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CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE
AND
CONTRACTOR NAME

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Division of TennCare, hereinafter referred to as the 'State" or "TENNCARE" and Contractor Legal Entity Name, hereinafter referred to as the "CONTRACTOR," is for the provision of statewide managed care services for physical health services, behavioral health services, and long term services and supports for eligible TennCare enrollees, as further defined in the "SCOPE OF SERVICES."

The CONTRACTOR is a/an Individual, For-Profit Corporation, Non-Profit Corporation, Special Purpose Corporation Or Association, Partnership, Joint Venture, Or Limited Liability Company
CONTRACTOR Place of Incorporation or Organization:
CONTRACTOR Edison Registration ID #

WHEREAS, the purpose of this Contract is to assure the provision of quality physical health, behavioral health, and long-term care services while controlling the costs of such services;

WHEREAS, consistent with waivers granted by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, the State of Tennessee has been granted the authority to pay a monthly prepaid capitated payment amount to Health Maintenance Organizations (HMOs), referred to as Managed Care Organizations or MCOs, for rendering or arranging necessary physical health, behavioral health, and long-term care services to persons who are enrolled in Tennessee's TennCare program and health care coverage for uninsured children who are not eligible for TennCare coverage and are enrolled in CoverKids;

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

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

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

SECTION A SCOPE OF SERVICES:

The CONTRACTOR shall provide all service and deliverables as required, described, and detailed herein and shall meet all service and delivery timelines as specified by this Contract.

SECTION A.1 DEFINITIONS

Listed below are the Definitions, Acronyms, and Abbreviations used in this Contract. These terms utilize the meaning used in TennCare rules and regulations. However, the following terms, when used in this Contract, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, and other Sections of this Contract, the specific language in the Contract shall govern.

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (see 42 CFR 455.2).

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

1. Meeting general requirements in Section A.2.2;

2. Enrollment and disenrollment in accordance with Sections A.2.4 and A.2.5;

3. Additional services and use of incentives in Section A.2.6.6;

4. Health education and outreach in Section A.2.7.4;

5. Meeting requirements for coordination of services specified in Section A.2.9, including care coordination for CHOICES members and the CONTRACTOR's electronic visit verification system, except for purposes of ECF CHOICES, costs related to the provision of support coordination;

6. Establishing and maintaining a provider network in accordance with the requirements specified in Section A.2.11, Attachments III, IV and V;

7. Utilization Management as specified in Section A.2.14;

8. Quality Management/ Quality Improvement activities as specified in Section A.2.15;

9. Production and distribution of Member Materials as specified in Section A.2.17;

10. Customer service requirements in Section A.2.18;

11. Grievance and appeals processing and resolution in accordance with Section A.2.19;

12. Determination of recoveries from third party liability resources in accordance with Section A.2.21.4;

13. Claims Processing in accordance with Section A.2.22;

14. Maintenance and operation of Information Systems in accordance with Section A.2.23;

15. Personnel requirements in Section A.2.29;

16. Production and submission of required reports as specified in Section A.2.30;

17. Administration of this Contract in accordance with policies and procedures;

18. All other Administration and Management responsibilities as specified in Attachments II through IX and Sections A.2.20, A.2.21, A.2.24, A.2.25, A.2.26, A.2.27, and A.2.28;

19. Premium tax; and

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

Adult Protective Services (APS) – An office within the Tennessee Department of Human Services that investigates reports of abuse, neglect (including self-neglect) or financial exploitation of vulnerable adults. APS staff assess the need for protective services and provide services to reduce the identified risk to the adult.

Adverse Benefit Determination – As defined at 42 C.F.R. §438.400(b).

Affiliate – Any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the CONTRACTOR.

Aging Caregiver - An individual who is at least seventy-five (75) years old and is the custodial parent or custodial caregiver of an individual with an intellectual disability or an individual who is at least eighty (80) years old and is the custodial parent or custodial caregiver of an individual with a developmental disability (other than an intellectual disability) pursuant to T.C.A. § 33-5-112 as amended.

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.

At Risk for Institutionalization – For purposes of CHOICES, a requirement for eligibility to enroll in CHOICES Group 3 (including Interim CHOICES Group 3), whereby an individual does not meet the NF LOC criteria in place as of July 1, 2012, but meets the NF LOC criteria in place as of June 30, 2012, as defined in TennCare Rule 1200-13-01-.10(4) such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As it relates to CHOICES Group 3, includes only SSI eligible adults age sixty-five (65) or older or age twenty-one (21) or older with physical disabilities. As it relates to Interim CHOICES Group 3, open for enrollment only between July 1, 2012 and June 30, 2015, includes only adults age sixty-five (65) or older or age twenty-one (21) or older with physical disabilities who receive SSI or meet Nursing Facility Financial eligibility criteria.

For purposes of ECF CHOICES, the minimum medical eligibility (i.e., level of care) requirement to enroll in ECF CHOICES Group 4 or 5, whereby an Applicant does not meet NF LOC criteria, but has an intellectual or developmental disability as defined under T.C.A. § 33-1-101 as amended, including for an Applicant with ID, limitations in two (2) or more adaptive skill areas (i.e., communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work); and for an Applicant age five (5) or older with DD, substantial functional limitations in three (3) or more major life activities (i.e., self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency); such that, in the absence of the provision of a moderate level of ECF CHOICES home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement.

Back-up Plan – A written plan that is a required component of the PCSP for all CHOICES members receiving companion care or the PCSP or person-centered support plan, as appropriate, for CHOICES or ECF CHOICES members receiving non-residential CHOICES or ECF CHOICES HCBS in their own home and which specifies unpaid persons as well as paid consumer-directed workers and/or contract providers (as applicable) who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled CHOICES or ECF CHOICES HCBS providers or workers are unavailable or do not arrive as scheduled. A CHOICES or ECF CHOICES member or his/her representative may not elect, as part of the back-up plan, to go without services. The back-up plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The member and his/her representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services. The FEA will assist as needed with the development and verification of the initial back-up plan for consumer direction. The Care Coordinator or Support Coordinator shall be responsible for assistance as needed with implementing the back-up plan and for updating and verifying the back-up plan on an ongoing basis.

Base Capitation Rate – The amount established by TENNCARE pursuant to the methodology described in Section C.3 of this Contract as compensation for the provision of all covered services.

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

Behavioral Health Services – Mental health and/or substance abuse services.

Beneficiary Support System – The Beneficiary Support System is an entity independent of TennCare MCOs that provides support to applicants and enrollees before and after enrollment pursuant to 42 C.F.R § 438.71. Specific to CHOICES and ECF CHOICES, the State's Beneficiary Support System contractor will assist applicants and enrollees with navigation of the CONTRACTOR's appeals and grievance processes upon request by applicants and enrollees.

Benefit Appeal – As distinguished from an Eligibility Appeal, a "Benefit Appeal" concerns an enrollee's request to contest an MCC's adverse benefit determination by receiving a State Fair Hearing (SFH). CMS has determined that the provisions contained in 42 C.F.R. 438 subpart F, which require MCOs to maintain an internal appeal system, and which require enrollees to exhaust the MCO internal appeal process before being permitted to request a SFH, are satisfied by TENNCARE's requirement that the CONTRACTOR comply with the "Reconsideration" phase of the state fair hearing process (also called the "appeal process"). In accordance with CMS approval, the CONTRACTOR shall not have an internal appeal process that enrollees are required to exhaust before they may request a SFH through the TENNCARE appeal process. The CONTRACTOR's "Reconsideration" of its initial adverse benefit determination during the TENNCARE appeal process is deemed by CMS to satisfy the requirement for a MCO-level appeal.

Benefit Appeal System – Synonymous with State Fair Hearing (SFH) System, SFH Process, Appeal System, and Appeal Process. References to Appeal System or Appeal Process refers to both (1) the *processes* the CONTRACTOR implements to comply with its TENNCARE Appeal Process-related obligations (such as timely issuance of a compliant Notice of Adverse Benefit Determination (NABD), timely compliance with the Reconsideration phase of the Appeal Process, timely compliance with TENNCARE-issued directives instructing CONTRACTOR to approve and arrange provision of a benefit in accordance with an Order resulting from the Appeal Process, etc.), and (2) the processes the CONTRACTOR implements to collect, track and maintain the information gathered in accordance with the Appeal Process.

Benefits – The package of health care services, including physical health, behavioral health, and long-term care services, that define the covered services available to TennCare enrollees assigned to the CONTRACTOR's MCO pursuant to this Contract.

Breach (with respect to Protected Health Information (PHI)) - The acquisition, access, use, or disclosure of protected health information in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the protected health information.

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

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

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

Capitation Payment – The fee that is paid by TENNCARE to the CONTRACTOR for each member covered by this Contract. The CONTRACTOR is at financial risk as specified in Section C.3 of this Contract for the payment of services incurred in excess of the amount of the capitation payment. "Capitation Payment" includes Base Capitation Rate payments unless otherwise specified.

Capitation Rate – The amount established by TENNCARE pursuant to the methodology described in Section C.3 of this Contract, including the base capitation rates.

Care Coordination Team – If an MCO elects to use a care coordination team, the care coordination team shall consist of a Care Coordinator and specific other persons with relevant expertise and experience who are assigned to support the Care Coordinator in the performance of care coordination activities for a CHOICES member as specified in this Contract and in accordance with Section A.2.9.6, but shall not perform activities that must be performed by the Care Coordinator, including comprehensive assessment, caregiver assessment, development of the PCSP, and minimum Care Coordination contacts.

Care Coordination Unit – A specific group of staff within the MCO's organization dedicated to CHOICES that is comprised of Care Coordinators and Care Coordinator supervisors and which may also include care coordination teams.

Care Coordinator – The individual who has primary responsibility for performance of care coordination activities for a CHOICES member as specified in the Contractor Risk Agreement and meets the qualifications specified in Section A.2.9.6 of the Contractor Risk Agreement.

Caregiver – For purposes of CHOICES or ECF CHOICES, a person who is (a) a family member or is unrelated to the member but has a close, personal relationship with the member and (b) routinely involved in providing unpaid support and assistance to the member. A caregiver may be also designated by the member as a representative for CHOICES or ECF CHOICES or for consumer direction of eligible CHOICES or ECF CHOICES HCBS.

CEA – Cost Effective Alternative (see Section A.2.6.5 of this Contract).

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

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

CFR – Code of Federal Regulations.

Child Protective Services (CPS) – A program division of the Tennessee Department of Children's Services whose purpose is to investigate allegations of child abuse and neglect and provide and arrange preventive, supportive, and supplementary services.

CHIPRA - is defined as the Children's Health Insurance Program Reauthorization Act, a federal law.

CHOICES At-Risk Demonstration Group – Individuals who are age sixty-five (65) and older and adults age twenty-one (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 June 30, 2015. Individuals enrolled in the CHOICES At-Risk Demonstration Group as of June 30, 2015, may continue to qualify in this group after June 30, 2015 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 June 30, 2015)
Persons age sixty-five (65) and older and adults age twenty-one (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 Contract 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.

CHOICES Home and Community-Based Services (HCBS) – Services that are available only to eligible persons enrolled in CHOICES Group 2 or Group 3 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only certain CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost neutrality cap.

CHOICES Member – A member who has been enrolled by TENNCARE into CHOICES.

Chronic Condition – as defined by Population Health (and AHRQ) is a condition that lasts twelve (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).

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

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

CMS – Centers for Medicare & Medicaid Services.

Community-Based Residential Alternatives (CBRA) to institutional care – For purposes of CHOICES and ECF CHOICES:

(a) Residential services that offer a cost-effective, community-based alternative to NF care for individuals who are elderly and/or adults with Physical Disabilities and for individuals with I/DD.

(b) CBRAs include, but are not limited to:

1. Services provided in a licensed facility such as Assisted Care Living Facilities and Critical Adult Care Homes, and residential services provided in a licensed home or in the person's home by an appropriately licensed provider such as Community Living Supports and Community Living Supports-Family Model; and

2. Companion Care.

Confidential Information – Any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is created under this Contract. Any such information relating to individuals enrolled in the TennCare program ("TennCare members"), or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained under this Contract, shall also be treated as "Confidential Information" to the extent that confidential status is afforded such information under state and federal laws or regulations. All Confidential Information shall not be subject to disclosure under the Tennessee Public Records Act.

Consumer – Except when used regarding consumer direction of eligible CHOICES or ECF CHOICES HCBS, an individual who uses a mental health or substance abuse service.

Consumer-Directed Worker (Worker) – An individual who has been hired by a CHOICES or ECF CHOICES member participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS or his/her representative to provide one or more eligible CHOICES or ECF CHOICES HCBS to the member. Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the member.

Consumer Direction of Eligible CHOICES or ECF CHOICES HCBS – The opportunity for a CHOICES or ECF CHOICES member assessed to need specified types of CHOICES or ECF CHOICES HCBS including for purposes of CHOICES, attendant care, personal care, in-home respite, companion care; and for purposes of ECF CHOICES, personal assistance, supportive home care, hourly respite, and community transportation; and/or any other service specified in TennCare rules as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s) and for ECF CHOICES, the delivery of each eligible ECF CHOICES HCBS within the authorized budget for that service.

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

Contractor Risk Agreement (CRA) – The Contract between the CONTRACTOR and TENNCARE regarding requirements for operation and administration of the managed care TennCare program, including CHOICES and ECF CHOICES.

Cost Neutrality Cap – The requirement that the cost of providing care to a member in CHOICES Group 2, including CHOICES HCBS and Medicaid reimbursed home health and private duty nursing, shall not exceed the cost of providing nursing facility services to the member, as determined in accordance with TennCare policy. A member's individual cost neutrality cap shall be the average cost of Level 1 nursing facility care, or upon implementation of the new nursing facility reimbursement methodology, the average cost of nursing facility care (the Level 1/Level 2 distinction will be eliminated), 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 application, because the member would qualify to receive Enhanced Respiratory Care reimbursement in a nursing facility.

CoverKids - the State Child Health Plan under Title XXI of the social Security Act State Children's Health Insurance Program.

CoverKids Pregnant Women - (formerly referred to as "CoverKids Pregnant Women/Unborn Children"). Provides coverage for the unborn children of pregnant women with no source of coverage, who meet the CoverKids eligibility requirements.

Covered Services – See Benefits.

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

Days – Calendar days unless otherwise specified.

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

DHHS – United States Department of Health and Human Services.

Disenrollment – The removal of an enrollee from participation in the CONTRACTOR's MCO and deletion from the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

ECF CHOICES Consumer Directed Home and Community-Based Services (HCBS) – Services that are available only to eligible persons enrolled in ECF CHOICES Groups 4, 5, 6, 7 or 8 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only certain ECF CHOICES HCBS are eligible for Consumer Direction. ECF CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although home health and private duty nursing services are subject to estate recovery and shall, for members enrolled in ECF CHOICES Group 6 who are granted an exception to the expenditure cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 or 8 who also have an expenditure cap based on the comparable cost of institutional care, be counted for purposes of determining whether an ECF CHOICES member's needs can be safely met in the community within his or her individual expenditure cap.

ECF CHOICES Group (Group) – One of the five groups of TennCare enrollees who are enrolled in ECF CHOICES. All Groups in ECF CHOICES receive services in the community. These Groups are:

Group 4
(Essential Family Supports) - Children under age twenty one (21) with I/DD living at home with family who meet the NF LOC and need and are receiving HCBS as an alternative to NF Care, or who, in the

absence of HCBS, are "At risk of NF placement;" and adults age 21 and older with I/DD living at home with family caregivers who meet the NF LOC and need and are receiving HCBS as an alternative to NF care, or who, in the absence of HCBS, are "At risk of NF placement," and elect to be in this group. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like, Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

Group 5
(Essential Supports for Employment and Independent Living) - Adults age twenty-one (21) and older, unless otherwise specified by TENNCARE, with I/DD who do not meet nursing facility level of care, but who, in the absence of HCBS are "At Risk" of nursing facility placement. To qualify in this group, the adult must be SSI eligible or qualify in the Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups. An eligible adult age 21 and older who meets NF LOC may enroll in ECF CHOICES Group 5, so long as the person's needs can be safely and appropriately met in the community and at a cost that does not exceed the Expenditure Cap, including individuals with I/DD who have an aging caregiver. On a case-by-case basis, TENNCARE may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 5, if they meet eligibility criteria.

Group 6
(Comprehensive Supports for Employment and Community Living) - Adults age twenty-one (21) and older, unless otherwise specified by TENNCARE, with I/DD who meet nursing facility level of care and need and are receiving specialized services for I/DD. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. On a case-by-case basis, TENNCARE may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 6, if they meet eligibility criteria.

Group 7
(Intensive Behavioral Family Supports) – [Except as modified in the final approved amendment to the TennCare 1115 Demonstration and only upon approval and implementation of such amendment,] children under age twenty one (21) who live at home with family caregivers and have I/DD and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at significant risk of harm, threaten the sustainability of the family living arrangement, and place the child at significant risk of placement outside the home (e.g., State custody, hospitalization, residential treatment, incarceration). The child must meet the NF LOC and need and receive HCBS as an alternative to NF Care. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. This group shall be implemented by MCO based on TENNCARE's determination of the MCO's readiness to deliver services statewide and in accordance with program requirements.

Group 8
(Comprehensive Behavioral Supports for Employment and Community Living) – [Except as modified in the final approved amendment to the TennCare 1115 Demonstration and only upon approval and implementation of such amendment,] adults age twenty-one (21) and older, unless otherwise specified by TENNCARE, with I/DD and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment, meet nursing facility level of care, and need and are receiving specialized services for I/DD. A person must be in one of the following target groups: 1) adults with severe psychiatric or behavioral symptoms whose family is no longer capable of supporting the individual due to the severity and frequency of behaviors; 2) emerging young adults (age 18-21) with I/DD and severe psychiatric or behavioral symptoms aging out of the foster care system; and 3) adults with I/DD and severe psychiatric or behavioral symptoms following a crisis event and/or psychiatric inpatient stay

and/or transitioning out of the criminal justice system or a long-term institutional placement (including residential psychiatric treatment facility). To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. On a case-by-case basis, TENNCARE may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 8, if they meet eligibility criteria. This group shall be implemented by MCO based on TENNCARE's determination of the MCO's readiness to deliver services statewide and in accordance with program requirements.

ECF CHOICES Home and Community-Based Services (HCBS) – Services that are available only to eligible persons enrolled in ECF CHOICES Groups 4, 5, 6, 7, or 8 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only certain ECF CHOICES HCBS are eligible for Consumer Direction. ECF CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although home health and private duty nursing services are subject to estate recovery and shall, for members enrolled in ECF CHOICES Group 6 who are granted an exception to the expenditure cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 or 8 who also have an expenditure cap based on the comparable cost of institutional care, be counted for purposes of determining whether an ECF CHOICES member's needs can be safely met in the community within his or her individual expenditure cap.

ECF CHOICES Member - A member who has been enrolled by TENNCARE into ECF CHOICES.

ECF CHOICES Referral List – The listing of Potential Applicants that have completed both a screening and intake process to determine interest in and eligibility for applying for enrollment into the ECF CHOICES program.

Electronic Visit Verification (EVV) System – An electronic system that meets the minimum functionality requirements prescribed by TENNCARE which provider staff must use to check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of specified CHOICES and ECF CHOICES HCBS and which may also be utilized for submission of claims. Any such system shall comply with the 21st Century Cures Act.

Eligible – Any person certified by TENNCARE as eligible to receive services and benefits under the TennCare program or the CoverKids program. As it relates to CHOICES and ECF CHOICES a person is eligible to receive CHOICES or ECF CHOICES benefits only if he/she has been enrolled in CHOICES or ECF CHOICES by TENNCARE.

Eligible CHOICES HCBS – Attendant care, personal care, in-home respite, companion care services and/or any other CHOICES HCBS specified in TennCare rules and regulations as eligible for consumer direction for which a CHOICES member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s). Eligible CHOICES HCBS do not include home health or private duty nursing services.

Eligible ECF CHOICES HCBS – Personal assistance, supportive home care, hourly respite, community transportation, and/or any other ECF CHOICES HCBS specified in TennCare rules as eligible for consumer direction which an ECF CHOICES member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s) and the delivery of each eligible ECF CHOICES HCBS within the authorized budget for that service. Eligible ECF CHOICES HCBS do not include home health, private duty nursing services, or Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS).

Eligible Individual – With respect to Tennessee's Money Follows the Person Rebalancing Demonstration (MFP) and pursuant to Section 6071(b)(2) of the Deficit Reduction Act of 2005 (DRA), (Pub. L. 109-171 (S. 1932)) (Feb. 8, 2006) as amended by Section 2403 of the Patient Protection and Affordable Care Act of 2010 (ACA), (Pub. L. 111-148) (May 1, 2010), the State's approved MFP Operational Protocol and TennCare Rules, a member who qualifies to participate in MFP. Such person, immediately before beginning participation in the MFP demonstration project, shall:

1. Reside in a Qualified Institution, i.e., a Nursing Facility (NF), hospital, or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and have resided in any combination of such Qualified Institutions for a period of not less than ninety (90) consecutive days.

    a. Inpatient days in an institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) may be counted only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.

    b. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.

    c. Short-term continuous care in a nursing facility, to include Level 2 nursing facility reimbursement, for episodic conditions to stabilize a condition rather than admit to hospital or to facilitate hospital discharge, and inpatient rehabilitation facility services reimbursed by the CONTRACTOR (i.e., not covered by Medicare) as a cost-effective alternative (Refer to Section A.2.6.5) and provided in a Qualified Institution shall be counted for purposes of meeting the ninety (90) day minimum stay in a Qualified Institution established under ACA.

2. For purposes of this Contract, an Eligible Individual must reside in a Qualified Institution and be eligible to enroll and transition seamlessly into CHOICES Group 2, or ECF CHOICES (applicable only when the person meets NF level of care) or one of the 1915(c) HCBS Waivers, without delay or interruption.

3. Meet nursing facility or ICF/IID level of care, as applicable, and, but for the provision of ongoing CHOICES HCBS or ECF CHOICES HCBS, continue to require such level of care provided in an inpatient facility.

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

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

Employer of Record – The member participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS or a representative designated by the member to assume the consumer direction of eligible CHOICES or ECF CHOICES HCBS functions on the member's behalf.

Employment and Community First (ECF) CHOICES - A managed long-term services and supports program that offers home and community-based services to eligible individuals with intellectual and developmental disabilities enrolled in the program in order to promote competitive employment and integrated community living as the first and preferred option.

Employment Informed Choice – The process the CONTRACTOR shall complete for working age members (ages sixteen (16) to sixty-two (62) enrolled in ECF CHOICES who are eligible for, and want to receive, Community Integration Support Services and/or Independent Living Skills Training services when the member is not either: (1) working in Individualized Integrated Employment or Individualized Integrated Self-Employment (with or without support services, depending on need); or (2) actively pursuing Individualized Integrated Employment or Individualized Integrated Self-Employment (with Supported Employment Individual or comparable Vocational Rehabilitation/Special Education/Workforce services). Members who receive Community Living Supports or Community Living Supports-Family Model services are never eligible to receive Community Integration Support Services and/or Independent Living Skills Training services. The Employment Informed Choice process includes, at minimum, an orientation to Individualized Integrated Employment and Individualized Integrated Self-Employment, employment supports/services, Vocational Rehabilitation, and basic benefits/work incentives education provided by the member's Support Coordinator; the authorization and completion of Exploration services in order to explore various employment options that are aligned with the member's interests, aptitudes, experiences and/or skills, to address concerns or questions, and ensure an informed choice regarding Individualized Integrated Employment and Individualized Integrated Self-Employment. Community Integration Support Services and/or Independent Living Skills Training services can be authorized and on-going at the same time as the Exploration service, up to a combined maximum of twenty (20) hours per week. Upon completion of Exploration services, if the member elects to pursue Individualized Integrated Employment or Individualized Integrated Self-Employment, the Support Coordinator shall proceed with authorization of the appropriate employment service(s) and/or referral to Vocational Rehabilitation; and Community Integration Support Services and/or Independent Living Skills Training may continue or begin, up to a maximum of 30 hours per week, when combined with and including at least one employment service. Upon completion of Exploration services, if the member elects not to pursue Individualized Integrated Employment or Self-Employment, a signed acknowledgement from the member/representative shall be obtained to continue or begin receiving Community Integration Support Services and/or Independent Living Skills Training, up to a combined maximum of twenty (20) hours per week.

Engaged – When a member has interactive contact with care management or other member facing/engagement programs.

Enhanced Respiratory Care (ERC) – Specialized types of assistance provided to individuals with certain significant respiratory care needs as part of the medically necessary services delivered in an appropriately licensed and dual certified NF/SNF, consisting of Ventilator Weaning, Chronic Ventilator Care, or Tracheal Suctioning including Sub-Acute and Secretion Management, and for which a NF may, pursuant to TennCare rules, be eligible to receive Enhanced Respiratory Care Reimbursement.

Enrollee – A person who has been determined eligible for TennCare or CoverKids and who has been enrolled in the TennCare or CoverKids program (see Member, also). Synonymous with Member. For purposes of TennCare Enrollee Benefit Appeals and the TennCare Enrollee Benefit Appeal-related provisions in Section A.2.19 herein, "Enrollee" means (1) enrollee, (2) enrollee's parent, (3) enrollee's legal guardian, or (4) Enrollee-Authorized Representative. For purposes of provider agreements in Sections A.2.12.23, and missed visits of home health services in Section A.2.15.9, "Enrollee" means not only (1) the enrollee, (2) the enrollee's parent, or (3) the enrollee's legal guardian, but also a person who has a close, personal relationship with the enrollee and is routinely involved in providing unpaid support and assistance to them.

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

Enrollee-Authorized Representative – For purposes of Enrollee Benefit Appeals, and the Enrollee- Benefit Appeal-related provisions in Section A.2.19 herein, "Enrollee Authorized Representative" means a competent adult who has the Enrollee's signed, written authorization to act on the Enrollee's behalf during the appeal process in accordance with 42 CFR 435.923. The written authority to act shall specify any limits of the representation. For example, if the enrollee wants to authorize his treating provider to frame the issue under dispute and file his request for a SFH, but if his treating provider will not be receiving the Notice of Hearing and will not be representing the enrollee during the hearing, these limitations shall be indicated on the Enrollee-Authorized Representative documentation.

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

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

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

Ethical and Religious Directives (often called the ERDs) - means a document that offers moral guidance on various aspects of health care delivery and is based on a religious organization's theological and moral teachings.

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

Expenditure Cap – The annual limit on expenditures for CHOICES or ECF CHOICES that a member enrolled in CHOICES Group 3 or ECF CHOICES HCBS, as applicable, can receive. For purposes of the Expenditure Cap for members in CHOICES Group 3 and ECF CHOICES Group 4, the cost of minor home modifications is not counted in calculating annual expenditures for CHOICES HCBS or ECF CHOICES HCBS. For purposes of the Expenditure Cap for members in ECF CHOICES Group 6 who are granted an exception to the Expenditure Cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 and 8 who also have an Expenditure Cap based on the comparable cost of institutional care, the cost of home health and private duty nursing shall be counted against the member's Expenditure Cap.

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

Family Member - For purposes of a Qualified Residence under the State's MFP Rebalancing Demonstration, a family member includes a person with any of the following relationships to the member, whether related by blood, marriage, or adoption, and including such relationships (as applicable) that may have been established through longstanding (a year or more) foster care when the member was a minor:

1. Spouse, and parents and siblings thereof;
2. Sons and daughters, and spouses thereof;
3. Parents, and spouses and siblings thereof;
4. Brothers and sisters, and spouses thereof;
5. Grandparents and grandchildren, and spouses thereof; and
6. Domestic partner and parents thereof, including domestic partners of any individual in 2 through 5 of this definition. A domestic partner means an adult in a committed relationship with another adult. Committed relationship means one in which the member, and the domestic partner of the member, are each other's sole domestic partner (and are not married to or domestic partners with anyone else); and share responsibility for a significant measure of each other's common welfare and financial obligations.

Step and in-law relationships are included in this definition, even if the marriage has been dissolved, or a marriage partner is deceased.

Family member may also include the member's legal guardian or conservator or someone who was the legal guardian or conservator of the member when the member was a minor or required a legal guardian or conservator.

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

Fiscal Employer Agent (FEA) – An entity contracting with the State and/or an MCO that helps CHOICES and ECF CHOICES members participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS. The FEA provides both financial administration and supports brokerage functions for CHOICES and ECF CHOICES members participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS. This term is used by the IRS to designate an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6 and Notice 2003-70, as the agent to members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA and FUTA taxes. The FEA also files state income tax withholding and unemployment insurance tax forms and pays the associated taxes and processes payroll based on the eligible CHOICES or ECF CHOICES HCBS authorized and provided.

FQHC – Federally Qualified Health Center.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (see 42 CFR 455.2).

General Marketing – Any communication or activity that can reasonably be interpreted as intended to promote the CONTRACTOR, including, but not limited to, advertising, publicity, and positioning.

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

East Grand Region – Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union, and Washington Counties

Middle Grand Region – Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence , Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson Counties

West Grand Region – Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, and Weakley Counties

Grievance – A complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. See 42 C.F.R. §438.400(b).

Grievance System – The processes the CONTRACTOR implements to handle grievances, as well as the processes to collect and track information about them. See 42 C.F.R. §438.400(b).

Group One Children - are CoverKids enrollees who are members of families with incomes between two hundred percent (200%) and two hundred fifty percent (250%) of the federal poverty level (FPL) as reported by the State to the Contractor for the coverage period.

Group Two Children - are CoverKids enrollees who are members of families below two hundred percent (200%) of the federal poverty level (FPL) as reported by the State to the Contractor for the coverage period.

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.

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

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

HIPAA - Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164.

HITECH - Health Information Technology for Economic and Clinical Health Act, Pub.L.111-5, Div. A, Title XIII, § 13001(a), Feb. 17, 2009, 123 Stat. 226.

Home and Community-Based Services (HCBS) – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES or ECF CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES and ECF CHOICES HCBS are eligible for Consumer Direction. CHOICES and ECF CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost neutrality cap. The cost of home health and private duty nursing shall also be counted against the member's Expenditure Cap for members in ECF CHOICES Group 6 who are granted an exception to the Expenditure Cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 and 8 who also have an Expenditure Cap based on the comparable cost of institutional care.

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

Individualized Integrated Employment – Sustained paid employment in a competitive or customized job with an employer for which an individual is compensated at or above the state's minimum wage, with the optimal goal being not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Individualized Integrated Self-Employment – Sustained paid self-employment that is home-based or conducted in an integrated setting(s) where net income in relation to hours worked is equivalent to no less than the state's minimum wage, after a reasonable self-employment start-up period.

Individually Identifiable Health Information – Any information, including demographic information, collected from an individual, that (a) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (b) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and identifies the individual; or, with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

Individuals with Limited English Proficiency (LEP) – Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand the English language.

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

Integrated Support Coordination Team (IST) – For purposes of ECF CHOICES Groups 7 and 8, the team consisting of the member's Support Coordinator and the Behavior Supports Director as defined in 2.29.1.3.6 or a similarly qualified behavior supports professional, who shall be responsible for performing in close collaboration the required Support Coordination functions as specified in this Contract, including (but not limited to) comprehensive initial and ongoing assessments, development and implementation of the PCSP, monitoring progress and outcomes, and transition planning

Interactive Contact – As it pertains to Population Health, it is two-way interaction between the MCO and the member, during which the member receives self-management support, health education, or care coordination through one of the following methods: telephone; in-person contact (i.e., individual or group); online contact; interactive web-based module; live chat; secure email; video conference; or interactive voice response. Interactive Contact shall not include any of the following: completion of a health appraisal; contact made for the sole purpose of making an appointment, leaving a message, or verifying receipt of materials; contact made for the sole purposes of informing members of the availability of affinity programs (e.g., subsidized gym memberships, device purchases, discounted weight loss subscriptions).

Interagency Review Committee – The committee composed of staff from TennCare and DIDD that reviews requests submitted on behalf of a Potential Applicant in order to determine whether the Potential Applicant meets reserve capacity criteria as defined in TennCare Rule 1200-13-01-.02 or in Operational Procedures submitted to CMS. Except for individuals with ID or DD who have an Aging Caregiver or as otherwise specified by TennCare, a determination by the Interagency Review Committee that a Potential Applicant meets reserve capacity criteria shall be required before DIDD or an MCO proceeds with an enrollment visit to determine if the Potential Applicant qualifies to enroll in ECF CHOICES in a reserve capacity slot designated for such purpose.

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

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

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

Level of Need – The categorization of the intensity level of practical supports needed by a member enrolled in ECF CHOICES Group 6 based on an objective assessment utilizing the American Association of Intellectual and Developmental Disabilities Supports Intensity Scale. The member's assessed level of need, including consideration of exceptional medical or behavioral needs as identified in the assessment, is used to establish the member's Expenditure Cap, required Support Coordinator-to-member ratios, and frequency of required Support Coordination contacts in the ECF CHOICES program.

Limited English Proficient (LEP) - Means potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. See 42 C.F.R. §438.10(a).

Long-Term Care Ombudsman Program – A statewide program for the benefit of individuals residing in long-term care facilities, which may include nursing homes, residential homes for the aged, assisted care living facilities, and community-based residential alternatives developed by the State. The Ombudsman is available to help these individuals and their families resolve questions or problems. The program is authorized by the federal Older Americans Act and administered by the Tennessee Commission on Aging and Disability (TCAD).

Long-Term Services and Supports (LTSS) - Services and supports provided under the CHOICES, ECF CHOICES, 1915(c) HCBS Waivers, PACE program, and to individuals in ICF/IIDs, of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Maintenance of Effort (MOE) – Provisions in the American Recovery and Reinvestment Act (ARRA) (Pub. L. 111–5) (Feb. 17, 2009) and the Affordable Care Act (ACA) to ensure that States' coverage for adults under the Medicaid program remains in place and that "eligibility standards, methodologies, and procedures" are not more restrictive than those in place as of July 1, 2008 for purposes of the ARRA and March 23, 2010, for purposes of the ACA pending the establishment of specific provisions of ACA (i.e., a fully operational Exchange) on January 1, 2014.

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

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

Medical Expenses – Shall be determined as follows:

1. Medical Expenses include the amount paid to providers for the provision of covered physical health, behavioral health, and/or long-term care services to members pursuant to the following listed Sections of the Contract:

    a. Section A.2.6.1, CONTRACTOR Covered Benefits;

    b. Section A.2.6.4, Second Opinions;

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

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

    e. Capitated payment to licensed providers;

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

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

    For purposes of ECF CHOICES, Medical Expenses shall also include costs related to the provision of Support Coordination.

2. Medical Expenses do not include:

    a. Section A.2.6.2 TennCare Benefits Provided by TENNCARE;

    b. Section A.2.6.7 Cost Sharing and Patient Liability;

    c. Section A.2.10 Services Not Covered;

    d. Services eligible for reimbursement by Medicare; or

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

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

4. This definition does not apply to NAIC filings.

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 – 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 Loss Ratio (MLR) – The percentage of capitation payment received from TENNCARE that is used to pay medical expenses, including for purposes of ECF CHOICES, costs related to the provision of support coordination.

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

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

Member – A TennCare enrollee who enrolls in the CONTRACTOR's MCO under the provisions of this Contract (refer to Enrollee).

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

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

MOE Demonstration Group – Individuals who are age 65 and older and adults age 21 and older with disabilities who (1) meet nursing home financial eligibility, (2) do not meet the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare CHOICES services, are "at risk" of institutionalization. The MOE Demonstration Group is open only between July 1, 2012, through June 30, 2015. Individuals enrolled in the MOE Demonstration Group as of June 30, 2015, may continue to qualify in this group after June 30, 2015, 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 MOE Demonstration Group and in CHOICES 3.

Money Follows the Person Rebalancing Demonstration (MFP) – A federal grant established under the Deficit Reduction Act and extended under the Affordable Care Act that will assist Tennessee in transitioning Eligible Individuals from a Qualified Institution into a Qualified Residence in the community and in rebalancing long-term care expenditures. The grant provides enhanced match for HCBS provided during the first 365 days of community living following transition.

NAIC – National Association of Insurance Commissioners.

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

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

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.

Non-Reportable Event - An event as defined at Section A.2.12.21 which the contracted provider is not required to report to the CONTRACTOR or DIDD, but which the provider shall be responsible for documenting, addressing, tracking and trending in order to prevent similar occurrences in the future whenever possible.

Office of the Comptroller of the Treasury – The Comptroller of the Treasury is a State of Tennessee constitutional officer elected by the General Assembly for a term of two years. Statutes prescribe the comptroller's duties, the most important of which relate to audit of state and local government entities and participation in the general financial and administrative management of state government.

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

One-Time CHOICES HCBS – Specified CHOICES HCBS which occur as a distinct event or which may be episodic in nature (occurring at less frequent irregular intervals or on an as needed basis for a limited duration of time). One-time HCBS include in-home respite, in-patient respite, assistive technology, minor home modifications, and/or pest control.

One-Time ECF CHOICES HCBS – Specified ECF CHOICES HCBS other than employment services and supports which occur as a distinct event or which may be episodic in nature (occurring at less frequent irregular intervals or on an as needed basis for a limited duration of time). One-time ECF CHOICES HCBS include: Conservatorship and Alternatives to Conservatorship Counseling and Assistance, Minor Home Modifications, Individual Education and Training Services, Specialized Consultation and Training, Adult Dental Services, Community Support Development, Organization and Navigation, Family Caregiver Education and Training, Assistive Technology, Adaptive Equipment and Supplies, Peer-to-Peer Support and Navigation for Person Centered Planning, Self-Direction, Integrated Employment/Self Employment, and Independent Community Living, Respite, Family-to-Family Support, and Health Insurance Counseling/Forms Assistance.

