the following minimum standard interventions:

	Health Risk Management Program: **Lowest Risk Level** Minimum Interventions
1.	One documented non-interactive communication each year. The communication shall address self management education emphasizing the following: A. Increasing the members knowledge of their chronic condition B. The importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of the emotional aspect of their condition E. Self efficacy & support
2.	Offering of individual support for self management if member desires to become engaged.
3.	Availability of 24/7 nurse line.
4.	Availability of health coaching
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections 2.8.4.3.4 and 2.8.4.3.5 of this Agreement.

2.8.4.3.8 The CONTRACTOR shall provide to members, who are not participating in a Medical Home Lock-in project, in the medium risk level within the Health Risk Management Program the following minimum standard interventions:

	Health Risk Management Program: **Medium Risk Level** Minimum Interventions
1.	Two documented non-interactive communications each year which shall emphasize self management education addressing the following: A. Members knowledge of their chronic condition B. Importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of emotional aspects of their condition E. Self efficacy & support
2.	Offering of interactive communications for self management if need is identified and member desires to become engaged.
3.	Availability of 24/7 nurse line.
4.	Health coaching to provide self management education and support if the need is identified or as requested by eligible members.
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections 2.8.4.3.4 and 2.8.4.3.5 of this Agreement.

2.8.4.3.9 The CONTRACTOR shall provide to members, who are not participating in a Medical Home Lock-in project, in the highest risk level within the Health Risk Management Program the following minimum interventions:

	Health Risk Management Program: **Highest Risk Level** Minimum Interventions
1.	Four documented non-interactive communications each year which shall emphasize the following: A. Members knowledge of their chronic condition B. Importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of emotional aspects of their condition E. Self efficacy & support
2.	Offering of interactive communications for self management if need is identified and member desires to become engaged which may include; A. Documented action plan as appropriate if the need is identified or are requested by eligible members B. Referrals and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs C. Monitoring and follow up which shall consist of activities and contacts that are necessary to ensure services, appointments and community resources were furnished as planned and shall be appropriately documented for reporting purposes

	D. Defined monitoring for gaps in care
3.	Availability of 24/7 nurse line
4.	Health coaching to provide self management education and support if the need is identified or as requested by eligible members
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections 2.8.4.3.4 and 2.8.4.3.5

2.8.4.4 Care Coordination Program

For all eligible members the CONTRACTOR shall provide a Care Coordination Program designed to help non-CHOICES members who may or may not have a chronic disease but have acute health needs or risks that need immediate attention. The goal of the Care coordination program is to assure members get the services they need to prevent or reduce an adverse health outcome. Services provided are short-term and time limited in nature and should not be confused with the CHOICES Care Coordination Program. Services may include assistance in making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the members' immediate needs, PCP reconnection and offering other resources or materials related to wellness, lifestyle, and prevention. Members receiving care coordination may be those members that were identified for, but declined complex case management

2.8.4.5. Chronic Care Management Program

For all eligible level 2 non-pregnant members the CONTRACTOR shall provide a **Chronic Care Management Program**. The goal of the program is to improve the quality of life, health status and utilization of services, of members with multiple chronic conditions, by providing intense self management education and support.

2.8.4.5.1 The CONTRACTOR shall develop and operate the "opt in" chronic care management program per NCQA standard QI 8 for disease management.

2.8.4.5.2 The CONTRACTOR shall make three outreach attempts to contact each newly identified member as eligible for Chronic Care Management to offer the member enrollment in the program. All eligible members must have three outreach attempts within three months of their identification. For those members where contact failed but appear on the next refreshed list the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days.

2.8.4.5.3 Engagement rates for the Chronic Care Management program will be monitored by TENNCARE with baseline determined the first year with improvement from baseline expected in subsequent years. The NCQA Significant Improvement Chart will serve as the measurement of improvement in subsequent years.

2.8.4.5.4 The CONTRACTOR shall conduct a **comprehensive Health Risk Assessment** (HRA) for all members enrolled in the Chronic Care management Program. The HRA should include screening for mental health and substance abuse for all members and screening for physical conditions when member condition is behavioral.

2.8.4.5.5 The CONTRACTOR shall provide to members, who are not participating in a Medical Home Lock-in project, enrolled in the **CHRONIC CARE MANAGEMENT PROGRAM** the following minimum standard interventions:

Chronic Care Management Program Minimum Interventions	
1.	Monthly interactive contacts addressing the following with one face-to-face visit as deemed appropriate by the CONTRACTOR: A. Development of a supportive member and health coach relationship B. Disease specific management skills such as medication adherence and monitoring of the member's condition C. Negotiating with members for appropriate health and behavioral changes D. Problem solving techniques E. The emotional impact of member's condition F. Self efficacy G. Referral and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs H. Regular and sustained monitoring and follow-up
2.	Clinical reminders related to gaps in care.
3.	Suggested elements of the member's plan of care.
4.	Provision of after hour assistance with urgent or emergent needs.

2.8.4.5.6 The CONTRACTOR shall provide ongoing member assessment for the need to move these members into a lower risk classification or to the complex case management program for services.

2.8.4.6 High Risk Maternity

The CONTRACTOR shall provide a **Level 2 High Risk Maternity Program** for eligible members identified as described in Sections 2.8.2.3 and2.8.2.3.1 of this Agreement. The goal of the program is to engage pregnant women into timely prenatal care and aim for delivery of a healthy, term infant without complications.

2.8.4.6.1 The CONTRACTOR shall provide screening for risk factors to include screening for mental health and substance abuse. This screening shall follow the attempt protocol referenced in Section 2.8.4.5.1 of this Agreement.

2.8.4.6.2 The CONTRACTOR shall operate its high risk maternity program using an "Opt In" methodology. Program services shall be provided to eligible members that agree to participate in the program.

2.8.4.6.3 The CONTRACTOR shall provide to members enrolled in the **Level 2 HIGH RISK MATERNITY PROGRAM** the following minimum standard interventions:

	High Risk Maternity Program Minimum Interventions
1.	One interactive contact to the member per month of pregnancy to provide intense case management including the following:
	Development of member support relationship by face to face visit or other means as appropriate.
	Monthly interactive contacts to support and follow-up on patient self management. If prenatal visits have not been kept more frequent calls are required.
	Comprehensive HRA to include screening for mental health and substance abuse.
	Development and implementation of individualized care plan.
	Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required.
	Referrals to appropriate community–based resources and follow-up for these referrals.
	If applicable, provide information on availability of tobacco cessation benefits, support and referrals to cessation services including TN tobacco Quitline.
2.	Provide prenatal packets including:
	Encouragement to enroll in Text4Baby.
	Encouragement (social marketing) to enroll in High Risk Maternity program.
	Information on preterm labor education.
	Information on breast feeding.
	Information on secondhand smoke.
	Information on safe sleep.
	Trimester specific health information.
	Information on importance of postpartum visit.
	Information on post partum Depression.
	Help Us Grow Successfully (HUGS) TDOH program information.
	Information on inter-conception health, including dangers of Becoming pregnant while using narcotics and long term Contraception.

2.8.4.7 Complex Case Management

The CONTRACTOR shall provide a **Complex Case Management Program** (CCMP) for eligible members, identified by criteria listed in Section 2.8.2 of this Agreement. The goal of the program is to move members to optimal levels of health and well-being by providing timely coordination of quality services and self management support.

2.8.4.7.1 The CONTRACTOR shall offer complex case management to all members identified as eligible. Members will have the right to participate or decline participation.

2.8.4.7.2 The CONTRACTOR shall make three (3) outreach attempts as detailed in Section 2.8.4.5.2 of this agreement.

2.8.4.7.3 The CONTRACTOR shall develop and implement the Complex Case Management Program according to NCQA standard QI 7 for complex case management.

2.8.4.7.4 The CONTRACTOR shall conduct a comprehensive Health Risk Assessment to assess member's needs to include screening for mental health and substance abuse for all members identified with a physical condition and screening for physical conditions when member's condition is behavioral.

2.8.4.7.5 The CONTRACTOR shall provide defined ongoing member assessment for the need to move these members into a lower risk classification or into the Chronic Care Management Program.

2.8.4.7.6 The CONTRACTOR shall provide to members enrolled in the **COMPLEX CASE MANAGEMENT PROGRAM** the following:

Complex Case Management Program Minimum Interventions	
1.	Monthly interactive member contacts to provide individual self management support emphasizing the following:
	One face –to –face visit as deemed appropriate by MCO
	Development of a supportive member and health coach relationship
	Teaching disease specific management skills such as medication adherence and monitoring of the member's condition
	Negotiating with members for appropriate health and behavioral changes
	Providing problem solving techniques
	Assist with the emotional impact of the member's condition
	Self efficacy
	Providing regular and sustained monitoring and follow-up
	Referral and linkages
2.	Providing clinical reminders around HEDIS/gaps in care
3.	Providing after hours assistance with urgent or emergent member needs

2.8.5 Program Description

The CONTRACTOR shall develop and maintain a Population Health **Program Description** addressing all Sections of the CRA and following the guidance documents issued by the Bureau of TennCare, Quality Oversight Division. The program description shall include a written description of how the plan assures that members less than 21 years of age will have their health risks identified and their health needs met at the appropriate risk level.

2.8.6 Clinical Practice Guidelines

Population Health programs shall utilize evidence-based clinical practice guidelines that have been formally adopted and updated as described in current NCQA standards. A list of clinical practice guidelines for conditions referenced in Section 2.8.2.1.2.1 of this Agreement, as well as Maternity, Obesity, and Preventive Services must be submitted for review by TENNCARE on an annual basis. For

conditions other than those referenced in this citation policies and procedures established addressing how the health plan assures that information provided to member is based on current best practices.

2.8.7 Informing and educating Members

The CONTRACTOR shall inform all members of the availability of Population Heath Programs and how to access and use the program services. The member shall be provided information regarding their eligibility to participate, how to self refer, and how to either appropriately "opt in" or "opt out" of a program.

2.8.8 Informing and Educating Practitioners

The CONTRACTOR shall educate providers regarding the operation and goals of all Population Health programs. The providers should be given instructions on how to access appropriate services as well as the benefits to the provider. For members receiving interactive interventions, the CONTRACTOR shall notify the practitioners by letter, email, fax, or via a secure web portal of their patient's involvement.

2.8.9 System support and capabilities

The CONTRACTOR shall maintain and operate centralized information system necessary to conduct population health risk stratification. Systems recording program documentation shall meet NCQA Complex Case Management specifications and include the capability of collecting and reporting short term and intermediate outcomes such as member behavior change. The system shall be able to collect and query information on individual members as needed for follow-up confirmations and to determine intervention outcomes.

2.8.10 CHOICES

The CONTRACTOR shall include CHOICES members **and** dual eligible CHOICES members when risk stratifying its entire population.

2.8.10.2 The CONTRACTOR's Population Health Program description shall describe how the organization integrates a CHOICES member's information with other CONTRACTOR activities, including but not limited to, Utilization Management (UM), Health Risk assessment information, Health Risk Management and Chronic Care Management programs to assure programs are linked and enrollees receive appropriate and timely care.

2.8.10.3 The CONTRACTOR's Population Health Program description shall address how the CONTRACTOR shall ensure that, upon enrollment into CHOICES, Health Risk Management or Chronic Care Management activities are integrated with CHOICES care coordination processes and functions. and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care services, including appropriate management of chronic conditions. If a CHOICES member has one or more chronic conditions, the member's care coordinator may use the CONTRACTOR's applicable Population Health Program's tools and resources, including staff with specialized training, to help manage the member's condition, and shall integrate the use of these tools and resources with care coordination. Population Health staff shall supplement, but not supplant, the role and responsibilities of the member's care coordinator/care coordination team.

2.8.10.4 The CONTRACTOR's program description shall also include the method for addressing the following for CHOICES members:

2.8.10.4.1 Notifying the CHOICES care coordinator of the member's participation in a Population Health Program;

2.8.10.4.2 Providing member information collected to the CHOICES care coordinator.

2.8.10.4.3 Provide to the CHOICES Care Coordinator any educational materials given to the member through these programs;

2.8.10.4.4 Ensure that the care coordinator reviews Population Health educational materials verbally with the member and with the member's caregiver and/or representative (as applicable) and Coordinate follow-up that may be needed regarding the Population Health program, such as scheduling screenings or appointments with the CHOICES Care Coordinator;

2.8.10.4.5 Ensure that the Care Coordinator integrates into the member's plan of care aspects of the Population Health Program that would help to better manage the member's condition; and

2.8.10.4.6 Ensure that the member's care coordinator shall be responsible for coordinating with the member's providers regarding the development and implementation of an individualized treatment plan which shall be integrated into the member's plan of care and which shall include monitoring the member's condition, helping to ensure compliance with treatment protocols, and to the extent appropriate, lifestyle changes which will help to better ensure management of the member's condition (see Section 2.9.6 of this Agreement).

2.8.10.5 As part of a Population Health Program, the CONTRACTOR shall place CHOICES members into appropriate programs and/or stratification within a program, not only according to risk Level or other clinical or member-provided information but also by the type of setting in which long-term care services are delivered, i.e., nursing facility, community-based residential alternative, or home-based. The targeted interventions for CHOICES members should not only be based on risk level but also based on the setting in which the member resides.

2.8.10.5.1 Targeted methods for informing and educating CHOICES members shall not be limited to mailing educational materials;

2.8.10.6 The CONTRACTOR shall include CHOICES process data in quarterly and annual reports as indicated in Section 2.30.5 of this Agreement. CHOICES members will not be included in outcome measures in annual Population Health reports.

2.8.10.7 The CONTRACTOR shall ensure that upon a member's enrollment in CHOICES, if applicable, all High Risk Population Health Management CONTRACTOR activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care needs. The care coordinator may use resources and staff from the CONTRACTOR's MCO Complex Case Management Program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team.

2.8.10.8 The CONTRACTOR, in addition to requirements pertaining to nursing facility to community transitions (see Section 2.9.6.8), members in CHOICES Group 1 who are under the age of 21 and who are residents of a nursing facility and have requested to transition home, shall provide coordination of care by the CHOICES Care Coordinator and the Population Health Complex Case Management staff:

2.8.10.8.1 The member will be informed by CHOICES Care Coordinator of disenrollment from CHOICES upon discharge from Nursing Facility;

2.8.10.8.2 Within three (3) business days of a request to transition by or on behalf of a Group 1 member under age 21, the member will be referred by the CHOICES Care Coordinator to MCO Case Management for service identification and implementation in the home setting;

2.8.10.8.3 The Population Health Complex Case Manager will be responsible for developing a service plan for the home setting;

2.8.10.8.4 The CHOICES Care Coordinator will communicate weekly via phone or face-to-face visits with the Population Health Complex Case Management staff, the member and/or the member's parent or guardian (as applicable and appropriate), and the nursing facility staff to ensure timely progression of the transition plan until it is determined that the transition is not appropriate or until the plan is complete; and

2.8.10.8.5 Any EPSDT benefits needed by the child in the community as an alternative to nursing facility care, including medically necessary home health or private duty nursing, as applicable, shall be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and EPSDT benefits.

2.8.11 Evaluation

2.8.11.1 The CONTRACTOR shall collect and report process and outcome data as indicated on Population Health quarterly and annual report templates provided by TENNCARE. Outcome data for these reports will include short, intermediate and long term measures.

2.8.11.2 The CONTRACTOR shall provide in the annual report for the programs, with interactive interventions, an active participation rate as designed by NCQA.

2.8.11.3 The CONTRACTOR shall evaluate and report member satisfaction based upon NCQA requirements, on Population Health programs with interactive interventions.

2.8.11.4 The CONTRACTOR shall assess member's functional status, using the SF12 survey, or other appropriate tool used for children or the intellectually disabled, for members in the high risk Chronic Care Management program and the Complex Case Management program.

2.8.12 Special Projects

2.8.12.1 New Member mini Heath Risk Assessments. The CONTRACTOR shall make reasonable attempts to assess member's health risks. Information such as weight, nutrition, substance abuse and physical inactivity collected from assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.

2.8.12.1.1 During 2013, the first year of implementation, the CONTRACTOR shall continue to conduct their current new member HRA and identify the method for incorporating HRA information into the identification system for eligibility into Population Health programs.

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

2.8.12.2 The CONTRACTOR shall conduct at least one rapid cycle improvement project annually. The rapid cycle improvement projects shall address increasing member engagement rates in the High Risk opt in level of Population Health programs. The project plan is to be reported in the quarterly report before implementation. The project should then be conducted with the results to be reported in the next Population Health Quarterly Report.

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

2.8.13.1 The CONTRACTOR shall by January 1, 2013 stratify all members into the three risk categories described in Section 2.8.1.1.

2.8.13.2 The CONTRACTOR shall by March 31, 2013 have all disease management managed members receiving services at the end of the fourth quarter of 2012 transitioned to the new level 1 or level 2 Population Health programs.

2.8.13.3 The CONTRACTOR shall by January 31, 2013 have all members engaged in case management, at the end of the fourth quarter of 2012, transitioned to the appropriate Level 2 Population Health program.

2.8.13.4 The CONTRACTOR shall by April 30, 2013 have submitted all required operational data for the first three months of the transition period.

2.8.13.5 The CONTRACTOR shall by April 30, 2013 provide evidence in the quarterly Population Heath Quarterly report, as cited above, that a method is in place to identify the targeted population for prenatal visit verification. (see Section 2.8.4.2.3)

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

12. Section 2.9.5.3 shall be deleted in its entirety and the remaining Section 2.9.5 shall be renumbered accordingly, including any references thereto.

13. Section 2.9.6.1.4 shall be amended by adding new language to the end of the existing language as follows:

2.9.6.1.4 Long-term care services identified through care coordination and provided by the CONTRACTOR shall build upon and not supplant a member's existing support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services

that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance. However, once a member qualifies for CHOICES, he is no longer eligible to receive services under the State-funded Options program (see Rule 0030-2-1-.01), and neither the State nor the CONTRACTOR can require that services available to a member through CHOICES be provided instead through programs funded by Title III of the Older Americans Act.

14. Section 2.9.6.1.6 shall be deleted and replaced as follows:

2.9.6.1.6 The CONTRACTOR shall compute Care Coordination CHOICES-related timelines as follows;

2.9.6.1.6.1 The date of receipt of the referral by the CONTRACTOR (which shall not include any additional days for the CONTRACTOR to process the referral or assign to appropriate staff) shall be the anchor date for the referral process. The anchor date is not included in the calculation of days.

2.9.6.1.6.2 The anchor date for the enrollment process shall be the latter of 1) the date the Bureau transmits the 834 file to the CONTRACTOR; or 2) the date of CHOICES enrollment as indicated on the 834 file. The anchor date is not included in the calculation of days.

2.9.6.1.6.3 The Business Day (see Section 1) immediately following the anchor date is day one (1) of timelines utilizing business days. Each subsequent business day is included in the computation.

2.9.6.1.6.4 The calendar day immediately following the anchor date is day one (1) of timelines utilizing calendar days. Each subsequent calendar day is included in the computation.

15. Section 2.9.6.1.9 shall be deleted and replaced as follows:

2.9.6.1.9 The CONTRACTOR shall ensure that, upon enrollment into CHOICES, the appropriate level of Population Health (see Section 2.8.4 of this Agreement) activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care needs. The care coordinator may use resources and staff from the CONTRACTOR's Population Health programs, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the care coordinator/care coordination team.

16. Section 2.9.6.2.3 shall be deleted and replaced as follows and all references shall be updated accordingly.

2.9.6.2.3 *Functions of the Single Point of Entry (SPOE)*

2.9.6.2.3.1 For persons wishing to apply for CHOICES, TENNCARE or its designee may employ a screening process, using the tools and protocols specified by TENNCARE, to assist with intake for persons new to both TENNCARE and CHOICES. Such screening process shall assess: (1) whether the applicant appears to meet categorical and financial eligibility criteria for CHOICES, and (2) whether the applicant appears to meet level of care eligibility for enrollment in CHOICES.

2.9.6.2.3.2 For persons identified by TENNCARE or its designee as meeting the screening criteria, or for whom TENNCARE or its designee opts not to use a screening process, TENNCARE or its designee will conduct a face-to-face intake visit with the applicant. As part of this intake visit TENNCARE or its designee will, using the tools and protocols specified by TENNCARE, conduct a level of care and needs assessment; and assess the member's existing natural support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance.

2.9.6.2.3.3 TENNCARE or its designee shall conduct the intake visit, including the level of care and needs assessment, in the applicant's place of residence, except under extenuating circumstances (such as the member's hospitalization), which shall be documented in writing.

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

decision regarding his/her acceptance of risk; and (b) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and (9) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

2.9.6.2.3.5 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES.

2.9.6.2.3.6 TENNCARE will notify the CONTRACTOR via the outbound 834 enrollment file when a person has been enrolled in CHOICES, the member's CHOICES Group, and any applicable patient liability amounts (See Section 2.6.7). For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and Section 2.6.1.5.2.3), which shall be the average cost of Level 1 nursing facility care unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as applicable) in the level of care.

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

17. Section 2.9.6.2.5 shall be amended by adding new Sections 2.9.6.2.5.8 through 2.9.6.2.5.9.2 as follows and the remaining Section shall be renumbered accordingly, including any references thereto.

2.9.6.2.5.8 As part of the face-to-face visit for members in CHOICES Group 2, the Care Coordinator shall make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the member regarding the individual cost neutrality cap, including that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting;

2.9.6.2.5.8.1 If the Care Coordinator determines that the member's needs cannot be safely met in the community within the member's individual cost neutrality cap, the Care Coordinator shall assist the member in transitioning to a more appropriate care delivery setting, or if the member refuses, proceed with disenrollment from CHOICES.

2.9.6.2.5.9 As part of the face-to-face visit for members in CHOICES Group 3, the Care Coordinator shall provide explanation to the member regarding the fifteen thousand dollar ($15,000) expenditure cap and make a determination whether the member's needs can be safely met within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of

$15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers and make a determination whether the member's needs can be safely met within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers;

2.9.6.2.5.9.1 If the member has been conditionally enrolled into CHOICES Group 3 and is in a nursing facility, the Care Coordinator shall work with the nursing facility to coordinate timely transition to the community and initiation of CHOICES HCBS.

2.9.6.2.5.9.2 If the Care Coordinator determines that the member's needs cannot be safely met in the community within the array of services and supports that would be available as described in 2.9.6.5.9, the Care Coordinator shall, pursuant to protocols established by TENNCARE, coordinate with TENNCARE to review the member's level of care, and if nursing facility level of care is approved, to facilitate transition to CHOICES Group 1 or 2.

18. The renumbered Sections 2.9.6.2.5.10 and 11 shall be deleted and replaced as follows:

2.9.6.2.5.10 As part of the face-to-face visit for members in CHOICES Group 2 or Group 3, the care coordinator shall review, and revise as necessary, the member's risk assessment, develop a risk agreement ,and have the member or his/her representative sign and date the risk agreement.

2.9.6.2.5.11 As part of the face-to-face visit, for members determined to need eligible CHOICES HCBS, the care coordinator shall verify the member's interest in participating in consumer direction and obtain written confirmation of the member's decision. The care coordinator shall also, using current information regarding the CONTRACTOR's network, provide member education regarding choice of contract providers for CHOICES HCBS, subject to the provider's availability and willingness to timely deliver services, and obtain signed confirmation of the member's choice of contract providers.

19. Section 2.9.6.3.1.3 shall be amended by deleting the phrase "DM MCO case management," and replacing it with "Population Health" as follows:

2.9.6.3.1.3 Referral from CONTRACTOR's staff including but not limited to Population Health and UM staff;

20. Section 2.9.6.3.1.5.4 shall be amended by deleting and replacing the word "DM" with the words "Population Health" as follows:

2.9.6.3.1.5.4 Data collected through the Population Health and/or UM processes.

21. Section 2.9.6.3.2 shall be amended by deleting and replacing the acronym "MOE" with the words "CHOICES At-Risk".

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

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

23. Section 2.9.6.5.1.1 shall be amended by deleting and replacing the words "disease management" with "Population Health".

24. Section 2.9.6.6.1.1 shall be amended by deleting and replacing the words "disease management" with "Population Health".

25. Section 2.9.6.8.2 shall be amended by deleting and replacing the words "MCO Case Management" with "Population Health" and updating the reference to Section "2.9.5.4.1" with "2.9.5.3.1".

26. The first sentence of Section 2.9.6.8.7 shall be amended by deleting the phrase "using a tool and protocol specified" and replacing it with the phrase "in accordance with protocols developed".

27. Section 2.9.6.9.1.1.2 shall be amended by deleting and replacing the words "disease management" with "Population Health".

28. Section 2.9.6.9.3.1.1shall be amended by deleting and replacing Section 2.9.6.9.3.1.1.1 and adding new Sections 2.9.6.9.3.1.1.3 through 2.9.6.9.3.1.1.3.2 as follows:

2.9.6.9.3.1.1.1 If the level of care assessment indicates a change in the level of care, or if the assessment was prompted by a request by a member, a member's representative or caregiver or another entity for a change in level of services, the level of care shall be forwarded to TENNCARE for determination;

2.9.6.9.3.1.1.3 For all persons enrolled into the CHOICES program (CHOICES Group 1 or 2) prior to implementation of the new NF Level of Care (LOC) criteria on July 1, 2012, the CONTRACTOR shall be obligated to assess the person's LOC as follows:

2.9.6.9.3.1.1.3.1 The CONTRACTOR shall, for purposes of LOC eligibility to remain in the CHOICES Group in which the member is enrolled, assess the member's LOC eligibility be based on the criteria in place at the time of the member's enrollment into that CHOICES group.

2.9.6.9.3.1.1.3.2 The CONTRACTOR shall also, for purposes of complying with the Terms and Conditions of the State's Waiver, assess the member's LOC eligibility based on the new LOC criteria in place as of July 1, 2012. The CONTRACTOR shall report the results of the LOC reassessment to TENNCARE. This information will be used by the State in its expenditure reporting to CMS.

29. Section 2.9.6.9.3.3 shall be amended by deleting and replacing the words "disease management" with "Population Health".

30. The third sentence in Section 2.9.6.10.9 shall be amended by deleting the phrase "as applicable," between the words "agreement" and "shall" as follows:

2.9.6.10.9 For members electing to participate in consumer direction, the member's care coordinator shall develop and/or update risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as

well as measures to mitigate these risks. The member's representative (if applicable) shall participate in the risk assessment process. The new or updated risk agreement, shall be signed by the member (or the member's representative, as applicable). The CONTRACTOR shall provide a copy of the risk agreement to the member/representative and the FEA.

31. Section 2.9.6.11.18.21 shall be amended by deleting and replacing the words "disease management" with "Population Health".

32. Section 2.9.6.11.18 shall be amended by adding new Sections 2.9.6.11.18.32 through 2.9.6.11.18.35 as follows:

2.9.6.11.18.32 The Care Coordinator's role and responsibility in implementing the Advance Determination process including qualifying criteria, when the process may be implemented, and what documentation must be presented to support the determination pursuant to TENNCARE rule 12 13 01-05.

2.9.6.11.18.33 The Care Coordinator's role and responsibility in assessing members who have been conditionally enrolled into CHOICES and coordination with the nursing facility to facilitate timely transition, when appropriate.

2.9.6.11.18.34 The Care Coordinator's role and responsibility in facilitating denial of enrollment into or termination of enrollment from CHOICES Groups 2 or 3 when a determination has been made that the applicant or member (as applicable) cannot be safely served within the member's cost neutrality cap (CHOICES Group 2) or Expenditure Cap (CHOICES Group 3).

2.9.6.11.18.35 The Care Coordinator's role and responsibility in facilitating access to other medically TennCare covered benefits, including home health and behavioral health services.

33. The fifth paragraph in Section 2.9.7.4.10.10 shall be amended by deleting the phrase "as applicable," between the words "agreement" and "shall" as follows:

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

34. Section 2.9.8.3.6 shall be amended by deleting and replacing the word "Tennessee" with the word "TENNCARE".

35. Section 2.9.8.8.1 shall be amended by adding a new Section 2.9.8.8.1.1 as follows:

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

36. Section2.9.9.1 shall be deleted and replaced as follows:

2.9.9.1 General

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

37. Section 2.9.9.8 shall be deleted and replaced as follows:

2.9.9.8 Population Health and CHOICES Care Coordination

The CONTRACTOR shall use its Population Health, and CHOICES care coordination programs (see Sections 2.9.5, 2.8, and 2.9.6) to support the continuity and coordination of covered physical health, behavioral health, and long-term care services and the collaboration between physical health, behavioral health, and long-term care providers. The CONTRACTOR has the option to allow members, e.g., members who have been determined to be high risk based on Population Health stratification (see Section 2.8.3), to be enrolled in an appropriate level Population Health Program (see Section 2.8.4 of this Agreement). For CHOICES members, Population Health activities shall be integrated with the care coordination process (see Sections 2.9.5.3, and 2.9.6.1.9).