Ongoing CHOICES HCBS – Specified CHOICES HCBS which are delivered on a regular and ongoing basis, generally one or more times each week, or (in the case of community-based residential alternatives and PERS) on a continuous basis. Ongoing HCBS include community-based residential alternatives, personal care, attendant care, home-delivered meals, personal emergency response systems (PERS), and/or adult day care.

Ongoing ECF CHOICES HCBS – Specified ECF CHOICES HCBS which are delivered on a regular and ongoing basis, generally one or more times each week, or in the case of community-based residential alternatives on a continuous basis, or which may be one component of a continuum of services intended to achieve employment. Ongoing ECF CHOICES HCBS include: Supportive Home Care, Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS), Family Caregiver Stipend in lieu of Supportive Home Care, Independent Living Skills Training, Community Integration Support Services, Personal Assistance, Community Transportation, Community Living Supports (CLS), Community Living Supports Family Model (CLS-FM), Intensive Behavioral Community Transition and Stabilization Services, Exploration, Discovery, Benefits Counseling, Situational Observation and Assessment, Job Development or Self-Employment Plan, Job Development or Self-Employment Start Up, Job Coaching (including Competitive, Integrated Employment and Self-Employment), Supported Employment – Small Group, Co-worker Supports, Career Advancement, and Integrated Employment Path Services (Time Limited Pre-Vocational Training).

Oral Interpretation - Is the act of listening to something in one language (source language) and orally translating it into another language (target language).

PASRR – Preadmission Screening and Resident Review.

Patient Liability – The amount of an enrollee's income, as determined by the State, to be collected each month to help pay for the enrollee's long-term care services.

Person-Centered Support Plan (PCSP) – As it pertains to CHOICES and ECF CHOICES, the PCSP is a written plan developed by the Support Coordinator or Care Coordinator in accordance with person-centered planning requirements set forth in federal regulation, and in TennCare policies and protocols, using a person-centered planning process that accurately documents the member's strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the member to help them achieve their preferred lifestyle and goals, and to meet their identified unmet needs (after considering the availability and role of unpaid supports provided by family members and other natural supports) through paid services provided by the member's MCO and other payor sources. The person-centered planning process is directed by the member with long-term support needs and may include a representative whom the member has freely chosen to assist the member with decision-making, and others chosen by the member to contribute to the process. If the member has a guardian or conservator, the member shall lead the planning process to the maximum extent possible, and the guardian or conservator shall have a participatory role as needed and defined by the individual, except as explicitly defined under State law and the order of guardianship or conservatorship. Any decisions made on the member's behalf should be made using principles of substituted judgment and supported decision-making. This planning process, and the resulting PCSP, will assist the member in achieving a personally defined lifestyle and outcomes in the most integrated community setting appropriate, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health, welfare, and personal growth. Services in CHOICES and ECF CHOICES shall be authorized, provided, and reimbursed only as specified in the PCSP.

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

Plan of Care – As it pertains to Population Health the plan of care 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 CHOICES Care Coordination or ECF CHOICES Support Coordination.

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

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

Presumptive Eligibility – An established period of time during which certain pregnant women are eligible for TennCare Medicaid. During this period of time the presumptively eligible enrollee must complete a full application for Medicaid in order to stay on the program. Eligibility extends from the presumptive eligibility effective date through the end of the following month unless a full Medicaid application is completed. When a full Medicaid application is completed, presumptive eligibility is provided until an eligibility determination is made on the full Medicaid application.

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

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

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

Priority Enrollee – An enrollee that has been identified by TENNCARE as vulnerable due to certain mental health diagnoses.

Privacy Breach – The acquisition, access, use, or disclosure of PHI in a manner which compromises the security or privacy of the PHI as governed by the provisions of HIPAA and other federal and state laws. For purposes of this definition, "compromises the security or privacy of the protected health information" means poses a significant risk of financial, reputational, or other harm to the individual.

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

Protected Health Information (PHI) – Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

Provider – An institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished. Provider does not include consumer-directed workers (refer to Consumer-Directed Worker); nor does provider include the FEA (refer to Fiscal Employer Agent).

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

Qualified Institution – With respect to Tennessee's MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(3) of the DRA, a hospital, nursing facility, or ICF/IID.

1. An institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) shall be a Qualified Institution only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.

2. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under the Affordable Care Act.

Qualified Residence – With respect to Tennessee's MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(6) of the DRA, the residence in the community in which an Eligible Individual will reside upon transition to the community which shall be one of the following:

1. A home owned or leased by an Eligible Individual or the individual's family member;

2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the Eligible Individual or the individual's family has domain and control; or

3. A residence in a community-based residential setting in which no more than four (4) unrelated individuals reside.

Additional requirements pertaining to a Qualified Residence set forth in MFP Policy Guidance issued by the Centers for Medicare and Medicaid Services (CMS) shall apply for all persons participating in MFP.

Quality Management/Quality Improvement (QM/QI) – The development and implementation of strategies to assess and improve the performance of a program or organization on a continuous basis. This includes the identification of key measures of performance, discovery and data collection processes, identification and remediation of issues, and systems improvement activities.

Reconsideration - Mandatory component of the TENNCARE Benefit Appeal Process by which an MCO reviews and renders a decision affirming or reversing the adverse benefit determination at issue in the enrollee's request for SFH. An MCO satisfies the plan-level requirements of 42 C.F.R. 438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a physician other than the original reviewing physician; and produces a timely written finding.

Recoupment – The process by which an MCO, the State of Tennessee or the Federal government, or any of their Bureaus, Agencies or Contractors recover Title XIX monies paid to an MCO, provider or enrollee.

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

Regulatory Requirements – Any requirements imposed by applicable federal, state or local laws, rules, regulations, court orders and consent decrees, a program contract, or otherwise imposed by TENNCARE in connection with the operation of the program or the performance required by either party under an agreement.

Reportable Event – For the purposes of ECF CHOICES, a Reportable Event is an event that is classified as Tier 1, Tier 2, or Tier 3, as defined by TENNCARE, that the contracted provider, CONTRACTOR, or FEA staff shall be responsible for reporting to the CONTRACTOR and/or DIDD, as specified by TENNCARE. The contracted provider, CONTRACTOR, and/or DIDD, as applicable, shall be responsible for managing, tracking and trending in order to prevent similar occurrences in the future whenever possible as is further detailed in Section A.2.15.7.6 of this CRA.

Representative – In general, for CHOICES and ECF CHOICES members, a person who is at least eighteen (18) years of age and is authorized by the member to participate in care or support planning and implementation and to speak and/or make decisions on the member's behalf, including but not limited to identification of needs, preference regarding services and service delivery settings, and communication and resolution of complaints and concerns , provided that any decision making authority not specifically delegated to a legal representative (e.g., a guardian or conservator) is retained by the member unless he or she chooses to allow a (non-legal) representative whom he or she has freely chosen to make such decisions. As it relates to consumer direction of eligible CHOICES or ECF CHOICES HCBS, a person who is authorized by the member to direct and manage the member's worker(s), and signs a representative agreement. The representative for consumer direction of eligible CHOICES or ECF CHOICES HCBS must also: be at least eighteen (18) years of age; have a personal relationship with the member and understand his/her support needs; know the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate workers.

Representative Agreement – The agreement between a CHOICES or ECF CHOICES member electing consumer direction of eligible CHOICES or ECF CHOICES HCBS who has a representative direct and manage the consumer's worker(s) and the member's representative that specifies the roles and responsibilities of the member and the member's representative.

Reserve Capacity Slot– For the purposes of ECF CHOICES, the state's authority to reserve a finite number of program slots in a particular ECF CHOICES Group for persons in specified circumstances as defined in TennCare Rule 1200-13-01-.02 or in Operational Procedures submitted to CMS.

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

Risk Assessment - As part of the person-centered planning process for members in CHOICES Group 2 and 3, the CONTRACTOR shall assess risk based on member preference for service delivery, including risks specific to consumer direction, and shall further ass2.9.6.12.21.ess risk in instances in which a member's health, safety, or wellness has changed. If, during this assessment, risk is identified, each risk shall be incorporated individually into the PCSP in the applicable section(s), and each risk must include a corresponding mitigation strategy. The CONTRACTOR shall routinely assess risks identified in the member's PCSP, as well as corresponding mitigation strategies, to determine whether such risks are ongoing, and if so, whether the existing mitigation strategies continue to be appropriate.

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

Safeguarding Enrollee Information – To maintain reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of the information; to protect against any reasonably anticipated threats or hazards to the security or integrity of the information; and to protect against unauthorized uses or disclosures of the information.

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

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

Self-Direction of Health Care Tasks – A decision by a CHOICES or ECF CHOICES member participating in consumer direction to direct and supervise a paid worker delivering eligible CHOICES or ECF CHOICES HCBS in the performance of health care tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that a CHOICES or ECF CHOICES member participating in consumer direction may elect to have performed by a consumer-directed worker as part of the delivery of eligible CHOICES or ECF CHOICES HCBS s/he is authorized to receive.

Service Agreement – The agreement between a CHOICES or ECF CHOICES member electing consumer direction of HCBS (or the member's representative) and the member's consumer-directed worker that specifies the roles and responsibilities of the member (or the member's representative) and the member's worker.

Service Gap – A delay in initiating any long-term care service and/or a disruption of a scheduled, ongoing CHOICES or ECF CHOICES HCBS that was not initiated by a member, including late and missed visits.

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

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

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

SSA – Social Security Administration.

SSI – Supplemental Security Income.

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

State – The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Tennessee Department of Finance and Administration, the Office of Inspector General, the Division of TennCare, the Tennessee Bureau of Investigation, Medicaid Fraud Control Division, the Tennessee Department of Mental Health and Substance Abuse Services, the Tennessee Department of Children's Services, the Tennessee Department of Health, the Tennessee Department of Commerce and Insurance, and the Office of the Attorney General.

State Fair Hearing (SFH) – The Benefit Appeal Process set forth in subpart E of part 431 chapter IV, title 42 under which TennCare enrollees have the right to request a SFH (synonymous with "Appeal") to contest MCC-proposed Adverse Benefit Determinations. CoverKids/CHIP program enrollees do not have the right to receive a SFH, but may receive a CoverKids "Review". See 42 CFR §438.400(b).

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 Contract (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 Contract. 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 Contract. Agreements to provide covered services as described in Section A.2.6 of this Contract shall be considered provider agreements and governed by Section A.2.12 of this Contract.

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

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

Support Coordination Team – If an MCO elects to use a support coordination team, the support coordination team shall consist of a Support Coordinator and specific other persons with relevant expertise and experience who are assigned to support the Support Coordinator in the performance of support coordination activities for an ECF CHOICES member as specified in this Contract and in accordance with Section A.2.9.6, but shall not perform activities that must be performed by the Support Coordinator, including comprehensive assessment, caregiver assessment, development of the PCSP, and minimum Support Coordination contacts. In the case of ECF CHOICES Groups 7 and 8, certain Support Coordination activities shall be completed by an Integrated Support Coordination Team as defined herein.

Support Coordination Unit – A specific group of staff within the MCO's organization dedicated to ECF CHOICES that is comprised of Support Coordinators and Support Coordinator supervisors and which may also include support coordination teams. Integrated Support Coordination Teams shall be part of the Support Coordination Unit.

Support Coordinator – The individual who has primary responsibility for performance of support coordination activities for an ECF CHOICES member as specified in the CRA and meets the qualifications specified in Section A.2.9.6 of the CRA. In the case of ECF CHOICES Groups 7 and 8, certain Support Coordination activities shall be performed by the Integrated Support Coordination Team, as defined herein.

Supports Broker – An individual assigned by the FEA to each CHOICES or ECF CHOICES member participating in consumer direction who assists the member/representative as needed in performing certain employer of record functions as follows: developing job descriptions; recruiting, interviewing, and hiring workers; member and worker enrollment in consumer direction and consumer direction training; and developing (as part of the onboarding process for new workers) a schedule for the member's workers that comports with the schedule at which services are needed by the member as reflected in the plan of care or PCSP, as applicable. The supports broker shall also assist the member as needed with developing and verifying the initial back-up plan for consumer direction. The supports broker collaborates with the member's Care Coordinator or Support Coordinator, as appropriate. The supports broker does not have authority or responsibility for consumer direction. The member or member's representative must retain authority and responsibility for consumer direction.

System of Support (SOS) – A comprehensive person-centered approach to the delivery of Behavioral Crisis, Prevention, Intervention, and/or Stabilization services (see Section A.2.7.2.8.4) for individuals with I/DD who experience challenging behaviors that place them and/or others at risk of harm with a primary focus on coordination of services and supports, improved linkages, and increased capacity of paid and unpaid caregivers to prevent, stabilize, and manage crisis events in order to empower individuals with I/DD to live the lives they want in their communities.

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

TCA – Tennessee Code Annotated.

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

TennCare or TennCare Program **–** The program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs. For purposes of the contract requirements herein, references to TennCare or the TennCare Program shall include CoverKids unless otherwise specified.

TennCare CHOICES in Long-Term Care (CHOICES) – A program in which long-term care services for elders and/or persons with physical disabilities are integrated into TennCare's managed care delivery system.

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

TENNCARE Pre-Admission Evaluation Tracking System (PAE Tracking System) – A component of the State's Medicaid Management Information System and the system of record for all Pre-Admission Evaluation (i.e., level of care) submissions and level of care determinations, as well as enrollments into and transitions between LTSS programs, including CHOICES, ECF CHOICES, and the State's MFP Rebalancing Demonstration (MFP), as a tracking mechanism for referral list management in ECF CHOICES, and which shall also be used to gather data required to comply with tracking and reporting requirements pertaining to MFP.

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

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

TennCare Kids – Tennessee's EPSDT program; see EPSDT.

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

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

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

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

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

Tennessee Department of Human Services (DHS) – The state agency having the statutory authority to provide human services to meet the needs of Tennesseans and enable them to achieve self-sufficiency.

Tennessee Department of Intellectual and Developmental Disabilities (DIDD) – The state entity contracted by TennCare to serve as the Operational Administrative Agency for day-to-day operation of Section 1915(c) HCBS waivers for persons with ID. Formerly known as the Division of Intellectual Disabilities Services (DIDS), DIDD is responsible for the performance of contracted functions for ECF CHOICES as specified in the Interagency Agreement for ECF CHOICES between TennCare and DIDD.

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.

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

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

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 to a CHOICES or ECF CHOICES member as a cost-effective alternative to continued institutional care for which the CONTRACTOR is responsible for payment (e.g., a nursing facility or inpatient psychiatric care at a Regional Mental Health Institute) in order to facilitate transition to the community. The allotment is only appropriate when such a member will, upon transition, will receive more cost-effective home and community based services either non-residential services or consumer directed companion care in their own home, residential services in a non-provider owned residential setting, or for limited items, as specified below in this section, in provider-owned residential settings. Provider-owned settings include settings which the provider owns, co-owns, has any ownership interest in, or has any affiliation with the entity that owns the home in which the member will reside. A Transition Allowance may also be provided as a cost-effective alternative when a member must transition out of the current living arrangement and would, but for the availability of the Transition Allowance, require placement in a medical institution for which the CONTRACTOR is responsible for payment, as stated above. The CONTRACTOR shall only be responsible for payment of nursing facility services when the person meets nursing facility level of care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain (including community resources that the CONTRACTOR is expected to assist the member in accessing first) 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 (rental security deposits required to obtain a lease—e.g., first and last month's rent—may be covered even if not refundable; ongoing rent may not), essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes. In provider-owned settings, the transition allowance shall only be used for household items and furnishings that are for the member's personal use, such as bedroom furniture, towels, linens, sheets, and other similar items as approved by TENNCARE. In provider-owned settings (as defined herein), a transition allowance shall not be used for rent or utility deposits or for household items and furnishings for common use of all persons residing in the home. Regardless of setting, items purchased as part of the Transition Allowance shall be the personal property of the member, not the provider.

Transition Team – Teams the CONTRACTOR shall maintain beginning July 1, 2015 to fulfill its obligations pursuant to Nursing Facility to Community Transitions (see Section A.2.9.6.8) and the MFP Rebalancing Demonstration (see Section A.2.9.8). The Transition Team shall consist of at least one (1) dedicated staff person without a caseload in each Grand Region in which the CONTRACTOR serves TennCare members, who also meets the qualifications of a Care Coordinator specified in Section A.2.9.6.12. The transition team may also include other persons with relevant expertise and experience who are assigned to support the Care Coordinator(s) in the performance of transition activities for a CHOICES Group 1 member. Any such staff shall not be reported in the Care Coordinator ratios specified in Section A.2.9.6.12, and shall be responsible for proactively identifying TennCare members in NFs who are candidates to transition to the community and to further assist with the completion of the transition process specified in Section A.2.9.6.8. All transition activities identified as responsibilities of the Care Coordinator shall be completed by an individual who meets all of the requirements to be a Care Coordinator.

Unsecured PHI – PHI information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of DHHS.

USC – United States Code.

Vital Documents - Vital Documents may include, but are not limited to, consent and complaint forms, intake and application forms with the potential for important consequences, notices pertaining to the reduction, denial, delay, suspension or termination of services, certain critical outreach documents (i.e. case management and Population Health documents) and any other documents designated by the State. At a minimum, all Vital Documents shall be available in the Spanish language.

Warm Transfer – A telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.

Waste - is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Wellness – An approach to health care that emphasizes not merely the absence of disease or infirmity but the pursuit of optimum health. It is an active process of helping members become aware of and make choices that will help them to achieve a healthy and more fulfilling life. Wellness includes preventing illness, prolonging life, and improving quality of life, as opposed to focusing solely on treating diseases. Wellness is a condition of good physical and mental health, especially when accomplished and maintained by personal choice and action, including proper diet, exercise, and health habits.

Worker – Refer to Consumer-Directed Worker.

Written Translation - Is the replacement of a written text from one language (source language) into an equivalent written text in another language (target language).

SECTION A.2 – PROGRAM REQUIREMENTS

A.2.1 REQUIREMENTS PRIOR TO OPERATIONS

A.2.1.1 **Licensure**

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

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

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

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

A.2.1.2 **Readiness Review**

2.1.2.1 Prior to the start date of operations and any substantive program changes or amendments, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that it is able to meet the requirements of this Contract. This shall include the implementation of the CoverKids program as a part of this Contract for which services shall begin January 1, 2021.

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

2.1.2.3 Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR. TennCare or CoverKids enrollees may not be enrolled with the CONTRACTOR until TENNCARE has determined that the CONTRACTOR is able to meet the requirements of this Contract and other actions may be taken by TENNCARE as determined necessary to ensure CONTRACTOR readiness to meet program requirements.

2.1.2.4 If the CONTRACTOR is unable to demonstrate its ability to meet the requirements of this Contract, as determined by TENNCARE, within the time frames specified by

TENNCARE, TENNCARE may terminate this Contract in accordance with Section E.14 of this Contract and shall have no liability for payment to the CONTRACTOR or may institute Immediate Sanctions as described in Section E.29 of this Contract.

A.2.2 GENERAL REQUIREMENTS

A.2.2.1 The CONTRACTOR agrees to serve all Grand Regions within the scope of this statewide Contract. For purposes of enrollment, enforcement, and reporting, this Contract shall constitute three (3) separate enforceable agreements (one per Grand Region). Performance with this Contract will be monitored on a regional as well as statewide basis and sanctions may be assessed on a regional or statewide basis as determined by TENNCARE. If TENNCARE terminates the use of CONTRACTOR's services in one (1) or more Grand Regions pursuant to Sections D.3 and E.14.6 Termination for Convenience or Sections D.4 and E.14.2 Termination for Cause, this Contract shall remain in full force and effect for the remaining Grand Regions, if any, in which CONTRACTOR continues to provide services.

2.2.1.1 The start date of operations will be implemented by Grand Region as described in RFP Number 31865-00368 unless it is determined by TENNCARE and agreed upon by the CONTRACTOR to implement the start date of operations in a Grand Region sooner than described.

A.2.2.2 The CONTRACTOR shall comply with all the provisions of this Contract and any amendments thereto and shall act in good faith in the performance of these provisions. The CONTRACTOR shall respect the legal rights (including rights conferred by the Contract) of every enrollee, regardless of the enrollee's family status as head of household, dependent, or otherwise. Nothing in this Contract may be construed to limit the rights or remedies of enrollees under state or federal law. The CONTRACTOR acknowledges that failure to comply with provisions of this Contract may result in the assessment of liquidated damages and/or termination of the Contract in whole or in part, and/or imposition of other sanctions as set forth in this Contract.

A.2.2.3 The CONTRACTOR shall be responsible for the administration and management of all aspects of this Contract including all subcontractors, providers, employees, agents, and anyone acting for or on behalf of the CONTRACTOR.

A.2.2.4 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 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. If the CONTRACTOR is a foreign domiciled health maintenance organization, the manner in which the CONTRACTOR shall comply with the requirements of TCA 56-11-101 et seq. are outlined in a Memorandum of Understanding between the CONTRACTOR and the Tennessee Department of Commerce and Insurance, TennCare Oversight Division, which is incorporated herein by reference. The information disclosed or filed in accordance with the requirements of TCA 56-11-101 et. seq. shall be considered Confidential Information pursuant to TCA 56-11-108.

A.2.2.5 The CONTRACTOR shall operate a Dual Eligible Special Needs Plan (D-SNP) in each of the counties in Tennessee, and shall coordinate Medicare as well as Medicaid, including CHOICES and ECF CHOICES, benefits for dual eligible members. If the CONTRACTOR does not currently operate a D-SNP in each of the counties in Tennessee, the CONTRACTOR shall submit a plan, including specified timeframes, for establishing and operating a D-SNP in each

of the counties in Tennessee. The CONTRACTOR shall work with TENNCARE to align, whenever possible, enrollment of dual eligible members in the same plan for both Medicare and Medicaid services.

A.2.2.6 In accordance with the terms and conditions of the RFP Number 31865-00368 the CONTRACTOR is bound by the responses it has submitted through that process. Accordingly, the CONTRACTOR agrees to incorporate by reference its responses to the RFP into the terms and conditions of this contract as set forth in Section E.7. of this Contract. From time to time during the term of this Contract, TENNCARE shall provide the CONTRACTOR with a list of specific requirements as submitted by the CONTRACTOR in response to the RFP Number 31865-00368. The CONTRACTOR shall respond to the specified listing by providing an initial overview of the requirements identified by TENNCARE and continuing to provide quarterly updates thereafter. The CONTRACTOR shall submit a report and workplan describing how each of the identified requirements will be or have been implemented. The CONTRACTOR shall provide an ongoing quarterly update based on a schedule determined by TENNCARE to detail progress of the implementation of these requirements until otherwise directed by TENNCARE. The failure of the CONTRACTOR to provide a response by TENNCARE under the requirements of this section shall be considered a Level B liquidated damage violation and damages shall accrue in accordance with Section B.2 of the Liquidated Damages Chart (Section E.29.2.2.7 of this Contract) for any failure, including timeliness, of the CONTRACTOR to respond as required.

A.2.2.7 Effective January 1, 2021, the CONTRACTOR shall administer CoverKids benefits as described in this Contract. Requirements set forth in the Contract shall be inclusive of the CoverKids program unless otherwise specified in this Contract, including provisions related to services that are not specifically included as covered CoverKids services described in Section A.2.6.1.7. Section A.2.19 Grievances and Appeals of this Contract shall not apply to CoverKids. Review of CoverKids decisions shall be governed by TennCare Division rule 1200-13-21-.07 in accordance with T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

A.2.3 ELIGIBILITY FOR TENNCARE AND COVERKIDS

A.2.3.1 Overview

TennCare is Tennessee's Medicaid program operating under the authority of a research and demonstration project approved by the federal government pursuant to Section 1115 of the Social Security Act. CoverKids is the State Child Health Plan under Title XXI of the social Security Act State Children's Health Insurance Program. Eligibility for TennCare and CoverKids is determined by the State in accordance with federal requirements and state law and policy.

A.2.3.2 Eligibility Categories

TennCare currently consists of traditional Medicaid coverage groups (TennCare Medicaid) and an expanded population (TennCare Standard). CoverKids consists of coverage groups (Group One Children) and (Group Two Children) as described below.

2.3.2.1 <u>TennCare Medicaid</u>

As provided in state rules and regulations, TennCare Medicaid covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged, and

individuals with disabilities. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

2.3.2.2 TennCare Standard

TennCare Standard includes the Standard Spend Down (SSD) population, the CHOICES At Risk Demonstration Group, CHOICES 217-Like HCBS Group, Interim ECF CHOICES At-Risk Demonstration Group, ECF CHOICES At-Risk Demonstration Group, ECF CHOICES 217-Like HCBS Group, ECF CHOICES Working Disabled Demonstration Group, and an expanded population of children. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

2.3.2.3 CoverKids

CoverKids includes children under age 19 and Mothers of unborn eligible who do not qualify for TennCare but meet the condition of “Group One Children” or “Group two Children”. CoverKids includes "Group One Children" who are enrollees who are members of families with incomes between two hundred percent (200%) and two hundred fifty percent (250%) of the federal poverty level (FPL) as reported by the State to the CONTRACTOR for the coverage period; and "Group Two Children" who are enrollees who are members of families below two hundred percent (200%) of FPL as reported by the State to the CONTRACTOR for the coverage period.

A.2.3.3 **TennCare CHOICES and ECF CHOICES Groups**

As specified in Section A.2.6.1.5, in order to receive covered long-term care services, a member must be enrolled by TENNCARE into one of the CHOICES or ECF CHOICES Groups (as defined in Section A.1).

A.2.3.4 **TennCare/CoverKids Applications**

The CONTRACTOR shall not cause applications for TennCare or CoverKids to be submitted. However, as provided in Section A.2.9.6.3, the CONTRACTOR shall facilitate members’ eligibility determination for CHOICES and ECF CHOICES enrollment. The CONTRACTOR shall also conduct outreach and provide assistance as needed to members enrolled in CHOICES and ECF CHOICES in completing an annual renewal packet for eligibility redetermination. In addition, the CONTRACTOR shall be responsible for 1) assisting members who have significant disabilities and/or complex medical needs and who have been determined by TENNCARE to no longer qualify for Medicaid in any other eligibility category in applying for Katie Beckett Part A or qualifying in the Katie Beckett Continued Eligibility Group, as applicable, and in accordance with processes and timelines established by TENNCARE; 2) applying comparable cost of care requirements for children in the Katie Beckett Continued Eligibility Group in accordance with processes established by TENNCARE; and 3) for assisting families of members in the Katie Beckett Continued Eligibility Group plan and prepare for the child’s transition to employment and community living with as much independence as possible upon becoming an adult, and in completing an application for Supplemental Security Income (SSI) when the member turns eighteen (18).

A.2.3.5 **Eligibility Determination and Determination of Cost Sharing**

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

A.2.3.6 **Eligibility for Enrollment in an MCO**

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

A.2.4 ENROLLMENT IN AN MCO

A.2.4.1 **General**

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

A.2.4.2 **Authorized Service Area**

2.4.2.1 Grand Region

Enrollees will be enrolled in MCOs by Grand Region(s) of the state. The specific counties in each Grand Region are listed in Section A.1 of this Contract.

2.4.2.2 CONTRACTOR's Authorized Service Area

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

XEast Grand Region **X**Middle Grand Region **X**West Grand Region

2.4.2.2.1 The CONTRACTOR must serve all Grand Regions in the state.

2.4.2.2.2 If for any reason it is determined by TENNCARE that the CONTRACTOR is not adequately serving one or more authorized Grand Regions, TENNCARE may, pursuant to Sections D.3 and E.14.6 Termination for Convenience or Sections D.4 and E.14.2 Termination for Cause of this Contract, at any time, terminate authorization of any or all of the Grand Regions being served and disenroll the enrollees in the Grand Region from the health plan.

2.4.2.2.3 To the extent possible and practical, TENNCARE shall provide advance notice to all other MCOs of the approved closing, limiting, or re-opening of enrollment of any MCO serving the Grand Region whichever is applicable; however, failure by TENNCARE to provide advance notice shall not limit in any manner the responsibility of each MCO to comply with the terms of this Contract.

2.4.2.2.4 If authorization to serve a specific Grand Region is terminated, regardless of the reason, the CONTRACTOR shall submit a termination plan as specified in Section E.14.8 of this Contract, specific to the Grand Region being terminated.

A.2.4.3 **Maximum Enrollment**

2.4.3.1 The CONTRACTOR agrees to accept enrollment in the CONTRACTOR's MCO of up to fifty percent (50%) of the eligible population in the applicable Grand Region. TENNCARE shall determine and notify the CONTRACTOR of the number of eligibles in the applicable Grand Region and the CONTRACTOR's maximum enrollment limit, which shall be approximately fifty percent (50%) of the eligible population in the applicable Grand Region.

2.4.3.1.1 If TENNCARE determines an MCO (hereafter called an Underperforming MCO), other than the CONTRACTOR, is not adequately serving one or more Grand Regions and determines the CONTRACTOR has adequate capacity and it is necessary to transfer additional enrollment from the Underperforming MCO into the CONTRACTOR's plan, the CONTRACTOR agrees to accept enrollment of up to seventy percent (70%) of the eligible population in the applicable Grand Region.

2.4.3.2 TENNCARE may establish an enrollment threshold for the CONTRACTOR at a percentage of the CONTRACTOR's maximum enrollment limit and may limit enrollee assignment in certain circumstances in order to remain within the threshold. This enrollment threshold may be adjusted by TENNCARE at its discretion.

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

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

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

2.4.3.6 Upon the request of TENNCARE, the CONTRACTOR shall demonstrate to the satisfaction of TENNCARE it has the capacity to serve the number of enrollees in the maximum enrollment limit.

A.2.4.4 **MCO Selection and Assignment**

2.4.4.1 General

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

2.4.4.2 Current TennCare Enrollees

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

2.4.4.3 New TennCare Enrollees

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

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

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

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

2.4.4.4 Children in State Custody

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

2.4.4.4.1 Notwithstanding the enrollment requirements of Section A.2.4.4, children in the custody of DCS enrolled in TennCare Select who transition to ECF CHOICES and exit

State custody shall not remain enrolled in TennCare Select after this transition. In instances in which children transitioning have physicians of a specialty type that are not contracted with the receiving MCO, the CONTRACTOR shall ensure that children transitioning out of State custody and enrolling in the MCO's health plan shall continue to have access to such providers for up to ninety (90) calendar days or until the child may be reasonably transferred without disruption to a contract provider, unless specified otherwise by TENNCARE.

2.4.4.5 Enrollment in MCO Other than the MCO Selected

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

2.4.4.6 Auto Assignment

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

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

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

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

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

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

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

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

2.4.4.6.5 During implementation of this Contract there may be a one-time exception to the auto assignment process described above. If an incumbent MCO (defined herein as an MCO other than TennCare Select that had a contract with the Division of TennCare immediately preceding the start date of operations under this Contract) will provide covered services as of the start date of operations under this Contract in the same Grand Region as the previous contract, current TennCare enrollees who are known to be

members of the incumbent MCO may be assigned by TENNCARE to remain with the incumbent MCO with enrollment effective the start date of operations. Current TennCare enrollees who are not known to be members of an incumbent MCO will be assigned by TENNCARE to an MCO in accordance with the process described in Section A.2.4.4.6. However, TENNCARE will assign current TennCare enrollees to ensure similar levels of enrollment as of the start date of operations for the MCOs serving the Grand Region.

2.4.4.7 Non-Discrimination

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

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

2.4.4.8 Family Unit

If an individual is determined eligible for TennCare and has another family member already enrolled in an MCO, that individual shall be enrolled in the same MCO. This does not apply when the individual or family member is assigned to TennCare Select. If the newly enrolled family member opts to change MCOs during the 90-day change period (see Section A.2.4.7.2.1), all family members in the case will be transferred to the new MCO.

A.2.4.5 **Effective Date of Enrollment**

2.4.5.1 Initial Enrollment of Current TennCare Enrollees

The effective date of initial enrollment in an MCO for TennCare enrollees who are enrolled in accordance with Section A.2.4.4.2 shall be the date provided on the outbound 834 enrollment file from TENNCARE. In general, the effective date of enrollment for these enrollees will be the start date of operations.

2.4.5.2 Ongoing Enrollment

In general, a member's effective date of enrollment in the CONTRACTOR's MCO will be the member's effective date of eligibility for TennCare. For SSI enrollees the effective date of eligibility/enrollment is determined by the Social Security Administration in approving SSI coverage for the individual. The effective date of eligibility for other TennCare enrollees is the date of application or the date of the qualifying event (e.g., the date the spend down obligation is met for medically needy enrollees). The effective date on the outbound 834 enrollment file provided by TENNCARE to the CONTRACTOR shall govern regardless of the other provisions of this Section A.2.4.5.2.

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

the payment of claims incurred by the enrollee during the period of eligibility prior to the start date of operations as specified in Section B.1.

2.4.5.4 Enrollment Prior to Notification

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

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

2.4.5.4.3 TENNCARE shall make payments to the CONTRACTOR from the effective date of an enrollee's date of enrollment/eligibility. If the effective date of enrollment/eligibility precedes the start date of operations, payment shall be made in accordance with Section C.3.

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

A.2.4.6 **Eligibility and Enrollment Data**

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. If the CONTRACTOR has reason to believe they may not meet this requirement based on unusual circumstances, the CONTRACTOR must notify TENNCARE and TENNCARE may make an exception without requiring a Corrective Action Plan.

2.4.6.2 The CONTRACTOR shall provide a daily electronic eligibility file (inbound 834) to TENNCARE as specified and in conformance to data exchange format and method standards outlined in Section A.2.23.5.

A.2.4.7 **Enrollment Period**

2.4.7.1 General

2.4.7.1.1 The CONTRACTOR shall be responsible for the provision and costs of all covered physical health and behavioral health services provided to enrollees during their period

of enrollment with the CONTRACTOR. The CONTRACTOR shall also be responsible for the provision and costs of covered long-term care services provided to CHOICES and ECF CHOICES members.

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

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

2.4.7.2 Changing MCOs

2.4.7.2.1 *90-Day Change Period*

After becoming eligible for TennCare and enrolling in the CONTRACTOR's MCO (whether the result of selection by the enrollee or assignment by TENNCARE), enrollees shall have one (1) opportunity, anytime during the ninety (90) day period immediately following the date of enrollment with the CONTRACTOR's MCO or the date TENNCARE sends the member notice of enrollment in an MCO, whichever is later, to request to change MCOs. Children eligible for TennCare as a result of being eligible for SSI may request to enroll in another MCO or remain with TennCare Select.

2.4.7.2.2 *Annual Choice Period*

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

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

2.4.7.2.2.3 Enrollees who select a new MCO shall have one (1) opportunity anytime during the ninety (90) day period immediately following the specified enrollment effective date in the newly selected MCO to request to change MCOs.

2.4.7.2.3 *Appeal Based on Hardship Criteria*

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

2.4.7.2.4 *Additional Reasons for Disenrollment*

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

2.4.7.3 Member Moving out of Grand Region

The CONTRACTOR shall be responsible for the provision and cost of all covered services for any member moving outside the CONTRACTOR's Grand Region until the member is disenrolled by TENNCARE. TENNCARE shall continue to make payments to the CONTRACTOR on behalf of the enrollee until such time as the

enrollee is enrolled in another MCO or otherwise disenrolled by TENNCARE (e.g., enrollee is terminated from the TennCare program). TENNCARE shall notify the CONTRACTOR promptly upon enrollment of the enrollee in another MCO.

A.2.4.8 **Transfers from Other MCOs**

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

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

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

A.2.4.9 **Enrollment of Newborns**

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

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

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

2.4.9.3.1 Disenroll the newborn from the incorrect MCO;

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

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

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

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

2.4.9.5 There are circumstances in which a newborn's mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborns within the time frames specified in Section A.2.22.4 of this Contract. A CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn, during any period of enrollment in the CONTRACTOR's MCO, because the newborn's mother is not a member of the CONTRACTOR's MCO. However, it is recognized that in complying with the claims processing time frames specified in Section A.2.22.4 of this Contract, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn enrolled in the CONTRACTOR's MCO at the time of payment but the newborn's eligibility may subsequently be moved to another MCO. In such event, the MCO in which the newborn is first enrolled (first MCO) may submit supporting documentation to the MCO in which the newborn is moved (second MCO) and the second MCO shall reimburse the first MCO within thirty (30) calendar days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the newborn prior to the newborn's eligibility having been moved to the second MCO. Such reimbursement shall be the actual amount expended by the first MCO. The second MCO agrees that should the second MCO fail to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second MCO and to reimburse the first MCO. In the event that the CONTRACTOR fails to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE may assess liquidated damages as specified in Section E.29.2. Should it become necessary for TENNCARE to intervene in such cases, both the second MCO and the first MCO agree that TENNCARE shall be held harmless by both MCOs for actions taken by TENNCARE to resolve the dispute.

A.2.4.10 **Information Requirements Upon Enrollment**

As described in Section A.2.17 of this Contract, 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 or ECF CHOICES provider directory. In addition, the CONTRACTOR shall provide CHOICES members with CHOICES member education materials and ECF CHOICES members with ECF CHOICES member education materials (see Section A.2.17.7).

A.2.5 DISENROLLMENT FROM AN MCO

A.2.5.1 **General**

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

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

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

2.5.2.1 The member selects another MCO during the ninety (90) day change period after enrollment with the CONTRACTOR's MCO and is enrolled in another MCO;

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

2.5.2.3 A request by the member to change MCOs based on hardship criteria (pursuant to TennCare rules and regulations) is approved by TENNCARE, and the member is enrolled in another MCO.

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

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

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

2.5.2.7 A CHOICES or ECF CHOICES member may request reassignment and shall have cause to change MCO assignment if all requirements are met in TennCare Rule 1200-13-13-.03(2)(c), or TennCare Rule 1200-13-14-.03(2)(c) as applicable;

2.5.2.8 During the appeal process, if TENNCARE determines it is in the best interest of the enrollee and TENNCARE (see Section A.2.19.3.9);

2.5.2.9 The member loses eligibility for TennCare;

2.5.2.10 TENNCARE grants members the right to terminate enrollment pursuant to Section E.29.1, and the member is enrolled in another MCO;

2.5.2.11 The CONTRACTOR no longer participates in TennCare; or

2.5.2.12 This Contract expires or is terminated.

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

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

2.5.3.1 Adverse changes in the enrollee's health;

2.5.3.2 Pre-existing medical or behavioral health conditions;

2.5.3.3 High cost medical or behavioral health bills;

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

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

2.5.3.6 Enrollee's diminished mental capacity; or

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

A.2.5.4 **Informing TENNCARE of Potential Ineligibility**

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

A.2.5.5 **Effective Date of Disenrollment from an MCO**

2.5.5.1 Member Requested Disenrollment

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

2.5.5.2 Other Disenrollments

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

A.2.6 BENEFITS/SERVICE REQUIREMENTS AND LIMITS

A.2.6.1 **CONTRACTOR Covered Benefits**

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

2.6.1.2 The CONTRACTOR shall integrate the delivery of physical health, behavioral health and long-term care services. This shall include but not be limited to the following:

2.6.1.2.1 The CONTRACTOR shall operate a member services toll-free phone line (see Section A.2.18.1) that is used by all members, regardless of whether they are calling about physical health, behavioral health and/or long-term care services. The CONTRACTOR shall not have a separate number for members to call regarding behavioral health and/or long-term care services. The CONTRACTOR may either route the call to another entity or conduct a "warm transfer" to another entity, but the CONTRACTOR shall not require an enrollee to call a separate number regarding behavioral health and/or long-term care services.

2.6.1.2.2 If the CONTRACTOR's nurse triage/nurse advice line is separate from its member services line, the CONTRACTOR shall comply with the requirements in Section A.2.6.1.2.2 as applied to the nurse triage/nurse advice line. The number for the nurse triage/nurse advice line shall be the same for all members, regardless of whether they are calling about physical health, behavioral health and/or long-term services, and the

CONTRACTOR may either route calls to another entity or conduct "warm transfers," but the CONTRACTOR shall not require an enrollee to call a separate number.

2.6.1.2.3 As required in Section A.2.9.6, the CONTRACTOR shall ensure continuity and coordination among physical health, behavioral health, and long-term services and supports and ensure collaboration among physical health, behavioral health, and long-term services and supports providers. For CHOICES members and ECF CHOICES members, the member's Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, shall ensure continuity and coordination of physical health, behavioral health, and long-term services and supports, and facilitate communication and ensure collaboration among physical health, behavioral health, and long-term services and supports providers.

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

2.6.1.2.5 The CONTRACTOR shall provide the appropriate level of Population Health services (see Section A.2.8.4 of this Contract) to non-CHOICES and non-ECF 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 A.2.9.6.1.9 of this Contract, the CONTRACTOR shall ensure that upon enrollment into CHOICES or ECF CHOICES, the appropriate level of Population Health activities are integrated with CHOICES care coordination or ECF CHOICES support coordination processes and functions, and that the member's assigned Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, has primary responsibility for coordination of all the member's physical health, behavioral health and long-term services and supports needs. The member's Care Coordinator or Support 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 or Support Coordinator/support coordination team. The CONTRACTOR shall report on its Population Health activities per requirements in Section A.2.30.5.

2.6.1.2.6 If the CONTRACTOR uses different Systems for physical health services, behavioral health and/or long-term care services, these systems shall be interoperable. In addition, the CONTRACTOR shall have the capability to integrate data from the different systems.

2.6.1.2.7 The CONTRACTOR's administrator/project director (see Section A.2.29.1.3.1) shall be the primary contact for TENNCARE regarding all issues, regardless of the type of service, and shall not direct TENNCARE to other entities. The CONTRACTOR's administrator/project director shall coordinate with the CONTRACTOR's Behavioral Health Director who oversees behavioral health activities (see Section A.2.29.1.3.5 of this Contract) for all behavioral health issues and the senior executive responsible for CHOICES activities (see Sections A.2.29.1.3.7 of this Contract) for all issues pertaining to the CHOICES and ECF CHOICES programs.

2.6.1.3 CONTRACTOR Physical Health Benefits Chart for TennCare Members (Excluding CoverKids)

SERVICE		BENEFIT LIMIT
Inpatient Hospital Services		**Medicaid/Standard Eligible, Age 21 and older:** As medically necessary. Inpatient rehabilitation hospital facility services are not covered for adults unless determined by the CONTRACTOR to be a cost effective alternative (see Section A.2.6.5). **Medicaid/Standard Eligible, Under age 21:** As medically necessary, including rehabilitation hospital facility.
Outpatient Hospital Services		As medically necessary.
Physician Inpatient Services		As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services		As medically necessary.
TennCare Kids Services		**Medicaid/Standard Eligible, Age 21 and older:** Not covered. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. See Section A.2.7.6.
Preventive Care Services		As described in Section A.2.7.5.
Lab and X-ray Services		As medically necessary.
Hospice Care		As medically necessary. Shall be provided by a Medicare-certified hospice.

SERVICE		BENEFIT LIMIT
Dental Services		**Dental Services shall be provided by the Dental Benefits Manager or in some cases, through an HCBS waiver program for persons with intellectual disabilities.** However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM or though an HCBS waiver program for persons with intellectual disabilities.
Vision Services		**Medicaid/Standard Eligible, Age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery. **Medicaid/Standard Eligible, Under age 21:** Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements.
Home Health Care		**Medicaid /Standard Eligible, Age 21 and older:** Covered as medically necessary and in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).

SERVICE		BENEFIT LIMIT
Pharmacy Services		**Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.** The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid. Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section A.2.6.2.2).
Durable Medical Equipment (DME)		As medically necessary. Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations.
Medical Supplies		As medically necessary. Specified medical supplies shall be covered/non-covered in accordance with TennCare rules and regulations.
Emergency Air And Ground Ambulance Transportation		As medically necessary.
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)		Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XI). Non emergency transportation services shall be provided in accordance with federal law and the Division of TennCare's rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XI) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section A.1 of the Contract). If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an escort.

SERVICE		BENEFIT LIMIT
		Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18). The CONTRACTOR is not responsible for providing NEMT to HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities and HCBS provided through the CHOICES program. However, as specified in Section A.2.11.1.8 in the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III), the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity. The CONTRACTOR shall be responsible for providing NEMT to dental services for ECF CHOICES members, including medical and dental services related to such dental services. Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XI) is not a covered NEMT service, unless otherwise allowed or required by TENNCARE as a pilot project or a cost effective alternative service. If the member is a child, transportation shall be provided in accordance with TennCare Kids requirements (see Section A.2.7.6.4.6). Failure to comply with the provisions of this Section may result in liquidated damages.
Renal Dialysis Services		As medically necessary.

SERVICE		BENEFIT LIMIT
Private Duty Nursing		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard), when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Private duty nursing services are limited to services that support the use of ventilator equipment or other life sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Prior authorization required, as described Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and 1200-13-14-.01 (for TennCare Standard) when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative. Prior authorization required as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).
Speech Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements.
Occupational Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements.

SERVICE		BENEFIT LIMIT
Physical Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements.
Organ and Tissue Transplant And Donor Organ Procurement		**Medicaid/Standard Eligible, Age 21 and older:** All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements. Experimental or investigational transplants are not covered.
Reconstructive Breast Surgery		Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast shall only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Chiropractic Services		**Medicaid/Standard Eligible, Age 21 and older:** Not covered unless determined by the CONTRACTOR to be a cost effective alternative (see Section A.2.6.5). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements.

2.6.1.4 CONTRACTOR Behavioral Health Benefits Chart

SERVICE		BENEFIT LIMIT
Psychiatric Inpatient Hospital Services (including physician services)		As medically necessary.
24-hour Psychiatric Residential Treatment		**Medicaid/Standard Eligible, Age 21 and older:** As medically necessary. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Outpatient Mental Health Services (including physician services)		As medically necessary.
Inpatient, Residential & Outpatient Substance Abuse Benefits[1]		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Behavioral Health Intensive Community Based Treatment		As medically necessary.
Psychiatric-Rehabilitation Services		As medically necessary.
Behavioral Health Crisis Services		As necessary.
Lab and X-ray Services		As medically necessary.
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)		Same as for physical health (see Section A.2.6.1.3 above).

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

2.6.1.4.1 The CMS Managed Care Rules specify that an MCO may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K. In accordance with this requirement, this Contract identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by TENNCARE.

2.6.1.4.1.1 In accordance with 42 CFR 438.905(a), the CONTRACTOR must comply with 42 CFR Subpart K—Parity in Mental Health and Substance Use Disorder Benefits requirements for all enrollees of a MCO in states that cover both medical/surgical benefits and mental health or substance use disorder benefits under the state plan.

2.6.1.4.1.2 TENNCARE does not impose an annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to medical/surgical benefits provided to enrollees through a contract with the state, therefore, the CONTRACTOR shall not impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits, in accordance with 42 CFR 438.905(b), 42 CFR 438.905(c), and 42 CFR 438.905(e).

2.6.1.4.1.3 In accordance with 42 CFR 438.910(b)(1), the CONTRACTOR shall not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees (whether or not the benefits are furnished by the same managed care contractor).

2.6.1.4.1.4 In accordance with 42 CFR 438.910(b)(2) and as specified in the benefit charts of Section A.2.6.1.3 and A.2.6.1.4, if an enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the MCO enrollee in every classification in which medical/surgical benefits are provided.

2.6.1.4.1.5 In accordance with 42 CFR 438.910(c)(3), the CONTRATOR shall not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

2.6.1.5 <u>Long-Term Care Benefits for CHOICES Members</u>

2.6.1.5.1 In addition to physical health benefits (see Section A.2.6.1.3) and behavioral health benefits (see Section A.2.6.1.4), the CONTRACTOR shall provide long-term care services (including CHOICES HCBS and nursing facility care) as described in this Section A.2.6.1.5 to members who have been enrolled into CHOICES by TENNCARE, as shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

2.6.1.5.2 TennCare enrollees will be enrolled by TENNCARE into CHOICES if the following conditions, at a minimum, are met:

2.6.1.5.2.1 TENNCARE or its designee determines the enrollee meets the categorical and financial eligibility criteria for Group 1, 2 or 3;

2.6.1.5.2.2 For Groups 1 and 2, TENNCARE determines that the enrollee meets nursing facility level of care including for Group 2, that the enrollee needs ongoing CHOICES HCBS in order to live safely in the home or community setting and to delay or prevent nursing facility placement;

2.6.1.5.2.3 For Group 2, the CONTRACTOR or, for new TennCare applicants, TENNCARE or its designee, determines that the enrollee's combined CHOICES HCBS, private duty nursing and home health care can be safely provided at a cost less than the cost of nursing facility care for the member;

2.6.1.5.2.4 For Group 3, TENNCARE determines that the enrollee meets the at-risk level of care; and

2.6.1.5.2.5 For Groups 2 and 3, but excluding Interim Group 3, if there is an enrollment target, TENNCARE determines that the enrollment target has not been met or, for Group 2, approves the CONTRACTOR's request to provide CHOICES HCBS as a cost effective alternative (see Section A.2.6.5). Enrollees transitioning from a nursing facility to the community will not be subject to the enrollment target for Group 2 but must meet categorical and financial eligibility for Group 2.

2.6.1.5.3 The following long-term care services are available to CHOICES members, per Group, when the services have been determined medically necessary by the CONTRACTOR.

Service and Benefit Limit	**Group 1**	**Group 2**	**Group 3**
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives		X	(Specified CBRA services and levels of reimbursement only. See below)[1]
Personal care visits (up to 2 visits per day at intervals of no less than 4 hours between visits)		X	X
Attendant care (up to 1080 hours per calendar year; up to 1400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks)		X	X
Home-delivered meals (up to 1 meal per day)		X	X

[1] CBRAs for which Group 3 members are eligible include only: Assisted Care Living Facility services, Community Living Supports 1 (CLS1), and Community Living Supports-Family Model 1 (CLS-FM1)

Service and Benefit Limit	Group 1	Group 2	Group 3
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to $900 per calendar year)		X	X
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

2.6.1.5.3.1 The CONTRACTOR shall review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF stays for Group 2 and Group 3 members only when (1) the member is enrolled in CHOICES Group 2 or 3, as applicable, and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 and Group 3 members and shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members.

2.6.1.5.3.1.1 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 visits shall not be consecutive. Further, 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.

2.6.1.5.3.1.2 The CONTRACTOR shall monitor, on an ongoing basis, members utilizing the short-term NF benefit, and shall submit to TENNCARE on a monthly basis a member-by-member status for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why

the benefit limit has been exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community or transition to Group 1, as applicable, including the anticipated timeline.

2.6.1.5.4 In addition to the benefit limits described above, in no case shall the CONTRACTOR exceed the member's individual cost neutrality cap (as defined in Section A.1 of this Contract) for CHOICES Group 2 or the expenditure cap for Group 3.

2.6.1.5.4.1 For CHOICES members in Group 2, the services that shall be compared against the member's individual cost neutrality cap include the total cost of CHOICES HCBS and Medicaid reimbursed home health care and private duty nursing. 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 pursuant to Section A.2.6.5.2 of this Contract including, as applicable: CHOICES HCBS in excess of specified CHOICES benefit limits, the one-time transition allowance for Group 2 and NEMT for Groups 2 and 3.

2.6.1.5.4.2 For CHOICES members in Group 3, the total cost of CHOICES HCBS, excluding minor home modifications, shall not exceed the expenditure cap (as defined in Section A.1 of this Contract).

2.6.1.5.5 CHOICES members may, pursuant to Section A.2.9.7, choose to participate in consumer direction of eligible CHOICES HCBS and, at a minimum, hire, fire and supervise workers of eligible CHOICES HCBS.

2.6.1.5.6 The CONTRACTOR shall, on an ongoing basis, monitor CHOICES members' receipt and utilization of long-term care services and identify CHOICES members who are not receiving long-term care services. Pursuant to Section A.2.30.11.4, the CONTRACTOR shall, on a monthly basis, notify TENNCARE regarding members that have not received long-term care services for a thirty (30) day period of time. The CONTRACTOR shall be responsible for immediately initiating disenrollment of any member who is not receiving TennCare-reimbursed long-term care services and is not expected to resume receiving long-term care services within the next thirty (30) days, except under extenuating circumstances which must be reported to TennCare on the CHOICES Utilization Report. Acceptable circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. Such notification and/or disenrollment shall be based not only on receipt and/or payment of claims for long-term care services, but also upon review and investigation by the CONTRACTOR as needed to determine whether the member has received long-term care services, regardless of whether claims for such services have been submitted or paid.

2.6.1.5.7 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term care services to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:

2.6.1.5.7.1 A member in Group 2 for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member' cost neutrality cap, and the member declines to transition to a nursing facility;

2.6.1.5.7.2 A member in Group 2 or 3 who repeatedly refuses to allow a Care Coordinator entrance into his/her place of residence (Section A.2.9.6);

2.6.1.5.7.3 A member in Group 2 or 3 who refuses to receive critical HCBS as identified through a comprehensive assessment and documented in the member's PCSP; and

2.6.1.5.7.4 A member in Group 1 who fails to pay his/her patient liability and the CONTRACTOR is unable to find a nursing facility willing to provide services to the member (Section A.2.6.7.2).

2.6.1.5.7.5 A member in Group 2 or 3 who refuses to pay his/her patient liability and for whom the CONTRACTOR is either: 1) in the case of persons receiving CBRA services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the CONTRACTOR is unwilling to continue to serve the member, and the Division of TennCare has determined that no other MCO is willing to serve the member.

2.6.1.5.7.6 The CONTRACTOR's request to no longer provide long-term care services to a member shall include documentation regarding specific reason for which disenrollment is requested (for example, documentation of repeated attempts to visit a member or repeated refusal of services, including dates, times, and reasons given, as applicable) and other documentation to support the request as specified by TENNCARE. It must be evident from the documentation that the CONTRACTOR has made diligent and repeated attempts to address the issue and maintain continuity of the member's enrollment and services. The State shall make any and all determinations regarding whether the CONTRACTOR may discontinue providing long-term care services to a member, disenrollment from CHOICES, and, as applicable, termination from TENNCARE.

2.6.1.5.8 The CONTRACTOR may submit to TENNCARE a request to disenroll from CHOICES a member who is not receiving any Medicaid-reimbursed LTC services based on the CONTRACTOR's inability to reach the member only when the CONTRACTOR has exhausted all reasonable efforts to contact the member, and has documented such efforts in writing, which must be submitted with the disenrollment request. Efforts to contact the member shall include, at a minimum:

2.6.1.5.8.1 Multiple attempts to contact the member, his/her representative or designee (as applicable) by phone. Such attempts must occur over a period of at least two (2) weeks and at different times of the day and evening, including after business hours. The CONTRACTOR shall attempt to contact the member at the phone number provided in the outbound 834 enrollment file, any additional phone numbers the CONTRACTOR has on file, including referral records and case management notes; and phone numbers that may be provided in TENNCARE's PAE Tracking System. The CONTRACTOR shall also contact the member's Primary Care Provider and any contracted LTSS providers that have delivered services to the member during the previous six (6) months in order to obtain contact information that can be used to reach the member;

2.6.1.5.8.2 At least one (1) visit to the member's most recently reported place of residence except in circumstances where significant safety concerns prevent the CONTRACTOR from completing the visit, which shall be documented in writing; and

2.6.1.5.8.3 An attempt to contact the member by mail at the member's most recently reported place of residence at least two (2) weeks prior to the request to disenroll.

2.6.1.6 Long-Term Services and Supports Benefits for ECF CHOICES Members

2.6.1.6.1 In addition to physical health benefits (see Section A.2.6.1.3) and behavioral health benefits (see Section A.2.6.1.4), the CONTRACTOR shall provide long-term services and supports as described in this Section A.2.6.1.6 to members who have been enrolled into ECF CHOICES by TENNCARE, as shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

2.6.1.6.2 TennCare enrollees will be enrolled by TENNCARE into ECF CHOICES in accordance with criteria set forth in the approved 1115 waiver and TennCare rule.

2.6.1.6.3 The following long-term services and supports are available to ECF CHOICES members, per Group and subject to all applicable service definitions, benefit limits, and Expenditure Caps, when the services have been determined medically necessary by the CONTRACTOR.

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
Respite (up to 30 days per calendar year **or** up to 216 hours per calendar year only for persons living with unpaid family caregivers)	X	X	X		
Supportive home care (SHC)	X				
Family caregiver stipend in lieu of SHC (up to $500 per month for children under age 18; up to $1,000 per month for adults age 18 and older)	X				
Community integration support services (subject to limitations specified in the approved 1115 waiver and TennCare Rule)	X	X	X	X	
Community transportation	X	X	X	X	
Independent living skills training (subject to limitations specified in the approved 1115 waiver and TennCare Rule)	X	X	X	X	
Assistive technology, adaptive equipment and supplies (up to $5,000 per calendar year)	X	X	X	X	X
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)	X	X	X	X	X
Community support development, organization and navigation	X			X	
Family caregiver education and training (up to $500 per calendar year)	X			X	

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
Family-to-family support	X			X	
Decision-making supports (up to $500 per lifetime)	X	X	X	X	X
Health insurance counseling/forms assistance (up to 15 hours per calendar year)	X			X	
Personal assistance (up to 215 hours per month)		X	X		
Community living supports (CLS)		X	X		
Community living supports—family model (CLS-FM)		X	X		
Individual education and training (up to $500 per calendar year)		X	X		X
Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living (up to $1,500 per lifetime)		X	X		X
Specialized consultation and training (up to $5,000 per calendar year[1])		X	X		X
Adult dental services (up to $5,000 per calendar year; up to $7,500 across three consecutive calendar years)	X[2]	X	X		X
Employment services/supports as specified below (subject to limitations specified in the approved 1115 waiver and in TennCare Rule)	X	X	X	X	X
– Supported employment—individual employment support – Exploration – Benefits counseling – Discovery – Situational observation and assessment – Job development plan or self-employment plan – Job development or self-employment start up – Job coaching for individualized, integrated employment or self-employment – Co-worker supports	X	X	X	X	X

[1] For adults in the Group 6 benefit group determined to have exceptional medical and/or behavioral support needs, and for adults in Group 8, specialized consultation services are limited to $10,000 per person per calendar year.
[2] Limited to adults age 21 and older.

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
– Career advancement					
Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS)				X	
Intensive Behavioral Community Transition and Stabilization Services					X

2.6.1.6.4 In addition to the benefits specified above which shall be delivered in accordance with the definitions, including limitations set forth in the approved 1115 waiver and in TennCare rule, a person enrolled in ECF CHOICES Groups 4, 5, and 6 may receive short-term nursing facility care, without being required to disenroll from their ECF CHOICES group until such time that it is determined that transition back to HCBS in ECF CHOICES will not occur within ninety (90) days from admission. A person enrolled in ECF CHOICES Groups 7 and 8 shall not be eligible to receive short-term nursing facility care.

2.6.1.6.5 The CONTRACTOR shall review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF stays for Groups, 4, 5 and 6 members only when (1) the member is enrolled in ECF CHOICES Group 4, 5, or 6 and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 4, 5, and 6 members and shall ensure that the member is disenrolled from ECF CHOICES if a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for ECF CHOICES Group 4, 5, and 6. A person enrolled in ECF CHOICES Groups 7 or 8 is not eligible for a short-term NF stay and must be disenrolled from ECF CHOICES in order to receive Medicaid-reimbursed NF services.

2.6.1.6.6 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 visits shall not be consecutive. Further, 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 ECF CHOICES Group 4, 5 or 6 (as applicable) is appropriate.

2.6.1.6.7 The CONTRACTOR shall monitor, on an ongoing basis, members utilizing the short-term NF benefit, and shall submit to TENNCARE on a monthly basis a member-by-member status for each Group 4, 5, or 6 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 4, 5, or 6 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why the benefit limit has been

exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community including the anticipated timeline.

2.6.1.6.8 The cost of such services shall not be counted toward the person's expenditure cap. During the short-term stay, the person's patient liability amount will continue to be calculated based on the community personal needs allowance in order to allow the person to maintain his/her community residence. Additional tracking, reporting and monitoring processes will be put in place for these services.

2.6.1.6.9 ECF CHOICES benefits will be subject to an annual per member expenditure cap. Specifically:

2.6.1.6.9.1 Individuals receiving Group 4 benefits will be subject to a $15,000 cap, not counting the cost of minor home modifications;

2.6.1.6.9.2 Individuals receiving Group 5 benefits will be subject to a $30,000 cap. The State may grant an exception for emergency needs up to $6,000 in additional services per year, but shall not permit expenditures to exceed a hard cap of $36,000 per calendar year, except that, for purposes of compliance with the federal HCBS Settings Rule, a member receiving Community Living Supports may be permitted to exceed the cap when necessary to permit access to Supported Employment and/or Individual Employment Support benefits.

2.6.1.6.9.2.1 The exception applies only to newly requested Individual Employment Support benefits; previously approved Individual Employment Support benefits that have been provided within a member's Expenditure Cap shall not be shifted above the Expenditure Cap by adding other HCBS which are not eligible for this exception.

2.6.1.6.9.2.2 For a Group 5 member requiring a Community Stabilization and Transition rate of reimbursement for Community Living Supports (CLS), the higher cost of transitional CLS shall be excluded from the Group 5 member's Expenditure Cap for the year in which the transitional CLS are required, when a member is expected to be safely and appropriately served within the Group 5 Expenditure Cap, once transition to the appropriate ongoing CLS level occurs and the transitional rate ends.

2.6.1.6.9.3 Individuals receiving Group 6 benefits will be subject to an annual expenditure cap as follows:

2.6.1.6.9.3.1 Individuals in Group 6 with low need as determined by the State shall be subject to a $45,000 expenditure cap. The State may, on a case-by-case basis, grant an exception for emergency or one-time (including transitional CLS) needs up to seven thousand five hundred dollars ($7,500) per calendar year. Except as provided below, the CONTRACTOR shall not permit HCBS expenditures to exceed a hard cap of $52,500 per calendar year.

2.6.1.6.9.3.2 Individuals in Group 6 with moderate need as determined by the State shall be subject to a $67,500 expenditure cap. The State may, on a case-by-case basis, grant an exception for emergency or one-time (including transitional CLS) needs up to seven thousand five hundred dollars ($7,500) per calendar year. Except as provided below, the CONTRACTOR shall not permit HCBS expenditures to exceed a hard cap of $75,000 per calendar year.

2.6.1.6.9.3.2.1 Any exception for emergency or one-time needs that may be granted shall apply only for the calendar year in which the exception is approved.

2.6.1.6.9.3.2.2 For purposes of compliance with the federal HCBS Settings Rule, a member receiving Community Living Supports may be permitted to exceed the $75,000 hard cap when necessary to permit access to Supported Employment and/or Individual Employment Support benefits.

2.6.1.6.9.3.2.3 This exception shall apply *only* to newly requested Individual Employment Support benefits. Previously approved Individual Employment Support benefits that have been provided within a member's Expenditure Cap shall not be shifted above the Expenditure Cap by adding other HCBS which are not eligible for this exception.

2.6.1.6.9.3.3 Individuals with high need as determined by the State shall be subject to a $88,250 expenditure cap. The State may, on a case-by-case basis, grant an exception for emergency or one-time (including transitional CLS) needs up to seven thousand five hundred dollars ($7,500) per calendar year. Except as provided below, the CONTRACTOR shall not permit HCBS expenditures to exceed a hard cap of $95,750 per calendar year.

2.6.1.6.9.3.4 The State may grant an exception as follows: for individuals with DD and exceptional medical/behavioral needs as determined by the State, up to the average cost of NF plus specialized services that would be needed for persons with such needs determined appropriate for NF placement; or for individuals with ID and exceptional medical/behavioral needs as determined by the State, up to the average cost of private ICF/IID services.

2.6.1.6.9.3.4.1 No exceptions to the Expenditure Cap shall be permitted for individuals with exceptional medical/behavioral needs as determined by the State. When a member's Expenditure Cap is based on the comparable cost of institutional care (an individual cost neutrality cap), the member's Expenditure Cap shall not be exceeded.

2.6.1.6.9.4 Individuals receiving Group 7 benefits shall be subject to an expenditure cap based on the comparable cost of institutional care as determined by TENNCARE.

2.6.1.6.9.4.1 Any home health or PDN services the member receives shall be counted against the expenditure cap.

2.6.1.6.9.4.2 While integrated in the delivery system, behavioral health services (other than IBFCTSS) shall not be counted against the expenditure cap.

2.6.1.6.9.4.3 No exceptions to the expenditure cap shall be permitted for individuals in ECF CHOICES Group 7.

2.6.1.6.9.5 Individuals receiving Group 8 benefits shall be subject to an expenditure cap based on the comparable cost of institutional care, as determined by TENNCARE, which may as determined appropriate, take into account the cost of short-term inpatient psychiatric hospitalization or other restrictive treatment setting for which the CONTRACTOR would otherwise be responsible for payment.

2.6.1.6.9.5.1 Any home health or PDN services the member receives shall be counted against the expenditure cap.

2.6.1.6.9.5.2 While integrated in the delivery system, behavioral health services (other than IBCTSS) will not be counted against the expenditure cap.

2.6.1.6.9.5.3 No exceptions to the expenditure cap shall be permitted for individuals in ECF CHOICES Group 8

2.6.1.6.10 ECF CHOICES members may, pursuant to Section A.2.9.7, choose to participate in consumer direction of eligible ECF CHOICES HCBS and, at a minimum, hire, fire and supervise workers of eligible ECF CHOICES HCBS.

2.6.1.6.11 The CONTRACTOR shall, on an ongoing basis, monitor ECF CHOICES members' receipt and utilization of long-term services and supports and identify ECF CHOICES members who are not receiving long-term services and supports. Pursuant to Section A.2.30.11.4, the CONTRACTOR shall, on a monthly basis, notify TENNCARE regarding members that have not received long-term services and supports for a thirty (30) day period of time. The CONTRACTOR shall be responsible for immediately initiating disenrollment of any member who is not receiving TennCare-reimbursed long-term services and supports and is not expected to resume receiving long-term services and supports within the next thirty (30) days, except under extenuating circumstances which must be reported to TennCare on the CHOICES and ECF CHOICES Utilization Report. Acceptable circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. Such notification and/or disenrollment shall be based not only on receipt and/or payment of claims for long-term services and supports, but also upon review and investigation by the CONTRACTOR as needed to determine whether the member has received long-term services and supports, regardless of whether claims for such services have been submitted or paid.

2.6.1.6.12 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term services and supports to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:

2.6.1.6.12.1 A member in any ECF CHOICES Group for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member' expenditure cap when the member is unable or unwilling to transition to a different ECF CHOICES Group in which the member's needs could be safely and effectively met within the expenditure cap that would be applied in that Group;

2.6.1.6.12.2 A member in any ECF CHOICES Group who repeatedly refuses to allow a Support Coordinator entrance into his/her place of residence (Section A.2.9.6);

2.6.1.6.12.3 A member in any ECF CHOICES Group who refuses to receive critical HCBS as identified through a comprehensive assessment and documented in the member's PCSP; and

2.6.1.6.12.4 A member in any ECF CHOICES Group who refuses to pay his/her patient liability and for whom the CONTRACTOR is either: 1) in the case of persons receiving CBRA services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the CONTRACTOR is unwilling to continue to serve the member, and the Division of TennCare has determined that no other MCO is willing to serve the member.

2.6.1.6.13 The CONTRACTOR's request to no longer provide long-term services and supports to a member shall include documentation as specified by TENNCARE. The State shall make any and all determinations regarding whether the CONTRACTOR may discontinue providing long-term services and supports to a member, disenrollment from ECF CHOICES, and, as applicable, termination from TennCare.

2.6.1.6.14 The CONTRACTOR may submit to TENNCARE a request to disenroll from ECF CHOICES a member who is not receiving any Medicaid-reimbursed long-term services and supports based on the CONTRACTOR's inability to reach the member only when the CONTRACTOR has exhausted all reasonable efforts to contact the member, and has documented such efforts in writing, which must be submitted with the disenrollment request. Efforts to contact the member shall include, at a minimum:

2.6.1.6.14.1 Multiple attempts to contact the member, his/her representative or designee (as applicable) by phone. Such attempts must occur over a period of at least two (2) weeks and at different times of the day and evening, including after business hours. The CONTRACTOR shall attempt to contact the member at the phone number provided in the outbound 834 enrollment file, any additional phone numbers the CONTRACTOR has on file, including referral records and case management or support coordination notes; and phone numbers that may be provided in TENNCARE's PAE Tracking System. The CONTRACTOR shall also contact the member's Primary Care Provider and any contracted providers of long-term services and supports that have delivered services to the member during the previous six (6) months in order to obtain contact information that can be used to reach the member;

2.6.1.6.14.2 At least one (1) visit to the member's most recently reported place of residence except in circumstances where significant safety concerns prevent the CONTRACTOR from completing the visit, which shall be documented in writing; and

2.6.1.6.14.3 An attempt to contact the member by mail at the member's most recently reported place of residence at least two (2) weeks prior to the request to disenroll.

2.6.1.7 CoverKids Benefits (Effective January 1, 2021)

SERVICE		BENEFIT LIMIT
Ambulance Services, Air and Ground		As medically necessary.
Chiropractic care		**Children Under Age 19:** Maintenance visits not covered when no additional progress is apparent or expected to occur. **Mothers (Age 19 and over) of Eligible Unborn Children:** Not Covered
Clinic Services and other Ambulatory Health Care Services		As medically necessary
Dental Services		**Dental Services shall be provided by the Dental Benefits Manager** However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM
Disposable Medical Supplies		As medically necessary. Specified medical supplies shall be covered/non-covered in accordance with TennCare Division rules and regulations.
Durable Medical Equipment (DME)		Must be medically necessary. Durable medical equipment and other medically-related or remedial devices: Limited to the most basic equipment that will provide the needed care. Hearing aids are limited to one per ear per calendar year up to age 5, and limited to one per ear every two years thereafter. Specified DME services shall be covered/non-covered in accordance with TennCare Division rules and regulations.
Home Health Services		Prior approval required. Limited to 125 visits per enrollee per calendar year.
Hospice Care		As medically necessary. Shall be provided by a Medicare-certified hospice.
Inpatient Hospital Services		As medically necessary, including rehabilitation hospital facility.
Inpatient Mental Health and Substance Abuse Services		As medically necessary.
Lab and X-ray Services		As medically necessary.

SERVICE		BENEFIT LIMIT
Outpatient Mental Health and Substance Abuse Services		As medically necessary.
Outpatient Hospital Services		As medically necessary.
Pharmacy Services		**Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.** The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid. Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section A.2.6.2.2).
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.		Limited to 52 visits per calendar year per type of therapy.
Physician Inpatient Services		As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services		As medically necessary.
Prenatal care and pre-pregnancy family services and supplies		As medically necessary.
Preventive Care Services		As described in Section A.2.7.5.
Skilled Nursing Facility services		Limited to 100 days per calendar year following an approved hospitalization.
Surgical Services		As medically necessary.

SERVICE		BENEFIT LIMIT
Vision Services		**Children Under Age 19:** 1. Annual vision exam including refractive exam and glaucoma screening. 2. Prescription eyeglass lenses. Limited to one pair per calendar year. $85 maximum benefit per pair. 3. Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. $100 maximum benefit per pair. 4. Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. $150 maximum benefit per pair. **Mothers (Age 19 and over) of Eligible Unborn Children:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.

A.2.6.2 **TennCare Benefits Provided by TENNCARE**

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

2.6.2.1 Dental Services

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

2.6.2.2 Pharmacy Services

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

2.6.2.3 ICF/IID Services and Alternatives to ICF/IID Services

For qualified enrollees in accordance with TennCare policies and/or TennCare rules and regulations, TENNCARE covers the costs of long-term care institutional services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or alternative to an ICF/IID provided through a Home and Community Based Services (HCBS) waiver for persons with intellectual disabilities. The CONTRACTOR shall be responsible for providing HCBS to members with an intellectual or developmental

disability who are enrolled in ECF CHOICES, as an alternative to services in a Nursing Facility.

A.2.6.3 **Medical Necessity Determination**

2.6.3.1 The CONTRACTOR may place appropriate limits on a covered benefit. In accordance with the TennCare medical necessity rule, the CONTRACTOR may establish procedures for the determination of medical necessity and for the use of medically appropriate cost effective alternative benefits. The CONTRACTOR may also limit benefits for the purpose of utilization control in accordance with NCQA standards, as long as (1) the furnished benefits can reasonably achieve the purpose for which they are furnished, and as long as (2) the benefits furnished for enrollees with chronic conditions (or who require LTSS) are authorized in a manner that reflects the enrollee's ongoing need for such benefits. See 42 C.F.R. §438.3(e)(2) and 42 C.F.R. §438.210(a)(4). Additionally, the CONTRACTOR shall include in its review of medical necessity for CHOICES or ECF CHOICES HCBS and HCBS-related services, including Durable Medical Equipment, for individuals receiving HCBS in CHOICES, ECF CHOICES, or a Section 1915(c) HCBS Waiver, whether the HCBS or related service provide an opportunity for the member receiving long-term services and supports to have access to the benefits of community living, achieve person-centered goals, be free of undue restraint, and live and work in the setting of their choice as prescribed in TennCare policy.

2.6.3.2 The CONTRACTOR shall use written criteria based on sound clinical evidence to make utilization decisions. The written criteria shall specify procedures for appropriately applying the criteria. The criteria must satisfy NCQA standards. The CONTRACTOR shall apply objective and evidence-based criteria and take individual circumstances and the local delivery into account when determining the medical appropriateness of health care services.

2.6.3.3 The CONTRACTOR shall ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. The CONTRACTOR shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

2.6.3.4 The CONTRACTOR may deny benefits which are excluded under TennCare rule and may premise such denial on the applicable exclusion rule.

2.6.3.5 Prior to any reduction of home health or private duty nursing services prescribed by a treating physician for a chronic condition, the CONTRACTOR shall review nursing and aide care notes and the results of face-to-face assessments, including care coordination or case management visits conducted by the CONTRACTOR. The CONTRACTOR shall provide such documentation which supports the CONTRACTOR's medical necessity determination to TENNCARE upon request, including in response to any Appeal that may be filed regarding such action..

A.2.6.4 **Second Opinions**

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

A.2.6.5 **Use of Cost Effective Alternative Services**

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

2.6.5.2 For CHOICES and ECF CHOICES members, the CONTRACTOR may choose to provide the following as a cost effective alternative to other covered services:

2.6.5.2.1 CHOICES HCBS to CHOICES or ECF CHOICES members who would otherwise receive nursing facility care. If a member meets categorical and financial eligibility requirements for enrollment in Group 2 or ECF CHOICES and also meets the nursing facility level of care, as determined by TENNCARE, and would otherwise remain in or be admitted to a nursing facility (as determined by the CONTRACTOR and demonstrated to the satisfaction of TENNCARE), the CONTRACTOR may, at its discretion and upon TENNCARE written prior approval, offer that member CHOICES HCBS or ECF CHOICES HCBS, as appropriate, as a cost effective alternative to nursing facility care (see Section A.2.9.6.3.20). In this instance, TENNCARE will enroll the member receiving CHOICES HCBS or ECF CHOICES as a cost effective alternative to nursing facility services in Group 2 or in the appropriate ECF CHOICES Group, notwithstanding any enrollment target for the group that has been reached.