38. Section 2.9.11.3.1 shall be deleted and replaced as follows:

2.9.11.3.1 Analyzing prescription drug data and/or reports provided by the PBM or TENNCARE to identify high-utilizers and other members who inappropriately use pharmacy services and assign them to Population Health programs and/or refer them to CHOICES intake (see Section 2.9.6) as appropriate; if a CHOICES member is identified as a high-utilizer or as inappropriately using pharmacy services, relevant prescription drug data and/or reports for the member shall be provided to the member's care coordinator, and the care coordinator shall take appropriate next steps, which may include coordination with the member's PCP

39. Section 2.9 shall be amended by adding a new 2.9.14 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.9.14 Coordination with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) regarding the CONTRACTOR's Full Benefit Dual Eligible (FBDE) Members Enrolled in a D-SNP

2.9.14.1 The CONTRACTOR shall modify its IT systems to accept Medicare enrollment data and to load the data in the CONTRACTOR's case management system for use by Care Coordinators and case management, DM/Population Health and UM staff.

2.9.14.2 The CONTRACTOR shall coordinate with a FBDE member's D-SNP regarding discharge planning from any inpatient setting when Medicaid LTSS (NF or HCBS), Medicaid home health or private duty nursing, or other Medicaid services may be needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective and integrated setting.

2.9.14.2.1 The CONTRACTOR shall develop, for review and approval by TENNCARE, policies, procedures and training for CONTRACTOR staff, including Care Coordinators, regarding coordination with a FBDE member's D-SNP in discharge planning from an inpatient setting to the most appropriate, cost effective and integrated setting.

2.9.14.2.2 The CONTRACTOR shall receive and process in a timely manner a standardized electronic Daily Inpatient Admissions, Census and Discharge Report, from each D-SNP operating in the Grand Region served by the CONTRACTOR.

2.9.14.2.3 The CONTRACTOR shall provide a technical contact to address any technical problems in the submission of the daily Report.

2.9.14.2.4 The CONTRACTOR shall establish processes to ensure that notifications of inpatient admission are timely and appropriately triaged.

2.9.14.2.5 The CONTRACTOR shall establish tracking mechanisms to ensure that staff are timely and appropriately engaged in discharge planning, and for CHOICES members, that Care Coordinators are notified/engaged as appropriate.

2.9.14.2.6 The CONTRACTOR shall maintain daily reports for audit to determine appropriate and timely engagement in discharge planning.

2.9.14.3 The CONTRACTOR shall coordinate with a FBDE member's D-SNP regarding CHOICES LTSS that may be needed by the member; however, the D-SNP shall remain responsible for ensuring access to all Medicare benefits covered by the CONTRACTOR, including SNF and home health, and shall not supplant such medically necessary covered services with services available only through TennCare.

2.9.14.3.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies, procedures and training for processing in a timely manner requests for CHOICES LTSS from a FBDE member's D-SNP, including communication with the member's Care Coordinator and/or UM staff, response to the D-SNP submitter, collaboration between the Medical Director(s) of the D-SNP and MCO regarding medical necessity denials, and escalation procedures/contacts.

2.9.14.4 The CONTRACTOR shall coordinate with a FBDE member's D-SNP to ensure timely access to medically necessary covered Medicare benefits needed by a FBDE member, including members enrolled in the CHOICES program.

2.9.14.4.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies, procedures and training for staff, including Care Coordinators, regarding service requests to a FBDE member's D-SNP for Medicare benefits needed by the member.

2.9.14.5 The CONTRACTOR shall request, when appropriate, the D-SNP's participation in needs assessments and/or the development of an integrated person-centered plan of care for a TennCare CHOICES member, encompassing Medicare benefits provided by the CONTRACTOR as well as Medicaid benefits provided by the TennCare MCO.

2.9.14.5.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies, procedures, and training for engaging D-SNP participation in the CHOICES needs assessment/care planning process for a FBDE member, including the roles/responsibilities of the TennCare MCO and the D-SNP.

2.9.14.6 The CONTRACTOR shall submit to a FBDE member's D-SNP, as applicable and appropriate, referrals for case management and/or disease management/Population Health.

2.9.14.6.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies procedures and training for staff regarding the D-SNP case management and/or disease management/Population Health referral process.

2.9.14.7 The CONTRACTOR shall coordinate with each D-SNP operating in the Grand Region served by the CONTRACTOR and with the D-SNP's providers (including hospitals and physicians) in the CONTRACTOR's implementation of its nursing facility diversion program.

2.9.14.7.1 The CONTRACTOR shall provide to D-SNPs training on the CONTRACTOR's NF Diversion program, including the referral process.

2.9.14.7.2 The CONTRACTOR shall, pursuant to Section 2.9.6, accept and process from a member's D-SNP a referral for HCBS in order to delay or prevent NF placement.

2.9.14.8 The CONTRACTOR shall, pursuant to Section 2.9.6 receive and process from a FBDE member's D-SNP a referral for transition from a SNF to the community, and shall coordinate with the FBDE member's D-SNP to facilitate timely transition, as appropriate, including coordination of services covered by the CONTRACTOR and services covered by the D-SNP.

2.9.14.8.1 The CONTRACTOR shall provide to D-SNPs training on the CONTRACTOR's NF-to-community transition program, including the referral, screening and assessment process.

2.9.14.9 The CONTRACTOR shall participate, as appropriate, in D-SNP training regarding D-SNP responsibilities for coordination of Medicare and Medicaid benefits for FBDE members and benefits covered under the TennCare program, including CHOICES.

40. Section 2.11.1.3 shall be amended by adding a new Section 2.11.1.3.7 as follows:

2.11.1.3.7 Not discriminate against providers and entities in accordance with the federal prohibition against discrimination as provided for under the collective "federal health care provider conscience protection statutes," referenced individually as the Church Amendments, 42 U.S.C. § 300a–7, section 245 of the Public Health Service Act, 42 U.S.C. § 238n, and the Weldon Amendment, Consolidated Appropriations Act, 2010, Public Law 111–117, Div. D, Sec. 508(d), 123 Stat. 3034, 3279–80.

41. Section 2.11.6.1 shall be deleted and replaced in its entirety.

2.11.6.1 The CONTRACTOR shall contract with all current nursing facilities (as defined in TCA 71-5-1412(b)), that meet all CMS certification requirements, for a minimum of three (3) years following the effective date of CHOICES implementation. Pursuant to Public Chapter 971, such period is extended through June 30, 2015 if the facility is willing to contract with the CONTRACTOR under the same terms and conditions offered to any other participating facility; however this does not prevent the CONTRACTOR from enforcing the provisions of its contract with the facility. Thereafter, the CONTRACTOR shall contract with a sufficient number of nursing facilities in order to have adequate capacity to meet the needs of CHOICES members for nursing facility services

42. Section 2.11.6 shall be amended by deleting and replacing Section 2.11.6.7 and by adding a new Section 2.11.6.8 as follows:

2.11.6.7 The CONTRACTOR shall assist in developing an adequate qualified workforce for covered long-term care services. The CONTRACTOR shall actively participate with TENNCARE, other TennCare managed care contractors, and other stakeholders as part of a statewide initiative to develop and implement strategies to increase the pool of available qualified direct care staff and to improve retention of qualified direct care staff. The strategies may include, for example, establishing partnerships with local colleges and technical training schools to develop and implement training and/or certification programs for direct support staff; creating a registry of trained and/or certified staff with the ability to match people who need assistance with staff to provide such assistance based on individualized needs and preferences; providing incentives for providers who employ specially trained and/or certified staff and who assign staff based on member needs and preferences; and systems to encourage direct support staff to engage as an active participant in the care coordination team. The CONTRACTOR's active participation in this statewide initiative shall fulfill its obligation under this section; however the CONTRACTOR is not prohibited for pursuing additional

workforce development activities. The CONTRACTOR shall report annually to TENNCARE on the status of any additional qualified workforce development strategies it elects to implement (see Section 2.30.8.7)

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

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

43. Section 2.12.9.4 shall be deleted and replaced as follows:

2.12.9.4 Failure by the provider to obtain written approval from the CONTRACTOR for a subcontract that is for the purposes of providing TennCare covered services may lead to the contract being declared null and void at the option of TENNCARE. Claims submitted by the subcontractor or by the provider for services furnished by the subcontractor are considered to be improper payments and may be considered false claims. Any such improper payments may be subject to action under Federal and State false claims statutes or be subject to be recouped by the CONTRACTOR and/or TENNCARE as overpayment;

44. Section 2.12.9.61 shall be amended by adding the words "public" and "in English and Spanish" as follows:

2.12.9.61 Require that the provider display public notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. The CONTRACTOR shall ensure that providers have a correct and adequate supply of public notices in English and Spanish;

45. Section 2.12.9.65 shall be deleted and replaced as follows:

2.12.9.65 Specify that the provider agreements include the following nondiscrimination provisions:

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

2.12.9.65.2 Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency.

2.12.9.65.3 Require the provider to agree to cooperate with TENNCARE and the CONTRACTOR during discrimination complaint investigations.

2.12.9.65.4 Require the provider to assist TennCare enrollees in obtaining discrimination complaint forms and contact information for the CONTRACTOR's Nondiscrimination Office.

46. Section 2.13.8 shall be deleted and replaced in its entirety and shall read as follows:

2.13.8 **Medicaid Payment for Primary Care**

2.13.8.1 In accordance with the Patient Protection and Affordable Care Act of 2010 (The Affordable Care Act), for calendar years 2013 and 2014, the CONTRACTOR shall make payments for certain primary care services (as described by CMS) and furnished by primary care providers (as described by CMS and TENNCARE) in an amount that has been determined by CMS.

2.13.8.2 In addition to the routine claims payment reports required by this Agreement, the CONTRACTOR shall report to TENNCARE any information related to this requirement in a format described by TENNCARE.

47. Sections 2.14.1.16.2 and 2.14.1.16.5 shall be deleted and replaced as follows:

2.14.1.16.2 Enroll non-CHOICES members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period in the appropriate level of Population Health services (see Section 2.8.4 of this Agreement) and may use the information to identify members who may be eligible for CHOICES in accordance with the requirements in Section 2.9.6.3 if appropriate;

2.14.1.16.5 Assess the most likely cause of high utilization and develop a Population Health Complex Case Management (see Section 2.8.4 of this Agreement) plan based on results of the assessment for each non-CHOICES member.

48. Section 2.14.2.3 shall be deleted and replaced as follows:

2.14.2.3 Prior authorization requests shall be processed in accordance with 42 CFR § 438.210(d) and the guidelines described in TennCare rules and regulations which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request. Instances in which an enrollee's health condition shall be deemed to require an expedited authorization decision by the CONTRACTOR shall include requests for home health services for enrollees being discharged from a hospital or other inpatient setting when such home health services are needed to begin upon discharge.

49. Section 2.14.3.5.2 shall be amended by adding the words "hard copy" as follows:

2.14.3.5.2 The referral provider listing shall be in the format specified by TENNCARE for the hard copy provider directory in Section 2.17.8.

50. Section 2.14.5 shall be amended by adding a new Section 2.14.5.5 as follows and the remaining Section shall be renumbered accordingly including any references thereto.

2.14.5.5 The CONTRACTOR may determine the duration of time for which CHOICES HCBS will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES HCBS in accordance with the plan of care. Retroactive entry or adjustments in service authorizations for CHOICES HCBS should be made only when required to accommodate payment of services that had been authorized but an adjustment in the schedule of services was required based on the member's needs.

51. Section 2.14.9.3 shall be deleted and replaced as follows:

2.14.9.3 Emergency Room Utilization

The CONTRACTOR shall maintain a procedure to identify and evaluate member emergency room utilization by PCP panel. As provided in Section 2.14.1.16 of this Agreement, members who establish a pattern of accessing emergency room services shall be referred to the appropriate Population Health Program for follow-up services.

52. Section 2.15.1.6 shall be amended by adding a new Section 2.15.1.6.2 as follows and renumbering the remaining Sections accordingly including any references thereto.

2.15.1.6.2 The CONTRACTOR shall participate in workgroups and agree to establish and implement policies and procedures, including billing and reimbursement, that are agreed to and/or described by TENNCARE in order to address specific quality concerns. These initiatives shall include but not be limited to identification of prenatal and postpartum visits in a time effective manner especially when a provider bills for total obstetrical care using a global billing code.

53. Section 2.15.3.1.1 shall be deleted and replaced as follows:

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

54. Section 2.15.4 shall be deleted and replaced as follows:

2.15.4 Clinical Practice Guidelines

The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its Population Health Programs (see Section 2.8.6 of this Agreement). The guidelines shall be reviewed and revised whenever the guidelines change and at least every two (2) years. The CONTRACTOR is required to maintain an archive of its clinical practice guidelines for a period of five (5) years. Such archive shall contain each clinical guideline as originally issued so that the actual guidelines for prior years are retained for Program Integrity purposes.

55. Section 2.15.6.1.1 shall be amended by adding a new sentence at the end of the existing text as follows:

2.15.6.1.1 Beginning with HEDIS 2012, the CONTRACTOR shall utilize the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid Specifications as identified by NCQA. If, in the event the CONTRACTOR fails to pass the medical record review for any given standard and NCQA *mandates* administrative data must be submitted instead of hybrid, the administrative data may be used.

56. Section 2.15.7.1.3 shall be amended by deleting and replacing Section 2.15.7.1.3.3, adding a new Section 2.15.7.1.3.4 and renumbering the existing Section accordingly including any references thereto.

2.15.7.1.3.3 Theft against a CHOICES member;

2.15.7.1.3.4 Financial exploitation of a CHOICES member;

57. Section 2.17.5.2 through 2.17.5.2.1.1.3 shall be deleted and replaced as follows:

2.17.5.2 Teen Newsletter

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

2.17.5.2.1 The Teen Newsletter shall be a product of the TENNderCare MCC Collaborative. The MCOs will agree on five required topics to include in each newsletter. MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved in writing by TENNCARE.

2.17.5.2.1.1 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.2.1.1.1 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and

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

58. Section 2.17.8 shall be deleted and replaced as follows:

2.17.8 **Provider Directories**

2.17.8.1 The CONTRACTOR shall distribute information regarding general provider directories (see Section 2.17.8.5 below) to new members within thirty (30) calendar days of receipt of notification of enrollment in the CONTRACTOR's MCO or prior to the member's enrollment effective date. Such information shall include how to access the provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers.

2.17.8.2 The CONTRACTOR shall provide information regarding the CHOICES provider directory (see Section 2.17.8.6 below) to each CHOICES member as part of the face-to-face visit (for members enrolled through the SPOE) or face-to-face intake visit (for current members) as applicable, but not more than thirty (30) days from notice of CHOICES enrollment. Such information shall include how to access the CHOICES provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the CHOICES provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers.

2.17.8.3 The CONTRACTOR shall also be responsible for maintaining updated provider information in an online searchable electronic general provider directory and an online searchable electronic CHOICES provider directory. A PDF copy of the hard copy version shall not meet this requirement. The online searchable version of the general provider directory and the CHOICES provider directory shall be updated on a daily basis during the business week. In addition, the CONTRACTOR shall make available upon request, in hard copy format, a complete and updated general provider directory to all members and an updated CHOICES provider directory to CHOICES members. The hard copy of the general provider directory and the CHOICES provider directory shall be updated at least on an annual basis. Members receiving a hard copy and/or accessing a PDF version of the hard copy on the CONTRACTOR's website of the general provider directory or the CHOICES provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers, including the searchable electronic version of the general provider directory and the CHOICES provider directory and the CONTRACTOR's member services line.

2.17.8.4 Provider directories (including both the general provider directory and the CHOICES provider directory), and any revisions thereto, shall be submitted to TENNCARE for written approval prior to distribution to enrollees in accordance with Section 2.17.1 of this Agreement. The text of the directory shall be in the format prescribed by TENNCARE. In addition, the provider information used to populate the provider directory shall be submitted as a TXT file or such format as otherwise approved in writing by TENNCARE and be produced using the same extract process as the actual provider directory.

2.17.8.5 The CONTRACTOR shall develop and maintain a general provider directory, which shall be made available to all members. The provider directory shall be posted on the CONTRACTOR's website, and provided in hard copy upon request of the member. Members shall be advised in writing regarding how to access the provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers. The online version of the provider directory shall be updated on a daily basis. The general provider directory shall include the following: names, locations, telephone numbers, office hours, and non-English languages spoken by contract PCPs and specialists; identification of providers accepting new patients; and identification of whether or not a provider performs TENNderCare screens; hospital listings, including locations of emergency settings and post-stabilization services, with the name, location, and telephone number of each facility/setting; and a prominent notice that CHOICES members should refer to the CHOICES provider directory for information on long-term care providers.

2.17.8.6 The CONTRACTOR shall develop and maintain a CHOICES provider directory that includes long-term care providers. The CHOICES provider directory, which shall be made available to all CHOICES members, shall include the following: nursing facility listings with the name, location, and telephone number of each facility; community-based residential alternatives, by type, with the name, location, and telephone number of each facility; and a listing of other (non-residential) CHOICES HCBS providers with the name, location, telephone number, and type of services by county of each provider. The CHOICES provider directory shall be posted on the CONTRACTOR's website, and provided in hard copy upon request of the member. Members shall be advised in writing regarding how to access the CHOICES provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the CHOICES provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers. The online version of the CHOICES provider directory shall be updated on a daily basis.

59. Section 2.18.2 shall be deleted and replaced as follows:

2.18.2 **Interpreter and Translation Services**

2.18.2.1 The CONTRACTOR shall develop written policies and procedures for the provision of language interpreter and translation services, including effective communication assistance in alternative formats, such as, auxiliary aids to any member who needs such services The CONTRACTOR shall provide language and cultural competence training to subcontractors and contracted providers which shall include the potential impact of linguistic and cultural barriers on utilization, quality and satisfaction with care and how and when to access interpreter services and to promote their appropriate use during the medical encounter.

2.18.2.2 The CONTRACTOR shall provide language interpreter and translation services including effective communication assistance in alternative formats, such as, auxiliary aids free of charge to members.

2.18.2.3 Interpreter services should be available in the form of in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.

60. Section 2.18.6 shall be amended by adding a new Section 2.18.6.13 and renumbering the remaining Section accordingly, including any references thereto. The renumbered Section 2.18.6.14 shall be deleted and replaced as follows:

2.18.6.13 The CONTRACTOR shall submit all general correspondence intended for mass distribution that affects provider reimbursement, claims processing procedures, or documents that are referenced as a part of a CONTRACTOR's provider agreement template(s) (see Section 2.12.2) to TDCI for review and approval or acceptance, as appropriate (e.g., provider handbooks, newsletters, alerts, notices, reminders, other education material, etc.).

2.18.6.14 The CONTRACTOR's provider relations staff shall contact all contract providers on a semi-annual basis to update contract providers on CONTRACTOR initiatives and communicate pertinent information to contract providers. For providers located in Tennessee and out-of-state providers located in contigious counties, at least one of the two semi-annual contacts made in a year shall be face-to-face with the provider. Semi-annual contacts that are not conducted face-to-face shall be conducted via a phone conversation with the provider. The CONTRACTOR shall maintain records that provide evidence of compliance with the requirement in this Section 2.18.6.14, including when and how contact is made for each contract provider. The CONTRACTOR may submit an alternative plan to accomplish the intent of this requirement for review and approval by TENNCARE.

61. Section 2.20.2.4 shall be amended by adding the word "tips," in front of the word "confirmed" and by adding a new Section 2.20.2.4.1 and renumbering the remaining Section accordingly, including any references thereto.

2.20.2.4 The CONTRACTOR shall report all tips, confirmed or suspected fraud and abuse to TENNCARE and the appropriate agency as follows:

2.20.2.4.1 All tips (any program integrity case opened within the previous two (2) weeks) shall be reported to TennCare Office of Program Integrity and TBI MFCU;

62. Section 2.22.4 shall be amended by adding new Sections 2.22.4.11 through 2.22.4.12 as follows:

2.22.4.11 For purposes of timely filing (see Section 2.12.9.28):

2.22.4.11.1 For institutional claims that include span dates of service (i.e., a 'From' and 'Through' date on the claim), the 'Through' date on the claim shall be used for determining the date of service for claims filing timeliness. The CONTRACTOR shall provide a minimum of sixty (60) days from the date of initial notice of an invalid and/or insufficient claim or one hundred twenty (120) days from the date of service or "Through" date on a span bill, whichever is later, for submission of a valid, complete claim.

2.22.4.11.2 For claims submitted by physicians and other suppliers that include span dates of service, the line item 'From' date shall be used for determining the date of service for claims filing timeliness. The CONTRACTOR shall provide a minimum of sixty (60) days from the date of initial notice of an invalid and/or insufficient claim or one hundred twenty (120) days from the date of service or "Through" date on a span bill, whichever is later, for submission of a valid, complete claim.

2.22.4.11.3 For claims submitted by physicians and other suppliers that do not include span dates of service, the date of service shall be used for determining claims filing timeliness. The CONTRACTOR shall provide a minimum of sixty (60) days from the date of initial notice of an invalid and/or insufficient claim or one hundred twenty (120) days from the date of service, whichever is later, for submission of a valid, complete claim.

2.22.4.11.4 Beginning with claims for dates of service January 1, 2013 and following, except for 1) recovery of overpayments as required pursuant to Section 6402 of the Affordable Care Act and TENNCARE policy; and 2) retrospective adjustments of a nursing facility's per diem rate(s) (see Section 2.13.3.4), paid claims requiring correction or resubmission must be submitted as adjustments to the paid claim within 120 days of the date of payment notification. Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.

2.22.4.11.5 The provider has the right to file a dispute if he or she disagrees with a claim decision regarding the denial or compensation of a claim in accordance with section (2.12.9.)

2.22.4.11.6 The CONTRACTOR shall specify in its provider manual a period of time that is consistent with these requirements and to the extent that this reflects a change in the CONTRACTOR's current provider manual, shall issue notification to providers on or before January 2, 2013.

2.22.4.12 The CONTRACTOR shall, for a period to be determined by TENNCARE, permit CHOICES Nursing Facility and HCBS providers to resubmit and shall process any institutional or HCBS claims for dates of service on or after March 1, 2010, that were denied on the basis of timely filing when the claim was filed in accordance with 2.22.4.11.1, 2.22.4.11.2, or 2.22.4.11.3, as applicable, or for which the applicable minimum reprocessing time was not provided.

63. Section 2.23.4.3.7 shall be amended by adding the phrase (see Section 2.30.18.3) in the last sentence.

64. Section 2.23.5.2 shall be deleted and replaced as follows:

2.23.5.2 The CONTRACTOR shall systematically update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. The CONTRACTOR shall report to TENNCARE, in a form and format to be provided by TENNCARE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from TENNCARE and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance.

65. Section 2.25.9.1 shall be amended by deleting and replacing the words "disease management" with "Population Health".

66. Section 2.26.9 shall be amended by adding the words "and providers" as follows:

2.26.9 **Interpretation/Translation Services and Limited English Proficiency (LEP) Provisions**

The CONTRACTOR shall provide instruction for all direct service subcontractors and providers regarding the CONTRACTOR's written procedure for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, enrollees with Limited English Proficiency.

67. Section 2.28.6 shall be deleted in its entirety and the remaining Section shall be renumbered accordingly, including any references thereto.

68. The renumbered Sections 2.28.6 and 2.28.7 shall be deleted and replaced as follows:

2.28.6 All discrimination complaints against the CONTRACTOR, CONTRACTOR's employees, CONTRACTOR's providers, CONTRACTOR's provider's employees and CONTRACTOR's subcontractors shall be resolved according to the provisions of this Section 2.28.6.

2.28.6.1 Discrimination Complaints against the CONTRACTOR and/or CONTRACTOR's Employees. When complaints concerning alleged acts of discrimination committed by the CONTRACTOR and/or its employees related to the provision of and/or access to TennCare covered services are reported to the CONTRACTOR, the CONTRACTOR's nondiscrimination compliance officer shall send such complaints within two (2) business days of receipt to TENNCARE. TENNCARE shall investigate and resolve all alleged acts of discrimination committed by the CONTRACTOR and/or its employees. The CONTRACTOR shall assist TENNCARE during the investigation and resolution of such complaints. TENNCARE reserves the right to request that the CONTRACTOR's nondiscrimination compliance officer assist with conducting the initial investigations and to suggest resolutions of alleged discrimination complaints. If a request for assistance with an initial investigation is made by TENNCARE, the CONTRACTOR's nondiscrimination compliance officer shall provide TENNCARE with all requested information, including but not limited to, the identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; and the CONTRACTOR's suggested resolution. TENNCARE shall review the CONTRACTOR's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section 2.28.6.3 below. Any documentation or materials related to such investigation shall be considered confidential and not subject to disclosure to any third party, unless disclosure is otherwise required by law.

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

2.28.6.3 Corrective Action Plans to Resolve Discrimination Complaints. If a discrimination complaint against the CONTRACTOR, CONTRACTOR's employees, CONTRACTOR's providers, CONTRACTOR's provider's employees, or CONTRACTOR's subcontractors is determined by TENNCARE to be valid, TENNCARE shall, at its option and pursuant to Section 2.25.10, either (i) provide the CONTRACTOR with a corrective action plan to resolve the complaint, or (ii) request that the CONTRACTOR submit a proposed corrective action plan to TENNCARE for review and approval that specifies what actions the CONTRACTOR proposes to take to resolve the discrimination complaint. Upon provision of the corrective action plan to CONTRACTOR by TENNCARE, or approval of the CONTRACTOR's proposed corrective action plan by TENNCARE, the CONTRACTOR shall implement the approved corrective action plan to resolve the discrimination complaint. TENNCARE, in its sole discretion, shall determine when a satisfactory discrimination complaint resolution has been reached and shall notify CONTRACTOR of the approved resolution. A discrimination complaint resolution corrective action plan may consist of approved nondiscrimination training on relevant discrimination topics. Prior to use, the nondiscrimination training material shall be reviewed and approved by TENNCARE. Time periods for the implementation of the corrective action plan nondiscrimination training shall be designated by TENNCARE.

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

69. Section 2.29.1.3.19 shall be deleted and replaced as follows:

2.29.1.3.19 A staff person responsible for all Population Health and related issues, including but not limited to, Population Health activities and coordination between physical and behavioral health services;

70. Section 2.29.1.4 shall be deleted and replaced as follows:

2.29.1.4 In addition to the key staff requirements described above, the CONTRACTOR shall have sufficient full-time clinical and support staff to conduct daily business in an orderly manner. This includes but is not limited to functions and services in the following areas: administration, accounting and finance, fraud and abuse, utilization management including prior authorizations, Population Health, care coordination, QM/QI, member education and outreach, appeal system resolution, member services, provider services, provider relations, claims processing, and reporting.

71. Section 2.29.1.9 shall be deleted and replaced as follows:

2.29.1.9 The CONTRACTOR's project director, transition staff person, Medical Director, psychiatrist, CHOICES senior executive, financial staff, member services staff, provider services staff, provider relations staff, CHOICES provider claims education and assistance staff, UM staff,

appeals staff, , Population Health Complex Case Management staff care coordination staff, consumer advocate, and TENNderCare staff person shall be located in the State of Tennessee. However, TENNCARE may authorize exceptions to this requirement. The CONTRACTOR shall seek TENNCARE's written prior approval to locate any of these staff outside of the State of Tennessee. The CONTRACTOR's request to locate required in-state staff to an out-of-state location shall include a justification of the request and an explanation of how services will be coordinated. If financial staff are not located in Tennessee the CONTRACTOR shall have the ability to issue a check within five (5) calendar days of a payment directive from TENNCARE.