2.6.5.2.2 HCBS to CHOICES members in Group 2 in excess of the benefit limits described in Section A.2.6.1.5.3 and ECF CHOICES HCBS in excess of the benefit limits described in Section A.2.6.1.6 for ECF CHOICES members who meet the nursing facility level of care as a cost effective alternative to nursing facility care or covered home health services.

2.6.5.2.3 CHOICES HCBS to CHOICES members in Group 3 in excess of the benefit limits described in Section A.2.6.1.5.3 and ECF CHOICES to ECF CHOICES members in excess of the benefit limits described in Section to A.2.6.1.6 for ECF CHOICES members who do not meet the nursing facility level of care as a cost effective alternative to covered home health services. For members in Group 3 and members in ECF CHOICES who do not meet nursing facility level of care CHOICES HCBS in excess of benefit limits specified in Section A.2.6.1.5.3 and ECF CHOICES in excess of benefit limits specified in Section A.2.6.1.6 may not be offered as a cost effective alternative to nursing facility care.

2.6.5.2.4 Non-covered HCBS to CHOICES members in Group 2 and ECF CHOICES members who meet the nursing facility level of care not otherwise specified in this Contract or in applicable TennCare policies and procedures, upon written prior approval from TENNCARE.

2.6.5.2.5 For CHOICES Group 1 members transitioning from a nursing facility to Group 2 or Group 3 or ECF CHOICES, a one-time transition allowance, per member. The amount of the transition allowance shall not exceed two thousand dollars ($2,000). The allowance may be used for rent and/or utility deposits (rental security deposits required to obtain a lease—e.g., first and last month's rent—may be covered even if not refundable; ongoing rent may not), essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes. In provider-owned settings (including settings which the provider owns, co-owns, has any ownership interest in, or has any affiliation with the entity that owns the home in which the member will reside), the transition allowance shall only be used for household items and furnishings that are for the member's personal use, such as bedroom furniture, towels, linens, sheets, and other similar items as approved by TENNCARE. A transition allowance shall not be used for rent or for household items and furnishings for common use of all persons residing in the home. Regardless of setting, items purchased as part of the Transition Allowance shall be the personal property of the member, not the provider. When the CONTRACTOR elects to provide a Transition Allowance to a member transitioning to CHOICES Group 3 or ECF CHOICES, the amount of the Transition Allowance shall be applied to the member's Expenditure Cap.

2.6.5.2.6 For CHOICES members in Groups 2 or 3, non-emergency medical transportation (NEMT) not otherwise covered by this Contract.

2.6.5.3 If the CONTRACTOR chooses to provide cost effective alternative services to a CHOICES or ECF CHOICES member, in no case shall the cost of CHOICES HCBS, private duty nursing and home health care exceed the member's Expenditure Cap for Group 2 exceed a member's cost neutrality cap. In no case shall the cost of ECF CHOICES HCBS, private duty nursing and home health care for members in ECF CHOICES Group 6 who are granted an exception to the expenditure cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 and 8 who also have an Expenditure Cap based on the comparable cost of institutional care. For CHOICES members enrolled in Group 3 and ECF CHOICES members, the total cost of CHOICES HCBS or ECF CHOICES, as applicable, excluding, for members in Group 3 and Group 4 the cost of minor home modifications, shall not 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 A.2.6.5.2 of this Contract 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. The total cost of ECF CHOICES HCBS includes all covered ECF CHOICES HCBS and other non-covered services the CONTRACTOR elects to offer as a cost-effective alternative to nursing facility care for members who meet nursing facility level of care, including a transition allowance, or to other covered benefits for all ECF CHOICES members, including ECF CHOICES HCBS in excess of specified benefit limits.

2.6.5.4 The CONTRACTOR may elect, at its sole discretion, to exceed the limits for adult dental services in ECF CHOICES as specified in Section A.2.6.1.6.3 as a cost-effective alternative service when the provision of such additional dental services would be medically appropriate and offer a more cost-effective alternative to other covered services the member would otherwise require.

2.6.5.5 When the CONTRACTOR approves CHOICES or ECF CHOICES HCBS as a CEA to another covered benefit (including but not limited to home health, private duty nursing, or nursing facility services) and subsequently elects to reduce or terminate such CEA service, the CONTRACTOR shall, prior to initiating the adverse action, review whether the covered benefit will, upon reduction or termination of the CEA service, be medically necessary. The CONTRACTOR shall review previous and current comprehensive assessments and the PCSP to ensure that the member's needs will continue to be met safely with the benefits the member will continue to receive and will make such documentation available in the course of any appeal pertaining to the CEA service and as requested by TENNCARE.

A.2.6.6 **Additional Services and Use of Incentives**

2.6.6.1 The CONTRACTOR shall not advertise any services that are not required by this Contract other than those covered pursuant to Section A.2.6.1 of this Contract.

2.6.6.2 The CONTRACTOR shall not offer or provide any services other than services covered by this Contract (see Section A.2.6.1) or services provided as a cost effective alternative (see Section A.2.6.5) of this Contract. 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.

A.2.6.7 **Cost Sharing and Patient Liability**

2.6.7.1 General

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing or patient liability responsibilities for covered services except to the extent that cost sharing or patient liability responsibilities are required for those services by TENNCARE in accordance with TennCare Division rules and regulations, including but not limited to, not holding enrollees liable for debt due to insolvency of the CONTRACTOR or non-payment by the State to the CONTRACTOR. Any cost sharing imposed on Medicaid enrollees shall be in accordance with Medicaid FFS requirements at 42 CFR 447.50 through 42 CFR 447.82. Further, the CONTRACTOR and all providers and subcontractors shall not charge enrollees for missed appointments.

2.6.7.2 Patient Liability

2.6.7.2.1 TENNCARE will notify the CONTRACTOR of any applicable patient liability amounts for CHOICES and ECF CHOICES members via the outbound 834 enrollment file.

2.6.7.2.1.1 When TENNCARE notifies the CONTRACTOR of patient liability amounts for CHOICES or ECF CHOICES members via the outbound 834 enrollment file with an effective date any time other than the first day of the month, the CONTRACTOR shall determine and apply the pro-rated portion of patient liability for that month.

2.6.7.2.2 The CONTRACTOR shall delegate collection of patient liability for CHOICES Group 1 members to the nursing facility and shall pay the facility net of the applicable patient liability amount.

2.6.7.2.2.1 In accordance with the involuntary discharge process, including notice and appeal (see Section A.2.12.10.3), a nursing facility may refuse to continue providing services to a member who fails to pay his or her patient liability and for whom the nursing facility can demonstrate to the CONTRACTOR that it has made a good faith effort to collect payment.

2.6.7.2.2.2 If the CONTRACTOR is notified that a nursing facility is considering discharging a member (see Section A.2.12.10.3), the CONTRACTOR shall work to find an alternate nursing facility willing to serve the member and document its efforts in the member's files.

2.6.7.2.2.3 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member and the member otherwise qualifies to enroll in CHOICES Group 2, the CONTRACTOR shall determine if it can safely and effectively serve the member in the community and within the cost neutrality cap. If it can, and the CONTRACTOR is willing to continue serving a member who has failed to pay his or her patient liability or if TENNCARE determines that the member would not have patient liability in the community setting, the member shall be offered a choice of CHOICES HCBS. If the member chooses CHOICES HCBS, the CONTRACTOR shall forward all relevant information to TENNCARE for a decision regarding transition to Group 2 (Section A.2.9.6.8).

2.6.7.2.2.4 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member and the CONTRACTOR determines that it cannot safely and effectively serve the member in the community and within the cost neutrality cap, the member declines to enroll in Group 2, or TENNCARE determines that the member would continue to have patient liability in the community setting and the CONTRACTOR is unwilling to continue serving the member who has failed to pay his or her patient liability, or TENNCARE denies enrollment in Group 2, the CONTRACTOR may, pursuant to Section A.2.6.1.5.7, request to no longer provide long-term care services to the member.

2.6.7.2.3 For CHOICES Group 2 and 3 and ECF CHOICES members, patient liability shall be collected as follows:

2.6.7.2.3.1 The Contractor shall delegate collection of patient liability for CHOICES Group 2 and 3 and ECF CHOICES members who reside in a CBRA (i.e., an assisted care living facility, a home where the member receives community living supports or community living supports-family model, or adult care home as licensed under 68-11-201) to the CBRA provider and shall pay the provider net of the applicable patient liability amount.

2.6.7.2.3.2 The CONTRACTOR shall collect patient liability from CHOICES Group 2 and Group 3 and ECF CHOICES members (as applicable) who receive CHOICES HCBS or ECF CHOICES in his/her own home, including members who are receiving short-term nursing facility care, or who receive adult day care services and from Group 2 members who receive Companion Care.

2.6.7.2.3.2.1 The CONTRACTOR shall use calculated patient liability amounts to offset the cost of CHOICES Group 2 or CHOICES Group 3 or ECF CHOICES benefits (or CEA services provided as an alternative to covered CHOICES Group 2 or Group 3 or ECF CHOICES benefits) reimbursed by the CONTRACTOR for that month.

2.6.7.2.3.2.2 The CONTRACTOR shall not collect patient liability that exceeds the cost of CHOICES Group 2 or CHOICES Group 3 or ECF CHOICES benefits (or CEA services provided as an alternative to CHOICES Group 2 or Group 3 or ECF CHOICES benefits) reimbursed by the CONTRACTOR for that month.

2.6.7.2.3.2.3 The CONTRACTOR shall, upon notification in the outbound 834 enrollment file of retroactive adjustments in patient liability amounts based on Item D deductions, without requiring any action on the part of the member or provider, adjust the Group 2 or Group 3 or ECF CHOICES member's patient liability for the following month(s) until reimbursement of any overpayment is accomplished, or shall refund any overpayments within thirty (30) days of a request from the member or when the member will not continue to have patient liability obligations going forward.

2.6.7.2.3.3 If a Group 2 or Group 3 or ECF CHOICES member fails to pay required patient liability, pursuant to Section A.2.6.1.5.7.6, the CONTRACTOR may request to no longer provide long-term services and supports to the member.

2.6.7.2.3.4 The CONTRACTOR shall not waive or otherwise fail to establish and maintain processes for collection of patient liability in accordance with this Contract.

2.6.7.3 Preventive Services

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

2.6.7.4 Cost Sharing Schedule

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

2.6.7.5 Provider Requirements

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

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

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

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

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

2.6.7.5.2 The CONTRACTOR shall require, as a condition of payment, that the provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing or patient liability responsibilities due from the enrollee as payment in full for the service. Except in the circumstances described above, if the CONTRACTOR is aware that a provider, or a collection agency acting on the provider's behalf, bills an enrollee for amounts other than the applicable amount of TennCare cost sharing or patient liability responsibilities due from the enrollee, the CONTRACTOR shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. If a provider continues to bill an enrollee after notification by the CONTRACTOR, the CONTRACTOR shall refer the provider to the Tennessee Bureau of Investigation.

A.2.7 SPECIALIZED SERVICES

A.2.7.1 Emergency Services

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

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

2.7.1.3 The CONTRACTOR shall provide coverage for inpatient and outpatient emergency services, furnished by a qualified provider, regardless of whether the member obtains the services from a contract provider, that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson

standard. These services shall be provided without prior authorization in accordance with 42 CFR 438.114. The CONTRACTOR shall pay for any emergency screening examination services conducted to determine whether an emergency medical condition exists and for all emergency services that are medically necessary until the member is stabilized. However, the CONTRACTOR shall have policies to determine when non-emergency services are provided in an outpatient emergency setting.

2.7.1.4 If an emergency screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition exists, the CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the member. The CONTRACTOR shall be required to pay for all emergency services which are medically necessary until the clinical emergency is stabilized. This includes all medical and behavioral health services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the member's condition is likely to result from, or occur during, discharge of the member or transfer of the member to another facility. If there is a disagreement between the treating facility and the CONTRACTOR concerning whether the member is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending provider(s) actually caring for the member at the treating facility prevails and is binding on the CONTRACTOR. The CONTRACTOR, however, may establish arrangements with a treating facility whereby the CONTRACTOR may send one of its own providers with appropriate emergency room privileges to assume the attending provider's responsibilities to stabilize, treat, and transfer the member, provided that such arrangement does not delay the provision of emergency services.

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

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

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

A.2.7.2 **Behavioral Health Services**

2.7.2.1 <u>General Provisions</u>

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

2.7.2.1.2 The CONTRACTOR shall provide behavioral health services in accordance with this Contract, TennCare Rules and Regulations and TennCare policies, including Section A.2.6 and Attachment I of this Contract, and TennCare Medical Necessity Rule 1200-13-16.

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

2.7.2.1.3.1 Community mental health agencies;

2.7.2.1.3.2 Intensive Community Based Treatment Service agencies;

2.7.2.1.3.3 Tennessee Health Link Providers;

2.7.2.1.3.4 Psychiatric rehabilitation agencies;

2.7.2.1.3.5 Psychiatric and substance abuse residential treatment facilities; and

2.7.2.1.3.6 Psychiatric and substance abuse inpatient facilities.

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

2.7.2.2 <u>Psychiatric Inpatient Hospital Services</u>

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

2.7.2.2.2 The CONTRACTOR shall require that all psychiatric inpatient facilities are accredited by the Joint Commission and accept voluntary and involuntary admissions.

2.7.2.2.3 Members discharged from psychiatric inpatient hospitals shall be evaluated for mental health and substance abuse services as medically necessary and provided with appropriate behavioral health follow-up services.

2.7.2.3 <u>24-Hour Psychiatric Residential Treatment</u>

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

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

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

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

2.7.2.3.5 Members discharged from all RTFs shall be evaluated for mental health and substance abuse services as medically necessary and provided with appropriate behavioral health follow-up services.

2.7.2.4 Outpatient Mental Health Services

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

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

2.7.2.5 Inpatient, Residential & Outpatient Substance Abuse Services

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

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

2.7.2.6 Behavioral Health Intensive Community Based Treatment Services

2.7.2.6.1 The CONTRACTOR shall provide Behavioral Health Intensive Community Based Treatment Services only through providers licensed by the State to provide mental health outpatient services.

2.7.2.6.2 The CONTRACTOR shall provide Behavioral Health Intensive Community Based Treatment services according to the standards set by TENNCARE and outlined in Attachment I.

2.7.2.6.3 Tennessee Health Link

2.7.2.6.3.1 The CONTRACTOR shall provide Tennessee Health Link services according standards set by TENNCARE and outlined in Attachment I.

2.7.2.6.4 The CONTRACTOR shall require Tennessee Health Link Care Coordinators to involve the member, the member's family or parent(s), or legally appointed representative, PCP, Care Coordinator for CHOICES members, and other agency representatives, if appropriate and authorized by the member as required, in mental health case management activities.

2.7.2.6.5 The CONTRACTOR shall ensure the continuing provision of Tennessee Health Link services to members under the conditions and time frames indicated below:

2.7.2.6.5.1 Members receiving Tennessee Health Link services at the start date of Tennessee Health Link program operations shall be maintained in Tennessee Health Link until such time as the member no longer qualifies on the basis of medical necessity or refuses treatment;

2.7.2.6.5.2 Members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities shall be provided with appropriate follow-up behavioral health services. If eligible, members will be referred to Tennessee Health link for services; and

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

2.7.2.7 Psychiatric Rehabilitation Services

The CONTRACTOR shall provide psychiatric rehabilitation services in accordance with the requirements in Attachment I. As described in Attachment I, the covered array of services available under psychiatric rehabilitation are psychosocial rehabilitation, supported employment, peer recovery services, family support services, illness management and recovery, and supported housing. An individual may receive one or more of these services and may receive different services from different providers.

2.7.2.8 Behavioral Health Crisis Services

2.7.2.8.1 *Entry into the Behavioral Health Crisis Services System*

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

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

2.7.2.8.1.3 As required in Section A.2.11.6.3, the CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by the State.

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

2.7.2.8.1.5 Prior to admission to a psychiatric inpatient hospital on an involuntary basis, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a crisis team consultation is completed for all members evaluated by a licensed physician or psychologist as described in TennCare policy. In addition, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a face-to-face evaluation by a mandatory pre-screening agent (MPA), is conducted to assess eligibility for emergency involuntary admission to an RMHI (Regional Mental Health Institute)

and determine whether all available less drastic alternatives services and supports are unsuitable.

2.7.2.8.2 *Behavioral Health Crisis Respite and Crisis Stabilization Services*

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

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

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

2.7.2.8.3 The CONTRACTOR shall monitor behavioral health crisis services and report information to TENNCARE upon request.

2.7.2.8.4 *Behavioral Crisis Prevention, Intervention, and Stabilization Services for Members with Intellectual or Developmental Disabilities (I/DD)*

2.7.2.8.4.1 The CONTRACTOR shall provide Behavioral Crisis Prevention, Intervention, and Stabilization Services for members with intellectual or developmental disabilities (I/DD). The CONTRACTOR shall develop and maintain a network of providers with sufficient experience and expertise in providing behavioral services to members with I/DD to assist and support the person or agency primarily responsible (whether paid or unpaid) for supporting a member with I/DD who is experiencing a behavioral crisis that presents a threat to the member's health and safety or the health and safety of others. Behavioral Crisis Prevention, Intervention, and Stabilization Services are typically initiated on-site at the crisis location to help prevent unnecessary institutional placement or psychiatric hospitalization. Such services shall include:

2.7.2.8.4.1.1 Assessing the nature of a crisis to determine whether the situation can be stabilized in the current location or if a more intensive level of intervention is necessary (e.g., behavioral respite, or when appropriate, inpatient mental health treatment);

2.7.2.8.4.1.2 Arranging the more intensive level of intervention when necessary;

2.7.2.8.4.1.3 Direction to those present at the crisis or direct intervention to de-escalate behavior or protect others in the immediate area;

2.7.2.8.4.1.4 Identification of potential triggers, including history of traumatic stress (as applicable), and development or refinement of interventions, including trauma informed care strategies, to address behaviors or issues that precipitated the behavioral crisis; and/or

2.7.2.8.4.1.5 Training and technical assistance to those who support the member on trauma informed care, crisis interventions, and strategies to mitigate issues that resulted in the crisis.

2.7.2.8.4.2 The CONTRACTOR shall, pursuant to A.2.30.8.1, report to TENNCARE the network of providers with experience and expertise in providing behavioral services to members with I/DD to deliver the services specified in A.2.7.2.8.4.1 above.

2.7.2.9 Judicial Services

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

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

2.7.2.9.2.1 Psychiatric treatment for persons found by the court to require judicial psychiatric hospitalization (TCA 33-6 part 4 and part 5). The CONTRACTOR may apply medical necessity criteria to the situation after twenty-four (24) hours of emergency services, unless there is a court order prohibiting release;

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

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

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

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

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

2.7.2.10 Mandatory Outpatient Treatment

2.7.2.10.1 The CONTRACTOR shall provide mandatory outpatient treatment for individuals found not guilty by reason of insanity following a thirty (30) to sixty (60) calendar day inpatient evaluation. Treatment can be terminated only by the court pursuant to TCA 33-7-303(b).

2.7.2.10.2 The State will assume responsibility for all forensic services other than the mandatory outpatient treatment service identified in Section A.2.7.2.10.1 (TCA 33-7-301(a), 33-7-301(b), 33-7-303(a) and 33-7-303(c)).

A.2.7.3 **Self-Direction of Health Care Tasks**

The CONTRACTOR shall, in accordance with TennCare rules and regulations, permit CHOICES or ECF CHOICES members the option to direct and supervise a consumer-directed worker who is providing eligible CHOICES or ECF CHOICES HCBS in the performance of health care tasks.

A.2.7.4 **Health Education and Outreach**

2.7.4.1 The CONTRACTOR shall develop programs and participate in activities to enhance the general health and well-being of members. Health education and outreach programs and activities shall include TennCare Kids outreach activities (See Section A.2.7.6.2) and may also include the following:

2.7.4.1.1 General physical, behavioral health and long-term care education classes;

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

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

2.7.4.1.4 Nutrition counseling;

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

2.7.4.1.6 Prevention and treatment of substance abuse;

2.7.4.1.7 Self-care training, including self-examination;

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

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

2.7.4.1.10 Education for members on the significance of their role in their overall health and welfare and available resources;

2.7.4.1.11 Education for caregivers on the significance of their role in the overall health and welfare of the member and available resources;

2.7.4.1.12 Education, at least annually, for members and caregivers about identification and reporting of suspected abuse and neglect;

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

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

2.7.4.2 The CONTRACTOR shall submit an Annual Outreach Plan no later than August 15 of each year for review and approval by TENNCARE. The Plan will be effective for the Federal Fiscal Year, which is October 1-September 30.

2.7.4.2.1 The TennCare Kids Annual Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: EPSDT screening goals, plans for outreach in counties/regions and/or subpopulations as directed in the Annual EPSDT Strategy Meeting, and plans for collaborations among partners and stakeholders. A TennCare Kids Year-End Update of the Plan shall be due no later than sixty (60) days following the end of a Federal Fiscal Year in a format approved by TENNCARE. This Year-End Update must include an appraisal of the objectives in the Plan and an assessment of outreach conducted in the previous Federal Fiscal Year in a format approved by TENNCARE.

2.7.4.2.1.1 Each plan must include:

2.7.4.2.1.1.1 Methodology for developing the plan to include data assessments conducted, policy and procedure reviews, and any research that may have been conducted.

2.7.4.2.1.1.2 Outreach efforts must include both written and oral communications and must address both rural and urban areas of the state and efforts to reach minorities and other underserved populations.

2.7.4.2.1.1.3 Outreach efforts to teens.

2.7.4.2.1.1.4 Provider outreach and education.

2.7.4.2.1.2 Each plan must be resubmitted quarterly with updates on progress included.

2.7.4.2.2 The CONTRACTOR shall submit a monthly report that includes the number of EPSDT screening claims processed by region for service dates beginning with the current federal fiscal year (October 1) through the last day of the current month. This report shall be due by the 20th day after the end of the reporting month.

A.2.7.5 **Preventive Services**

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

2.7.5.2 <u>Prenatal Care</u>

2.7.5.2.1 The CONTRACTOR shall provide or arrange for the provision of medically necessary prenatal care to members beginning on the date of their enrollment in the CONTRACTOR's MCO. This requirement includes pregnant women who are presumptively eligible for TennCare, enrollees who become pregnant, as well as enrollees who are pregnant on the effective date of enrollment in the CONTRACTOR's MCO. The requirement to provide or arrange for the provision of medically necessary prenatal care shall include assistance in making a timely appointment for a woman who is presumptively eligible and shall be provided as soon as the CONTRACTOR becomes aware of the enrollment. For a woman in her second or third trimester, the

appointment shall occur as required in Section A.2.11.5.2. In the event a member enrolling in the CONTRACTOR's MCO is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall comply with the requirements in Sections A.2.9.2.2 and A.2.9.2.3 regarding prior authorization of prenatal care.

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

2.7.5.2.3 The CONTRACTOR shall notify all contract providers that any unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR. Unreasonable delay in care for pregnant members shall mean failure of the prenatal care provider to meet the accessibility requirements required in Section A.2.11.5 of this Contract.

A.2.7.6 **TennCare Kids**

2.7.6.1 General Provisions

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

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

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

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

2.7.6.1.5 The CONTRACTOR shall:

2.7.6.1.5.1 Require that providers provide TennCare Kids services;

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

2.7.6.1.5.3 Educate contract providers about proper coding and encourage them to submit the appropriate diagnosis codes identified by TENNCARE in conjunction with evaluation and management procedure codes for TennCare Kids services. The CONTRACTOR must offer this education quarterly either via webinar or classroom setting, or in partnership with the Tennessee Chapter of the American Academy of Pediatrics, and provide proof of quarterly trainings;

2.7.6.1.5.4 Educate contract providers about how to submit claims with appropriate codes and modifiers as described in standardized billing requirements (e.g., CPT, HCPCS, etc.) and require that they adjust billing methodology according to described components of said procedure codes/modifiers. The CONTRACTOR must offer this education quarterly either via webinar or classroom setting, or in partnership with the Tennessee Chapter of the American Academy of Pediatrics, and provide proof of quarterly trainings; and

2.7.6.1.5.5 Monitor provider compliance with required TennCare Kids activities including compliance with proper coding.

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

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

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

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

2.7.6.1.10 The CONTRACTOR's TennCare Kids and Quality staff shall participate in a collaborative workgroup, consisting of the MCOs, the Tennessee Department of Health, and TennCare. This workgroup will address, but is not limited to, innovative ways to improve EPSDT screening rates.

2.7.6.2 Member Education and Outreach

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

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

2.7.6.2.2.1 If the CONTRACTOR's TennCare Kids screening rate is below ninety percent (90%), as determined in the most recent CMS 416 report, the CONTRACTOR shall conduct New Member Calls for all new members under the age of twenty-one (21) to inform them of TennCare Kids services including assistance with appointment scheduling and transportation to appointments.

2.7.6.2.2.2 The CONTRACTOR shall have the ability to conduct TennCare Kids outreach in formats appropriate to members who are blind, deaf, illiterate or have Limited English Proficiency. At least one of the 6 outreach attempts identified above shall advise members regarding how to request and/or access such assistance and/or information. The CONTRACTOR shall collaborate with agencies that have established procedures for working with special populations in order to develop effective outreach materials.

2.7.6.2.3 The CONTRACTOR shall have a mechanism for systematically notifying families when TennCare Kids screens are due.

2.7.6.2.4 As part of its TennCare Kids policies and procedures, the CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. This process for follow up shall include provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. The CONTRACTOR shall make at least two (2) efforts per year in excess of the six (6) "outreach contacts" to get the member in for a screening. The efforts shall be in different formats.

2.7.6.2.5 The CONTRACTOR shall have a process for determining if a member who is eligible for TennCare Kids has used no services within a year. Two (2) reasonable attempts to re-notify such members about TennCare Kids must be made and shall be in different formats.

2.7.6.2.6 The CONTRACTOR shall make available to members and families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare members as described in Section A.2.17.8 of this Contract.

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

2.7.6.2.8 The CONTRACTOR shall provide member education, outreach, and screening events in community settings. Screening events shall be conducted in each of the Grand Regions, covered by this Contract in accordance with the following specifications (See Section A.2.7.4.2):

2.7.6.2.8.1 Beginning in Federal Fiscal Year 2020, screening events and/or campaigns shall be implemented statewide, with focus on those areas identified with low EPSDT screening rates, following guidance from the previous FFY data and the EPSDT Strategy Meeting.

2.7.6.2.8.2 The CONTRACTOR shall conduct screening events and/or campaigns through each region it serves to ensure all members have reasonable access to EPSDT outreach during a Federal Fiscal Year. Results of the CONTRACTOR's or STATE's CMS 416 report, as well as county demographics, shall be utilized in determining counties for targeted activities and in developing strategies for specific age groups. The CONTRACTOR shall develop outreach strategies for specific populations including members who have limited English proficiency, low literacy levels, behavioral health needs, special health care needs or who are pregnant.

2.7.6.3 <u>Screening</u>

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

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

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

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

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

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

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

2.7.6.3.3.5 Appropriate laboratory tests (including lead toxicity screening appropriate for age and risk factors). All children are considered at risk and shall be screened for lead poisoning. All children shall receive a screening blood lead test at twelve (12) and twenty-four (24) months of age. Children between the ages of thirty-six (36) months and seventy-two (72) months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test shall be used when screening Medicaid-eligible children. A blood lead test equal to or greater than five (5) ug/dL obtained by capillary specimen (finger stick) shall be confirmed by using a venous blood sample; and

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

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

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

2.7.6.4 <u>Services</u>

2.7.6.4.1 Should screenings indicate a need, the CONTRACTOR shall provide all necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) (Section 1905(a) of the Social Security Act) to correct or ameliorate or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan (see Section A.2.7.6.4.8). This includes, but is not limited to, the services detailed below.

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

2.7.6.4.3 The CONTRACTOR shall coordinate with the DBM to ensure that TennCare Kids eligible members receive dental care services furnished by direct referral to a dentist, at as early an age as necessary, and at intervals which meet reasonable standards of

dental practice as determined by the State and at other intervals as medically necessary to determine the existence of a suspected illness or condition.

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

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

2.7.6.4.6 *Transportation Services*

2.7.6.4.6.1 The CONTRACTOR shall provide transportation assistance for a child and for the child's escort or accompanying adult, including related travel expenses, cost of meals, and lodging en route to and from TennCare covered services. The requirement to provide the cost of meals shall not be interpreted to mean that a member (or the child's escort or accompanying adult) can request meals while in transport to and from care. Reimbursement for meals and lodging shall only be provided when transportation for a TennCare covered service cannot be completed in one (1) day and would require an overnight stay.

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

2.7.6.4.7 *Services for Elevated Blood Lead Levels*

2.7.6.4.7.1 The CONTRACTOR shall provide follow up for elevated blood lead levels. Determining elevated blood levels requiring follow-up shall be in accordance with current CDC guidelines. Elevated blood lead follow up guidelines include follow up blood tests and investigations to determine the source of lead, when indicated.

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.

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

2.7.6.4.7.4 If the lead inspection does not reveal the presence of lead paint in the home, there may be a need for other testing, such as risk assessments involving water and soil

sampling or inspections of sites other than the primary residence if the child spends a substantial amount of time in another location. The CONTRACTOR is not responsible for either the risk assessments or the lead inspection at the secondary site. However, the CONTRACTOR shall contact the DOH when these services are indicated as this agency is responsible for these services.

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

2.7.6.4.8 *Services Chart*

Pursuant to federal and state requirements, TennCare enrollees under the age of 21 are eligible for all services listed in Section 1905(a) of the Social Security Act. These services, and the entity responsible for providing them to TennCare enrollees under the age of 21, are listed below. Notwithstanding any other provision of this Contract, the CONTRACTOR shall provide all services for which "MCO" is identified as the responsible entity to members under the age of 21. All services, other than TennCare Kids screens and interperiodic screens, must be medically necessary in order to be covered by the CONTRACTOR. The CONTRACTOR shall provide all medically necessary TennCare Kids covered services regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the CONTRACTOR or by a contract provider.

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(1) Inpatient hospital services (other than services in an institution for mental diseases)		MCO	
(2)(A) Outpatient hospital services		MCO	
(2)(B) Rural health clinic services (RHCs)		MCO	MCOs are not required to contract with RHCs if the services are available through other contract providers.
(2)(C) Federally-qualified health center services (FQHCs)		MCO	MCOs are not required to contract with FQHCs if they can demonstrate adequate provider capacity without them.
(3) Other laboratory and X-ray services		MCO	
(4)(A) Nursing facility services for individuals age 21 and older			Not applicable for TennCare Kids

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(4)(B) EPSDT services		MCO for physical health and behavioral health services; DBM for dental services except as described in Section A.2.6.1.3; PBM for pharmacy services as described except as in Section A.2.6.1.3	
(4)(C) Family planning services and supplies		MCO; PBM for pharmacy services except as described in Section A.2.6.1.3	
(5)(A) Physicians' services furnished by a physician, whether furnished in the office, the patient's home, a hospital, or a nursing facility		MCO	
(5)(B) Medical and surgical services furnished by a dentist		DBM except as described in Section A.2.6.1.3	
(6) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law		MCO	See Item (13)
(7) Home health care services		MCO	
(8) Private duty nursing services		MCO	
(9) Clinic services		MCO	
(10) Dental services		DBM except as described in Section A.2.6.1.3	
(11) Physical therapy and related services		MCO	
(12) Prescribed drugs, dentures, and prosthetic devices, and eyeglasses		MCO; PBM for pharmacy services except as described in Section A.2.6.1.3; DBM for dentures	
(13) Other diagnostic, screening, preventive, and rehabilitative services, including any		MCO for physical health and behavioral health services;	The following are considered practitioners of the healing arts in Tennessee law:[1]

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

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level		DBM for dental services except as described in Section A.2.6.1.3; PBM for pharmacy services except as described in Section A.2.6.1.3	• Alcohol and drug abuse counselor • Athletic trainer • Audiologist • Certified acupuncturist • Certified master social worker • Certified nurse practitioner • Certified professional counselor • Certified psychological assistant • Chiropractic physician • Chiropractic therapy assistant • Clinical pastoral therapist • Dentist • Dental assistant • Dental hygienist • Dietitian/nutritionist • Dispensing optician • Electrologist • Emergency medical personnel • First responder • Hearing instrument specialist • Laboratory personnel • Licensed clinical perfusionist • Licensed clinical social worker • Licensed practical nurse • Licensed professional counselor • Marital and family therapist, certified • Marital and family therapist, licensed

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
			• Massage therapist • Medical doctor • Medical doctor (special training) • Midwives and nurse midwives • Nurse aide • Occupational therapist • Occupational therapy assistant • Optometrist • Osteopathic physician • Pharmacist • Physical therapist • Physical therapist assistant • Physician assistant • Podiatrist • Psychological examiner • Psychologist • Registered nurse • Registered certified reflexologist • Respiratory care assistant • Respiratory care technician • Respiratory care therapist • Senior psychological examiner • Speech pathologist • Speech pathology aide • X-ray op in chiropractic physician's office • X-ray op in MD office • X-ray op in osteopathic office • X-ray op in podiatrist's office

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(14) Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases			Not applicable for TennCare Kids
(15) Services in an intermediate care facility for the individual with an intellectual disability		TENNCARE	
(16) Inpatient psychiatric services for individuals under age 21		MCO	
(17) Services furnished by a nurse-midwife		MCO	The MCOs are not required to contract with nurse-midwives if the services are available through other contract providers.
(18) Hospice care		MCO	
(19) Case management services		MCO	
(20) Respiratory care services		MCO	
(21) Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner		MCO	The MCOs are not required to contract with PNPs or CFNPs if the services are available through other contract providers.
(22) Home and community care for functionally disabled elderly individuals			Not applicable for TennCare Kids
(23) Community supported living arrangements services			Not applicable for TennCare Kids
(24) Personal care services		MCO	
(25) Primary care case management services			Not applicable
(26) Services furnished under a PACE program			Not applicable for TennCare Kids

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(27) Any other medical care, and any other type of remedial care recognized under state law.		MCO for physical and behavioral health services; DBM for dental services except as described in Section A.2.6.1.3; PBM for pharmacy services except as described in Section A.2.6.1.3	See Item (13)

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

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

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

2.7.6.4.8.4 **Note 4:** Certain services are covered under a Home and Community Based Services Program (i.e., ECF CHOICES or a 1915(c) Waiver) but are **not TennCare Kids services** because they are not listed in the Social Security Act Section 1905(a). These services include, but are not limited to, habilitation, prevocational, supported employment services, homemaker services and respite services. (See Section 1915(c)(4).)

2.7.6.4.8.5 **Note 5:** Certain services are not coverable even under a Home and Community Based Services Program and are **not TennCare Kids services**. These services include, but are not limited to, room and board, and special education and related services which are otherwise available through a Local Education Agency. (See Section 1915(c)(5).)

A.2.7.7 **Advance Directives**

2.7.7.1 The CONTRACTOR shall maintain written policies and procedures for advance directives that comply with all federal and state requirements concerning advance directives, including but not limited to 42 CFR 422.128, 438.3 and 489 Subpart I; TCA 32-11-101 *et seq.*, 34-6-201 *et seq.*, and 68-11-201 through 68-11-224; and any requirements as stipulated by the member. Any written information provided by the CONTRACTOR shall reflect changes in state law by the effective date specified in the law, if not specified then within thirty (30) calendar days after the effective date of the change.

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

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

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

2.7.7.5 For CHOICES members, the Care Coordinator shall educate members about their ability to use advance directives during the face-to-face intake visit for current members or the face-to-face visit with new members, as applicable.

2.7.7.6 For ECF CHOICES members, the Support Coordinator shall, upon enrollment into ECF CHOICES, educate members about their ability to use advance directives during the face-to-face visit.

2.7.7.7 For all education activities required in this section pertaining to advance directives, the CONTRACTOR shall use materials provided by TENNCARE.

A.2.7.8 **Sterilizations, Hysterectomies and Abortions**

2.7.8.1 The CONTRACTOR shall cover abortions, sterilizations, and hysterectomies (ASH) pursuant to applicable federal and state law. The CONTRACTOR shall ensure that when coverage requires the completion of a specific form, the form is properly completed as described in the instructions with the original form maintained in the member's medical records and a copy submitted to the CONTRACTOR for retention in the event of audit. In the event of a TennCare audit the CONTRACTOR will provide additional supporting documentation to ascertain compliance with federal and state regulations. Such documentation may include admission history and physical, pre and post procedure notes, discharge summary, court records or orders, or other documentation utilized to authorize ASH procedures, specific to the type of procedure performed.

2.7.8.2 Sterilizations

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

2.7.8.2.1 At least thirty (30) calendar days, but not more than one hundred eighty (180) calendar days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least seventy-two (72) hours have passed since the member gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least thirty (30) calendar days before the expected date of delivery;

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

2.7.8.2.3 The member is mentally competent;

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

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

2.7.8.3 Hysterectomies

2.7.8.3.1 Hysterectomy shall mean a medical procedure or operation for the purpose of removing the uterus. The CONTRACTOR shall cover hysterectomies only if the following requirements are met:

2.7.8.3.1.1 The hysterectomy is medically necessary;

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

2.7.8.3.1.3 The member or her authorized representative, if any, has signed and dated an "ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION" form which is available on the Division of TennCare's web site, prior to the hysterectomy. Informed consent shall be obtained regardless of diagnosis or age in accordance with federal requirements. The form shall be available in English and Spanish, and assistance shall be provided in completing the form when an alternative form of communication is necessary. Refer to "ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION" form and instructions for additional guidance and exceptions.

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

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

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

2.7.8.4 Abortions

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

2.7.8.4.2 The CONTRACTOR shall ensure that a "CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION" form, which is available on TENNCARE's web site, is completed. The form shall be available in English and Spanish, and assistance shall be provided in completing the form when an alternative form of communication is necessary.

A.2.8 POPULATION HEALTH

A.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 member population and identify members 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

A.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. The CONTRACTOR shall systematically re-stratify the entire CONTRACTOR's member population at a minimum quarterly. The member population shall be stratified 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 criteria: no identified health risks; no identified chronic conditions [as identified by the Chronic Condition tool created by the Agency for Healthcare Research and Quality's (AHRQ) HCUP database]; and no indication of pregnancy; or no claims history. CHOICES and ECF CHOICES members with no claims data may be included in Level 0 until claims data is received or until member is stratified into the appropriate health risk level.

2.8.2.1.2 Level 1- The members eligible to participate at this level are members that do not meet the Level 0 or Level 2 criteria; or all members that meet Level 2 criteria who cannot be contacted by the processes referenced in Sections A.2.8.4.5.1, A.2.8.4.6.1, A.2.8.4.7.1 of this Contract, or those members that are eligible for Level 2 program enrollment but elect not to enroll in a Level 2 program.

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 chronic diseases that are prevalent in a significant number of members, or 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 Low, Medium, and High 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 A.2.8.4.2 of this Contract.

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 healthcare needs, health service needs, or risks which need immediate attention.

2.8.2.1.2.3 The CONTRACTOR shall place all Level 2 members who cannot be contacted by the process referenced in Section A.2.8.4.5.1 of this Contract, or chose not to enroll in a Level 2 program, in Level 1 programs.

2.8.2.1.3 Level 2 – Members eligible to participate at this level shall be determined by predictive modeling identifying approximately the top three percent (3%) of members, excluding High Risk Maternity 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 the **Complex Case Management Program** 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 approximately the top 3% as defined in Section A.2.8.2.1.4 of this Contract at a minimum of quarterly intervals to insure members with increasing health risks and needs are identified for Level 2 programs.

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 Program but choose not to participate, shall be enrolled in the Low Risk Maternity Program.

A.2.8.3 **Member Assessment**

2.8.3.1 The CONTRACTOR shall make a best effort to conduct an initial screening of each member's needs, within ninety (90) days of the effective date of enrollment for all new members to assess member's health risk utilizing a health risk assessment, also referred to as a health risk appraisal, that meets and/or exceeds the current National Committee for Quality Assurance (NCQA) Population Health Management standard, that has been approved by TENNCARE and Population Health staff, or a comprehensive health risk assessment that meets and/or exceeds the current National Committee for Quality Assurance (NCQA) Population Health Management standard. The CONTRACTOR shall make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful, within thirty (30) days of the initial outreach attempt. These timelines may be shortened or contact methods specified for specific parts of the program in contract sections below. The information collected from these health assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.

2.8.3.2 At time of enrollment and annually thereafter, the CONTRACTOR shall make a reasonable attempt to assess the member's health. The comprehensive health risk assessment required by Level 2 Population Health programs, CHOICES, Dual Special Needs Program (D-SNP), Select Community, and Department of Children's Services (DCS) can be used in lieu of the approved health assessment required by the contract. Members exempt from the health assessment are those members that have completed

an approved health assessment or a comprehensive health risk assessment in the prior twelve (12) months. The completed approved health assessment or comprehensive health risk assessment data may be shared among TennCare MCOs and used to meet the annual requirement. At the request of TENNCARE, the CONTRACTOR shall share with TENNCARE, or other MCCs serving the member, the results of any identification and assessment of that member's needs to assist in facilitating the administration of health related services and to prevent duplication of those activities.

2.8.3.3 The CONTRACTOR shall conduct a comprehensive Health Risk Assessment (HRA) for all members enrolled in the Chronic Care Management, Complex Case Management, and High Risk Maternity Programs. The HRA should include screening for physical conditions, mental health, and substance abuse for all members.

2.8.3.4 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).

2.8.3.5 The CONTRACTOR shall conduct an assessment for the need of a face to face visit for members considered to have high health risks that are enrolled in the Chronic Care Management, Complex Case Management, or High Risk Maternity programs. The CONTRACTOR shall assess the need for a face-to-face visit using the standard assessment criteria provided by TENNCARE. If needed, such a visit shall be conducted following consent of the member.

A.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 Wellness, Low Risk Maternity, Health Risk Management, Chronic Care Management, High Risk Pregnancy and Complex Case Management Population Health Programs listed in Section A.2.8.1 of this Contract. Activities, interventions, and education objectives appropriate for members will vary for each program with increasing engagement and intensity as level of risk increases. All Population Health programs shall include the provisions of clinical reminders around HEDIS/gaps in care, and after-hours assistance with urgent or emergent member needs. The Wellness, Low Risk Maternity, Health Risk Management, Chronic Care Management, High Risk Pregnancy and Complex Case Management Population Health programs will have a minimum standard set of interventions and frequency of touches but utilize varying modes of communication to attain the program objective. The CONTRACTOR shall develop and operate all Population Health programs using an "opt out" methodology. Population Health program services shall be provided to all eligible members unless they specifically ask to be excluded.

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.

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 self-management tools per PHM 4: Wellness and Prevention, as well as the following minimum intervention:

Wellness Program Minimum Intervention	
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 inter-conception 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 lifestyles

2.8.4.2 **Low Risk Maternity Program**

The CONTRACTOR shall provide a **Low Risk Maternity Program** for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. 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 provide defined ongoing member monitoring for the need to move these members into the High Risk Maternity Program.

2.8.4.2.1.1 The CONTRACTOR shall provide to members eligible for the Low Risk Maternity Program the following minimum standard interventions:

Low Risk 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 A.2.8.4.5.1 of this Contract.
2.	One non-interactive intervention to the member for the duration of the pregnancy to include, at a minimum, information on pregnancy, newborn, and inter-conception health.
3.	Access number to appropriate support, to include a maternity nurse/social worker, when appropriate, if member would like to engage in sustained maternity management.
4.	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.
5.	Referrals to appropriate community–based resources and follow-up for these referrals.

2.8.4.3 **Health Risk Management Program**

For eligible Level 1 members, who are not pregnant, identified as designated in Section A.2.8.2.1.3.1 of this Contract, 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 self-management tools per PHM 4: Wellness and Prevention (Element H), as well as self-monitoring, co-morbidities, cultural beliefs, and appropriate communication with providers.

2.8.4.3.2 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 A.2.8.4.3.5 of this Contract.

2.8.4.3.3 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.

2.8.4.3.4 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.

2.8.4.3.5 The CONTRACTOR shall provide to members in the Health Risk Management Program the following minimum standard interventions:

Health Risk Management Program: Minimum Interventions	
1.	Four documented non-interactive communications each year. The communications shall address self-management education emphasizing the following: A. Increasing the members knowledge of chronic health conditions B. The importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of the emotional aspect of health conditions E. Self-efficacy & support
2.	Offering of individual support for self-management if member desires to become engaged.
3.	Availability of 24/7 NurseLine.
4.	Availability of health coaching

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 and non-ECF CHOICES members who may or may not have a chronic disease but have acute healthcare needs, health service needs, or risks which 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 CHOICES Care Coordination or ECF CHOICES Support Coordination. 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 at a minimum make three outreach attempts to contact each newly identified member as eligible for Chronic Care Management to inform the member about the program. For those members known to have urgent or critical needs, more and varied types of contact attempts may be indicated. All non-critical eligible members must have three outreach attempts within three months of their identification. For those members where contact failed but who appear on the next refreshed list, the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days.

2.8.4.5.2 The CONTRACTOR shall provide to members 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. Development and implementation of individualized care plan 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

2.8.4.5.3 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 Program**

The CONTRACTOR shall provide a **High Risk Maternity Program** for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. 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 at a minimum make three (3) outreach attempts as detailed in Section A.2.8.4.5.1 of this Contract to contact newly identified members eligible for the High Risk Maternity Program to inform the member about the program. For those members known to have urgent or critical needs, more and varied types of contact attempts may be indicated. All non-critical eligible members must have three outreach attempts within three months of their identification. For those members where contact failed but who appear on the next refreshed list, the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days.

2.8.4.6.2 The CONTRACTOR shall provide to members enrolled in the 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 to include information on pregnancy, newborn, and inter-conception health.
	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 Tennessee Tobacco QuitLine.

2.8.4.7 **Complex Case Management Program**

The CONTRACTOR shall provide a **Complex Case Management Program** for eligible members, identified by criteria listed in Section A.2.8.2.1.4.2 of this Contract. 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 at a minimum make three (3) outreach attempts as detailed in Section A.2.8.4.5.1 of this Contract to contact newly identified members eligible for Complex Care Management to inform the member about the program. The outreach attempts shall be completed within the appropriate timeframes according to NCQA standard PHM 5 for Complex Case Management. For those members known to have urgent or critical needs, more and varied types of contact attempts may be indicated. 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.

2.8.4.7.2 The CONTRACTOR shall develop and operate the Complex Case Management per NCQA standard PHM 5: Complex Case Management.

2.8.4.7.3 The CONTRACTOR shall provide to members enrolled in the Complex Case Management Program monthly interactive member contacts to provide individual self-management support.

A.2.8.5 **Program Strategy**

The CONTRACTOR shall develop and maintain a Population Health Program Strategy that meets or exceeds the NCQA standard PHM 1: PHM Strategy. The Division of TennCare requests an annual analysis of your PHM activities and any edits to your strategy, based on the data that was collected for the reporting year. At each MCOs discretion, the analysis required by NCQA may be submitted to TennCare to fulfill this requirement.

A.2.8.6 **Clinical Practice Guidelines**

Population Health programs shall utilize evidence-based clinical practice guidelines.

A.2.8.7 **System Support and Capabilities**

The CONTRACTOR shall maintain and operate a 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, such as non-interactive and interactive touches as needed for follow-up confirmations and to determine intervention outcomes.

A.2.8.8 **CHOICES and ECF CHOICES**

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

2.8.8.1 The CONTRACTOR's Population Health Program Strategy shall include a CHOICES/ECF CHOICES section that describes how the organization integrates a CHOICES or ECF 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.

2.8.8.2 The CONTRACTOR's CHOICES/ECF CHOICES section of the Population Health Strategy shall address how the CONTRACTOR shall ensure that, upon enrollment into CHOICES or ECF CHOICES, Health Risk Management or Chronic Care Management activities are integrated with CHOICES care coordination or ECF CHOICES support coordination processes and functions and that the member's assigned Care Coordinator or Support Coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term services and supports, including appropriate management of chronic conditions. If a CHOICES or ECF CHOICES member has one or more chronic conditions, the member's Care Coordinator or Support 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 or support coordination. Population Health staff shall supplement, but not supplant, the role and responsibilities of the member's Care Coordinator/care coordination or Support Coordinator/support coordination team.

2.8.8.3 The CONTRACTOR's CHOICES/ECF CHOICES section of the Population Health Strategy shall also include the method for addressing the following for CHOICES or ECF CHOICES members:

2.8.8.3.1 Notifying the CHOICES Care Coordinator or ECF CHOICES Support Coordinator of the member's participation in a Population Health Program;

2.8.8.3.2 Providing member information collected to the CHOICES Care Coordinator or ECF CHOICES Support Coordinator;

2.8.8.3.3 Provide to the CHOICES Care Coordinator or ECF CHOICES Support Coordinator any educational materials given to the member through these programs;

2.8.8.3.4 Ensure that the Care Coordinator or Support 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 or ECF CHOICES Support Coordinator;

2.8.8.3.5 Ensure that the Care Coordinator or Support Coordinator integrates into the member's plan of care or PCSP, as applicable, aspects of the Population Health Program that would help to better manage the member's condition; and

2.8.8.3.6 Ensure that the member's Care Coordinator or Support 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 or PCSP, as applicable, 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 A.2.9.6 of this Contract).

2.8.8.4 As part of a Population Health Program, the CONTRACTOR shall place CHOICES and ECF 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 and ECF CHOICES members should not only be based on risk level but also based on the setting in which the member resides.

2.8.8.4.1 Targeted methods for informing and educating CHOICES and ECF CHOICES members shall not be limited to mailing educational materials.

2.8.8.5 The CONTRACTOR shall include CHOICES and ECF CHOICES process data in semi-annual and annual reports as indicated in Section A.2.30.5 of this Contract. CHOICES and ECF CHOICES members will not be included in outcome measures in annual Population Health reports.

2.8.8.6 The CONTRACTOR shall ensure that upon a member's enrollment in CHOICES or ECF CHOICES, if applicable, all High Risk Population Health Management CONTRACTOR activities are integrated with CHOICES care coordination or ECF CHOICES support coordination processes and functions, and that the member's assigned Care Coordinator or Support Coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term services and supports needs. The Care Coordinator or Support 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 or Support Coordinator/support coordination team.

2.8.8.7 The CONTRACTOR, in addition to requirements pertaining to nursing facility to community transitions (see Section A.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:

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

2.8.8.7.2 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;

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

2.8.8.7.4 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

2.8.8.7.5 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.

A.2.8.9 **Evaluation**

2.8.9.1 The CONTRACTOR shall collect and report process and outcome data as indicated on Population Health semi-annual and annual report templates provided by TENNCARE.

2.8.9.2 The CONTRACTOR shall conduct a live presentation on an annual basis for TENNCARE. The CONTRACTOR shall work collaboratively with TENNCARE in planning an annual schedule for presentations. The presentation shall contain an in-depth analysis of their Population Health program and should not be limited to information contained in the Annual Outcome Metric Report.

A.2.9 SERVICE COORDINATION

A.2.9.1 General

2.9.1.1 The CONTRACTOR shall be responsible for the management, coordination, and continuity of care for all its TennCare members and shall develop and maintain policies and procedures to address this responsibility. For CHOICES and ECF CHOICES members, these policies and procedures shall specify the role of the Care Coordinator/care coordination or Support Coordinator/support coordination team, or the Integrated Support Coordination Team, as applicable, in conducting these functions (see Section A.2.9.6).

2.9.1.2 The CONTRACTOR shall:

2.9.1.2.1 Coordinate care among PCPs, specialists, behavioral health providers, and long-term services and supports providers;

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

2.9.1.2.3 Monitor members with ongoing medical or behavioral health conditions;

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

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

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

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

2.9.1.2.8 The CONTRACTOR shall submit an implementation plan for making admission, discharge and transfer data from applicable hospitals available to all primary care practices. The CONTRACTOR shall also provide an implementation plan for providing PCPs access to pharmacy data;

2.9.1.2.8.1 No later than December 31, 2017, the CONTRACTOR shall provide notification of all participating hospital admission and discharge data currently available to the CONTRACTOR in standardized HL7 2.3 or 2.5 format to TENNCARE using the manner prescribed by TENNCARE. Additionally, the CONTRACTOR shall provide all clinical documentation currently sent to the CONTRACTOR, including but not limited to, Lab, Radiology reports, Dictated Reports, Pharmacy Orders and CCDA's as allowed by applicable laws. The clinical information shall be sent by the CONTRACTOR in standardized HL7 2.3 or 2.5 format to TENNCARE in the manner prescribed by TENNCARE.

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

2.9.1.2.10 In addition to the functions provided in this section, for CONTRACTOR's members on the ECF CHOICES referral list, the CONTRACTOR shall assist the member in accessing covered benefits; provide referrals to other services and supports, as appropriate; ensure that such individuals have the CONTRACTOR's contact information, are informed that they may contact the CONTRACTOR at this number if their needs or circumstances change such that they believe they may qualify in a category for which enrollment into ECF CHOICES is open, or if they need assistance in accessing a covered benefit; that CONTRACTOR staff, either support coordination or case management staff, contact the member at least annually to review the member's needs and circumstances, ensure that the member is in the appropriate priority category on the ECF CHOICES referral list, and to provide any additional case management services or assist the member in accessing any other covered benefits that may be beneficial; and ensures that the referral list contains updated member contact information, as applicable. The CONTRACTOR shall maintain an internal tracking system for coordination requirements in this Section A.2.9.1.2.10 and shall be able to produce documentation of such activities upon request by TENNCARE.

A.2.9.2 **Transition of New Members**

2.9.2.1 In the event an enrollee entering the CONTRACTOR's MCO, either as a new TennCare enrollee or transferring from another MCO, is receiving medically necessary covered services in addition to or other than prenatal services (see below for enrollees receiving only prenatal services) the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. Except as specified in this Section A.2.9.2 or in Sections A.2.9.3 or A.2.9.6, this requirement shall not apply to long-term services and supports.

2.9.2.1.1 For medically necessary covered services, other than long-term services and supports, being provided by a non-contract provider, the CONTRACTOR shall provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption to a contract provider, whichever is less. The CONTRACTOR may require prior authorization for continuation of services beyond thirty (30) calendar days; however, the CONTRACTOR is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

2.9.2.1.2 For medically necessary covered services, other than long-term services and supports, being provided by a contract provider, the CONTRACTOR shall provide continuation of such services from that provider but may require prior authorization for continuation of such services from that provider beyond thirty (30) calendar days. The CONTRACTOR may initiate a provider change only as otherwise specified in this Contract.

2.9.2.1.3 For medically necessary covered long-term services and supports for CHOICES and ECF CHOICES members who are new to both TennCare and CHOICES or ECF CHOICES, the CONTRACTOR shall provide long-term services and supports as specified in Sections A.2.9.6.2.4, A.2.9.6.2.5, A.2.6.1.5 and A.2.6.1.6.

2.9.2.1.4 For covered long-term services and supports for CHOICES and ECF CHOICES members who are transferring from another MCO, the CONTRACTOR shall be responsible for continuing to provide covered long-term services and supports, including both CHOICES and ECF CHOICES HCBS authorized by the transferring

MCO and nursing facility services, without regard to whether such services are being provided by contract or non-contract providers.

2.9.2.1.4.1 For a member in CHOICES Group 2 or 3 or ECF CHOICES, the CONTRACTOR shall continue CHOICES or ECF CHOICES HCBS authorized by the transferring MCO for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce these services unless a Care Coordinator or Support Coordinator, as applicable, has conducted a comprehensive needs assessment and developed a PCSP, and the CONTRACTOR has authorized and initiated CHOICES or ECF CHOICES HCBS in accordance with the member's new PCSP. If a member in CHOICES Group 2 or 3 or ECF CHOICES Group 4, 5, or 6 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services and/or reimbursement approved by TENNCARE (see Section A.2.14.1.14). For a member in Group 1, the CONTRACTOR shall provide nursing facility services to the member in accordance with the level of nursing facility services and/or reimbursement approved by TENNCARE (see Section A.2.14.1.14); however, the member may be transitioned to the community in accordance with Section A.2.9.6.8 of this Contract.

2.9.2.1.4.2 For a member in CHOICES Group 2 or 3 or ECF CHOICES transferring from another MCO, within thirty (30) days of notice of the member's enrollment with the CONTRACTOR, a Care Coordinator or Support Coordinator, as applicable, shall conduct a face-to-face visit (see Section A.2.9.6.2.5), including a comprehensive assessment (see Section A.2.9.6.5) and a caregiver assessment, and develop a PCSP, as applicable (see Section A.2.9.6.6), and the CONTRACTOR shall authorize and initiate CHOICES HCBS or ECF CHOICES HCBS in accordance with the new PCSP (see Section A.2.9.6.2.5). If a member in Group 2 or 3 or ECF CHOICES Group 4, 5, or 6 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR, a Care Coordinator or Support Coordinator, as applicable, shall complete a face-to-face visit prior to the expiration date of the level of nursing facility services approved by TENNCARE, but no later than thirty (30) days after enrollment to determine appropriate comprehensive assessment and care planning activities (see Section A.2.9.6.2.5 for members who will be discharged from the nursing facility and remain in Group 2 or 3 or ECF CHOICES and Section A.2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to thirty (30) days after enrollment, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate prior to the member's exhaustion of the 90-day short-term NF benefit.

2.9.2.1.4.3 If at any time before conducting a comprehensive assessment for a member in CHOICES Group 2 or 3 or ECF CHOICES, the CONTRACTOR becomes aware of an increase in the member's needs, a Care Coordinator, Support Coordinator, or the Integrated Support Coordination Team, as applicable, shall immediately conduct a comprehensive assessment and update the member's PCSP, and the CONTRACTOR shall initiate the change in services within ten (10) days of becoming aware of the increase in the member's needs.

2.9.2.1.4.4 For a member in CHOICES Group 1, a Care Coordinator shall conduct a face-to-face in-facility visit within thirty (30) days of the member's enrollment with the

CONTRACTOR and conduct a comprehensive assessment as determined necessary by the CONTRACTOR (see Section A.2.9.6.5).

2.9.2.1.4.5 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the PCSP developed by the CONTRACTOR without any disruption in services.

2.9.2.1.4.6 The CONTRACTOR shall not:

2.9.2.1.4.6.1 Transition nursing facility residents or residents of community-based residential alternatives to another facility unless (1) the member or his/her representative specifically requests to transition, which shall be documented in the member's file, (2) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations;

2.9.2.1.4.6.2 Transition Group 1 members to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 or the member meets the at-risk level of care and is enrolled in CHOICES Group 3 (see Section A.2.9.6.8 for requirements regarding nursing facility to community transition);

2.9.2.1.4.6.3 Admit a member in CHOICES Group 2 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and (1) is expected to require short-term nursing facility services for ninety (90) days or less; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap, and the member agrees to transition to a nursing facility and enroll in Group 1;

2.9.2.1.4.6.4 Admit a member enrolled in CHOICES Group 3 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and (1) is expected to require short-term nursing facility services for ninety (90) days or less; or (2) the member chooses to transition to a nursing facility and enroll in Group 1; or

2.9.2.1.4.6.5 Transition members in Group 2 or 3 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall provide

continuation of HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.

2.9.2.2 In the event an enrollee entering the CONTRACTOR's MCO, either as a new TennCare enrollee or transferring from another MCO, is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal care, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider.

2.9.2.2.1 If the member is receiving services from a non-contract provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services, without any form of prior approval, until such time as the CONTRACTOR can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

2.9.2.2.2 If the member is receiving services from a contract provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the postpartum period.

2.9.2.3 In the event an enrollee entering the CONTRACTOR's MCO, either as a new TennCare enrollee or transferring from another MCO, is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) through the postpartum period, without any form of prior approval.

2.9.2.4 If a member enrolls in the CONTRACTOR's MCO from another MCO, the CONTRACTOR shall immediately contact the member's previous MCO and request the transfer of "transition of care data" as specified by TENNCARE. If the CONTRACTOR is contacted by another MCO requesting "transition of care data" for a member who has transferred from the CONTRACTOR to the requesting MCO (as verified by the CONTRACTOR), the CONTRACTOR shall provide such data in the timeframe and format specified by TENNCARE.

2.9.2.5 If the CONTRACTOR becomes aware that a CHOICES or ECF CHOICES member will be transferring to another MCO, the CONTRACTOR (including, but not limited to the member's Care Coordinator or care coordination team or Support Coordinator or support coordination team, or the Integrated Support Coordination Team, as applicable) shall, in accordance with protocols established by TENNCARE, work with the other MCO in facilitating a seamless transition for that member.

2.9.2.6 The CONTRACTOR shall ensure that any member entering the CONTRACTOR's MCO is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing and patient liability amounts (see Section A.2.6.7 of this Contract).

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

A.2.9.3 **Transition of CHOICES Members Receiving Long-Term Care Services at the Time of Implementation**

2.9.3.1 For each member who is enrolled in CHOICES and newly enrolled with the CONTRACTOR as of the date of implementation in each Grand Region covered by this Contract, as identified by TENNCARE (herein referred to as "transitioning CHOICES members"), the CONTRACTOR shall assign a Care Coordinator prior to the first face-to-face visit. If the face-to-face visit will not occur within ten (10) days after the implementation of this Contract, the CONTRACTOR shall send the member written notification within ten (10) calendar days of implementation that explains how the member can reach the care coordination unit for assistance with concerns or questions pending the assignment of a specific Care Coordinator.

2.9.3.2 For each transitioning CHOICES member, the CONTRACTOR shall be responsible for the costs of continuing to provide covered long-term care services authorized by the member's previous MCO, including, as applicable, CHOICES HCBS in the member's approved PCSP and nursing facility services without regard to whether such services are being provided by contract or non-contract providers for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate seamless transition to the new provider.

2.9.3.3 For members in CHOICES Groups 2 and 3 the CONTRACTOR shall continue HCBS in the member's approved PCSP for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce HCBS unless the member's Care Coordinator has conducted a comprehensive needs assessment and developed a PCSP and the CONTRACTOR has authorized and initiated HCBS in accordance with the member's new PCSP. If a member in CHOICES Groups 2 or 3 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services \and/or reimbursement approved by TENNCARE (see Section A.2.14.1.14).

2.9.3.4 For a transitioning member in CHOICES Group 2 or 3, within ninety (90) days of implementation, the member's Care Coordinator shall conduct a face-to-face visit (see Section A.2.9.6.2.5), including a comprehensive assessment (see Section A.2.9.6.5), and develop a PCSP (see Section A.2.9.6.6), and the CONTRACTOR shall authorize and initiate CHOICES HCBS in accordance with the new PCSP. If a member in Groups 2 or 3 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR, the member's Care Coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing services approved by TENNCARE, but no more than ninety (90) days after implementation, to determine appropriate comprehensive assessment and care planning activities (see Section A.2.9.6.2.5 for members who will be discharged from the nursing facility and remain in Group 2 or 3 and Section A.2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to ninety (90) days after implementation, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate.

2.9.3.5 If at any time before conducting a comprehensive assessment for a transitioning member in CHOICES Groups 2 or 3, the CONTRACTOR becomes aware of an increase in the member's needs, the member's Care Coordinator shall immediately conduct a comprehensive assessment and update the member's PCSP, and the CONTRACTOR shall initiate the change in services within ten (10) days of becoming aware of the change in the member's needs.

2.9.3.6 The CONTRACTOR shall provide nursing facility services to a transitioning member in Group 1 in accordance with the level of nursing facility services and/or reimbursement approved by TENNCARE (see Section A.2.14.1.14); however, the member may be transitioned to the community in accordance with Section A.2.9.6.8 of this Contract.

2.9.3.7 For a transitioning member in CHOICES Group 1 who, at the time of enrollment with the CONTRACTOR, has resided in a nursing facility for less than ninety (90) days, the member's Care Coordinator shall conduct a face-to-face in-facility visit within ninety (90) days of implementation and conduct a comprehensive assessment as determined necessary by the CONTRACTOR (see Section A.2.9.6.5.1). For a transitioning member in CHOICES Group 1 who, at the time of implementation, has resided in a nursing facility for ninety (90) days or more, the member's Care Coordinator shall conduct a face-to-face in-facility visit within six (6) months of the member's enrollment with the CONTRACTOR and conduct a comprehensive assessment as determined necessary by the CONTRACTOR (see Section A.2.9.6.5.1).

2.9.3.8 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the PCSP developed by the CONTRACTOR without any disruption in services.

2.9.3.9 The CONTRACTOR shall not:

2.9.3.9.1 Transition nursing facility residents or residents of community-based residential alternatives to another facility unless (1) the member or his/her representative specifically requests to transition, which shall be documented in the member's file, (2) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider. If the community-based residential facility where the member is currently residing is not a contract provider, then the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility. If the member is transitioned to a contract facility, then the CONTRACTOR shall facilitate a seamless transition to the new facility. If the nursing facility where the member is currently residing is a non-contract provider, then the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider, if the provider is eligible for enrollment in Medicaid, and reimburse such services from the non-contract nursing facility in accordance with TennCare rules and regulations; (b) authorize continuation of the services and reimburse such services from the non-contract nursing facility in accordance with TennCare rules and regulations, pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations;

2.9.3.9.2 Transition Group 1 members to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 (see Section A.2.9.6.8 for requirements regarding nursing facility to community transition);

2.9.3.9.3 Admit a member in CHOICES Group 2 or 3 to a nursing facility unless (1) the member requires a short-term nursing facility care stay (see Section A.2.6.1.5.3.1); (2) the member chooses to transition to a nursing facility and enroll in Group 1 and meets the nursing facility level of care standards in effect as of July 1, 2012; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap, and the member agrees to transition to a nursing facility and enroll in Group 1; or

2.9.3.9.4 Transition members in Group 2 or 3 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall provide continuation of CHOICES HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.

A.2.9.4 **Coordination and Collaboration for Members receiving Home Health or Private Duty Nursing Services**

2.9.4.1 The CONTRACTOR shall actively engage all members receiving home health (HH) or private duty nursing (PDN) services, as defined in TennCare Rule 1200-13-13-.01, respectively, in excess of adult benefit limits and/or coverage criteria. The CONTRACTOR shall meet the following milestone requirements and provide documentation as required below, and as requested by TENNCARE, that the following milestones are met:

2.9.4.1.1 For all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, as applicable, in preparation for and during the eighteenth (18th) year of age, the CONTRACTOR shall:

2.9.4.1.1.1 Identify all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, at least two (2) months prior to the member turning eighteen (18) years of age.

2.9.4.1.1.2 Create an internal mechanism to track and review all cases, including outreach and education, assessment and transition planning discussions and activities for members at or older than eighteen (18) years of age who are receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria. The internal tracking mechanism should be able to provide status updates as requested and in the form and format determined by TENNCARE. The internal tracking mechanism shall include but is not limited to the following:

2.9.4.1.1.2.1 Member Name;

2.9.4.1.1.2.2 Demographics;

2.9.4.1.1.2.3 1915(c) HCBS waiver status;

2.9.4.1.1.2.4 Intellectual/Developmental Disability (I/DD) status;

2.9.4.1.1.2.5 Current number of hours of HH or PDN;

2.9.4.1.1.2.6 Ventilator or tracheostomy dependent, or other complex respiratory care needs that qualify for PDN;

2.9.4.1.1.2.7 Date of completed listed milestone as appropriate;

2.9.4.1.1.2.8 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached a brief description of why the CONTRACTOR was unable to complete listed milestone;

2.9.4.1.1.2.9 Member transition plan of care.

2.9.4.1.1.3 Complete internal re-assessment of skilled and unskilled hands-on care needs that includes input of member, family, and home care agency staff, and review of service documentation regarding actual skilled and unskilled hands-on care services provided and their frequency. Additionally, the re-assessment should address clinical respiratory evaluation for all members that are ventilator dependent or have a tracheostomy or other complex respiratory care needs that qualify for PDN.

2.9.4.1.1.4 Complete an in-home or face-to-face visit with member and the member's family that includes but is not limited to the following topics:

2.9.4.1.1.4.1 Provide information regarding aging into the adult benefit category;

2.9.4.1.1.4.2 Re-address supported decision-making and legal issues (including, but not limited to competency, power of attorney, etc.) related to a member turning eighteen (18) years of age;

2.9.4.1.1.4.3 Discuss any school-related transitions, if applicable;

2.9.4.1.1.4.4 Provide education to member regarding TennCare HH and PDN benefits, including the adult HH and PDN benefit;

2.9.4.1.1.4.5 Provide education on ECF CHOICES and CHOICES programs, unless the member is enrolled in a Section 1915(c) HCBS waiver;

2.9.4.1.1.4.6 Assist, as needed with referral and intake/enrollment processes, as applicable for CHOICES or ECF CHOICES, unless the member is enrolled in a Section 1915(c) HCBS waiver and in such case, only as referred by TENNCARE.

2.9.4.1.1.5 Provide a Semi-Annual report to TENNCARE demonstrating the completion of the above items required in Section A.2.9.4.1.1 for each applicable member. This report does not need to include the actual case notes referenced in Section A.2.9.4.1.1.2.8.

2.9.4.1.2 For all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, as applicable, in preparation for and during the nineteenth (19th) year of age, the CONTRACTOR shall:

2.9.4.1.2.1 Identify all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, at least two (2) months prior to the member turning nineteen (19) years of age.

2.9.4.1.2.2 Continue to track all members internally in accordance with Section A.2.9.4.1.1.2. Additionally, the CONTRACTOR's Care team shall have quarterly multidisciplinary care coordination reviews to discuss and provide status updates for all members at or older than nineteen (19) years of age receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria,. The internal tracking mechanism shall include but is not limited to the following:

2.9.4.1.2.2.1 Member Name;

2.9.4.1.2.2.2 Demographics;

2.9.4.1.2.2.3 1915(c) HCBS waiver status;

2.9.4.1.2.2.4 Intellectual/Developmental Disability (I/DD) status;

2.9.4.1.2.2.5 Current number of hours of HH or PDN;

2.9.4.1.2.2.6 Ventilator or tracheostomy dependent, or other complex respiratory care needs that qualify for PDN;

2.9.4.1.2.2.7 Date of completed listed milestone as appropriate;

2.9.4.1.2.2.8 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached, a brief description of why the CONTRACTOR was unable to complete listed milestone;

2.9.4.1.2.2.9 Member transition plan of care.

2.9.4.1.2.3 Complete in-home reassessment of skilled and unskilled hands-on care needs that incorporates input of member, family, and home care agency staff, and review of service documentation regarding actual skilled and unskilled hands-on care services provided and their frequency. Additionally, the re-assessment should address clinical respiratory evaluation for all members that are ventilator dependent or have a tracheostomy or other complex respiratory care needs that qualify for PDN.

2.9.4.1.2.4 Coordinate joint interdisciplinary face-to-face in-home visit including but not limited to the HH or PDN care coordinator and ECF CHOICES and CHOICES Care and Support Coordinator Team or Advocate unless the member is enrolled in a Section 1915(c) HCBS waiver, in which case the joint interdisciplinary face-to-face in-home visit shall be coordinated to include the member's Independent Support Coordinator rather than the ECF CHOICES and CHOICES Care and Support Coordinator Team.

2.9.4.1.2.5 Complete a face-to-face in-home visit with member and the member's family that includes but is not limited to the following topics:

2.9.4.1.2.5.1 Provide education to members regarding TennCare HH and PDN benefits, including the adult HH and PDN benefit;

2.9.4.1.2.5.2 Review of the Turning Twenty-One (21) Member Handbook and accompanying acknowledgment form;

2.9.4.1.2.5.3 Review any pertinent clinical care plan with input from home care providers and PCP representatives.

2.9.4.1.2.6 Provide a Semi-Annual report to TENNCARE demonstrating the completion of the above items required in Section A.2.9.4.1.2 for each applicable member. This report should not include the actual case notes referenced in Section A.2.9.4.1.2.2.8.

2.9.4.1.3 For all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, as applicable, in preparation for and during the first three (3) months of their twentieth (20th) year of age, the CONTRACTOR shall:

2.9.4.1.3.1 Identify all members receiving HH or PDN services above the adult benefit limit at least one (1) month prior to the member turning twenty (20) years of age.

2.9.4.1.3.2 Continue to track all members internally in accordance with Sections A.2.9.4.1.1.2 and A.2.9.4.1.2.2. Additionally, the CONTRACTOR's Care team will have monthly multidisciplinary care coordination reviews to discuss and provide status updates for all members at or older than twenty (20) years of age receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria. The internal tracking mechanism shall include but is not limited to the following:

2.9.4.1.3.2.1 Member Name;

2.9.4.1.3.2.2 Demographics;

2.9.4.1.3.2.3 1915(c) HCBS waiver status;

2.9.4.1.3.2.4 Intellectual/Developmental Disability (I/DD) status;

2.9.4.1.3.2.5 Current number of hours of HH or PDN;

2.9.4.1.3.2.6 Ventilator or tracheostomy dependent, or other complex respiratory care needs that qualify for PDN;

2.9.4.1.3.2.7 Date of completed listed milestone as appropriate;

2.9.4.1.3.2.8 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached, a brief description of why the CONTRACTOR was unable to complete listed milestone;

2.9.4.1.3.2.9 Member transition plan of care.

2.9.4.1.3.3 Complete in-home reassessment of skilled and unskilled hands-on care needs that incorporates input of member, family, and home care agency staff, and review of service documentation regarding actual skilled and unskilled hands-on care services provided and their frequency. Additionally, the re-assessment should address clinical respiratory evaluation for all members that are ventilator dependent or have a tracheostomy or other complex respiratory care needs that qualify for PDN.

2.9.4.1.3.4 Coordinate joint interdisciplinary face-to-face in-home visit including but not limited to the HH or PDN care coordinator and ECF CHOICES and CHOICES Care and Support Coordinator Team or Advocate unless the member is enrolled in a Section 1915(c) HCBS waiver, in which case the joint interdisciplinary face-to-face in-home visit shall be coordinated to include the member's Independent Support Coordinator rather than the ECF CHOICES and CHOICES Care and Support Coordinator Team.