72. Section 2.30.5 and 2.30.5.1shall be deleted and replaced as follows:

2.30.5 Disease Management/Population Health Reports

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

73. Section 2.30.5.3 shall be deleted and replaced as follows:

2.30.5.3 The CONTRACTOR shall submit on March 30, 2013, a *Population Health Program Description* following the guidance provided by TENNCARE addressing Section 2.8 of this Agreement. The program description shall include a written description of how the plan assures that members less than 21 years of age will have their health risks identified and their health needs met at the appropriate risk Level. The program description shall also include a CHOICES narrative as outlined in Section 2.8.11 of this Agreement and address the Clinical Practice Guidelines reference in Section 2.8.6 of this Agreement.

74. Section 2.30.6.1 through 2.30.6.1.3 shall be deleted and replaced as follows:

2.30.6.1 MCO Case Management Reports

2.30.6.1.1 The CONTRACTOR shall submit an annual *MCO Case Management Services Report* that addresses the activities in Section 2.9.5 of the prior Agreement by July 1 of 2013.

75. Section 2.30.8.1 shall be deleted and replaced as follows:

2.30.8.1 The CONTRACTOR shall submit a monthly *Provider Enrollment File* that includes information on all providers of TennCare health services, including physical, behavioral health, and long-term care providers (see Section 2.11). This includes but is not limited to, PCPs, physician specialists, hospitals, home health agencies, CMHAs, nursing facilities, CHOICES HCBS providers, and emergency and non-emergency transportation providers. For CHOICES HCBS providers, the *Provider Enrollment File* shall identify the type(s) of CHOICES HCBS the provider is contracted to provide and the specific counties in which the provider is contracted to deliver CHOICES HCBS, by service type. The report shall include contract providers as well as all non-contract providers with whom the CONTRACTOR has a relationship. During any period of readiness review, the CONTRACTOR shall submit this

report as requested by TENNCARE. Each monthly *Provider Enrollment File* shall include information on all providers of covered services and shall provide a complete replacement for any previous *Provider Enrollment File* submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.

76. Section 2.30.8.7 shall be deleted and replaced as follows:

2.30.8.7 The CONTRACTOR shall submit an annual *CHOICES Qualified Workforce Strategies Report* that describes any additional strategies the CONTRACTOR elects to undertake to assist in the development of an adequate qualified workforce for covered long-term care services, increase the available qualified direct care staff, and improve the retention of qualified direct care staff (see Section 2.11.6.7). At a minimum, the report shall include a brief description of each of any additional strategies the CONTRACTOR elects to undertake; activities associated with each of the CONTRACTOR's strategies, including associated partnerships; timeframes for implementing each strategy and associated activities; the status of each strategy and associated activities; and a brief summary of the current and anticipated impact of each strategy and associated activities. Should the CONTRACTOR elect not to pursue additional activities (beyond the statewide initiative), this report shall be submitted timely and shall report that the CONTRACTOR has elected not to pursue additional activities beyond the statewide initiative.

77. Section 2.30.12.6 shall be deleted and replaced by new Sections 2.30.12.6 and 7 and the remaining Sections of 2.30.12 shall be renumbered accordingly, including any references thereto.

2.30.12.6 The CONTRACTOR shall submit an annual *Report of Audited HEDIS Results* by June 15 of each year (see Sections 2.15.6).

2.30.12.7 The CONTRACTOR shall submit an annual Report of Audited CAHPS Results by June 15 of each year (see Sections 2.15.6).

78. The existing Section 2.30.12.9 shall be deleted in its entirety including any references thereto.

79. Section 2.30.13.3 shall be deleted in its entirety and the renumbered Section 2.30.13.3 shall be deleted and replaced by new Sections 2.30.13.3 and 4 as follows:

2.30.13.3 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that encompasses behavioral and physical health. The report shall summarize the provider survey methods and findings and must provide an analysis of opportunities for improvement (see Section 2.18.7.4) The report shall be submitted by July 1 each year.

2.30.13.4 The CONTRACTOR shall submit an annual *CHOICES Provider Satisfaction Survey Report* that addresses results for CHOICES long-term care providers. The report shall summarize the provider survey methods and findings, must provide an analysis of opportunities for improvement (see Section 2.18.7.5) in addition to CHOICES items specified in the protocols provided by TENNCARE. The report shall be submitted by July 1 each year.

80. Section 2.30.16.2.1 shall be amended by deleting the reference to Section "2.30.17.3" and replacing it with the reference to "2.30.18.3".

81. Section 2.30.18 shall be amended by adding a new Section 2.30.18.4 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.30.18.4 The CONTRACTOR shall submit a quarterly *Encounter/MLR Reconciliation Report* and a *Companion Data File* to demonstrate the reconciliations between the submissions of encounter files and MLR Claim Triangle reports.

2.30.18.4.1 The companion data file shall be in an Excel format and shall represent a claim triangle report in terms of claim counts and total payment based on all encounter batch files submitted to TennCare EDI during the prior quarter with delineations by 'paid month', 'incurred month', 'claim types (as it is defined in the MLR Triangle report)', and 'encounter batch file ID'.

2.30.18.4.2 The reconciliation report shall include an overall assessment of reporting integrities between the two Claim Triangle reports in terms of counts and amount based on the common delineations. When the two reports are not reconciling under the common delineations, the CONTRACTOR shall address the root causes of the gaps with proposed corrective action plans.

82. Section 2.30.22.2 shall be deleted in its entirety and the remaining Section shall be renumbered accordingly, including any references thereto.

83. The renumbered Section 2.30.22.2 shall be deleted and replaced as follows:

2.30.22.2 Annually, TENNCARE shall provide the CONTRACTOR with a Nondiscrimination Compliance Plan Template. The CONTRACTOR shall answer the questions contained in the Compliance Plan Template and submit the completed *Compliance Plan* to TENNCARE within ninety (90) days of the end of the calendar year with any requested documentation, which shall include, but is not limited to, the Assurance of Nondiscrimination. The signature date of the CONTRACTOR's Nondiscrimination Compliance Plan shall be the same as the signature date of the CONTRACTOR's Assurance of Nondiscrimination. These deliverables shall be in a format specified by TENNCARE.

84. The renumbered Section 2.30.22.3.2 shall be deleted and replaced as follows:

2.30.22.3.2 A listing of all complaints filed by employees, members, providers and subcontractors in which discrimination is alleged related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR. Such listing shall include, at a minimum: identity of the complaintant, complainant's relationship to the CONTRACTOR, circumstances of the complaint, type of covered service related to the complaint, date complaint filed, the CONTRACTOR's resolution, date of resolution, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint. For each complaint reported as resolved the CONTRACTOR shall submit a copy of the complainant's letter of resolution.

85. Section 3.1.2 shall be amended by deleting the phrase ",any payments related to FQHC/RHC costs" and by deleting the reference to "(see Section 3.15)" so that the amended Section 3.1.2 shall read as follows:

3.1.2 The CONTRACTOR agrees that capitation payments, any payments related to processing claims for services incurred prior to the start date of operations pursuant to Section 3.7.1.2.1, any payments for claims incurred during a period of retroactive eligibility greater than twelve (12) months prior to the member's date of enrollment with the CONTRACTOR, any incentive payments (if applicable) and any payments that offset the CONTRACTOR's cost for the development and implementation of an electronic visit verification system (EVV) are payment in full for all services provided pursuant to this Agreement. TENNCARE shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as an HMO in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at TCA 56-32-101 *et seq*. or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at TCA 56-51-101 *et seq*. or any subsequent amendments thereto. TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement.

86. Section 3.3.1 shall be deleted and replaced as follows:

3.3.1 The CONTRACTOR will be paid a base capitation rate for each enrollee based on the enrollee's rate category. Rate categories are based on various factors, including the enrollee's enrollment in CHOICES, category of aid, age/sex combination and the Grand Region served by the CONTRACTOR under this Agreement. TENNCARE shall take Third Party Liability (TPL) into account in the development of capitation rates consistent with this Agreement (Section 2.21.4 and the definition of Medical Expenses described herein). This recognizes that it is the CONTRACTOR that is primarily responsible for TPL recoveries and that medical claims experience used for rate setting is net of any TPL recoveries of subrogation activities. The rate categories and the specific rates associated with each rate category are specified in Attachment XII.

87. Section 3.4 shall be amended by adding a new Section 3.4.7 and renumbering the remaining Section accordingly, including any references thereto.

3.4.7 With respect to Post Eligibility Treatment of Income (PETI), TENNCARE will perform a review of patient liability experience to determine remaining liability that had not been addressed in the managed care rate setting process. If additional adjustments are necessary, the adjustments will be made on a periodic basis to assure the correct application of federal funds.

88. Section 3.7.1 shall be amended by adding a new Section 3.7.1.7 and renumbering the existing Section accordingly, including any references thereto.

3.7.1.7 The CONTRACTOR shall, at TENNCARE's discretion and pursuant to policies or protocols established by TENNCARE, participate in a periodic capitation reconciliation process regarding CHOICES capitation payments to verify the receipt of nursing facility services or ongoing HCBS during each month that a CHOICES capitation payment was made, and to adjust the capitation payment for all months during which such services were not provided to the member, except under specific circumstances defined by TENNCARE in policies and protocols. Such reconciliation process shall be conducted based on encounters submitted to TENNCARE by the CONTRACTOR pursuant to Section 2.23.4 of this Agreement.

89. Section 3.12 shall be deleted in its entirety and the remaining Section 3 shall be renumbered accordingly, including any references thereto.

90. The renumbered Section 3.14.1.1 shall be deleted and replaced as follows:

3.14.1.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed three billion, nine hundred ninety two million, four hundred eighty five thousand, eight hundred dollars ($3,992,485,800.00).

91. Section 4.2.1 shall be amended by deleting and replacing "June 30, 2013" with "June 30, 2014" as follows:

4.2.1 **Term of the Agreement**

This Agreement, including any amendments and any changes made by notice to adjust the capitation rates, shall be effective commencing on May 19, 2008 and ending on June 30, 2014.

92. Section 4.20.2.2.7 shall be amended by adding a new Level A.32 Program Issue/Damage as follows:

A.32	Failure to ensure that a level of care (i.e., PAE) and supporting documentation submitted with the level of care is accurate and complete, satisfies all technical requirements specified by TENNCARE, and accurately reflects the member's current medical and functional status. (see Section 2.9.6.3.14.)		$2,000 per occurrence These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement

93. Section 4.20.2.2.7 shall be amended by deleting and replacing the Program Issues/Damage of Level B.2, adding additional language to the Damage Section of B.21., and adding a new Level B.25 as follows:

B.2	Failure to provide a timely and acceptable corrective action plan or comply with corrective action plans as required by TENNCARE		$500 per calendar day for each day the corrective action plan is late, or for each day the CONTRACTOR fails to comply with an accepted corrective action as required by TENNCARE $2000 for failure to provide an acceptable initial corrective action plan as determined by TENNCARE in addition to $500 per calendar day from the date of notice of deficiency by TENNCARE for each day the corrective action plan remains deficient If subsequent corrective action plans are deficient, the $500 per calendar day shall continue until an acceptable plan as determined by TENNCARE is received

B.21	Failure to meet any timeframe regarding care coordination for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6) other than the timeframes referenced in A.16 or A.17		$5,000 per month for each timeframe that the CONTRACTOR's performance is 85-89% $10,000 per month for each timeframe that the CONTRACTOR's performance is 80-84% $20,000 per month for each timeframe that the CONTRACTOR's performance is 75-79% $50,000 per month for each timeframe that the CONTRACTOR's performance is 70-74% $100,000 per month for each timeframe that the CONTRACTOR's performance is 69% or less These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement. In instances where the denominator is less than two hundred (200), TENNCARE may opt, at its discretion, to apply a $500 per occurrence assessment in lieu of the methodology described above. This per occurrence amount shall be multiplied by two (2), totaling a $1,000 per occurrence assessment when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement.

B.25	Failure to meet individual Annual Quality Survey standards in subsequent years		$5000 per occurrence for repeating a deficiency(ies) in subsequent years

94. Attachments III and IV shall be amended by adding the following language to the end of the existing text:

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

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

95. Attachment V shall be deleted and replaced in its entirety as follows:

ATTACHMENT V

ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

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

Access to Behavioral Health Services

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

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

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **ADULT** members --- Travel distance does not exceed 60	Within 30 calendar days

	miles for at least 75% of **CHILD** members and does not exceed 90 miles for at least 90% of **CHILD** members	
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization	Travel distance does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **ADULT** members --- The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **CHILD** members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may includeSupported Employment, Illness Management & Recovery, or Peer Support	Not subject to geographic access standards	Within 10 business days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

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

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

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

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult – 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult – 27 or 28 Child – D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child – C7, D7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Support	88
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult – 40 Child – E2
Crisis Stabilization	Adult 41

96. Attachment VI shall be amended by adding a "MCE TIP SUBMISSION FORM" as described below in front of the existing "POTENTIAL FRAUD ALLEGATION REFERRAL FORM" and "REPORT TENNCARE RECIPIENT FRAUD OR ABUSE" forms.

MCE TIP SUBMISSION FORM

related to

POTENTIAL PROVIDER FRAUD and PATIENT SAFETY

(template with sample data)

DATE: Month/Day/Year

TO: TBI, Medicaid Fraud Control Unit (MFCU)
TennCare, Office of Program Integrity

FROM: Your MCE Name

Contact Person: 1st & Last name; Telephone; EMail;

SOURCE OF TIP(s):
HOTLINE

INFORMATION OF TIP(s):
ABC Clinic, John Smith MD, Family Practice

Describtion of allegation of wrong doing: (example: Dr Smith is being reviewed for upcoding E&M)

MCE CONTRACT PERSON ON THE TIP(s):
JOHN DOW

TennCare Recommended MCC TIP/Referral Protocol:

1) The submission of documents related to the provider fraud and abuse referral should be via TennCare SFTP server **(path: tncare.sftp.state.tn.us/tncare/MCC###/orr/OPI/in)** with password protections on Documents;
2) Concurrently, a notice of submission should be e-mailed to ProgramIntegrity.TennCare@tn.gov with a subject line stating "MCC### Notice of Referral Submission via SFTP" along with password notices on opening documents.

97. Attachment VIII shall be deleted and replaced as follows:

ATTACHMENT VIII
DELIVERABLE REQUIREMENTS

GENERAL

This is a preliminary list of deliverables. The CONTRACTOR and TENNCARE shall agree to the appropriate deliverables, deliverable format/submission requirements, submission and approval time frames, and technical assistance as required. Deliverables shall be submitted to the TennCare Bureau unless otherwise specified.