2.9.4.1.3.5 Complete a face-to-face in-home visit with member and the member's family that includes but is not limited to the following topics:

2.9.4.1.3.5.1 Provide education to members regarding TennCare HH and PDN benefits, including the adult HH and PDN benefit;

2.9.4.1.3.5.2 Re-review of the Turning Twenty-One (21) Member Handbook and accompanying acknowledgment form;

2.9.4.1.3.5.3 Determine and document any anticipated changes to the member's support plan/environment when turning twenty-one (21) and update ECF CHOICES person-centered support plan if already enrolled unless the member is enrolled in a Section 1915(c) HCBS waiver, in which case the CONTRACTOR shall work with the Independent Support Coordinator to update the member's Individual Support Plan;

2.9.4.1.3.5.4 Review any pertinent clinical care plan with input from home care providers and PCP representatives;

2.9.4.1.3.6 Contact member's primary care provider and/or specialist to discuss member's benefit limit change and review the transition plan of care.

2.9.4.1.3.7 Provide a Semi-Annual report to TENNCARE demonstrating the completion of the above items required in Section A.2.9.4.1.3 for each member. This should not include the actual case notes referenced in Section A.2.9.4.1.3.2.8.

2.9.4.1.4 For all members age twenty (20) years six (6) months and older receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, as applicable, the CONTRACTOR shall:

2.9.4.1.4.1 Continue to track all members internally in accordance with Sections A.2.9.4.1.1.2, A.2.9.4.1.2.2, and A.2.9.4.1.3.2. Additionally, the CONTRACTOR's Care team will have weekly multidisciplinary care coordination reviews to discuss and provide status updates for all members at or older than twenty (20) years six (6) months of age receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria. The internal tracking mechanism shall include but is not limited to the following:

2.9.4.1.4.1.1 Member Name;

2.9.4.1.4.1.2 Demographics;

2.9.4.1.4.1.3 1915(c) HCBS waiver status;

2.9.4.1.4.1.4 Intellectual/Developmental Disability (I/DD) status;

2.9.4.1.4.1.5 Current number of hours of HH or PDN;

2.9.4.1.4.1.6 Ventilator or tracheostomy dependent, or other complex respiratory care needs that qualify for PDN as defined in TennCare Rule 1200-13-13-.01 (101);

2.9.4.1.4.1.7 Date of completed listed milestone as appropriate;

2.9.4.1.4.1.8 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached, a brief description of why the CONTRACTOR was unable to complete listed milestone;

2.9.4.1.4.1.9 Member transition plan of care.

2.9.4.1.4.2 At least monthly include the care coordination team of the prospective MCO of the member in the multidisciplinary care coordination reviews.

2.9.4.1.4.3 Re-evaluate all members and confirm if member is considering CHOICES or ECF CHOICES, unless the member is enrolled in a Section 1915(c) HCBS waiver.

2.9.4.1.4.3.1 For members receiving HH or PDN services above the adult benefit limit and/or coverage criteria considering home and community based services CHOICES or ECF CHOICES the CONTRACTOR shall contact LTSS within five (5) business days of discovery that a member is above such limit and/or coverage criteria to discuss transition of the member, unless the member is enrolled in a Section 1915(c) HCBS waiver. This shall include but is not limited to discussing and initiating the intake process for CHOICES or ECF CHOICES. For CHOICES group 2 or 3, the member cannot enroll until age twenty-one (21) but the MCO can complete a person-centered support plan (PCSP) with the member/family to demonstrate what services will be provided. For ECF CHOICES, enrollment can occur earlier and allows the member to initiate some ECF CHOICES services and also begin the process of hiring CD workers if they choose that option.

2.9.4.1.4.4 For members not willing to transition to HH and/or PDN services, as applicable, that comport with adult benefit limits upon turning age 21, and considering home and community based CHOICES or ECF CHOICES and not enrolled in a Section 1915(c) HCBS waiver, or alternatively, enrolled in a Section 1915(c) HCBS waiver, but not participating with the CONTRACTOR and the Independent Support Coordinator to make needed adjustments in the member's Individual Support Plan:

2.9.4.1.4.4.1 Require the Medical Director (or equivalent) to conduct peer-to-peer review with the member's PCP of the care plan;

2.9.4.1.4.4.2 Develop and provide a proposed plan that outlines how the services within CHOICES/ECF CHOICES program, in combination with medically necessary covered home health or private duty nursing for adults age 21 and older, as applicable, could support the member in lieu of current skilled or home health services, and in the case of a person enrolled in a Section 1915(c) HCBS waiver, in lieu of 1915(c) waiver services as well. The proposed plan will be developed based on the member's current diagnosis, medical and behavioral needs and not considered final. A complete CHOICES/ECF CHOICES assessment and development of the person centered support plan would occur should the member choose to enroll in the CHOICES/ECF CHOICES program, which for a person

enrolled in a Section 1915(c) HCBS waiver would require disenrollment from that waiver program;

2.9.4.1.4.4.3 If the member is enrolled in a Section 1915(c) HCBS waiver, but not participating with the CONTRACTOR and the Independent Support Coordinator to make needed adjustments in the member's Individual Support Plan, work with the Independent Support Coordinator to develop proposed updates to the member's Individual Support Plan that could, in combination with medically necessary covered home health or private duty nursing for adults age 21 and older, as applicable, support the member in lieu of current skilled or home health services. The proposed plan will be developed based on the member's current diagnosis, medical and behavioral needs and shall not be considered final. Updates could be finalized with the member and his/her Circle of Support in order to facilitate timely transition to adult benefits; and

2.9.4.1.4.4.4 Maintain detailed documentation of all contacts and activities described in this section, including efforts to educate the member and family, and to engage them in planning for the member's transition to adult benefit limits and the development of home and community based services (and other alternatives, as applicable) that could support the member in lieu of current skilled or home health services; and provide monthly reports to TENNCARE for each member outlining continued engagement, assessments, transition planning discussions and activities, reduction status and supporting documentation. The report shall also include clinical assessment documenting whether the patient is ventilator dependent or has a tracheostomy or other complex respiratory care needs that qualify for PDN and current skilled nursing needs.

2.9.4.1.4.5 Provide TENNCARE with a weekly report that identifies member name, identifying information and selected MCO. At TENNCARE's discretion, the report should contain at least the following elements:

2.9.4.1.4.5.1 Member name;

2.9.4.1.4.5.2 Demographics;

2.9.4.1.4.5.3 1915(c) HCBS waiver status;

2.9.4.1.4.5.4 Intellectual/Developmental Disability (I/DD) status

2.9.4.1.4.5.5 Initial MCO choice (at 20 ½ years of age);

2.9.4.1.4.5.6 If no patient choice, auto assigned MCO at 20 ½ years of age;

2.9.4.1.4.5.7 Transition plan (Yes/No);

2.9.4.1.4.5.8 MCO assignment at 20 years and 9 months of age;

2.9.4.1.4.5.9 "In-person" meeting between TCS and assigned MCO regarding the impending transition;

2.9.4.1.4.5.10 Date of change for MCO assignment since last report, if applicable.

2.9.4.1.5 For all members who are enrolled in TennCare Select receiving HH or PDN services, in excess of adult benefit limits and/or coverage criteria, as applicable, between the ages of twenty (20) years three (3) months of age and twenty-one (21) years of age and have been identified for potential prospective assignment to CONTRACTOR, the CONTRACTOR shall:

2.9.4.1.5.1 Coordinate and participate in joint face-to-face introduction and meeting with member and member's family, TennCare Select care team and prospective MCO CONTRACTOR care team shall occur no later than the member being twenty (20) years and six (6) months of age.

2.9.4.1.5.2 To begin no later than the member being twenty (20) years and six (6) months of age, participate at least monthly in multidisciplinary care coordination reviews between prospective MCO CONTRACTOR care coordination team and TennCare Select care coordination team.

2.9.4.1.5.3 Provide documentation, at the request of TENNCARE and in the form and format determined by TENNCARE, from the prospective MCO CONTRACTOR that includes but is not limited to the following information:

2.9.4.1.5.3.1 Member Name;

2.9.4.1.5.3.2 Demographics;

2.9.4.1.5.3.3 Current number of hours of HH or PDN;

2.9.4.1.5.3.4 Ventilator or tracheostomy dependent, or other complex respiratory care needs;

2.9.4.1.5.3.5 Date of completed listed milestone as appropriate;

2.9.4.1.5.3.6 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached, a brief description of why CONTRACTOR was unable to complete listed milestone;

2.9.4.1.5.3.7 Member transition plan of care.

2.9.4.1.6 For all members receiving HH or PDN services, in excess of adult benefit limits and/or coverage criteria, as applicable, that are eighteen (18), nineteen (19) or twenty (20) years of age during the implementation of the requirements in Sections A.2.9.4.1.1 through A.2.9.4.1.5, the CONTRACTOR shall perform the requirements for the member's respective age within six (6) months of January 1, 2018. However, the CONTRACTOR shall not be required to perform the requirements applicable to the ages younger than the member. By way of example, if a member is nineteen (19) years of age during the first year of implementation of the requirements in Sections A.2.9.4.1.1 through A.2.9.4.1.5, within six (6) months the CONTRACTOR shall perform the requirements applicable in a member's nineteenth (19th) year of age per Section A.2.9.4.1.2 but is not required to perform the requirements applicable in a member's eighteenth (18th) year of age per Section A.2.9.4.1.1.

2.9.4.1.7 For any member receiving HH or PDN services, in excess of adult benefit limits and/or coverage criteria, as applicable, that is twenty-one (21) years of age or older after the implementation of Sections A.2.9.4.1.1 through A.2.9.4.1.5 the CONTRACTOR shall perform the following requirements within fifteen (15) months of implementation of said requirements:

2.9.4.1.7.1 Identify all members receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria.

2.9.4.1.7.2 Create internal mechanism to track and review all cases, including outreach and education, assessment and transition planning discussions and activities for members who are receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria. The internal tracking mechanism should be able to provide status updates as requested and in the form and format determined by TENNCARE. The internal tracking mechanism shall include but is not limited to the following:

2.9.4.1.7.2.1 Member Name;

2.9.4.1.7.2.2 Demographics;

2.9.4.1.7.2.3 Current number of hours of HH or PDN;

2.9.4.1.7.2.4 Ventilator or tracheostomy dependent, or other complex respiratory care needs that qualify for PDN;

2.9.4.1.7.2.5 Date of completed listed milestone as appropriate;

2.9.4.1.7.2.6 Case notes, including outreach and education, assessments and transition planning discussions and activities. If milestones not reached, a brief description of why the CONTRACTOR was unable to complete listed milestone;

2.9.4.1.7.2.7 Member transition plan of care.

2.9.4.1.7.3 Complete the requirements of Section A.2.9.4.1.2.5.

2.9.4.1.7.4 Complete the requirements of Section A.2.9.4.1.3.5.

2.9.4.1.7.5 At the sole discretion of TENNCARE, an On Request Report (ORR) may be issued to the CONTRACTOR to obtain information for review by TENNCARE prior to the CONTRACTOR issuing an adverse benefit determination (ABD), reducing PDN and/or HH for any member age twenty-one (21) years old or older receiving PDN and/or HH services in excess of adult benefit limits and/or coverage criteria.

2.9.4.1.7.6 The ORR from TENNCARE may include requests for information and documentation, including but not limited to, transition planning discussions, nursing notes, home health aide notes, assessments, current plan of care, alternative plans of care, and information regarding missed shifts.

2.9.4.1.8 For all members eighteen (18) years of age or older who are receiving HH or PDN services in excess of adult benefit limits and/or coverage criteria, as applicable, in compliance with an Administrative Law Judge's (ALJ) order or provided as a cost-effective alternative (CEA), the CONTRACTOR shall perform the following requirements:

2.9.4.1.8.1 Identify the applicable member.

2.9.4.1.8.2 Fulfill the requirements in Contract Section A.2.9.4.1 for these members.

2.9.4.1.8.3 Six (6) months after the ALJ order or the determination of the cost-effective alternative and every six (6) months thereafter, complete internal re-assessment of skilled and unskilled hands-on care needs that includes input from the member, family, and home care agency staff, and review of service documentation regarding actual skilled and unskilled hands-on care services provided and their frequency. Additionally, this re-assessment shall address clinical respiratory evaluation for all members that are ventilator dependent or have a tracheostomy or other complex respiratory care needs.

2.9.4.1.8.4 The CONTRACTOR's Medical Director (or equivalent) shall conduct peer-to-peer review with the member's PCP of the care plan, determine if the member's clinical status has changed, the appropriateness of the ALJ ordered services, and/or whether the service still qualifies as a cost-effective alternative. Depending on the CONTRACTOR's determination, the CONTRACTOR shall take the appropriate action.

2.9.4.1.8.5 Provide TENNCARE with a Semi-Annual report demonstrating the above items required in section A.2.9.4.1.8 for each applicable member.

A.2.9.5 **Transition of Care**

2.9.5.1 The CONTRACTOR shall actively assist members with chronic or acute medical or behavioral health conditions, members who are receiving long-term care services, and members who are pregnant in transitioning to another provider when a provider currently treating their chronic or acute medical or behavioral health condition, currently providing their long-term care services, or currently providing prenatal services has terminated participation with the CONTRACTOR. For CHOICES members, this assistance shall be provided by the member's Care Coordinator/care coordination team.

2.9.5.1.1 Except as provided below regarding members who are in their second or third trimester of pregnancy, the CONTRACTOR shall provide continuation of such provider for up to ninety (90) calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less.

2.9.5.1.2 For members in their second or third trimester of pregnancy, the CONTRACTOR shall allow continued access to the member's prenatal care provider and any provider currently treating the member's chronic or acute medical or behavioral health condition or currently providing long-term care services, through the postpartum period.

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

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

2.9.5.2.2 For CHOICES members in Groups 2 and 3 or ECF CHOICES, the requirement for a HCBS provider that is no longer willing or able to provide services to a member to cooperate with the member's Care Coordinator or Support Coordinator to facilitate a seamless transition to another HCBS provider (see Section A.2.12.11.1) and to continue to provide services to the member until the member has been transitioned to another HCBS provider, as determined by the CONTRACTOR, or as otherwise directed by the CONTRACTOR (see Section A.2.12.11.2);

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

2.9.5.2.4 A mechanism for assuring confidentiality;

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

2.9.5.2.6 An appropriate schedule for transitioning members from one (1) provider to another when there is medical necessity for ongoing care.

2.9.5.2.7 Specific transition language on the following special populations:

2.9.5.2.7.1 Priority Enrollees;

2.9.5.2.7.2 Persons who have addictive disorders;

2.9.5.2.7.3 Persons who have co-occurring disorders of both mental health and substance abuse disorders; and

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

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

2.9.5.2.7.4.2 Psychiatrist: three (3) months;

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

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

2.9.5.2.7.4.5 Psychiatric inpatient or residential treatment and supported housing: six (6) months.

A.2.9.6 **Care Coordination**

2.9.6.1 <u>General</u>

2.9.6.1.1 The CONTRACTOR shall provide care coordination to all members enrolled in TennCare CHOICES and support coordination to all members enrolled in ECF CHOICES in accordance with this Contract and to other TennCare members only in order to determine the member's eligibility for and facilitate the member's enrollment in TennCare CHOICES or ECF CHOICES. Except for the initial process for current members that is necessary to determine the member's eligibility for and facilitate the member's enrollment in TennCare CHOICES or ECF CHOICES, care coordination shall not be available to non-CHOICES members, and support coordination shall not be available to non-ECF CHOICES members.

2.9.6.1.2 The CONTRACTOR shall provide care coordination and support coordination in a comprehensive, holistic, person-centered manner.

2.9.6.1.3 The CONTRACTOR shall use care coordination as the continuous process of: (1) assessing a member's physical, behavioral, functional, and psychosocial needs; (2) identifying the physical health, behavioral health and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs; (3) ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term care services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and (4) facilitating access to other social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.

2.9.6.1.4 The CONTRACTOR shall use support coordination as the continuous process of: (1) identifying, developing, and supporting opportunities for a member's community involvement, including achieving and maintaining competitive, integrated employment consistent with the member's individual strengths, preferences and conditions for success; (2) leveraging member strengths, resource and opportunities available in the member's community, and natural supports available to the member in coordination with ECF services and supports to enable the member to achieve his/her desired lifestyle and goals for community involvement, employment and independent living and wellness; (3) assessing a member's physical, behavioral, functional, and psychosocial needs; (4) identifying the physical health, behavioral health and long-term services and other support services and assistance (e.g., vocational rehabilitation, housing or income assistance) that are necessary to enable the member to achieve his/her desired lifestyle, goals for community involvement, employment and independent living, and wellness, and to address identified needs; (5) ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term services and supports necessary to facilitate the member's community involvement, including achieving and maintaining competitive, integrated employment, consistent with the member's individual strengths, preferences and conditions for success and necessary to maintain or improve his or her physical or behavioral health status and functional abilities, to maximize independence, to ensure the member's rights and choices, health, safety and welfare, and as applicable, to delay or prevent the need for more restrictive and more expensive institutional placement; and (6) facilitating access to other support services and assistance the member needs to achieve his/her desired lifestyle, goals for community involvement, employment and independent living and wellness, and to address identified needs.

2.9.6.1.5 Long-term services and supports identified through care coordination or support 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.

2.9.6.1.6 The CONTRACTOR shall develop and implement policies and procedures for care coordination and for support coordination that comply with the requirements of this Contract.

2.9.6.1.7 The CONTRACTOR shall compute Care Coordination CHOICES-related timelines and Support Coordination ECF CHOICES-related timelines as follows:

2.9.6.1.7.1 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.

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

2.9.6.1.7.3 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.

2.9.6.1.7.4 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.

2.9.6.1.8 The CONTRACTOR's failure to meet requirements, including timelines, for care coordination or support coordination set forth in this Contract, except for good cause, constitutes non-compliance with this Contract. Such failure shall not affect any determination of eligibility for CHOICES or ECF CHOICES enrollment, which shall be based only on whether the member meets CHOICES or ECF CHOICES eligibility and enrollment criteria, as defined pursuant to the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Contract, and TennCare policies and protocols. Nor shall such failure affect any determination of coverage for CHOICES or ECF CHOICES benefits which shall be based only on the covered benefits for the applicable CHOICES or ECF CHOICES group in which the member is enrolled as defined pursuant to the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Contract, and TennCare policies and protocols; and in accordance with requirements pertaining to medical necessity.

2.9.6.1.9 The CONTRACTOR shall ensure that its care coordination and support coordination program complies with 42 CFR 438.208 and 42 § C.F.R. 441.301(c)(4)-(6).

2.9.6.1.10 The CONTRACTOR shall ensure that, upon enrollment into CHOICES or ECF CHOICES, the appropriate level of Population Health (see Section A.2.8.4 of this Contract) activities are integrated with CHOICES care coordination or ECF CHOICES support coordination processes and functions, and that the member's assigned Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term services and supports needs. The Care Coordinator, Support Coordinator, or Integrated Support Coordination Team 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, Support Coordinator/support coordination team, or Integrated Support Coordination Team, as applicable.

2.9.6.2 <u>Intake Process for Members New to Both TennCare and CHOICES or ECF CHOICES</u>

2.9.6.2.1 The CONTRACTOR shall refer all inquiries regarding CHOICES or ECF CHOICES enrollment by or on behalf of potential applicants who are not enrolled with the CONTRACTOR to TENNCARE or its designee, as applicable for each program. The form and format for such referrals shall be developed in collaboration with the CONTRACTOR and TENNCARE or its designee.

2.9.6.2.2 TENNCARE or its designee, as applicable for each program, will assist potential applicants who are not enrolled in TennCare with TennCare eligibility and CHOICES or ECF CHOICES intake and enrollment.

2.9.6.2.3 *Functions of TENNCARE or its designee in the CHOICES or ECF CHOICES Referral (including Screening, Intake, and Enrollment) Process*

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. For potential applicants for ECF CHOICES, TENNCARE or its designee shall employ an electronic referral form, using the protocols specified by TENNCARE, to assist with referral and screening for persons new to both TENNCARE and ECF CHOICES. The ECF CHOICES self-referral and screening process is mandatory. For both programs, such screening process shall assess: (1) whether the potential applicant appears to meet categorical and financial eligibility criteria for CHOICES or ECF CHOICES, as applicable; and (2) whether the potential applicant appears to meet level of care eligibility for enrollment in CHOICES or ECF CHOICES. For ECF CHOICES, the screening process shall also gather information that can be used by TENNCARE to prioritize the potential applicant for intake based on established prioritization and enrollment criteria. If the initial contact is not telephonic, or if TENNCARE or its designee is not able to provide assistance at the point of contact, within two (2) business days, TENNCARE or its designee shall contact the applicant to provide assistance to the potential applicant, as needed, in completing the online self-referral.

2.9.6.2.3.2 For persons 1) identified by TENNCARE or its designee as meeting the screening criteria; 2) who do not meet screening criteria but elect to proceed with intake; or 3) for CHOICES applicants 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 potential applicant.

2.9.6.2.3.3 As part of this intake visit for CHOICES, TENNCARE or its designee will, using the tools and protocols specified by TENNCARE, conduct a level of care and comprehensive assessment; and assess the potential applicant'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 individual through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance.

2.9.6.2.3.4 For ECF CHOICES intake visits, TENNCARE or its designee will, using the intake packet and protocols specified by TENNCARE, gather basic information that will allow TENNCARE to verify the potential applicant's target population and prioritize the applicant for enrollment based on established prioritization and enrollment criteria.

2.9.6.2.3.5 TENNCARE or its designee shall conduct the intake visit for potential CHOICES or ECF CHOICES applicants in the potential applicant's place of residence, except under extenuating circumstances (such as the member's hospitalization), which shall be documented in writing.

2.9.6.2.3.6 As part of the intake visit for potential CHOICES applicants, TENNCARE or its designee shall: (1) document and confirm the applicant's current address and phone number(s); (2) provide general CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (3) provide information about estate recovery; (4) 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; (5) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (6) 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; (7) 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; (8) 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; (9) for applicants who are seeking CHOICES HCBS: (a) conduct a risk assessment in accordance with protocols developed by TENNCARE and discuss with the applicant identified risks of receiving care in the home or community-based setting, the consequences of such risks, and strategies to mitigate the identified risks; and (b) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and (10) 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 upon enrollment, including that the CONTRACTOR will develop and approve a PCSP.

2.9.6.2.3.7 As part of the face-to-face intake visit for potential ECF CHOICES applicants, TENNCARE or its designee shall, in accordance with requirements set forth in protocol: (1) document and confirm the potential applicant's current address and phone number(s); (2) provide general ECF CHOICES education and information, as specified by TENNCARE, including an explanation of the PAE completion and submission process, and assist in answering any questions the potential applicant may have; and (3) gather all required supporting documentation needed by TENNCARE to verify target population and to prioritize the person for enrollment based on established prioritization and enrollment criteria. TENNCARE or its designee may complete actions required as part of the enrollment process (see A.2.9.6.2.3.9) and obtain the required signatures during the intake visit for potential applicants that TENNCARE or its designee determines are likely to qualify in either an open priority category or a reserve capacity slot, but shall not proceed with enrollment activities (including completion and submission of a PAE) until such time that TENNCARE's designee is notified by TENNCARE that the person meets prioritization criteria for enrollment into a category that is

currently open for enrollment and for which a slot is available, or that the person meets criteria for an available reserve capacity slot.

2.9.6.2.3.8 When it is determined by TENNCARE that a potential applicant for ECF CHOICES meets target population and also meets prioritization criteria for enrollment into a category that is currently open for enrollment and for which a slot is available, or that the person meets criteria for an available reserve capacity slot (which may require submission to the interagency review committee before such determination can be made), TENNCARE or its designee shall proceed with an enrollment visit. The enrollment visit may, on a case-by-case basis, be completed telephonically if it is determined during the intake visit that the applicant is likely to qualify in either an open priority category or a reserve capacity slot, actions required as part of the enrollment process (see A.2.9.6.2.3.9) including the required signatures have been completed, and an explanation of the PAE completion and submission process has been provided.

2.9.6.2.3.9 As part of the enrollment visit for ECF CHOICES, TENNCARE or its designee shall, as applicable (see 2.9.6.2.3.8.1) and in accordance with requirements set forth in protocol: (1) confirm or update, as applicable, the applicant's current address and phone number(s); (2) review ECF CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (3) make sure the applicant is aware that DIDD policy does not permit a person enrolled in ECF CHOICES to enroll in the Family Support Program operated by DIDD; (4) complete level of care (i.e., PAE) and Medicaid applications and provide assistance, as necessary, in gathering documentation needed by the State to determine medical and financial eligibility for reimbursement of LTSS, including post-eligibility provisions (i.e., patient liability); (5) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (6) provide information about estate recovery; (7) provide detailed information and obtain signed acknowledgement of understanding regarding an ECF CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability; (8) 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 ECF CHOICES and the functions of the CONTRACTOR upon enrollment, including that the CONTRACTOR shall work with the applicant to develop and approve a PCSP. The enrollment visit shall be face-to-face, except in circumstances described in A.2.9.6.2.3.7 where TENNCARE's designee has already completed actions required as part of the enrollment process and obtained the required signatures during the face-to-face intake visit, in which case TENNCARE's designee may proceed with enrollment, and shall contact the ECF CHOICES applicant either in person or telephonically within five (5) business days of the decision to proceed with enrollment to inform the applicant that TENNCARE's designee shall be completing and submitting the PAE on the applicant's behalf, and will explain that the applicant will receive the outcome of this submission from TENNCARE via mail.

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

2.9.6.2.3.11 TENNCARE will notify the CONTRACTOR via the outbound 834 enrollment file when a person has been enrolled in CHOICES or ECF CHOICES, the member's CHOICES or ECF CHOICES Group, and any applicable patient liability amounts (See Section A.2.6.7).

2.9.6.2.3.11.1 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 A.2.6.1.5.2.3), which shall be the average cost of Level 1 nursing facility care, or upon implementation of the new nursing facility reimbursement methodology, the average cost of nursing facility care because the Level 1/Level 2 distinction will be eliminated, 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, because the member would qualify to receive Enhanced Respiratory Care reimbursement in a nursing facility.

2.9.6.2.3.11.2 For members in ECF CHOICES, TENNCARE shall notify the CONTRACTOR of the member's expenditure cap (see definition in Section 1) on the outbound 271 file, and the CONTRACTOR shall receive, process, and update this file in accordance with Section A.2.4.6.1.

2.9.6.2.3.12 TENNCARE or its designee will make available to the CONTRACTOR all documentation from the intake visit (and for ECF CHOICES, the enrollment visit).

2.9.6.2.3.13 The CONTRACTOR shall complete all intake processes in Section A.2.9.6.2 within thirty (30) calendar days, unless an exception is granted by TENNCARE in writing due to extenuating circumstances beyond the CONTRACTOR's control. If TENNCARE grants an exception, such exception will provide the CONTRACTOR an additional thirty (30) calendar days to complete an intake process for the applicant, totaling sixty (60) calendar days to complete the intake process. If TENNCARE grants the CONTRACTOR an exception and the CONTRACTOR does not complete the intake process within sixty (60) calendar days, the CONTRACTOR shall close the referral, notify TENNCARE, and document the reason(s) the intake process was not completed for that applicant, and shall maintain such documentation and provide the documentation to TENNCARE upon request.

2.9.6.2.4 *Functions of the CONTRACTOR for Members in CHOICES Group 1*

2.9.6.2.4.1 For members enrolled in CHOICES Group 1, who are, upon CHOICES enrollment, receiving nursing facility services, the CONTRACTOR shall reimburse such services in accordance with the level of reimbursement for nursing facility services approved by TENNCARE (see Section A.2.14.1.14), except that, until the new nursing facility reimbursement methodology is effective in the TennCare Rules, the CONTRACTOR may reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement. Reimbursement for such services shall be for the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Group 1 who are, upon CHOICES enrollment, receiving nursing facility services, to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is

not a contract provider. If the nursing facility is a non-contract provider, the CONTRACTOR shall (a) provide continuation of the services pending enrollment of the facility as a contract provider, if the provider is eligible for enrollment in Medicaid, and reimburse such services from the non-contract nursing facility in accordance with TennCare rules and regulations; (b) provide continuation of the services pending facilitation of the member's transition to a contract facility and reimburse such services from the non-contract nursing facility in accordance with TennCare rules and regulations, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.

2.9.6.2.4.2 The CONTRACTOR shall, within thirty (30) calendar days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member and perform any additional comprehensive assessment deemed necessary by the CONTRACTOR (see Section A.2.9.6.5.1). The Care Coordinator shall review the PCSP developed by the nursing facility and may supplement the PCSP as necessary and appropriate (see Section A.2.9.6.6.1).

2.9.6.2.4.3 The CONTRACTOR shall not transition members in Group 1 to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility and is enrolled in Group 2 or a member enrolled in CHOICES on or after July 1, 2012 no longer meets nursing facility level of care but does meet the at-risk level of care and is enrolled in Group 3.

2.9.6.2.4.4 For purposes of the CHOICES program, the CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care (i.e., reimbursement, including the duration of such level of reimbursement) approved by TENNCARE (see Section A.2.14.1.14), except that, until the new nursing facility reimbursement methodology is effective in the TennCare Rules, the CONTRACTOR may reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement.

2.9.6.2.4.5 The CONTRACTOR shall be responsible for monitoring the member's continued need for and receipt of skilled and/or rehabilitative services in a NF only when approval of NF LOC is conditioned on the receipt of such services, and in such case, when skilled and/or rehabilitative services are no longer medically necessary, shall submit information needed by TENNCARE to reevaluate whether the member continues to meet level of care for nursing facility services (see also Section A.2.14.1.14).

2.9.6.2.4.6 Any time the CONTRACTOR submits a level of care application to TENNCARE for a member in a Nursing Facility, the CONTRACTOR shall, as expeditiously as possible and within no more than two (2) business days, notify the Nursing Facility that a level of care application has been submitted, and shall provide a copy of such application to the Nursing Facility.

2.9.6.2.5 *Functions of the CONTRACTOR for Members in CHOICES Groups 2 and 3, and ECF CHOICES*

2.9.6.2.5.1 For members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving community-based residential alternative services that are covered in CHOICES, the CONTRACTOR shall, immediately upon notice of the member's

enrollment in CHOICES, authorize such services from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not transition members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving services in a community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR; or (3) the facility where the member is residing is not a contract provider; if the facility is a non-contract provider, the CONTRACTOR shall authorize medically necessary services from the non-contract provider for at least thirty (30) days which shall be extended as necessary to ensure continuity of care pending the facility's enrollment with the CONTRACTOR or the member's transition to a contract provider.

2.9.6.2.5.2 For members in CHOICES Group 2 who upon CHOICES enrollment are receiving services in a community-based residential alternative setting, within ten (10) business days of notice of the member's enrollment in CHOICES the Care Coordinator shall conduct a face-to-face visit with the member, perform a comprehensive assessment (see Section A.2.9.6.5), develop a PCSP (see Section A.2.9.6.6), and authorize and initiate additional CHOICES HCBS specified in the PCSP (i.e., assistive technology).

2.9.6.2.5.3 For CHOICES and ECF CHOICES members, the Support Coordinator, Care Coordinator, or Integrated Support Coordination Team, as applicable, shall conduct a face-to-face visit with the member, initiate a comprehensive assessment in a manner sufficient to ensure strengths, needs, opportunities, and challenges are identified and addressed as set forth below, and conduct a caregiver assessment, and authorize and initiate CHOICES HCBS and ECF CHOICES HCBS as described and in accordance with timeframes specified in this section.

2.9.6.2.5.3.1 For CHOICES members, the CONTRACTOR shall authorize and initiate immediately needed CHOICES HCBS within ten (10) business days of receiving notice of a member's enrollment, except when a later date is requested by the member which shall be documented in writing (e.g., when a CHOICES member elects to participate in consumer direction and refuses services from an agency in the interim). CHOICES HCBS authorized and initiated while the member's comprehensive PCSP is developed will continue automatically after the comprehensive PCSP is developed, unless a limited duration is specified in the member's PCSP and authorized accordingly.

2.9.6.2.5.3.2 For ECF CHOICES members, the CONTRACTOR shall determine if the member immediately needs any ECF CHOICES HCBS while the comprehensive PCSP is developed. Immediately needed ECF CHOICES HCBS may include (but are not limited to) services that a person needs in order to facilitate timely discharge from an inpatient setting or to prevent inappropriate placement in an inpatient or other restrictive setting, to prevent imminent placement outside the person's current living arrangement, to address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm, or consistent with the program's primary goals, to prevent imminent loss of competitive integrated employment or an offer of such employment. Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS) and Intensive Behavioral Community Transition and Stabilization Services shall be considered "immediately needed" services. The CONTRACTOR may utilize other covered benefits or cost-effective alternative services as needed to address

immediate needs while ECF CHOICES services are put into place, or provide incentives to providers with prior approval from TENNCARE to provide such immediately needed services and to put in place sustainable strategies to enable the provider to do so on ongoing basis. The CONTRACTOR shall document immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs in the PCSP and shall authorize and initiate any immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs within ten (10) business days of receiving notice of a member's enrollment, or as expeditiously as needed to facilitate timely discharge, avoid inappropriate placement, or to avoid imminent loss of competitive integrated employment or an offer of such employment. In the case of immediately needed ECF CHOICES HCBS, initiation shall include the commencement of the actual provision of services (or other covered benefits or cost-effective alternative services). Any ECF CHOICES HCBS authorized and initiated while the member's comprehensive PCSP is developed shall continue automatically after the comprehensive PCSP is developed, unless a limited duration is specified in the member's PCSP and authorized accordingly. For ECF CHOICES members who were enrolled under one of the employment-related priority categories, the development of the person centered support plan process shall first address, the goals and support/service needs specific to the employment-related priority category through which the member gained enrollment into the program.

2.9.6.2.5.3.2.1 For members enrolled in ECF CHOICES Group 7, service initiation shall include the initial face-to-face contact with the IBFCTSS provider, full engagement of the IBFCTSS clinical team, and other in-home supports sufficient to meet person's needs. In the event that qualified staff must be identified and trained (e.g., in order to meet individualized needs), the Supportive Home Care component of the IBFCTSS benefit shall be initiated as soon as possible, but no more than 60 days following effective date of enrollment in Group 7, so long as other covered benefits or cost-effective alternative services are provided in the home to ensure the person's needs are met. The CONTRACTOR shall submit a copy of the PCSP, identifying immediately needed services, and a revised PCSP, as assessments are completed and remaining service components are put into place. Other covered benefits or CEA services shall be billed separately, and not as the Supportive Home Care component of the IBFCTSS benefit, until such time that qualified staff begin providing the Supportive Home Care component of the IBFCTSS benefit.

2.9.6.2.5.3.2.2 For members enrolled in ECF CHOICES Group 8, service initiation shall include the initial face-to-face contact with the IBCTSS provider, engagement of the IBCTSS clinical team for purposes of assessment/planning, and alternative placement services (e.g., crisis respite, etc.) sufficient to meet person's needs (unless the person is not yet stable/ready for discharge). In the event that qualified staff must be identified and trained (e.g., in order to meet individualized needs), IBCTSS shall be initiated as soon as possible, but no more than 60 days following the effective date of enrollment in Group 8, so long as other alternative placement services are in place to facilitate immediate transition (unless the person is not yet stable/ready for discharge). The CONTRACTOR shall submit a copy of the PCSP, identifying immediately needed (alternative placement) services, and shall notify TennCare when IBCTSS services are initiated. Alternative placement services shall be billed

separately, and not as the IBCTSS benefit, until such time that qualified staff are in place and the IBCTSS benefit is initiated.

2.9.6.2.5.3.3 The PCSP shall identify all CHOICES HCBS and ECF CHOICES HCBS that are needed, including those services that are immediately needed upon enrollment or other covered benefits or cost-effective alternative services to address immediate needs and those services identified through the person-centered planning process that are needed to help members achieve their goals across all domains of the PCSP.

2.9.6.2.5.3.4 The Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, shall, within thirty (30) calendar days of notice of enrollment in CHOICES or ECF CHOICES, complete the comprehensive assessment (see A.2.9.6.5.2.5), develop the PCSP, and authorize and initiate services as specified in the PCSP, except when a later date, for one or more specified services, is requested by the member which shall be documented in writing in the manner prescribed by TennCare, including but not limited to, (1) when an ECF CHOICES member elects to participate in consumer direction and refuses services from an agency in the interim; or (2) a member requests additional time to complete person-centered planning processes, select a provider and/or staff that are best aligned with his or her goals, needs, and preferences, or visit and select from available options or develop a Community Living Supports living arrangement. In non-urgent circumstances, which shall be distinct from those described in A.2.9.6.2.5.3.2, "initiation" may also take into account the time required by the selected provider to hire and train qualified staff if the CONTRACTOR has informed the member of any providers with existing trained staff available to initiate the service and the member has declined those providers. In this case, services shall be considered "initiated" if a provider has been selected by the member, the services have been authorized by the CONTRACTOR, the provider has agreed to provide the requested service(s), and the CONTRACTOR verifies that the provider is actively engaged in hiring and/or training staff to provide the requested services. The CONTRACTOR shall be responsible for ongoing follow-up with the provider selected by the member to ensure that these processes are completed timely and services commence. The PCSP shall be developed in accordance with protocols developed by TENNCARE and the principles of self-determination, including dignity of risk and supported decision-making. The CONTRACTOR shall discuss with the member opportunities, benefits, and potential negative outcomes associated with risks that may result from the member's decisions, and strategies to mitigate potential negative outcomes associated with identified risks, which shall be documented in the PCSP as appropriate.

2.9.6.2.5.3.4.1 In developing the PCSP for ECF CHOICES, the Support Coordinator shall ensure that the Employment Informed Choice Process is followed.

2.9.6.2.5.3.4.1.1 Upon completion of Exploration services, if the member elects not to pursue Individualized Integrated Employment or Self-Employment, the Support Coordinator shall obtain signed acknowledgement from the member/representative before Community Integration Support Services and/or Independent Living Skills Training may continue or be newly authorized. The signed acknowledgement is to be obtained after the Support Coordinator meets with the individual and involved family, guardian, or conservator, if applicable, to review results of Exploration services and the Exploration report and provide re-education or additional education on the

benefits of employment and supports available for employment. If the person still declines to pursue employment, and declines to participate in any employment service, the Support Coordinator shall obtain written confirmation of the person's informed choice not to pursue individualized, integrated employment or Self-Employment at the time. The meeting, including signing of the acknowledgement when applicable, shall occur within thirty (30) calendar days of the CONTRACTOR receiving the completed Exploration report. If Community Integration Support Services and/or Independent Living Skills Training are already authorized, these services may continue until the meeting is held and signed acknowledgement is obtained.

2.9.6.2.5.3.4.2 The CONTRACTOR shall ensure a seamless transition from (a) CHOICES HCBS or ECF CHOICES HCBS that are immediately needed by the member to (b) CHOICES HCBS or ECF CHOICES HCBS in the PCSP that are needed on an ongoing basis, including those immediately needed services that are also needed on an ongoing basis, with no gaps in care.

2.9.6.2.5.4 The Care Coordinator shall, for all other CHOICES members in Groups 2 and 3 not specified in Sections A.2.9.6.2.5.1 – A.2.9.6.2.5.2 above, within ten (10) business days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member, initiate a comprehensive assessment in a manner sufficient to ensure immediate needs are identified and addressed (see Section A.2.9.6.5), conduct a caregiver assessment, and authorize and initiate CHOICES HCBS, except when a later date is requested by the member which shall be documented in writing (e.g., when a CHOICES member elects to participate in consumer direction and refuses services from an agency in the interim).

2.9.6.2.5.5 At the discretion of the CONTRACTOR, authorization of home health or private duty nursing services may be completed by the Care Coordinator or through the CONTRACTOR's established UM processes but shall be in accordance with Section A.2.9.2.1 of this Contract, which requires the CONTRACTOR to continue providing medically necessary home health or private duty nursing services the member was receiving upon TennCare enrollment.

2.9.6.2.5.6 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless the member meets nursing facility level of care in place at the time of admission and (1) is expected to require short-term nursing facility services for ninety (90) days or less; (2) chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of a Group 2 member and at a cost that is less than the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in Group 1.

2.9.6.2.5.7 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless the member meets nursing facility level of care in place at the time of admission and: (1) is expected to require short-term nursing facility services for ninety (90) days or less; or (2) chooses to transition to a nursing facility and enroll in Group 1.

2.9.6.2.5.8 In preparation for the face-to-face visit, the Care Coordinator or Support Coordinator shall review in-depth the information from the intake AND enrollment process (see Section A.2.9.6.2.3), and the Care Coordinator or Support Coordinator shall consider that information when developing the member's PCSP during the planning meeting. To the extent appropriate, the Care Coordinator or

Support Coordinator may pre-populate basic information (such as demographics) into the PCSP, but this should not preempt a thoughtful person-centered planning process driven by the member to identify his or her needs and goals.

2.9.6.2.5.9 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;

2.9.6.2.5.10 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 need 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;

2.9.6.2.5.10.1 If the member has been approved for At-Risk level of care and expressed interest in enrollment 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, enrollment into CHOICES Group 3, and initiation of CHOICES HCBS.

2.9.6.2.5.10.2 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 Section A.2.9.6.2.5.10 the Care Coordinator shall, in a manner prescribed by TENNCARE, complete a *Safety Determination Request Form*, including all required documentation as required by TENNCARE, and 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.

2.9.6.2.5.11 As part of the face-to-face visit for members in CHOICES Group 2 or Group 3, the Care Coordinator shall conduct a risk assessment and incorporate identified risks and corresponding mitigation strategies into the member's PCSP.

2.9.6.2.5.12 As part of the face-to-face visit, for members determined to need eligible CHOICES HCBS or eligible ECF CHOICES HCBS, the Care Coordinator or Support Coordinator, as applicable, shall verify the member's interest in participating in consumer direction and obtain written confirmation of the

member's decision. The Care Coordinator or Support Coordinator shall also, using current information regarding the CONTRACTOR's network, provide member education regarding choice of contract providers for CHOICES HCBS or ECF CHOICES, subject to the provider's availability and willingness to timely deliver services, which shall include information, as applicable, regarding providers who are able to assign staff who are linguistically competent in the member and/or primary caregiver's primary spoken language, or in sign language, or who can facilitate non-verbal forms of communication, including the use of assistive technology, as applicable, and the use of other auxiliary aids or services in order to achieve effective communication and obtain signed confirmation of the member's choice of contract providers.

2.9.6.2.5.13 For purposes of CHOICES or ECF CHOICES HCBS, service authorizations shall include the amount, frequency, and duration of each service to be provided and, except for services provided through Consumer Direction, the schedule at which such care is typically needed or preferred, if applicable, and whether the member requests or agrees to accept flexibility in his/her typical schedule, as applicable and after the member has received education on options and advantages of flexible scheduling; the requested start date; and other relevant information as required by TENNCARE. The CONTRACTOR shall not lead a member to develop a schedule that is more prescriptive than is needed or preferred, or that does not provide for flexibility that the member may want—whether to allow flexibility so the member's preferred provider has capacity to deliver needed services or to provide the member with flexibility to adjust the schedule as his or her needs and preferences change. When a member's PCSP includes CHOICES or ECF CHOICES HCBS that will be delivered by multiple providers (e.g., Individual Employment Supports, Community Integration Support Services, and Personal Assistance), the CONTRACTOR shall be responsible for providing assistance to the member and providers to coordinate on an ongoing basis the scheduling of these services in accordance with the member's needs and preferences, and to avoid duplication. The CONTRACTOR shall be responsible for ensuring that the provider receives sufficient information as part of the referral to make an informed decision regarding the provider's ability to deliver services in accordance with the member's needs, including the member's zip code or specific area where the service is desired; the member's support needs, including specialized physical or behavioral health or functional support needs that could require special training or expertise; the amount and type of service needed; start date needed and/or desired; goals the service is intended to address with specificity to the extent necessary to reflect member preferences; schedule needed or preferred by the member or indication of flexible scheduling needed or preferred; staffing ratio if applicable (e.g., 1:1, 1:2 or 1:3 for Community Integration Support Services); member needs and preferences regarding staff and, if applicable, individuals who may be paired with the member to share staff support. The CONTRACTOR may share the PCSP (or relevant parts of the PCSP) as needed to address some or all of the information specified above. The CONTRACTOR shall be responsible for confirming the provider's capacity and commitment to initiate services as authorized on or before the requested start date, and if the provider is unable to initiate services as authorized on or before the requested start date, for arranging an alternative provider who is able to initiate services as authorized on or before the requested start date. The CONTRACTOR may determine, subject to requirements set forth in the approved service definitions, and in policy and protocol, the duration of time for which CHOICES or ECF CHOICES HCBS will be authorized. Additionally, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES or ECF CHOICES

HCBS in accordance with the PCSP, including transition from CHOICES HCBS or ECF CHOICES HCBS that are immediately needed by the member to .services needed on an ongoing basis, as specified in the PCSP. The CONTRACTOR shall further be responsible for ensuring that service authorizations are consistent with the PCSP, including the schedule at which services are needed or preferred (see above) and any updates to the PCSP, and/or schedule, and except in the following circumstance, for notifying providers in advance when a service authorization (including a schedule) will be changed. Retroactive entry or adjustments in service authorizations for CHOICES or ECF 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.

2.9.6.2.5.14 The member's Care Coordinator/care coordination or Support Coordinator/support coordination team shall provide at least verbal notification to the member prior to initiation of CHOICES HCBS or ECF CHOICES HCBS identified in the PCSP, as applicable regarding any change in providers selected by the member for each CHOICES or ECF CHOICES HCBS, including the reason such change has been made.

2.9.6.2.5.15 If the CONTRACTOR is unable to initiate any CHOICES HCBS or ECF CHOICES HCBS in accordance with the timeframes specified herein, the CONTRACTOR shall issue written notice to the member, documenting the service(s) that will be delayed, the reasons for the delay, and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.

2.9.6.2.5.16 TENNCARE may establish, pursuant to policies and protocols for management of waiting or referral lists, alternative timeframes for completion of specified intake functions and activities when there is a waiting or referral list, or upon implementation of ECF CHOICES.

2.9.6.3 <u>CHOICES and ECF CHOICES Intake Process for the CONTRACTOR's Current Members</u>

2.9.6.3.1 The CONTRACTOR shall develop and implement policies and procedures for ongoing identification of members who may be eligible for CHOICES. The CONTRACTOR shall use the following, at a minimum, to identify members who may be eligible for CHOICES:

2.9.6.3.1.1 Referral from member's PCP, specialist or other provider or other referral source;

2.9.6.3.1.2 Self-referral by member or referral by member's family or guardian;

2.9.6.3.1.3 Identification by the CONTRACTOR of a member receiving home health or private duty nursing services who will be subject to a reduction in covered services provided by the CONTRACTOR upon turning twenty-one (21) years of age (see Section A.2.9.4).

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

2.9.6.3.1.5 Notification of hospital admission (see Section A.2.12.9.44); and

2.9.6.3.1.6 Periodic review (at least quarterly) of:

2.9.6.3.1.6.1 Claims or encounter data;

2.9.6.3.1.6.2 Hospital admission or discharge data;

2.9.6.3.1.6.3 Pharmacy data; and

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

2.9.6.3.1.6.5 The CONTRACTOR may define in its policies and procedures other steps that will be taken to better assess if the members identified through means other than referral or notice of hospital admission will likely qualify for CHOICES, and may target its screening and intake efforts to a more targeted list of persons that are most likely to need and to qualify for CHOICES services.

2.9.6.3.1.6.6 TENNCARE may establish, pursuant to policies and protocols for management of waiting lists, alternative timeframes for completion this task when there is a waiting list.

2.9.6.3.1.6.7 The CONTRACTOR shall develop and implement policies and procedures for identification of members who may eligible for ECF CHOICES, as directed by TENNCARE pursuant to any outreach protocol that may be developed.

2.9.6.3.2 As part of its identification process for members who may be eligible for CHOICES, the CONTRACTOR may initiate a telephone screening process, using the tool and protocols specified by TENNCARE. Such screening process shall: (1) verify the member's current eligibility category based on information provided by TENNCARE in the outbound 834 enrollment file; for persons seeking access to CHOICES HCBS through enrollment in CHOICES Groups 2 or 3, identify whether the member meets categorical eligibility requirements for enrollment in such group based on his/her current eligibility category, and if not, whether the member appears to meet categorical and financial eligibility criteria for the Institutional (i.e., CHOICES 217-Like HCBS or CHOICES At-Risk Demonstration) category; (2) determine whether the member appears to meet level of care eligibility for CHOICES; and (3) for members seeking access to CHOICES HCBS through enrollment in CHOICES Group 2, determine whether it appears that the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. Such telephone screening shall be conducted at the time of the initial call by the CONTRACTOR unless the member requests that the screening be conducted at another time, which shall be documented in writing in the CHOICES intake record.

2.9.6.3.3 For referrals of potential applicants for ECF CHOICES, the CONTRACTOR shall provide basic education developed by TENNCARE about the program, and advise the potential applicant of the availability of TENNCARE's online self-screening tool, but shall offer assistance in completing the online screening tool, if needed or preferred.

2.9.6.3.3.1 For potential applicants who need assistance to complete the online self-referral tool, the CONTRACTOR shall provide telephonic assistance and shall utilize TENNCARE's online self-referral tool, capturing the information in the online referral system for purposes of referral list management. If the initial contact is not telephonic, or if TENNCARE or its designee is not able to provide assistance at the point of contact, within two (2) business days, TENNCARE or its designee

shall contact the applicant to offer assistance in completing the self-referral using the online self-referral tool.

2.9.6.3.4 For CHOICES referrals by or on behalf of a potential CHOICES member, regardless of referral source, if the CONTRACTOR uses a telephone screening process, and for all ECF CHOICES referrals on behalf of a potential ECF CHOICES member, the CONTRACTOR shall make every effort to conduct such screening process at the time of referral, unless the person making the referral is not able or not authorized by the member to assist with the screening process, in which case the CONTRACTOR shall complete the screening process as expeditiously as possible. The ECF CHOICES screening process shall be mandatory.

2.9.6.3.4.1 Documentation of at least three (3) attempts occurring over a period of no less than three (3) days to contact the member by phone (which shall include at least one (1) attempt to contact the member at the number most recently reported by the member and at least one (1) attempt to contact the member at the number provided in the referral, if different, and which shall occur at different times of the day and evening, including after business hours), followed by a letter sent to the member's most recently reported address that provides information about CHOICES or ECF CHOICES and how to obtain a screening for CHOICES or ECF CHOICES, shall constitute sufficient effort by the CONTRACTOR to assist a member who has been referred for CHOICES or ECF CHOICES, regardless of referral source. TENNCARE will review the CONTRACTOR's referral data, including the number of referred members the CONTRACTOR is unable to reach, and may institute additional requirements as necessary to ensure reasonable efforts to reach the member and complete the referral and intake process.

2.9.6.3.5 For persons referred for enrollment in CHOICES that are identified through notification of hospital admission, the CONTRACTOR shall work with the discharge planner to determine whether long-term care services may be needed upon discharge, and if so, shall complete all applicable screening and/or intake processes immediately to facilitate timely transition to the most integrated and cost effective long-term care delivery setting appropriate for the member's needs.

2.9.6.3.6 For identification by the CONTRACTOR of a member who may be eligible for CHOICES by means other than referral or notice of hospital admission, if the CONTRACTOR uses a telephone screening process, the CONTRACTOR shall complete the telephone screening process as expeditiously as possible.

2.9.6.3.6.1 Documentation of at least one (1) attempt to contact the member by phone at the number most recently reported by the member, followed by a letter sent to the member's most recently reported address that provides information about CHOICES and how to obtain a screening for CHOICES shall constitute sufficient effort by the CONTRACTOR to assist a member that has been identified by the CONTRACTOR by means other than referral.

2.9.6.3.7 If the CONTRACTOR uses a telephone screening process for potential CHOICES applicants, the CONTRACTOR shall document all screenings conducted by telephone and their disposition, with a written record.

2.9.6.3.8 If the member does not meet the telephone screening criteria for CHOICES, the CONTRACTOR shall within five (5) business days of the screening notify the member verbally and in writing in the format prescribed by TENNCARE: (1) that he/she does not appear to meet the criteria for enrollment in CHOICES; (2) that he/she has the right

to continue with the CHOICES intake process and, if determined not eligible, to receive notice of such denial, including the member's due process right to appeal; and (3) how, if the member wishes to proceed with the CHOICES intake process, the member can submit a written request to proceed with the CHOICES intake process to the CONTRACTOR. In the event that a member does submit such written request, the CONTRACTOR shall process the request as a new referral and shall conduct a face to-face intake visit, including level of care assessment and comprehensive assessment, within ten (10) business days of receipt of the member's written request, unless a later date is requested by the member, which shall be documented in writing in the CHOICES intake record.

2.9.6.3.9 If the CONTRACTOR is conducting a telephonic screening or assisting a potential ECF CHOICES applicant with a self-referral, and the potential applicant does not appear to meet the screening criteria for ECF CHOICES (i.e., does not appear to qualify for the program) based on the results of the screening tool, the CONTRACTOR shall:

2.9.6.3.9.1 Without screening any member out, advise the potential applicant during the call that he/she does not appear to meet the criteria for enrollment into ECF CHOICES; and

2.9.6.3.9.2 Provide the potential applicant with the opportunity to proceed with the self-referral, and with intake and potential enrollment into the program in accordance with TennCare established prioritization and enrollment, including target population, criteria.

2.9.6.3.9.3 If the potential applicant indicates during the call that he wants to proceed with the self-referral, the CONTRACTOR shall assist the potential applicant with completing the self-referral.

2.9.6.3.9.4 If the potential applicant indicates during the call that he does not want to proceed with the self-referral, the CONTRACTOR shall advise the potential applicant how to re-initiate a self-referral, including the availability of assistance as needed.

2.9.6.3.10 If, through the screening process described above, or upon other identification by the CONTRACTOR of a member who appears to be eligible for CHOICES for whom the CONTRACTOR opts not to use such screening process, within five business days, the Care Coordinator shall conduct a face-to-face intake visit with the member that includes a level of care assessment and a comprehensive assessment (see Section A.2.9.6.5) using tool(s) prior approved by TENNCARE and in accordance with the protocols specified by TENNCARE. For members seeking enrollment in ECF CHOICES, the CONTRACTOR shall complete the intake visit within five (5) business days, unless otherwise specified, of receiving the referral from TENNCARE via TENNCARE's electronic eligibility system except when the member requests a later date. The CONTRACTOR shall notify the member in advance of the intake visit documentation that the CONTRACTOR will need during the intake visit. TENNCARE may, at its discretion, modify these timelines in writing to the CONTRACTOR as necessary during program implementation and for efficient management of the referral process.

2.9.6.3.10.1 For members in a nursing facility or seeking nursing facility services, the Care Coordinator shall perform any additional comprehensive assessment deemed necessary by the CONTRACTOR (see Section A.2.9.6.5.1).

2.9.6.3.10.2 For members seeking CHOICES HCBS, during the intake visit the Care Coordinator shall, using the tools and protocols specified by TENNCARE, conduct a comprehensive assessment (See Section A.2.9.6.5) and shall 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; and identify the long-term care services and home health and/or private duty nursing services that may be needed by the member upon enrollment into CHOICES that would build upon and not supplant a member's existing natural support system. Additionally, the CONTRACTOR may perform the caregiver assessment (See Section A.2.9.6.5.2.6) during the intake visit, but shall perform the caregiver assessment no later than ten (10) business days after receipt of referral as detailed in Section A.2.9.6.3.12, but prior to the development of the PCSP to ensure that caregiver needs are addressed, as appropriate. The Care Coordinator or Support Coordinator shall also ensure that all identified caregivers have the Care Coordinator or Support Coordinator's name and contact information in accordance with Section A.2.9.6.4.2.

2.9.6.3.10.3 The CONTRACTOR shall complete all intake processes within thirty (30) calendar days, unless an exception is granted by TENNCARE in writing due to extenuating circumstances beyond the CONTRACTOR's control. If TENNCARE grants an exception, such exception shall provide the CONTRACTOR an additional thirty (30) calendar days to complete the intake process for the applicant, totaling sixty (60) calendar days to complete the intake process. If TENNCARE grants the CONTRACTOR an exception and the CONTRACTOR does not complete the intake process within sixty (60) calendar days, the CONTRACTOR shall close the referral, notify TENNCARE, and document the reason(s) the intake process was not completed for that applicant, and shall maintain such documentation and provide the documentation to TENNCARE upon request.

2.9.6.3.11 As part of the face-to-face intake visit for CHOICES, the Care Coordinator shall: (1) document and confirm the applicant's current address and phone number(s) and assist the member in updating his or her address with TENNCARE or the Social Security Administration, if applicable; (2) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (3) provide information about estate recovery; (4) provide assistance, as necessary, in gathering documentation needed by TENNCARE to determine categorical/financial eligibility for LTSS; (5) 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; (6) 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 (7) 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; (8) for members who are seeking CHOICES HCBS, the Care Coordinator, shall: (a) conduct a risk assessment to identify 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 to be included in the PCSP; and (b) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; (9) 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; (10) 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 (11) 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, which shall include information, as applicable, regarding providers who are able to assign staff who are linguistically competent in the member and/or primary caregiver's primary spoken language, or in sign language, or who can facilitate non-verbal forms of communication, including the use of assistive technology, as applicable, and the use of other auxiliary aids or services in order to achieve effective communication and obtain signed documentation of the member's choice of contract providers.

2.9.6.3.12 If the member does not meet appear to meet CHOICES enrollment criteria, the Care Coordinator may advise the member verbally: (1) that he/she does not appear to meet the criteria for enrollment in CHOICES; but shall also advise the member (2) that he/she has the right to continue with the CHOICES intake process and, if determined not eligible, to receive notice of such denial, including the member's due process right to a fair hearing.

2.9.6.3.12.1 The decision to discontinue the CHOICES intake process must be made by the member or the member's representative and the CONTRACTOR shall not encourage the member or member's representative to discontinue the process;

2.9.6.3.12.2 Upon the member's decision to continue the CHOICES intake, the Care Coordinator shall continue the intake process and complete all required activities, including submission of the level of care to TENNCARE;

2.9.6.3.12.3 Upon the member's decision to discontinue the CHOICES intake process, the Care Coordinator shall, in the manner prescribed by TENNCARE, document the member's decision to terminate the CHOICES intake process, including the member's or representative's signature and date. The CONTRACTOR shall maintain this documentation in the member's record and provide a copy to the member/representative; or

2.9.6.3.12.4 The CONTRACTOR shall provide the member with information about how to initiate a new CHOICES screening and intake process in the future.

2.9.6.3.13 If, during the face-to-face intake visit the member or the member's representative elects to terminate the intake process for any other reason (e.g., estate recovery, patient liability, or does not need the services available through CHOICES), the Care Coordinator shall, in the manner prescribed by TENNCARE, document the member's decision to terminate the CHOICES intake process, including the member's or representative's signature and date. The CONTRACTOR shall maintain this documentation in the member's record and provide a copy to the member/representative.

2.9.6.3.13.1 The decision to discontinue the CHOICES intake process must be made by the member or the member's representative and the CONTRACTOR shall not encourage the member or member's representative to discontinue the process;

2.9.6.3.13.2 The CONTRACTOR shall provide the member with information about how to initiate a new CHOICES screening and intake process in the future.

2.9.6.3.14 As part of the face-to-face intake visit for ECF CHOICES, the CONTRACTOR shall, using the intake packet and protocols specified by TENNCARE, gather information needed by TENNCARE to verify the potential applicant's target population and gather basic information that will allow TENNCARE to prioritize the potential applicant for enrollment based on established prioritization and enrollment criteria. The CONTRACTOR may complete actions required as part of the enrollment process (see A.2.9.6.3.16) and obtain the required signatures during the intake visit for potential applicants the CONTRACTOR determines are likely to qualify in either an open priority category or a reserve capacity slot but shall not proceed with enrollment activities (including completion and submission of a PAE) until such time that the CONTRACTOR is notified by TENNCARE that the person meets prioritization criteria for enrollment into a category that is currently open for enrollment and for which a slot is available, or that the person meets criteria for an available reserve capacity slot.

2.9.6.3.14.1 During the intake visit, the CONTRACTOR shall provide assistance to the member as needed in requesting and/or obtaining documentation to verify the member's target population as specified by TENNCARE, including an explanation of the PAE completion and submission process; however, the member and/or authorized representative shall be responsible for providing proof of eligibility for determination by TENNCARE prior to enrollment in ECF CHOICES.

2.9.6.3.14.2 If the CONTRACTOR does not obtain documentation during the face-to-face visit for ECF CHOICES that reasonably establishes that the member has an ID or DD the CONTRACTOR shall:

2.9.6.3.14.2.1 Advise the person verbally that they do not appear to meet target population for enrollment into ECF CHOICES but shall complete the intake (unless the person chooses to withdraw from the process and signs a form indicating such). If the person is found by TENNCARE not to qualify for enrollment based on target population, the person will receive formal notice of denial and due process, including the right to request a fair hearing regarding program eligibility.

2.9.6.3.14.2.1.1 The decision regarding whether to remain on the ECF CHOICES referral list must be made by the member or the member's representative, as applicable; the CONTRACTOR shall not encourage the member or member's representative to withdraw from the referral process for ECF CHOICES;

2.9.6.3.14.2.1.2 If the person requests to remain on the ECF CHOICES referral list, the CONTRACTOR shall note in the referral record and in the tracking system the outcome of the intake process.

2.9.6.3.14.2.1.3 If the person does not want to remain on the ECF CHOICES referral list, the CONTRACTOR shall request that the person sign a statement withdrawing from the referral process for ECF CHOICES, maintain such signed statement in the referral record, advise the person how to initiate a new referral in the future, and close the referral in the tracking system.

2.9.6.3.15 When it is determined by TENNCARE that a potential applicant for ECF CHOICES meets prioritization criteria for enrollment into a category that is currently open for enrollment and for which a slot is available, or that the member meets criteria for an available reserve slot (which may require submission to the interagency review committee before such determination can be made), the CONTRACTOR shall proceed with enrollment. A face-to-face enrollment visit shall be completed within five (5) business days, unless otherwise specified by TENNCARE, of determination to proceed with enrollment of applicant into ECF CHOICES (unless a later date is requested by the applicant), or in circumstances described in A.2.9.6.3.14 where the CONTRACTOR has already completed actions as required as part of the enrollment process and obtained the required signatures during the face-to-face intake visit, in which case the CONTRCTOR may proceed with enrollment to inform the applicant that the CONTRACTOR will be completing and submitting the PAE on the applicant's behalf, and will explain that the applicant will receive the outcome of this submission from TENNCARE via mail.

2.9.6.3.15.1 The CONTRACTOR shall conduct an enrollment visit or proceed with enrollment, as applicable, only when the CONTRACTOR is notified by TENNCARE that the person meets prioritization criteria for enrollment into a category that is currently open for enrollment and for which a slot is available, or that the person meets criteria for an available reserve capacity slot.

2.9.6.3.15.2 The CONTRACTOR shall complete all enrollment processes within thirty (30) calendar days, unless an exception is granted by TENNCARE in writing due to extenuating circumstances beyond the CONTRACTOR's control. If TENNCARE grants an exception, such exception shall provide the CONTRACTOR an additional thirty (30) calendar days to complete the enrollment process for the applicant, totaling sixty (60) calendar days to complete the enrollment process. If TENNCARE grants the CONTRACTOR an exception and the CONTRACTOR does not complete the enrollment process within sixty (60) calendar days, the CONTRACTOR shall close the referral, notify TENNCARE, and document the reason(s) the enrollment process was not completed for that applicant, and shall maintain such documentation and provide the documentation to TENNCARE upon request.

2.9.6.3.16 As part of the enrollment visit for ECF CHOICES, the CONTRACTOR shall, as applicable (see 2.9.6.3.15.1.) and in accordance with requirements set forth in protocol: (1) confirm or update, as applicable, the member's current address and phone number(s); (2) review ECF CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (3) make sure the member is aware that DIDD policy does not permit a person enrolled in ECF CHOICES to enroll in the Family Support Program operated by DIDD; (4) complete the level of care (i.e., PAE) application and provide assistance, as necessary, in

gathering documentation needed by the State to determine medical and financial eligibility for reimbursement of LTSS, including post-eligibility provisions (i.e., patient liability); (5) provide information about estate recovery; (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; (7) provide information regarding consumer direction; and (8) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in ECF CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will work with the applicant to develop and approve a PCSP.

2.9.6.3.16.1 The CONTRACTOR may, at its discretion, initiate the comprehensive assessment and determine immediately needed services as part of the face-to-face intake/enrollment visit for ECF CHOICES.

2.9.6.3.17 For CHOICES referrals by or on behalf of a potential CHOICES member, regardless of referral source, the Care Coordinator shall conduct the face-to-face intake visit and shall develop a PCSP as appropriate (see Section A.2.9.6.6), within ten (10) business days of receipt of such referral, unless a later date is requested by the member, which shall be documented in writing in the CHOICES intake record.

2.9.6.3.18 For members identified by the CONTRACTOR as potentially eligible for CHOICES by means other than referral, the Care Coordinator shall conduct the face-to-face intake visit and shall develop a PCSP, as appropriate (see Section A.2.9.6.6), and authorize and initiate CHOICES HCBS within thirty (30) days of identification of the member as potentially eligible for CHOICES. For persons identified through notification of hospital admission, the CONTRACTOR shall coordinate with the hospital discharge planner to determine whether long-term care services may be needed upon discharge, and if so, complete all applicable screening and/or intake processes immediately to facilitate timely transition to the most integrated and cost effective long-term care delivery setting appropriate for the member's needs.

2.9.6.3.19 Once completed, in the manner prescribed by TENNCARE the CONTRACTOR shall submit the level of care (i.e., PAE application) and supporting documentation, as specified by TENNCARE, to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap or expenditure cap, as applicable, to TENNCARE as soon as possible but no later than five (5) business days of the face-to-face visit.

2.9.6.3.19.1 If the Contractor determines that the member's assessed acuity score is less than nine (9) and the member's needs cannot be safely met in the community within the array of services and supports available if the member were enrolled in CHOICES Group 3 or ECF CHOICES Group 5, as applicable, or the member or his or her representative request a safety determination, the Contractor shall, in accordance with timeframes specified in A.2.9.6.3.18 and in a manner specified in TennCare protocol, complete the Safety Determination Request Form, including all required documentation, and submit the completed Safety Determination Request Form to TENNCARE along with the member's completed PAE.

2.9.6.3.19.2 If the CONTRACTOR is unable to obtain the supporting documentation within five (5) business days, such as required medical information, and the absence of such documentation delays the submission of the PAE to TENNCARE, the CONTRACTOR must document and continue efforts to collect supporting

documentation. Such efforts may include assisting member to secure physician visit, and or other medical appointments necessary in order to obtain required supporting documentation.

2.9.6.3.19.3 Efforts to collect supporting documentation required for the submission of the PAE shall include at least three (3) attempts utilizing the following methods or combination of methods: contacting the physician, medical facility, or other healthcare entity by telephone, fax and/or in writing; visiting the healthcare entity, if possible and practicable, to request and/or pick up the required documentation; and contacting the member by phone, face-to-face, or in writing to request assistance in obtaining the needed documentation. Multiple faxes or calls to the physician or provider shall not be sufficient. If a recent history and physical or other medical records supporting the functional deficits are not available (e.g., the applicant has not received medical care in the last 365 days), the CONTRACTOR shall help to arrange an appointment with the member's primary care provider in order to obtain the needed information.

2.9.6.3.19.4 The CONTRACTOR must submit the PAE to TENNCARE within twenty (20) business days from the date of the enrollment visit regardless of whether the CONTRACTOR has received the supporting documentation. After submitting the PAE to TENNCARE, if the PAE submission results in a denial or the inability to approve the level of care indicated on the PAE if supporting documentation had been submitted to support such approval, the CONTRACTOR shall continue diligent efforts to collect supporting documentation as specified in Section A.2.9.6.3.18.2. Pursuant to TennCare Rules, if within thirty (30) calendar days of the initial PAE submission, the CONTRACTOR obtains additional supporting documentation, the CONTRACTOR shall submit a revised PAE with the supporting documentation. After thirty (30) calendar days from the initial PAE submission have passed, the CONTRACTOR shall have no obligation to make efforts to collect supporting documentation, but shall be required to submit a new PAE with supporting documentation to TENNCARE if such documentation is subsequently received.

2.9.6.3.19.5 The CONTRACTOR shall be responsible for ensuring that the level of care, including Safety Determination Request Form, as applicable, is accurate and complete, satisfies all technical requirements specified by TENNCARE, and accurately reflects the member's current medical and functional status based on information gathered, at a minimum, from the member, his or her representative, the Care Coordinator's or Support Coordinator's direct observations, and the history and physical or other medical records which shall be submitted with the application. The CONTRACTOR shall note in the level of care any discrepancies between these sources of information, and shall provide explanation regarding how the CONTRACTOR addressed such discrepancies in the level of care. If a PAE is denied for insufficiency, inconsistency, or error, the PAE must be revised within one (1) business day to cure the deficiency and be resubmitted.

2.9.6.3.19.6 If TENNCARE receives a safety request from a NF or hospital on behalf of one of the CONTRACTOR's members, and the request contains insufficient medical evidence for TENNCARE to make a safety determination, TENNCARE may request that the CONTRACTOR conduct an assessment pursuant to TennCare Rules to gather additional information needed by TENNCARE to make a safety determination. If TENNCARE makes such a request, the CONTRACTOR shall conduct the assessments required pursuant to TennCare Rules and complete the Safety Determination Request Form, including all required documentation, within

five (5) business days from notification by TENNCARE, except when a delay results from the needs or request of the member which shall be documented in writing.

2.9.6.3.20 If a member is seeking access to CHOICES HCBS through enrollment in CHOICES Group 2 or access to ECF CHOICES HCBS through enrollment in ECF CHOICES Group 6 and the enrollment target for the group has been reached, the CONTRACTOR may, subject to established eligibility and enrollment criteria, elect to enroll the person into CHOICES Group 2 or ECF CHOICES Group 6, as applicable, as a cost-effective alternative if the person is currently receiving nursing facility services or would be imminently placed in a nursing facility, absent such enrollment and the availability of CHOICES or ECF CHOICES HCBS, as applicable. The CONTRACTOR shall notify TENNCARE if the CONTRACTOR wishes to enroll the person in CHOICES Group 2 or ECF CHOICES Group 6 as a cost effective alternative (CEA) to nursing facility care that would otherwise be provided, and shall submit to TENNCARE the following:

2.9.6.3.20.1 A written summary of the CONTRACTOR's CEA determination, including an explanation of the member's circumstances which warrant the immediate provision of nursing facility services unless CHOICES or ECF CHOICES HCBS are immediately available.

2.9.6.3.20.2 TENNCARE may request additional information as needed to confirm the CONTRACTOR's CEA determination and/or provider capacity to meet the member's needs, and shall, only upon receipt of satisfactory documentation, enroll the member in CHOICES or ECF CHOICES, as applicable.

2.9.6.3.21 The CONTRACTOR shall be responsible for (1) advising members who appear to meet the nursing facility level of care that are seeking access to CHOICES HCBS through enrollment in CHOICES Group 2 when an enrollment target has been (or will soon be) reached; (2) advising such persons that they may choose to receive nursing facility services if CHOICES Group 2 HCBS are not immediately available; (3) determining whether the person wants nursing facility services if CHOICES Group 2 HCBS are not immediately available; and (4) at the CONTRACTOR's sole discretion, making a determination regarding whether enrollment in Group 2 constitutes a CEA because the immediate provision of nursing facility services will otherwise be required and submitting appropriate documentation to TENNCARE if there is a waiting list for CHOICES Group 2 but the CONTRACTOR chooses to enroll a member in Group 2 as a CEA (see Section A.2.9.6.3.20.1).

2.9.6.3.22 If a person is processed for enrollment in an available slot in ECF CHOICES Group 5 and is determined to meet NF LOC for reasons other than a safety determination, and a slot is not available in ECF CHOICES Group 6, the CONTRACTOR shall offer the person the choice of enrolling in ECF CHOICES Group 5, so long as his or her needs can be safely met with the array of benefits available if enrolled in Group 5.

2.9.6.3.23 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES and ECF CHOICES. If the applicant does not meet target population or medical eligibility requirements as determined by TENNCARE, TENNCARE shall send written notification to the applicant and his or her designee, including information regarding the right to an appeal.

2.9.6.3.24 TENNCARE will notify the CONTRACTOR via the outbound 834 enrollment file when a person has been enrolled in CHOICES or ECF CHOICES and, if the member

is enrolled in CHOICES or ECF CHOICES, the member's CHOICES or ECF CHOICES Group and applicable patient liability amounts (see Section A.2.6.7).

2.9.6.3.24.1 For members in CHOICES Group 2 TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section A.1 and see Section A.2.6.1.5.2.3), which shall be the average cost of Level 1 nursing facility care, or upon implementation of the new nursing facility reimbursement methodology, the average cost of nursing facility care (the Level 1/Level 2 distinction will be eliminated), 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, because the member would qualify to receive Enhanced Respiratory Care reimbursement in a nursing facility.

2.9.6.3.24.2 For members in ECF CHOICES, TENNCARE will notify the CONTRACTOR of the member's expenditure cap (see definition in Section 1), on the outbound 271 file, and the CONTRACTOR shall receive, process, and update this file in accordance with Section A.2.4.6.1.

2.9.6.3.25 For all newly enrolled CHOICES Group 1 members, the CONTRACTOR shall reimburse NF services in accordance with the level of nursing facility services or reimbursement approved by TENNCARE, and as of the effective date of CHOICES enrollment, except that the CONTRACTOR may reimburse a lesser level of service which such lesser level of service is billed by the facility.

2.9.6.3.26 For CHOICES and ECF CHOICES members, the Care Coordinator, Support Coordinator, or Integrated Support Coordination Team, as applicable, shall complete a comprehensive assessment in a manner sufficient to ensure strengths, needs, opportunities, and challenges are identified and addressed in the PCSP, and conduct a caregiver assessment, and authorize and initiate CHOICES HCBS and ECF CHOICES HCBS as described and in accordance with timeframes specified in this section.

2.9.6.3.26.1 For CHOICES members, the CONTRACTOR shall authorize and initiate immediately needed CHOICES HCBS within ten (10) business days of receiving notice of a member's enrollment, except when a later date is requested by the member which shall be documented in writing (e.g., when a CHOICES member elects to participate in consumer direction and refuses services from an agency in the interim). CHOICES HCBS authorized and initiated while the member's comprehensive PCSP is developed will continue automatically after the comprehensive PCSP is developed, unless a limited duration is specified in the member's PCSP and authorized accordingly.