TENNCARE will require that some or all deliverables be reviewed and/or approved by TENNCARE during the readiness review and/or during operations. As specified by TENNCARE, material modifications to certain deliverables must be reviewed and/or approved by TENNCARE.

DELIVERABLE ITEMS

1. Evidence of TDCI license for CONTRACTOR and subcontractors (as applicable) to ensure compliance with Section 2.1.1

2. Notification that a member may satisfy any of the conditions for termination from the TennCare program in accordance with Section 2.5.4

3. Request for prior approval/notice of use of cost effective alternative services in accordance with Section 2.6.5

4. Request for prior approval of incentives in accordance with Section 2.6.6

5. Policies and procedures for patient liability that ensure compliance with Section 2.6.7.2

6. Policies and procedures for self-direction of health care tasks in accordance with Section 2.7.3

7. Description of health education and outreach programs and activities to ensure compliance with Section 2.7.4

8. TENNderCare policies and procedures that ensure compliance with the requirements of Section 2.7.6

9. Policies and procedures for advance directives that ensure compliance with Section 2.7.7

10. Population Health program policies and procedures that ensure compliance with Section 2.8

11. Service coordination policies and procedures that ensure compliance with Section 2.9.1

12. Policies and procedures for transition of new members that ensure compliance with the requirements of Section 2.9.2

13. Policies and procedures for transition of member receiving long-term care services at the time of CHOICES implementation that ensure compliance with Section 2.9.3

14. Transition of care policies and procedures that ensure compliance with Section 2.9.4

15. Care coordination policies and procedures that ensure compliance with Section 2.9.6

16. Policies and procedures for consumer direction of eligible CHOICES HCBS that ensure compliance with Section 2.9.7

17. Policies and procedures for coordination of physical health, behavioral health, and long-term care services that ensure compliance with Section 2.9.9

18. If CONTRACTOR subcontracts for the provision of behavioral health services, agreement with the subcontractor in accordance with Section 2.9.9.2 to ensure compliance with Section 2.9.9

19. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section 2.9.10

20. Policies and procedures for coordination of pharmacy services that ensure compliance with Section 2.9.11

21. Policies and procedures for coordination of dental services that ensure compliance with Section 2.9.12

22. Identification of members serving on the claims coordination committee in accordance with Section 2.9.12.5.3

23. Policies and procedures for coordination with Medicare that ensure compliance with Section 2.9.13

24. Policies and procedures for inter-agency coordination that ensure compliance with Section 2.9.16

25. Policies and procedures regarding non-covered services that ensure compliance with Section 2.10

26. Policies and procedures to develop and maintain a provider network that ensure compliance with Section 2.11.1, including policies and procedures for selection and/or retention of providers

27. Policies and procedures for PCP selection and assignment that ensure compliance with Section 2.11.2, including policies and procedures regarding change of PCP and use of specialist as PCP

28. Plan to identify, develop, or enhance existing inpatient and residential treatment capacity for adults and adolescents with co-occurring mental health and substance abuse disorders to ensure compliance with Section 2.11.5.2

29. Credentialing manual and policies and procedures that ensure compliance with Section 2.11.8

30. Policies and procedures that ensure compliance with notice requirements in Section 2.11.9

31. Notice of provider and subcontractor termination and additional documentation as required by Section 2.11.9.2

32. Provider agreement template(s) and revisions to TDCI as required in Section 2.12

33. Indemnity language in provider agreements if different than standard indemnity language (see Section 2.12.9.54)

34. Intent to use a physician incentive plan (PIP) to TennCare Bureau and TDCI (see Section 2.13.9)

35. Any provider agreement templates or subcontracts that involve a PIP for review as a material modification (to TDCI) as required by (see Section 2.13.9)

36. Pricing policies for emergency services provided by non-contract providers that ensure compliance with Section 2.13.10.1

37. Policies and procedures for PCP profiling to ensure compliance with Section 2.14.9

38. Information on PCP profiling as requested by TENNCARE (see Section 2.14.9)

39. QM/QI policies and procedures to ensure compliance with Section 2.15

40. Copy of signed contract with NCQA approved vendor to perform CAHPS as required by Section 2.15.5

41. Copy of signed contract with NCQA approved vendor to perform HEDIS audit as required by Section 2.15.5

42. Evidence that NCQA accreditation application submitted and fee paid (Section 2.15.5.1)

43. HEDIS BAT as required by Section 2.15.6

44. Copy of signed NCQA survey contract as required by Section 2.15.5.1

45. Notice of date for ISS submission and NCQA on-site review as required by Section 2.15.5.1

46. Notice of final payment to NCQA as required by Section 2.15.5.1

47. Notice of submission of ISS to NCQA as required by Section 2.15.5.1

48. Copy of completed NCQA survey and final report as required by Section 2.15.5.1

49. Notice of any revision to NCQA accreditation status

50. Policies and procedures regarding critical incident management and reporting to ensure compliance with Section 2.15.7.1

51. Policies and procedures regarding behavioral health adverse occurrence reporting to ensure compliance with Section 2.15.7.2

52. Report critical incidents or adverse occurrences to TENNCARE within twenty-four (24) hours pursuant to Sections 2.15.7.1, 2.15.7.2, and 2.15.7.3

53. Provider Preventable Conditions Reporting (see Section 2.15.8)

54. If applicable, information on the use of the name of the CONTRACTOR’s TennCare MCO pursuant to Section 2.16.3

55. Member materials as described in Section 2.17, including but not limited to, member handbook, quarterly member newsletters, identification card, and provider directory along with any required supporting materials

56. Member services phone line policies and procedures that ensure compliance with Section 2.18.1

57. Policies and procedures regarding interpreter and translation services that ensure compliance with Section 2.18.2

58. Provider service and phone line policies and procedures that ensure compliance with Section 2.18.4

59. Description of 24/7 ED Assistance Line (see Section 2.18.4.7)

60. Provider handbook that is in compliance with requirements in Section 2.18.5

61. Provider education and training plan and materials that ensure compliance with Section 2.18.6

62. Provider relations policies and procedures in compliance with Section 2.18.7

63. Protocols regarding one-on-one assistance to long-term care providers that ensure compliance with Section 2.18.7.2

64. Policies and procedures to monitor and ensure provider compliance with the Agreement (see Section 2.18.7.3)

65. Policies and procedures for a provider complaint system that ensure compliance with Section 2.18.8

66. FEA education and training plan and materials that ensure compliance with Section 2.18.9

67. Policies and procedures regarding member involvement with behavioral health services that ensure compliance with Section 2.18.10

68. Appeal and complaint policies and procedures that ensure compliance with Section 2.19

69. Fraud and abuse policies and procedures that ensure compliance with Section 2.20

70. Report all confirmed or suspected fraud and abuse to the appropriate agency as required in Section 2.20.2

71. Fraud and abuse compliance plan (see Section 2.20.3)

72. A risk assessment annually and “as needed” (see Section 2.20.3.2.2)

73. TPL policies and procedures that ensure compliance with Section 2.21.4

74. Accounting policies and procedures that ensure compliance with Section 2.21.7

75. Proof of insurance coverage (see Section 2.21.8)

76. Executed agreement for audit accounts that contains the required language (see Section 2.21.11)

77. Claims management policies and procedures that ensure compliance with Section 2.22

78. Internal claims dispute procedure (see Section 2.22.5)

79. EOB policies and procedures to ensure compliance with Section 2.22.8

80. Systems policies and procedures, manuals, etc. to ensure compliance with Section 2.23 (see Section 2.23.10)

81. Proposed approach for remote access in accordance with Section 2.23.6.10

82. Information security plan as required by Section 2.23.6.11

83. Notification of Systems problems in accordance with Section 2.23.7

84. Systems Help Desk services in accordance with Section 2.23.8

85. Notification of changes to Systems in accordance with Section 2.23.9

86. Notification of changes to membership of behavioral health advisory committee and current membership lists in accordance with Section 2.24.2

87. Notification of changes to membership of CHOICES Advisory Group and current membership lists in accordance with Section 2.24.3

88. An abuse and neglect plan in accordance with Section 2.24.4

89. Medical record keeping policies and procedures that ensure compliance with Section 2.24.6

90. Subcontracts (see Section 2.26)

91. HIPAA policies and procedures that ensure compliance with Section 2.27

92. Notification of breach and provisional breach in accordance with Section 2.27

93. Third (3rd) party certification of HIPAA transaction compliance in accordance with Section 2.27

94. Non-discrimination policies and procedures as required by Section 2.28

95. Names, resumes, and contact information of key staff as required by Section 2.29.1.2

96. Changes to key staff as required by Section 2.29.1.2

97. Staffing plan as required by Section 2.29.1.8

98. Changes to location of staff from in-state to out-of-state as required by Section 2.29.1.9

99. Background check policies and procedures that ensure compliance with Section 2.29.2.1

100. List of officers and members of Board of Directors (see Section 2.29.3)

101. Changes to officers and members of Board of Directors (see Section 2.29.3)

102. Eligibility and Enrollment Data (see Section 2.30.2.1)
103. Monthly Enrollment/Capitation Payment Reconciliation Report (see Section 2.30.2.2)
104. Quarterly Member Enrollment/Capitation Payment Report (see Section 2.30.2.3)
105. Information on members (see Section 2.30.2.4)
106. Annual Community Outreach Plan (see Section 2.30.3)
107. Psychiatric Hospital/RTF Readmission Report (see Section 2.30.4.1)
108. Post-Discharge Services Report (see Section 2.30.4.2)
109. Behavioral Health Crisis Response Report (see Section 2.30.4.3)
110. TENNderCare Report (see Section 2.30.4.4)
111. Population Health Update Report (see Section 2.30.5.1)
112. Population Health Report (see Section 2.30.5.2)
113. Population Health Program Description (see Section 2.30.5.3)
114. Status of Transitioning CHOICES Member Report (see Section 2.30.6.2)
115. CHOICES Nursing Facility Diversion Activities Report (see Section 2.30.6.3)
116. CHOICES Nursing Facility to Community Transition Report (see Section 2.30.6.4)
117. CHOICES HCBS Late and Missed Visits Report (see Section 2.30.6.5)
118. CHOICES Consumer Direction of eligible CHOICES HCBS Report (see Section 2.30.6.6)
119. CHOICES Care Coordination Report (see Section 2.30.6.7)
120. Monthly CHOICES Caseload and Staffing Ratio Report (see Section 2.30.6.8)
121. Quarterly MFP Participants Report (see Section 2.30.6.9)
122. Members identified as potential pharmacy lock-in candidates (see Section 2.30.6.10)
123. Pharmacy Services Report (see Section 2.30.6.11)
124. Pharmacy Services Report, On Request (see Section 2.30.6.12)
125. Provider Enrollment File (see Section 2.30.8.1)
126. Provider Compliance with Access Requirements Report (see Section 2.30.8.2)

127. PCP Assignment Report (see Section 2.30.8.3)
128. Report of Essential Hospital Services (see Section 2.30.8.4)
129. Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness (see Section 2.30.8.5)
130. Quarterly Behavioral Health Appointment Timeliness Summary Report (see Section 2.30.8.6)
131. CHOICES Qualified Workforce Strategies Report (see Section 2.30.8.7)
132. FQHC Reports (see Section 2.30.8.8)
133. Related Provider Payment Report (see Section 2.30.10.1)
134. Check Run Summaries Report (see Section 2.30.10.2)
135. Claims Data Extract Report (see Section 2.30.10.3)
136. Reconciliation Payment Report (see Section 2.30.10.4)
137. Administrative Services Only Invoice Report (See Section 2.30.10.5)
138. UM program description, work plan, and evaluation (see Section 2.30.11.1)
139. Cost and Utilization Reports (see Section 2.30.11.2)
140. Cost and Utilization Summaries (see Section 2.30.11.3)
141. Identification of high-cost claimants (see Section 2.30.11.4)
142. CHOICES Utilization Report (see Section 2.30.11.5)
143. Referral Provider Listing and supporting materials (see Section 2.30.11.6)
144. Emergency Department Threshold Report (see Section 2.30.11.7)
145. QM/QI Program Description, Associated Work Plan and Annual Evaluation (see Section 2.30.12.1)
146. Report on Performance Improvement Projects (see Section 2.30.12.2)
147. NCQA Accreditation Report (see Section 2.30.12.3)
148. NCQA revaluation of accreditation status based on HEDIS scores (see Section 2.30.12.4)
149. Medicaid HEDIS measures marked as “Not Reported” (see Section 2.30.12.5)
150. Reports of Audited HEDIS Results (see Section 2.30.12.6)
151. Reports of Audited CAHPS Results (see Section 2.30.12.7)
152. CHOICES HCBS Critical Incidents Report (see Section 2.30.12.8)

153. Behavioral Health Adverse Occurrences Report (see Section 2.30.12.9)

154. Member Services, Provider Services, and Utilization Management Phone Line Report (see Section 2.30.13.1.1)

155. 24/7 Nurse Triage Line Report (see Section 2.30.13.1.2)

156. ED Assistance Tracking Report (see Section 2.30.13.1.3)

157. Provider Satisfaction Survey Report (see Section 2.30.13.3)

158. CHOICES Provider Satisfaction Survey Report (see Section 2.30.13.4)

159. Member Complaints Report (see Section 2.30.14)

160. Fraud and Abuse Activities Report (see Section 2.30.15.1)

161. Policies in compliance with Section 1902(a)(68) of the Social Security Act (see Section 2.30.15.3)

162. Disclosure Submission Rate Report (see Section 2.30.15.4)

163. Program Integrity Exception List Report (see Section 2.30.15.5)

164. List of Involuntary Terminations Report (see Section 2.30.15.6)

165. Recovery and Cost Avoidance Report (see Section 2.30.16.1.1)

166. Other Insurance Report (see Section 2.30.16.1.2)

167. Medical Loss Ratio (MLR) Report (see Section 2.30.16.2.1)

168. Ownership and Financial Disclosure Report (see Section 2.30.16.2.2)

169. Annual audit plan (see Section 2.30.16.2.3)

170. Financial Plan and Projection of Operating Results Report (to TDCI) (see Section 2.30.16.3.1)

171. Comparison of Actual Revenues and Expenses to Budgeted Amounts Report (to TDCI) (see Section 2.30.16.3.2)

172. Annual Financial Report (to TDCI) (see Section 2.30.16.4.3)

173. Quarterly Financial Report (to TDCI) (see Section 2.30.16.3.4)

174. Audited Financial Statements (to TDCI) (see Section 2.30.16.3.5)

175. Claims Payment Accuracy Report (see Section 2.30.17.1)

176. EOB Report (see Section 2.30.17.2)

177. Claims Activity Report (see Section 2.30.17.3)

178. CHOICES Cost Effective Alternatives Report (see Section 2.30.17.4)

179. Systems Refresh Plan (see Section 2.30.18.1)

180. Encounter Data Files (see Section 2.30.18.2)

181. Electronic version of claims paid reconciliation (see Section 2.30.18.3)

182. Encounter/MLR Reconciliation Report (see Section 2.30.18.4)

183. Information and/or data to support encounter data submission (see Section 2.30.18.5)

184. Systems Availability and Performance Report (see Section 2.30.18.6)

185. Business Continuity and Disaster Recovery Plan (see Section 2.30.18.7)

186. Reports on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee (see Section 2.30.19.1)

187. Report on the Activities of the CONTRACTOR's CHOICES Advisory Group (see Section 2.30.19.2)

188. Subcontracted claims processing report (see Section 2.30.20.1)

189. HIPAA/HITECH Report (*Privacy/Security Incident Report*) (see Section 2.30.21)

190. Non-discrimination policy (see Section 2.30.22.1)

191. Non-Discrimination Compliance Plan and Assurance of Non-Discrimination (see Section 2.30.22.2)

192. Non-Discrimination Compliance Report (see Section 2.30.22.3)

193. Disclosure of conflict of interest (see Section 2.30.23.1)

194. Attestation Re: Personnel Used in Contract Performance (see Section 2.30.23.2)

195. Provider reimbursement rates for services incurred prior to the start date of operations in accordance with Section 3.7.1.2.1

196. Return of funds in accordance with Section 3.14.5

197. Termination plan in accordance with Section 4.4.8.2.8

198. Policies and procedures for delivering NEMT services, including an operating procedures manual, as provided in Section A.1 of Attachment XI

199. NEMT Reports (see Section A.19 of Attachment XI)

98. Section A.1 of Attachment XI shall be amended by adding a new Section A.1.3 as follows:

A.1.3 The CONTRACTOR shall develop and submit to the Bureau of TennCare for approval, a policy addressing No-Shows which limits the amount of trips a member can take when the CONTRACTOR has determined that the member has missed scheduled trips for NEMT services for a designated number of trips. Upon the approval of these policies by the Office of Contract Compliance, the CONTRACTOR shall assure all policies are implemented and followed by their NEMT brokers and their providers.

99. Section A.3.1 of Attachment XI shall be amended by adding additional language to the end of the existing text as follows:

A.3.1 Members or their representatives shall be allowed to make requests for NEMT services on behalf of members. For DCS enrollees (as defined in Exhibit A of this Attachment), representatives include the member's DCS liaison, foster parent, adoptive parent, or provider. For members enrolled in an HCBS waiver for persons with Intellectual Disabilities, the member's Independent Support Coordinator/Case Manager or the member's residential or day services provider may make requests for NEMT services, even when the member's residential or day services provider is also a the contract provider that will deliver the NEMT services to the member.

100. Section A.4.2 of Attachment XI shall be deleted and replaced as follows:

A.4.2 Verifying Eligibility for NEMT Services

A.4.2.1 The CONTRACTOR shall screen all requests for NEMT services to confirm each of the following items:

A.4.2.2 That the person for whom the transportation is being requested is a TennCare enrollee and enrolled in the CONTRACTOR's MCO;

A.4.2.3 That the service for which NEMT service is requested is a TennCare covered service (as defined in Exhibit A of this Attachment);

A.4.2.4 That the enrollee is eligible in accordance with policies and procedures approved by the Office of Contract Compliance regarding No-Shows; and

A.4.2.5 That the transportation is a covered NEMT service (see Section 2.6.1.3 of the Agreement).

101. Section A.4.6 of Attachment XI shall be deleted and replaced as follows:

A.4.6 Validating Requests

A.4.6.1 The CONTRACTOR shall conduct random pre-transportation validation checks prior to approving the request in order to prevent fraud and abuse. The amount validated shall be two percent (2%) of NEMT scheduled trips per month.

A.4.6.2 The CONTRACTOR may verify the need for an urgent trip with the provider prior to approving the trip.

A.4.6.3 If requested by TENNCARE, the CONTRACTOR shall conduct pre-transportation validation checks of trips requested by specified members and/or to specific services or providers.

A.4.6.4 Focus of the Pre-Validations shall be, but may not be limited to, members who utilize NEMT services frequently but do not have standing orders as well as members who routinely do not adhere to the seventy-two (72) hour notice requirement.

A.4.6.5 All pre-transportation validation checks shall be conducted within the timeframes specified in Section A.5.1.4 of this Attachment.

102. Section A.5.1 of Attachment XI shall be amended by adding a new Section A.5.1.2 as follows and renumbering the remaining Section accordingly, including any references thereto.

A.5.1.2 After approving a NEMT service to be provided by a NEMT provider (i.e., not fixed route), the CONTRACTOR shall schedule and assign the trip to an appropriate NEMT provider (see A.5.3 for persons enrolled in an HCBS waiver for persons with Intellectual Disabilities).

103. Section A.5.3 of Attachment XI shall be deleted and replaced as follows:

A.5.3 **Choice of NEMT Provider**

Except for persons enrolled in an HCBS waiver for persons with Intellectual Disabilities, the CONTRACTOR is not required to use a particular NEMT provider or driver requested by the member. However, the CONTRACTOR may accommodate a member's request to have or not have a specific NEMT provider or driver. If an HCBS waiver participant's residential or day services waiver provider is enrolled with the CONTRACTOR as an NEMT provider (pursuant to A.12.5), the CONTRACTOR shall permit the residential or day services waiver provider to provide medically necessary, covered NEMT services for waiver participants receiving HCBD ID waiver services from the provider, so long as the provider is able to provide the appropriate mode and level of service in a timely manner.

104. Section A.5.4 of Attachment XI shall be deleted and replaced as follows:

A.5.4 Notifying Members of Arrangements

If possible, the CONTRACTOR shall inform the member of the transportation arrangements (see below) during the phone call requesting the NEMT service. Otherwise, the CONTRACTOR shall obtain the member's preferred method (e.g., phone call, email, fax) and time of contact, and the CONTRACTOR shall notify the member of the transportation arrangements (see below) as soon as the arrangements are in place (within the timeframe specified in Section A.5.1.4 of this Attachment) and prior to the date of the NEMT service. Responsibility of determining whether transportation arrangements have been made shall not be delegated to the member. Information about transportation arrangements shall include but not be limited to the name and telephone number of the NEMT provider, the scheduled time and address of pick-up, and the name and address of the provider to whom the member seeks transport.

105. Section A.5.5.1 of Attachment XI shall be amended by adding a new sentence to the end of the existing language as follows:

A.5.5.1 The CONTRACTOR shall provide a trip manifest to the NEMT provider of all new trips requested prior to 5 p.m. on the same business day.

106. Section A.5.5.4 of Attachment XI shall be amended by deleting the word "or" and replacing it with the word "and" as follows:

A.5.5.4 If the CONTRACTOR notifies a NEMT provider of a trip assignment after the timeframe specified in Section A.5.5.1, the CONTRACTOR shall also contact the NEMT provider by telephone and electronically to confirm that the trip will be accepted.

107. Section A.5.7 of Attachment XI shall be amended by adding a new second sentence in the middle of existing language as follows:

A.5.7 Urgent Trips

For urgent trips (as defined in Exhibit A of this Attachment), the CONTRACTOR shall contact an appropriate NEMT provider so that pick-up occurs within three (3) hours after the CONTRACTOR was notified when the pick-up address is in an urban area and four (4) hours after the CONTRACTOR was notified when the pick-up address is in a non-urban area. Trip mileage does not determine if a trip is urban or non-urban. As provided in Section A.4.6.2 of this Agreement, the CONTRACTOR may verify the need for an urgent trip. Failure to comply with requirements regarding urgent trips may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

108. Section A.5.10.1.2 of Attachment XI shall be amended by deleting and replacing the word "category" with the word "level".

109. Section A.7.1 of Attachment XI shall be amended by adding additional language to the end of the existing text as follows:

A.7.1 The CONTRACTOR shall ensure that all vehicles meet or exceed applicable federal, state, and local requirements and manufacturer's safety, mechanical, operating, and maintenance standards while maintaining proof of compliance as to allow for unscheduled file audits.

110. Section A.8.2.1 of Attachment XI shall be amended by adding a new sentence to the end of the existing text as follows:

A.8.2.1 The CONTRACTOR shall ensure that all drivers receive appropriate training prior to providing services under the Agreement and annually thereafter. This shall include a minimum of thirty-two (32) hours of training prior to providing services under the Agreement and a minimum of fifteen (15) hours of annual training. Proof of all required training shall be maintained as to allow for unscheduled file audits.

111. Section A.8.3.6 through A.8.3.8 and Section A.8.3.11 of Attachment XI shall be deleted and replaced as follows:

A.8.3.6 The CONTRACTOR shall ensure that all drivers pass a physical examination prior to providing services under the Agreement and have additional physical examinations as necessary to ensure that a driver is qualified to drive a passenger vehicle (e.g., if the driver has a heart attack or stroke). The physical examination shall be at least as extensive as the medical examination required by the United States Department of Transportation's Federal Motor Carrier Safety Administration (FMCSA) for commercial drivers. Proof of exams shall be maintained in the driver file as to allow for unscheduled file audits.

A.8.3.7 The CONTRACTOR shall ensure that all drivers pass a drug test prior to providing services under the Agreement. In addition, the CONTRACTOR shall ensure that an alcohol or drug test is conducted when a trained supervisor/employer of a driver has reasonable suspicion to believe that the driver has violated the CONTRACTOR's policies and procedures regarding use of alcohol and/or controlled substances, that random drug and alcohol tests are conducted, and that post accident drug and alcohol testing is conducted. Each driver must have at least one (1) random drug and alcohol test per year. The CONTRACTOR's policies and procedures for drug and alcohol testing shall, at a minimum, meet the FMCSA's alcohol and drug testing requirements for motor carriers. Results of drug and alcohol testing shall be maintained in the driver's file as to allow for unscheduled file audits.

A.8.3.8 The CONTRACTOR shall ensure that criminal background checks pursuant to TCA 38-6-109 as well as national criminal background checks are conducted for all drivers prior to providing services under the Agreement and every five years thereafter. In addition, the CONTRACTOR shall ensure that random national criminal background checks are conducted. The CONTRACTOR shall develop a list of disqualifying criminal offenses, which at a minimum shall include the permanent and interim disqualifying criminal offenses that apply to applicants for a hazardous materials endorsement in Tennessee. Drivers that have been convicted or found not guilty by reason of insanity of any of the disqualifying criminal offenses shall not provide services under the Agreement. Results of background checks shall be maintained in the drivers file as to allow for unscheduled file audits.

A.8.3.11 The CONTRACTOR shall verify that drivers are not listed on the Tennessee Sexual Offender Registry or the equivalent registry in the state of the driver's residence prior to providing services under the Agreement and every year thereafter. This is in addition to the criminal background check and results shall be maintained in the driver's file as to allow for unscheduled file audits.

112. Section A.8.3.12 of Attachment XI shall be amended by adding the phrase "and annually thereafter" and Section A.8.3.12.5 shall be amended by deleting and replacing the phrase "thirty six (36)" with "twelve (12)" as follows:

A.8.3.12 The CONTRACTOR shall ensure that drivers pass a national driver license background check prior to providing services under the Agreement and annually thereafter. This initial national driver license background check shall, at a minimum, show the following:

A.8.3.12.5 Conviction for no more than two (2) minor moving traffic violations such as speeding, failure to stop, or improper operation of a motor vehicle within the previous twelve (12) months;

113. Section A.8.3.13 through A.8.3.13.6 of Attachment XI shall be deleted in its entirety and the remaining Section shall be renumbered as appropriate, including any references thereto.

114. The renumbered Section A.8.3 of Attachment XI shall be amended by adding a new Section A.8.3.17 as follows:

A.8.3.17 Proof of compliance of each driver requirement shall be maintained in the driver file as to allow for unscheduled file audits.

115. Section A.9.3 of Attachment XI shall be deleted and replaced as follows:

A.9.3 Between the hours of 7:00 PM and 5:00 AM in the time zone applicable to the Grand Region served by the CONTRACTOR (for example, in Middle, the applicable time zone shall be Central Time), the CONTRACTOR may use alternative arrangements to handle NEMT calls so long as there is no additional burden on the caller (e.g., the caller is not required to call a different number or to make a second call), and the call is promptly returned by the CONTRACTOR.

116. Section A.9.4 of Attachment XI shall be amended by adding new language to the end of the existing text as follows:

A.9.4 For hours that the CONTRACTOR is using alternative arrangements to handle NEMT calls (see Section A.9.3 of this Attachment), the CONTRACTOR shall provide an afterhours message in, at a minimum, English and Spanish instructing the caller how to access the alternative arrangement (not requiring a second call) and also offering the caller the opportunity to leave a message utilizing a process in which all messages are returned within (3) three hours and efforts continue until the member is reached provided that the message left by the enrollee is discernible and includes a valid phone number in which the enrollee can be contacted. All efforts made to reach a member who has left a message shall be documented in order to demonstrate compliance with this requirement.

117. Section A.9.7 of Attachment XI shall be amended by deleting A.9.7.1 in its entirey and renumbering the remaining Section accordingly, including any references thereto and the renumbered Section A.9.7.1 shall be amended by deleting and replacing the phrase "ninety percent (90%)" with "eighty-five percent (85%)".

118. Section A.9.8 of Attachment XI shall be amended by adding additional language to the end of existing text as follows:

A.9.8 If a NEMT call cannot be answered by a live voice within thirty (30) seconds, the CONTRACTOR shall provide a message in, at a minimum, English and Spanish advising the caller that the call will not be answered promptly and offering the caller the opportunity to leave a message. If the message requests the CONTRACTOR to return the call, the CONTRACTOR shall promptly return the call within three (3) hours and continue the effort until the member is reached provided that the message left by the enrollee is discernible and includes a valid phone number in which the enrollee can be contacted. All efforts made to reach a member who has left a message shall be documented in order to demonstrate compliance with this requirement.

119. Section A.9.12 of Attachment XI shall be amended by inserting the word "healthcare" in between the words "provider" and "queue" as follows:

A.9.12 The CONTRACTOR shall route incoming calls to the NEMT Call Center to, at minimum, an English-speaking member queue, a Spanish-speaking member queue, a NEMT provider queue, and a provider healthcare queue.

120. Sections A.9.14 of Attachment XI shall be amended by adding the word "healthcare" in front of the word "providers" as follows:

A.9.14 The CONTRACTOR shall develop NEMT Call Center scripts for calls requesting NEMT services that include a sequence of questions and criteria that the NEMT Call Center representatives shall use to determine the member's eligibility for NEMT services, the appropriate mode of transportation, the purpose of the trip and all other pertinent information relating to the trip (see Section A.4 of this Attachment). The CONTRACTOR may develop additional scripts for other types of NEMT calls from members, healthcare providers, and NEMT providers. Any script for use with an enrollee shall be written at the sixth (6^{th}) grade reading level and must be prior approved in writing by TENNCARE.

121. Section A.10.2 shall be deleted and replaced as follows:

A.10.2 The materials shall include, but not be limited to, information regarding eligibility for NEMT services, what services are covered/not covered, and how to request NEMT services, including the number to call, applicable timeframes, the approval and scheduling process, the use of fixed route, Standing Orders, and No-Show policies.

122. Section A.12.5 of Attachment XI shall be deleted and replaced as follows:

A.12.5 Notwithstanding an adequate network of providers or anything in this Agreement to the contrary, the CONTRACTOR shall provide Department of Intellectual and Developmental Disabilities (DIDD) residential and day service waiver providers the opportunity to become a NEMT provider if the provider is qualified to provide DIDD waiver transportation services (either as an individual transportation service or as a component of residential and/or day services) pursuant to provider qualifications applicable for such providers which shall be determined by DIDD. These providers shall only provide covered NEMT services to members receiving HCBS DIDD waiver services from the provider The CONTRACTOR shall reimburse these providers for covered NEMT to TENNCARE covered services (see definition in Exhibit A) and shall not reimburse these providers for NEMT to services provided though a HCBS DIDD waiver. The CONTRACTOR shall reimburse these providers in accordance with rates paid to other NEMT providers for the provision of NEMT services.

123. Section A.13.3 of Attachment XI shall be amended by adding a new Section A.13.3.9 as follows:

A.13.3.9 Require the NEMT provider to comply with all of the CONTRACTOR's NEMT policies and procedures, including but not limited to those policies regarding No-Shows.

124. Section A.13 of Attachment XI shall be amended by adding a new Section A.13.5 and renumbering the remaining Section accordingly, including any references thereto.

A.13.5 The CONTRACTOR shall develop and implement, subject to prior approval by TENNCARE, a template provider agreement specifically for DIDD waiver residential or day services provider which reflects only those NEMT requirements that are applicable to such providers, as may be further clarified by TENNCARE in policy or protocol.

125. Section A.14.3.1 of Attachment XI shall be deleted and replaced as follows:

A.14.3.1 The CONTRACTOR shall conduct post validation checks by matching NEMT billed claims to Healthcare provider billed claims validating two percent (2%) of NEMT claims received in a month and if the CONTRACTOR determines that transportation for a particular member was not to a TennCare covered service, the CONTRACTOR validates the next three (3) requests for that member before approving the requested trip (see Section A.4.6 of this Attachment)). If the CONTRACTOR suspects fraud or abuse, it shall comply with the fraud and abuse requirements of the Agreement.

126. Section A.17.6.1 of Attachment XI shall be deleted and replaced in its entirety.

A.17.6.1 The CONTRACTOR shall conduct a comprehensive inspection of all NEMT providers' vehicles prior to the implementation of NEMT requirements in this Attachment. Thereafter, the CONTRACTOR shall conduct a comprehensive inspection of all vehicles at least annually. The CONTRACTOR is not required to inspect fixed route vehicles, invalid vehicles, ambulances, DIDD residential or day services providers enrolled to provide NEMT for the waiver participants they serve, or vehicles for NEMT providers with which the CONTRACTOR does not have a provider agreement (see Section A.13.2 of this Attachment).

127. Section A.19 of Attachment XI shall be deleted and replaced as follows:

A.19 NEMT REPORTING

A.19.1 Approval and Utilization Reports

A.19.1.1 Approval Report. The CONTRACTOR shall submit a quarterly approval report that summarizes transportation requested, approved, modified and denied, including the modification and denial reason. The report shall provide this information by month and mode of transportation.

A.19.1.2 Pick-up and Delivery Standards Report. The CONTRACTOR shall submit a monthly report that documents the number of pick-ups that were late by a NEMT provider, and drop-offs where the member either missed or was late to an appointment and provides the average amount of time that the pick-ups or drop-offs were late.

A.19.1.3 Utilization Report. The CONTRACTOR shall submit a monthly utilization report that provides a summary of information on NEMT services provided to members. The report shall include, at minimum, by mode of transportation: the number of trips, number of unduplicated members, and number of miles.

A.19.2 NEMT Call Center Reports

A.19.2.1 The CONTRACTOR shall submit a monthly report that provides a summary and detail statistics on the NEMT Call Center telephone lines/queues and includes calls received, calls answered, total calls received during regular business hours and total calls received after business hours.

A.19.2.2 The CONTRACTOR shall submit a monthly report listing the name, position title and the identification code for all members of the call center staff.

A.19.3 NEMT Provider Enrollment File

The CONTRACTOR's monthly provider enrollment file shall include NEMT providers. In addition, the CONTRACTOR shall provide the following information to TENNCARE within timeframes described below:

A.19.3.1 Driver Roster. The CONTRACTOR shall provide a monthly driver roster for each NEMT provider that includes, at minimum: the driver's name, license number, and social security number.

A.19.3.2 Vehicle Listing. The CONTRACTOR shall provide a monthly vehicle listing for each NEMT provider that includes, at minimum: the type of vehicle and the vehicle's manufacturer, model, model year, and vehicle identification number.

A.19.3.3 NEMT Provider Listing. The CONTRACTOR shall provide a monthly provider listing, identifying the providers utilized during the reporting period listing the name, whether the provider is a participating or non-participating provider, mode of transportation and the county and state of the pick-up location. This report shall give the number of participating and non-participating providers as well as a grand total of all NEMT providers.

A.19.4 NEMT Claims Management Reports

A.19.4.1 The CONTRACTOR shall submit a monthly NEMT prompt payment report. The report shall include the number and percentage of clean NEMT claims that are processed within thirty (30) calendar days of receipt, the number and percentage of NEMT claims that are processed within sixty (60) calendar days of receipt, the number and percentage of NEMT claims and the dollar value and percentage of dollars associated with claims that are processed within the timeframes specified by TENNCARE (e.g., fifteen (15) days, thirty (30) days, etc.), and the average time (number of days) that it takes to process NEMT claims.

A.19.4.2 The CONTRACTOR shall submit a monthly NEMT claims payment accuracy report. The report shall be based on an audit conducted by the CONTRACTOR in accordance with Section 2.22.6 of the Agreement using a random sample of all "processed or paid" NEMT claims. The report shall include the number and percentage of NEMT claims that are paid accurately for each month.

A.19.5 NEMT Quality Assurance and Monitoring Reports

A.19.5.1 Member NEMT Complaint Report. The CONTRACTOR shall submit a monthly member complaints report (see Section 1 of the Agreement for the definition of complaint, which includes both written and verbal statements) that details the date which the complaint was reported, the date the issue occurred, who reported the complaint, the members name, transportation provider, complaint details, date of resolution and detail of the resolution. This report shall detail complaints received about the NEMT provider.

A.19.5.2 NEMT Provider Complaint Report. The CONTRACTOR shall submit a monthly NEMT provider complaints report that details the number of verbal and written complaints from the transportation provider about a member.

A.19.5.3 NEMT Quality Assurance Plan. As part of its annual QM/QI reporting required by the Agreement, the CONTRACTOR shall submit an annual NEMT quality assurance plan (see Section A.17.1 of this Attachment).

A.19.5.4 NEMT Validation Checks.

A.19.5.4.1 The CONTRACTOR shall submit a quarterly report summarizing the pre-transportation validation checks (see Section A.4.6 of this Attachment) conducted by the CONTRACTOR,.

A.19.5.4.2 The CONTRACTOR shall submit a quarterly report summarizing the post-transportation validation checks (see Section A.14.3 of this Attachment) conducted by the CONTRACTOR,.

A.19.5.5 Post-Payment Review Report. The CONTRACTOR shall submit an annual report summarizing the methods and findings for the post-payment review (see Section A.17.1.2.2 of this Attachment) and identifying opportunities for improvement.

A.19.5.6 Accidents and Incidents.

A.19.5.6.1 Immediately upon the CONTRACTOR or the subcontracted vendor becoming aware of any accident resulting in driver or passenger injury or fatality or incidents involving abuse or alleged abuse by the driver that occurs while providing services under the Agreement, the CONTRACTOR shall notify TENNCARE. The CONTRACTOR shall submit a written accident/incident report within five (5) business days of the accident/incident and shall cooperate in any related investigation. A police report shall be included in the accident/incident report or provided as soon as possible.

A.19.5.6.2 The CONTRACTOR shall submit a monthly report of all accidents, moving traffic violations, and incidents.

A.19.5.6.3 Failure by the CONTRACTOR to comply with Section A.19.5.6 shall result in the application of liquidated damages as described in Exhibit F.

A.19.5.7 Monitoring Plan.

A.19.5.7.1 The CONTRACTOR shall submit an annual NEMT provider monitoring plan (see Section A.17.3 of this Attachment).

A.19.5.7.2 The CONTRACTOR shall submit an annual report summarizing its monitoring activities, the findings, corrective actions, and improvements for NEMT services provided under the Agreement.

A.19.5.8 Satisfaction Survey Report. The CONTRACTOR shall submit a report (three months after the initial survey period and then annually) summarizing the member survey methods and findings and identifying opportunities for improvement.

128. Exhibit A of Attachment XI shall be amended by adding a new sentence to the end of the renumbered Item 18 and adding new Definitions for the terms "Urban Trip" and Non-Urban Trip" as follows:

10. Non-Urban Trip: Covered NEMT service not within a city and considered less populated, (rural as described by the US Census Bureau).

17. Urban Trip: Covered NEMT service within a city or a more populated area (not rural as described by the US Census Bureau)

18. Urgent Trip: Covered NEMT services required for an unscheduled episodic situation in which there is no immediate threat to life or limb but the enrollee must be seen on the day of the request (can be one (1) or multiple trip legs). A hospital as well as a Crisis Stabilization Unit discharge shall be an urgent trip.

129. The PERFORMANCE STANDARD/LIQUIDATED DAMAGE Chart in Exhibit F of Attachment XI shall be deleted and replaced as follows:

No.	PERFORMANCE STANDARD		LIQUIDATED DAMAGE
1	Ensure that members receive the appropriate level of service (see Section A.4.4 of this Attachment)		$500 per deficiency
2	Comply with the approval and scheduling timeframes (see Section A.5.1.3 of this Attachment)		$1,000 per deficiency
3	Comply with requirements regarding urgent trips (see Section A.5.7 of this Attachment)		$1500 per deficiency
4	Comply with pick-up and delivery standards (see Section A.6 of this Attachment)		$500 per deficiency

No.	PERFORMANCE STANDARD		LIQUIDATED DAMAGE
5	Comply with vehicle standards (see Section A.7 of this Attachment)		$1,000 per calendar day per vehicle that is not in compliance with ADA requirements $1,000 per vehicle that is allowed into service without an inspection in accordance with the requirements of the Agreement $2,500 per calendar day per vehicle that is not in compliance with a vehicle standard that would endanger health or safety for vehicle occupants $500 per calendar day per vehicle that is not in compliance with a vehicle standard that creates passenger discomfort or inconvenience $100 per calendar day per vehicle that is not in compliance with an administrative vehicle standard
6	Comply with driver training requirements and driver standards (see Section A.8 of this Attachment)		$2,500 per calendar day per driver for each calendar day that a driver is not in compliance with the driver standards
7	85% of all calls to the NEMT Call Center are answered by a live voice within thirty (30) seconds (see Section A.9 of this Attachment)		For the first deficiency: $5,000 for each full percentage point below 85% per month per line/queue For the second deficiency: $10,000 for each full percentage point below 85% per month per line/queue For the third and subsequent deficiencies: $15,000 for each full percentage point below 85% per month per line/queue
8	Less than 5% of calls to the NEMT Call Center are abandoned (see Section A.9 of this Attachment)		For the first deficiency: $5,000 for each full percentage point above 5% per month per line/queue For the second deficiency: $10,000 for each full percentage point above 5% per month per line/queue For the third and subsequent deficiencies: $15,000 for each full percentage point above 5% per month per line/queue

No.	PERFORMANCE STANDARD		LIQUIDATED DAMAGE
9	Average hold time for calls to the NEMT Call Center is no more than 3 minutes (see Section A.9 of this Attachment)		For the first deficiency: $5,000 for each 10 seconds over 3 minutes per month per line/queue For the second deficiency: $10,000 for each 10 seconds over 3 minutes per month per line/queue For the third and subsequent deficiencies: $15,000 for each 10 seconds over 3 minutes per month per line/queue
10	Process 90% of clean NEMT claims within thirty (30) calendar days of the receipt of the claim and process 99.5% of claims within sixty (60) calendar of receipt (see Section A.15.3 and Section A.15.4 of this Attachment)		$10,000 for each month determined not to be in compliance
11	97% of NEMT claims are paid accurately upon initial submission (see Section A.15.5 of this Attachment)		$5,000 for each full percentage point accuracy is below 97% for each quarter
12	Failure by the CONTRACTOR to notify TENNCARE of an Accident/Incident in accordance with Section A.19.5.6 of this Attachment		$1000 per occurrence

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2013.

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

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

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____
Mark Emkes
Commissioner

DATE: _____

VOLUNTEER STATE HEALTH PLAN, INC.

BY: _____
Scott C. Pierce
President & CEO VSHP

DATE: _____