2.9.6.3.26.2 For ECF CHOICES members, the CONTRACTOR shall determine if the member immediately needs any ECF CHOICES HCBS while the comprehensive PCSP is developed. Immediately needed ECF CHOICES HCBS may include but are not limited to services that a person needs in order to facilitate timely discharge from an inpatient setting or to prevent inappropriate placement in an inpatient or other restrictive setting, to prevent imminent placement outside the person's current living arrangement, to address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm, or consistent with the program's primary goals, to prevent imminent loss of competitive integrated employment or an offer of such employment. Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS) and Intensive Behavioral Community Transition and Stabilization Services shall be considered "immediately needed" services. The CONTRACTOR may utilize

other covered benefits or cost-effective alternative services as needed to address these immediate needs while ECF CHOICES services are put into place or provide incentives to providers with prior approval from TENNCARE to provide such immediately needed services and to put in place sustainable strategies to enable the provider to do so on ongoing basis. The CONTRACTOR shall document immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs in the PCSP and shall authorize and initiate any immediately needed ECF CHOICES HCBS or other covered benefits or cost-effective alternative services to address immediate needs within ten (10) business days of receiving notice of a member's enrollment or as expeditiously as needed to facilitate timely discharge or avoid inappropriate placement, or to avoid imminent loss of competitive integrated employment or an offer of such employment. In the case of immediately needed ECF CHOICES HCBS, initiation shall include the commencement of the actual provision of services (or other covered benefits or cost-effective alternative services). Any ECF CHOICES HCBS authorized and initiated while the member's comprehensive PCSP is developed shall continue automatically after the comprehensive PCSP is developed, unless a limited duration is specified in the member's PCSP and authorized accordingly. For ECF CHOICES members who were enrolled under one of the employment-related priority categories, the development of the person centered support plan process shall address first, the goals and support/service needs specific to the employment-related priority category through which the member gained enrollment into the program.

2.9.6.3.26.2.1 For members enrolled in ECF CHOICES Group 7, service initiation shall include the initial face-to-face contact with the IBFCTSS provider, full engagement of the IBFCTSS clinical team, and other in-home supports sufficient to meet person's needs. In the event that qualified staff must be identified and trained (e.g., in order to meet individualized needs), the Supportive Home Care component of the IBFCTSS benefit shall be initiated as soon as possible, but no more than 60 days following effective date of enrollment in Group 7, so long as other covered benefits or cost-effective alternative services are provided in the home to ensure the person's needs are met. The CONTRACTOR shall submit a copy of the PCSP, identifying immediately needed services, and a revised PCSP, as assessments are completed and remaining service components are put into place. Other covered benefits or CEA services shall be billed separately, and not as the Supportive Home Care component of the IBFCTSS benefit, until such time that qualified staff begin providing the Supportive Home Care component of the IBFCTSS benefit.

2.9.6.3.26.2.2 For members enrolled in ECF CHOICES Group 8, service initiation shall include the initial face-to-face contact with the IBCTSS provider, engagement of the IBCTSS clinical team for purposes of assessment/planning, and alternative placement services (e.g., crisis respite, etc.) sufficient to meet person's needs (unless the person is not yet stable/ready for discharge). In the event that qualified staff must be identified and trained (e.g., in order to meet individualized needs), IBCTSS shall be initiated as soon as possible, but no more than 60 days following the effective date of enrollment in Group 8, so long as other alternative placement services are in place to facilitate immediate transition (unless the person is not yet stable/ready for discharge). The CONTRACTOR shall submit a copy of the PCSP, identifying immediately needed (alternative placement) services, and shall notify TennCare when IBCTSS services are initiated. Alternative placement services shall be billed separately, and not as the IBCTSS benefit, until such time that qualified staff are in place and the IBCTSS benefit is initiated.

2.9.6.3.26.3 The Support Coordinator or Care Coordinator, as applicable, shall, within thirty (30) calendar days of notice of enrollment in CHOICES or ECF CHOICES, complete the comprehensive assessment (see A.2.9.6.5) and develop the PCSP and authorize and initiate services as specified in the PCSP except when a later date is requested, for one or more specified services, by the member which shall be documented in writing (e.g., these shall include but are not limited to, (1) when an ECF CHOICES member elects to participate in consumer direction and refuses services from an agency in the interim, or (2) a member requests additional time to complete person-centered planning processes, select a provider and/or staff that are best aligned with his or her goals, needs, and preferences, or visit and select from available options or develop a Community Living Supports living arrangement. In non-urgent circumstances, which shall be distinct from those described in 2.9.6.2.5.3.2, "initiation" may also take into account the time required by the provider to hire and train qualified staff if the CONTRACTOR has informed the member of any providers with existing trained staff available to initiate the service and the member has declined those providers. In this case, services shall be considered "initiated" if a provider has been selected by the member, the services have been authorized by the CONTRACTOR, the provider has agreed to provide the requested service(s), and the CONTRACTOR verifies that the provider is actively engaged in hiring and/or training staff to provide the requested services. The CONTRACTOR shall be responsible for ongoing follow-up with the provider selected by the member to ensure that these processes are completed timely and services commence. The PCSP shall be developed in accordance with protocols developed by TENNCARE and the principles of self-determination, including dignity of risk and supported decision-making. The CONTRACTOR shall discuss with the member opportunities, benefits, and potential negative outcomes associated with risks that may result from the member's decisions, and strategies to mitigate potential negative outcomes associated with identified risks, which shall be documented in the PCSP as appropriate.

2.9.6.3.26.3.1 In developing the PCSP for ECF CHOICES, the Support Coordinator shall ensure that the Employment Informed Choice Process is followed.

2.9.6.3.26.3.1.1 Upon completion of Exploration services, if the member elects not to pursue Individualized Integrated Employment or Self-Employment, the Support Coordinator shall obtain signed acknowledgement from the member/representative before Community Integration Support Services and/or Independent Living Skills Training may continue or be newly authorized. The signed acknowledgement is to be obtained after the Support Coordinator meets with the individual and involved family, guardian, or conservator, if applicable, to review results of Exploration services and the Exploration report and provide re-education or additional education on the benefits of employment and supports available for employment. If the person still declines to pursue employment, and declines to participate in any employment service, the Support Coordinator shall obtain written confirmation of the person's informed choice not to pursue individualized, integrated employment or Self-Employment at the time. The meeting, including signing of the acknowledgement when applicable, shall occur within thirty (30) calendar days of the CONTRACTOR receiving the completed Exploration report. If Community Integration Support Services and/or Independent Living Skills Training are already authorized, these services may continue until the meeting is held and signed acknowledgement is obtained.

2.9.6.3.26.3.2 The CONTRACTOR shall ensure a seamless transition from (a) CHOICES HCBS or ECF CHOICES HCBS that are immediately needed by the member or other covered benefits or cost-effective alternative services to address immediate needs to (b) CHOICES HCBS or ECF CHOICES HCBS in the PCSP identified through the person-centered planning process that are needed to help people achieve their goals across all domains of the PCSP, including those immediately needed services that are also needed on an ongoing basis, with no gaps in care.

2.9.6.3.26.4 Initiation of the comprehensive assessment and determination of immediately needed services for ECF CHOICES members may, at the CONTRACTOR's discretion, occur during the enrollment visit (i.e., prior to enrollment in ECF CHOICES).

2.9.6.3.27 For the CONTRACTOR's members enrolled into CHOICES Group 2 or Group 3 or ECF CHOICES, the member's Care Coordinator or Support Coordinator, as applicable, shall, within the timeframes prescribed in this section, authorize and initiate CHOICES or ECF CHOICES HCBS, as applicable.

2.9.6.3.27.1 For purposes of the CHOICES and ECF CHOICES programs, service authorizations for CHOICES HCBS or ECF CHOICES HCBS shall include the amount, frequency, and duration of each service to be provided, and except for services provided through Consumer Direction, the schedule at which such care is needed or preferred, if applicable, and whether the member requests or agrees to accept flexibility in his/her typical schedule, as applicable and after the member has received education on options and advantages of flexible scheduling; and other relevant information as required by TENNCARE. The CONTRACTOR shall not lead a member to develop a schedule that is more prescriptive than is needed or preferred, or that does not provide for flexibility that the member may want—whether to allow flexibility so the member's preferred provider has capacity to deliver needed services or to provide the member with flexibility to adjust the schedule as his or her needs and preferences change. When a member's PCSP includes CHOICES or ECF CHOICES HCBS that will be delivered by multiple providers (e.g., Individual Employment Supports, Community Integration Support Services, and Personal Assistance), the CONTRACTOR shall be responsible for providing assistance to the member and providers to coordinate on an ongoing basis the scheduling of these services in accordance with the member's needs and preferences, and to avoid duplication. The CONTRACTOR shall be responsible for ensuring that the provider receives sufficient information as part of the referral to make an informed decision regarding the provider's ability to deliver services in accordance with the member's needs, including: the member's zip code or specific area where the service is desired; the member's support needs, including specialized physical or behavioral health or functional support needs that could require special training or expertise; the amount and type of service needed; start date needed and/or desired; goals the service is intended to address with specificity to the extent necessary to reflect member preferences; schedule needed or preferred by the member or indication of flexible scheduling needed or preferred; billing code indicating staffing ratio if applicable (e.g., 1:1, 1:2 or 1:3 for Community Integration Support Services); member needs and preferences regarding staff and, if applicable, individuals who may be paired with the member to share staff support. The CONTRACTOR may share the PCSP (or relevant parts of the PCSP) as needed to address some or all of the information specified above. The CONTRACTOR shall also be responsible for confirming the provider's capacity and commitment to initiate services as authorized on or before the requested start date, and if the provider is unable to initiate services as authorized on or before the

requested start date, for arranging an alternative provider who is able to initiate services as authorized on or before the requested start date. The CONTRACTOR may determine, subject to requirements set forth in the approved service definitions, and in policy and protocol, the duration of time for which CHOICES HCBS or ECF CHOICES HCBS will be authorized. Additionally, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES or ECF CHOICES HCBS in accordance with the PCSP. The CONTRACTOR shall further be responsible for ensuring that service authorizations are consistent with the PCSP, including the schedule at which services are needed and any updates to the PCSP, and/or schedule, and except in the following circumstance, for notifying providers in advance when a service authorization (including a schedule) will be changed. Retroactive entry or adjustments in service authorizations for CHOICES HCBS or ECF 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.

2.9.6.3.27.2 Notwithstanding the address and/or phone number in the 834 file, for purposes of the EVV system (see Section A.2.9.6.13.6), the CONTRACTOR shall use the member's address or phone number or appropriate alternative phone number as confirmed during the intake and/or enrollment visit (see Section A.2.9.6.3.11) and updated (as applicable) during subsequent care coordination or support coordination contacts, through EVV alert monitoring or other member contacts for all HCBS that will be logged into the EVV system.

2.9.6.3.27.3 Except as required pursuant to Section A. 2.14.5.8, the CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section A.2.14.1.14). Until the new nursing facility reimbursement methodology is effective in the TennCare Rules, the CONTRACTOR may however reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement. If the CONTRACTOR elects to authorize nursing facility services, the CONTRACTOR may determine the duration of time for which nursing facility services 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 nursing facility services in accordance with the level of care and/or reimbursement approved by TENNCARE. Retroactive entry or adjustments in service authorizations for nursing facility services should be made only upon notification of retroactive enrollment into or disenrollment from CHOICES Group 1a or 1b via the outbound 834 file from TENNCARE.

2.9.6.3.27.4 The CONTRACTOR shall provide at least verbal notice to the member prior to initiation of CHOICES or ECF CHOICES HCBS identified in the PCSP, as applicable, regarding any change in providers selected by the member for each CHOICES or ECF CHOICES HCBS; including the reason such change has been made. If the CONTRACTOR is unable to place a CHOICES or ECF CHOICES member in the nursing facility or community-based residential alternative setting requested by the member, the Care Coordinator or Support Coordinator, as applicable, shall meet with the member and his/her representative to discuss the reasons why the member cannot be placed with the requested facility and the available options and identify an alternative facility.

2.9.6.3.27.5 If the CONTRACTOR is unable to initiate any long-term care service within the timeframes specified in this Contract or in TENNCARE protocol, the CONTRACTOR shall issue written notice to the member, documenting the service(s) that will be delayed, the reasons for the delay and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.

2.9.6.3.27.6 For members enrolled in CHOICES or ECF CHOICES who are, upon CHOICES or ECF CHOICES enrollment, receiving nursing facility or community-based residential alternative services from a contract provider, the CONTRACTOR shall authorize such services from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES or ECF CHOICES who are, upon CHOICES or ECF CHOICES enrollment, receiving services in a nursing facility or community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.

2.9.6.3.27.7 For members receiving nursing facility services, the Care Coordinator shall participate as appropriate in the nursing facility's care planning process (see Section A.2.9.6.5.1) and may supplement the facility's PCSP as necessary (see Section A.2.9.6.6.1).

2.9.6.3.27.8 The CONTRACTOR shall not divert or transition members in CHOICES Group 1 to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility and is enrolled in Group 2 or a member enrolled in CHOICES on or after July 1, 2012 no longer meets nursing facility level of care but does meet the at-risk level of care and is enrolled in Group 3.

2.9.6.3.27.9 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and : (1) is expected to require a short-term nursing facility care stay for ninety (90) days or less; (2) chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and at a cost that is less than the

member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in Group 1.

2.9.6.3.27.10 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and: (1) is expected to require short-term nursing facility services for ninety (90) days or less; or (2) chooses to transition to a nursing facility and enroll in Group 1.

2.9.6.3.27.11 The CONTRACTOR shall not admit a member enrolled in any ECF CHOICES Group or any member with I/DD who would qualify for enrollment in any ECF CHOICES Group to a nursing facility, including for short-term stay, without providing advance notification to TENNCARE, which shall include documentation of thoroughly exploring and exhausting all attempts to provide services in a more integrated community setting.

2.9.6.3.27.11.1 The member must meet the NF LOC in place at the time of admission and: (1) be expected to require short-term nursing facility services for ninety (90) days or less; or (2) make an informed choice to transition to a nursing facility and enroll in Group 1. Informed choice requires thorough exploration and exhaustion of all integrated community setting options.

2.9.6.3.27.11.2 A PASRR must be completed prior to admission, the member must be determined appropriate for placement in a nursing facility, and all identified specialized services must be coordinated by the CONTRACTOR immediately upon admission.

2.9.6.3.27.11.3 If a member enrolled in any ECF CHOICES Group or any member with I/DD who would qualify for enrollment in any ECF CHOICES Group is admitted to a nursing facility without the CONTRACTOR's knowledge (e.g., following discharge from an inpatient hospital stay of which the CONTRACTOR had no knowledge), the CONTRACTOR shall immediately commence assessment of the member's interest and ability to transition into a more integrated community setting, and shall assist the member in exploring all possible integrated community setting options.

2.9.6.3.27.11.4 The CONTRACTOR shall be responsible for ensuring seamless coordination of discharge planning on behalf of members enrolled in its companion D-SNP and for coordinating with other Medicare Advantage D-SNPs regarding members enrolled in a D-SNP that is not the CONTRACTOR's companion D-SNP (see Section A.2.9.13), which shall include appropriate triage of inpatient admission notifications and coordination in discharge planning when Medicaid LTSS or other Medicaid services are needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective and integrated setting.

2.9.6.3.27.12 Upon receiving notification from TENNCARE that a member's eligibility has ended, the CONTRACTOR shall within two (2) business days notify all providers of ongoing HCBS and for members receiving services through Consumer Direction the FEA that the member's CHOICES or ECF CHOICES eligibility has ended, which may be accomplished by notification in the EVV system when applicable. Such notification shall not be provided in advance of the actual end date of member's CHOICES or ECF CHOICES eligibility, as a prospective end date could be extended.

2.9.6.3.28 When the CONTRACTOR determines that a member with an intellectual disability or related condition or a member who has mental illness, whether such a member is CHOICES or non-CHOICES, is appropriate for nursing facility placement and specialized services are recommended in the member's PASRR, the nursing facility shall be required to confirm, in a manner specified by TENNCARE, its willingness and ability to provide the specialized services for the member. The CONTRACTOR shall ensure that any approved specialized services are part of the nursing facility's PCSP for the member and shall coordinate with the NF to ensure that such specialized services are delivered. This shall include the CONTRACTOR's timely authorization of medically necessary covered benefits, including NEMT to such benefits when provided outside the facility setting.

2.9.6.3.29 TENNCARE may establish, pursuant to policies and protocols for management of waiting or referral lists, alternative timeframes for completion of specified intake and enrollment functions and activities for persons when there is a waiting or referral list, or upon implementation of ECF CHOICES.

2.9.6.3.30 The CONTRACTOR shall complete all intake processes in Section A.2.9.6.3 within thirty (30) calendar days, unless an exception is granted by TENNCARE in writing due to extenuating circumstances beyond the CONTRACTOR's control. If TENNCARE grants an exception, such exception will provide the CONTRACTOR an additional thirty (30) calendar days to complete an intake process for the applicant, totaling sixty (60) calendar days to complete the intake process. If TENNCARE grants the CONTRACTOR an exception and the CONTRACTOR does not complete the intake process within sixty (60) calendar days, the CONTRACTOR shall close the referral, notify TENNCARE, and document the reason(s) the intake process was not completed for that applicant, and shall maintain such documentation and provide the documentation to TENNCARE upon request.

2.9.6.4 <u>Care Coordination upon Enrollment in CHOICES and Support Coordination upon Enrollment in ECF CHOICES</u>

2.9.6.4.1 Upon notice of a member's enrollment in CHOICES or ECF CHOICES, the CONTRACTOR shall assume responsibility for all care coordination or support coordination functions, as applicable, and all requirements pertaining thereto, including but not limited to requirements set forth in the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Contract, TennCare policies, procedures and protocols, and activities described herein (assessment and care planning activities for members currently enrolled with the CONTRACTOR shall begin prior to CHOICES enrollment and may begin for members currently enrolled with the CONTRACTOR prior to ECF CHOICES enrollment; see Section A.2.9.6.3).

2.9.6.4.2 The CONTRACTOR shall assign to each member a specific Care Coordinator or Support Coordinator who shall have primary responsibility for performance of care coordination or support coordination activities as specified in this Contract, and who shall be the member's point of contact for coordination of all physical health, behavioral health, and long-term services and supports. Members in ECF CHOICES Groups 7 and 8 shall be assigned a specific Integrated Support Coordination Team, as defined herein.

2.9.6.4.2.1 For CHOICES or ECF CHOICES members, who are, upon CHOICES or ECF CHOICES enrollment, receiving services in a nursing facility or a community-based residential alternative setting, the CONTRACTOR shall assign a specific

Care Coordinator or Support Coordinator prior to the first face-to-face visit required in this Contract. If the first face-to-face visit will not occur within the first ten (10) days of the member's enrollment in CHOICES or ECF CHOICES, the CONTRACTOR shall send the member written notification within ten (10) calendar days of the member's enrollment that explains how the member can reach the care coordination unit or the support coordination unit, as applicable, for assistance with concerns or questions pending the assignment of a specific Care Coordinator or Support Coordinator.

2.9.6.4.2.2 For CHOICES or ECF CHOICES members who, upon enrollment in CHOICES or ECF CHOICES, are not receiving services in a nursing facility or a community-based residential alternative setting, the CONTRACTOR shall assign a specific Care Coordinator or Support Coordinator, as applicable, and shall advise the member of the name of his/her Care Coordinator or Support Coordinator and provide contact information prior to the initiation of services (see Section A.2.9.6.2.5.3 and A.2.9.6.3.27), but no more than ten (10) calendar days following CHOICES or ECF CHOICES enrollment.

2.9.6.4.2.3 For all CHOICES members and ECF CHOICES members, the assigned Care Coordinator or Support Coordinator shall be linguistically competent in the member and primary caregiver's spoken language or in the use of sign language or other non-verbal forms of communication, including the use of assistive technology, as applicable, and the use of other auxiliary aids or services in order to achieve effective communication. If a Care Coordinator or Support Coordinator is assigned before the CONTRACTOR identifies the member's primary spoken language or other communication needs, and the Care Coordinator or Support Coordinator is not linguistically competent in the member and primary caregiver's primary spoken language or is unable to accommodate the use of sign language or other non-verbal forms of communication, including the use of assistive technology, as applicable, and the use of other auxiliary aids or services in order to achieve effective communication the CONTRACTOR shall assign a new Care Coordinator or Support Coordinator who is linguistically competent in the member and primary caregiver's primary spoken language, or who is trained in the use of sign language or other non-verbal forms of communication, including the use of assistive technology, as applicable, and the use of other auxiliary aids or services in order to achieve effective communication and shall notify the member of the new Care Coordinator or Support Coordinator and the reason for such assignment. If the CONTRACTOR is unable to assign a Care Coordinator for a CHOICES member or a Support Coordinator for an ECF CHOICES member who is linguistically competent in the member and primary caregiver's primary spoken language, or who is trained in the use of sign language or other non-verbal forms of communication, including the use of assistive technology, and the use of other auxiliary aids or services in order to achieve effective communication as applicable, the CONTRACTOR shall ensure the availability of translation services in the member and primary caregiver's primary spoken language or in sign language, or who can facilitate non-verbal forms of communication, including the use of assistive technology, as applicable, and the use of other auxiliary aids or services in order to achieve effective communication for all comprehensive assessment and care planning activities.

2.9.6.4.3 The CONTRACTOR may utilize a care coordination or support coordination team approach to performing care coordination or support coordination activities prescribed in Section A.2.9.6.

2.9.6.4.3.1 For each CHOICES or ECF CHOICES member, the CONTRACTOR's care coordination or support coordination team shall consist of the member's Care Coordinator or Support Coordinator and specific other persons with relevant expertise and experience appropriate to address the needs of CHOICES or ECF CHOICES members.

2.9.6.4.3.2 Care coordination or support coordination teams shall be discrete entities within the CONTRACTOR's organizational structure dedicated to fulfilling CHOICES or ECF CHOICES care coordination or support coordination functions.

2.9.6.4.3.3 The CONTRACTOR shall establish policies and procedures that specify, at a minimum: the composition of care coordination or support coordination teams; the tasks that shall be performed directly by the Care Coordinator or Support Coordinator as specified in this Contract, including comprehensive assessment, caregiver assessment, development of the PCSP or person-centered support plan, and all minimum care coordination or support coordination contacts; the tasks that may be performed by the Care Coordinator or Support Coordinator or the care coordination or support coordination team; measures taken to ensure that the Care Coordinator or Support Coordinator remains the member's primary point of contact for the CHOICES or ECF CHOICES program and related issues; escalation procedures to elevate issues to the Care Coordinator or Support Coordinator in a timely manner; and measures taken to ensure that if a member needs to reach his/her Care Coordinator or Support Coordinator specifically, calls that require immediate attention by a Care Coordinator or Support Coordinator are handled by a Care Coordinator or Support Coordinator and calls that do not require immediate attention are returned by the member's Care Coordinator or Support Coordinator the next business day.

2.9.6.4.3.4 The CONTRACTOR may elect to utilize specialized intake coordinators or intake teams for initial comprehensive assessment and care planning or support planning activities. All intake activities identified as responsibilities of the Care Coordinator or Support Coordinator shall be completed by an individual who meets all of the requirements to be a Care Coordinator or Support Coordinator. Should the CONTRACTOR elect to utilize specialized intake coordinators or intake teams, the CONTRACTOR shall develop policies and procedures which specify how the CONTRACTOR will coordinate a seamless transfer of information from the intake coordinator or team to the member's Care Coordinator or Support Coordinator.

2.9.6.5 <u>Comprehensive Assessment</u>

2.9.6.5.1 *For Members in CHOICES Group 1*

2.9.6.5.1.1 As part of the face-to-face intake visit for current members or face-to-face visit with new members in CHOICES Group 1, as applicable, a Care Coordinator shall conduct any comprehensive assessment deemed necessary by the CONTRACTOR, using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE. This assessment may include identification of targeted strategies related to improving overall wellness, health, functional, or quality of life outcomes (e.g., related to Population Health or pharmacy management) or to increasing and/or maintaining functional abilities, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit. The Care Coordinator shall ensure coordination of the member's physical health, behavioral health, and long-term

care needs and shall assess at least annually the member's potential for an interest in transition to the community. For children under the age of 21 in nursing facilities, this shall include explanation to the member or his parent or authorized representative, as applicable, of benefits available pursuant to EPSDT, including medically necessary benefits such as home health or private duty nursing that may be provided in the community as an alternative to nursing facility care.

2.9.6.5.1.2 Needs reassessments shall be conducted as the Care Coordinator deems necessary.

2.9.6.5.2 *For Members in CHOICES Groups 2 and 3*

2.9.6.5.2.1 The Care Coordinator shall conduct a comprehensive assessment using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE as part of its face-to-face visit with new members in CHOICES Groups 2 and 3 (see Section A.2.9.6.2.5) and as part of its face-to-face intake visit for current members applying for CHOICES Groups 2 and 3.

2.9.6.5.2.2 At a minimum, for members in CHOICES Group 2 and 3, the comprehensive assessment shall assess: (1) the member's overall wellness including physical, behavioral, functional, and psychosocial needs; (2) an evaluation of the member's financial health as it relates to the member's ability to maintain a safe and healthy living environment, which for individuals receiving community-based residential alternative services other than companion care, shall include the member's capabilities and desires regarding personal funds management; any training or assistance needed to support the member in managing personal funds or to develop skills needed to increase independence with managing personal funds; and any health, safety or exploitation issues that require limitations on the member's access to personal funds; (3) the member's interest in pursuing integrated, competitive employment and any barriers to pursuing employment (as applicable); (4) the member's opportunities to engage in community life and access community services and activities to the same degree as individuals not receiving HCBS; (5) the member's natural supports, including care being provided by family members and/or other caregivers, and long-term care services the member is currently receiving (regardless of payor), and whether there is any anticipated change in the member's need for such care or services or the availability of such care or services from the current caregiver or payor; (6) the physical health, behavioral health, and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health safety and welfare in the community, delay or prevent the need for institutional placement, and to support the member's individually identified goals and outcomes, including employment (as applicable) and integrated community living; (7) the member's food security, including whether referrals and application assistance for food stamps (i.e., SNAP benefits), WIC (if caring for a minor child), or other public or community resources are appropriate; and (8) the member's need for available assistive technology or any other auxiliary aids or services used to facilitate effective communication.

2.9.6.5.2.3 The comprehensive assessment shall be conducted at least annually and as the Care Coordinator deems necessary.

2.9.6.5.2.4 For CHOICES Group 2 and 3 members, the CONTRACTOR shall visit the member face-to-face within five (5) business days of becoming aware that the member has a significant change in needs or circumstances as defined in Section A.2.9.6.10.2.1.17 The Care Coordinator shall assess the member's needs, conduct a comprehensive assessment and update the member's PCSP as deemed necessary based on the member's circumstances.

2.9.6.5.2.4.1 For CHOICES Group 3 members whose change in needs result in a transition to Group 2, the CONTRACTOR shall request the transition by submitting a PAE to TENNCARE and upon receiving approval for the member's enrollment into Group 2, ensure that any new service(s) specified in the PCSP are initiated within five (5) business days, except when such service(s) may be initiated only upon completion of an adverse action pertaining to another service such that advance notice is required. In such case, the new service(s) shall be initiated upon expiration of the advance notice period or upon resolution of any timely filed appeal requiring continuation of the existing benefits.

2.9.6.5.2.5 *For ECF CHOICES members*

2.9.6.5.2.5.1 Upon enrollment in ECF CHOICES and as specified on an ongoing basis, the Support Coordinator shall conduct a comprehensive face-to-face comprehensive assessment using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE.

2.9.6.5.2.5.2 At minimum, for members in ECF CHOICES, the comprehensive assessment shall assess: (1) the member's strengths; (2) the natural and community supports (both currently involved and yet to be involved) available to the member, and the extent of the stability of each of those supports; (3) the member's preferences for lifestyle, employment, daily routine and community involvement, privacy, and direct support professionals; (4) the member's goals and needs related to: achieving his/her desired lifestyle and personal goals (including employment and community involvement goals); achieving and maintaining the best possible health and wellness; preserving and building natural and community supports; developing and maintaining a network of chosen and positive relationships; building skills and strategies for independence; achieving the greatest possible financial capabilities to maximize the member's ability to control personal income and other financial resources; understanding and exercising his/her rights, preserving guardianship of self, executing advance directives, utilizing durable power of attorney and/or power of attorney for health care; obtaining and maintaining safe, stable and affordable housing; building and preserving financial health; and mitigating risks associated with the member's desired lifestyle, chosen relationships, housing situation and/or impact of disability; (5) the member's overall wellness including physical, behavioral, functional, and psychosocial needs; (6) on-going clinical and/or functional conditions that may require intervention, a course of treatment and/or on-going monitoring; (7) any vulnerability and risk factors for abuse and neglect in the member's personal life or finances; (8) services or assistance programs the member may be receiving, may have access to and/or may be eligible for, in addition to, or in lieu of, services available through ECF CHOICES; and (9) supports, services, or items necessary to enable the member to achieve his/her preferred lifestyle and goals, to ensure community living, to facilitate gainful integrated employment, and to delay or prevent a decline in level of independence and functioning.

2.9.6.5.2.5.2.1 As a part of the comprehensive assessment, the MCO shall review the American Association of Intellectual and Developmental Disabilities Supports Intensity Scale results/reports (applicable for CHOICES Group 6 members only), all available medical records of the member and any other available background information.

2.9.6.5.2.5.2.2 The comprehensive assessment shall determine how natural and community supports available to the member can best be coordinated and supported through the ECF CHOICES program.

2.9.6.5.2.5.2.3 The comprehensive assessment shall include exploration with the member of the member's understanding of consumer direction and any desire to self-manage all or part of services available through consumer direction as specified in the PCSP.

2.9.6.5.2.5.3 The comprehensive assessment shall be conducted at least annually and as the Support Coordinator deems necessary.

2.9.6.5.2.5.4 For ECF CHOICES members, the CONTRACTOR shall visit the member face-to-face within five (5) business days of becoming aware that the member has a significant change in needs or circumstances as defined in Section A.2.9.6.10.2.1.17. The Support Coordinator shall assess the member's needs, conduct a comprehensive assessment and update the member's PCSP as deemed necessary based on the member's circumstances.

2.9.6.5.2.6 Caregiver Assessment

2.9.6.5.2.6.1 *For members in CHOICES Groups 2 and 3 or ECF CHOICES*

2.9.6.5.2.6.1.1 The Care Coordinator or Support Coordinator, as applicable, shall conduct a caregiver assessment using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE as part of its face-to-face visit with new members in CHOICES Groups 2 and 3 (see Section A.2.9.6.2.5) and as part of its face-to-face intake visit for current members applying for CHOICES Groups 2 and 3 and as part of its face-to-face visit with new members in ECF CHOICES.

2.9.6.5.2.6.1.1.1 The CONTRACTOR may conduct the caregiver assessment as part of the enrollment visit for the CONTRACTOR's current members.

2.9.6.5.2.6.1.2 At a minimum, for members in CHOICES Groups 2 and 3 or ECF CHOICES, the caregiver assessment shall include: (1) an overall assessment of the family member(s) and/or caregiver(s) providing services to the member to determine the willingness and ability of the family member(s) or caregiver(s) to contribute effectively to the needs of the member, including employment status and schedule, and other care-giving responsibilities (2) an assessment of the caregiver's own health and well-being, including medical, behavioral, or physical limitations as it relates to the caregiver's ability to support the member; (3) an assessment of the caregiver's level of stress related to caregiving responsibilities and any feelings of being overwhelmed; (4) identification of the caregiver's needs for training in knowledge and skills in assisting the person needing care; and (5) identification of any service and support needs to be better prepared for their care-giving role. Additionally, the

Care Coordinator or Support Coordinator shall ensure that all identified caregivers have the Care Coordinator or Support Coordinator's name and contact information in accordance with Section A.2.9.6.4.2.

2.9.6.5.2.6.1.3 The caregiver assessment shall be conducted at least once every 365 days as part of the annual review, upon a significant change in circumstances as defined in Section A.2.9.6.10.2.1.17, and as the Care Coordinator or Support Coordinator deems necessary.

2.9.6.6 Plan of Care

2.9.6.6.1 *For Members in CHOICES Group 1*

2.9.6.6.1.1 For members in CHOICES Group 1, the member's Care Coordinator may: (1) rely on the PCSP developed by the nursing facility for service delivery instead of developing a PCSP for the member; and (2) supplement the nursing facility plan of care as necessary with the development and implementation of targeted strategies to improve overall wellness, health, functional, or quality of life outcomes (e.g., related to Population Health or pharmacy management) or to increase and/or maintain functional abilities. A copy of any supplements to the nursing facility plan of care, and updates to such supplements, shall be maintained by the CONTRACTOR in the member's CHOICES file.

2.9.6.6.1.2 The member's Care Coordinator shall participate as appropriate in the nursing facility's care planning process and advocate for the member.

2.9.6.6.1.3 The member's Care Coordinator/Care Coordination team shall be responsible for coordination of the member's physical health, behavioral health, and long-term care needs, which shall include coordination with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the member's acute and/or chronic physical health or behavioral health conditions, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit, including services covered by the CONTRACTOR that are prescribed by the PASRR.

2.9.6.6.2 *For Members in CHOICES Groups 2 and 3and ECF CHOICES*

2.9.6.6.2.1 For members in CHOICES Groups 2 and 3 and ECF CHOICES, the Care Coordinator or Support Coordinator, as applicable, shall coordinate and facilitate a care or support planning team that includes, at a minimum, the member, persons chosen by the member to participate in comprehensive assessment and care or support planning, including the member's caregiver, as applicable; and the member's Care Coordinator or Support Coordinator, as applicable. As appropriate, the Care Coordinator or Support Coordinator, as applicable, shall include or seek input from other individuals such as the member's representative or other persons authorized by the member to assist with comprehensive assessment and care planning activities. If modifications to member rights in a provider-owned or controlled residential setting are proposed as detailed in Section A.2.9.6.6.2.4.5, the Care Coordinator or Support Coordinator shall seek input from the CONTRACTOR's Settings Compliance Committee (see A.2.24.5) prior to including such modifications in the member's PCSP. Comprehensive assessment (see A.2.9.6.5.2) caregiver assessment (see A.2.9.6.5.2.6) and person-centered

care planning (A.2.9.6.6.2) shall take place at times that are convenient for the member and accommodates the caregiver's participation, as applicable.

2.9.6.6.2.2 The CONTRACTOR shall ensure that Care Coordinators or Support Coordinators, as applicable, consult with the member's PCP, specialists, behavioral health providers, other providers, and interdisciplinary team experts, as needed when developing the plan of care or PCSP, as applicable. For members enrolled in ECF CHOICES Groups 7 or 8, person-centered planning processes shall be conducted by the Integrated Support Coordination Team as defined in this Contract.

2.9.6.6.2.3 The Care Coordinator or Support Coordinator, as applicable, shall verify that the decisions made by the care or support planning team are documented in a written, PCSP, using a template provided by TENNCARE. The CONTRACTOR shall document the PCSP in a format that ensures all content entered is visible and accessible to providers and others to whom the PCSP is distributed, whether viewed electronically or printed. The CONTRACTOR may amend the template format for distribution to providers and other parties, but shall maintain a current version of each member's PCSP in a format prescribed by TENNCARE to facilitate the provision of data to TENNCARE upon request.

2.9.6.6.2.4 When developing the PCSP for CHOICES and ECF CHOICES members, the CONTRACTOR shall comply with federal rules at 42 C.F.R. § 441.301(c) pertaining to person-centered planning and shall use the PCSP template required by TENNCARE. The PCSP shall be developed in accordance with protocols developed by TENNCARE and the principles of self-determination, including dignity of choice and supported decision-making, and shall meet PCSP quality standards as specified by TENNCARE. The CONTRACTOR shall discuss with the member opportunities, benefits, and potential positive and negative outcomes associated with risks that may result from the member's decisions, and strategies to mitigate potential negative outcomes associated with identified risks, when appropriate, which shall be documented in the PCSP as appropriate. The PCSP at a minimum shall include:

2.9.6.6.2.4.1 Pertinent demographic information regarding the member including the member's current address and phone number(s), the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning, and/or implementation of health care (including long-term care) related services and supports, (along with signed copies of all documents required in order to allow access to records or decision-making authority by the authorized representative(s), if applicable);

2.9.6.6.2.4.2 Documentation that the setting in which the member resides is chosen by the member and meets the HCBS Settings Rule requirements of 42 C.F.R. §441.301(c)(4)-(5);

2.9.6.6.2.4.2.1 If a CHOICES or ECF CHOICES member is already living in or chooses (without any involvement from the CONTRACTOR) to transition to an residence providing room and board for two or more unrelated individuals that is not licensed by the state, the CONTRACTOR shall be responsible for 1) assessing the setting, including but not limited to the lease agreement, to ensure that it comports with all HCBS setting requirements, including those requirements applicable to provider owned or controlled residences; 2) assessing the suitability of the living arrangement for the member; 3)

ensuring that the member is not restricted in his or her ability to manage his own financial resources; and 4) enhanced monitoring as needed to ensure continued compliance with HCBS settings requirements and to identify potential abuse, neglect or exploitation. CHOICES and ECF CHOICES HCBS shall not be provided (inside or outside such setting) for any member who resides in an unlicensed setting that does not comport with the HCBS settings rule.

2.9.6.6.2.4.2.2 If a CHOICES or ECF CHOICES member resides in a licensed setting other than those defined in the covered benefits for CHOICES or ECF CHOICES, as applicable, CHOICES or ECF CHOICES HCBS shall not be provided in the setting. Further, CHOICES or ECF CHOICES HCBS shall be provided for the member outside the setting only if the licensed setting in which the member resides fully comports with the HCBS settings rule.

2.9.6.6.2.4.3 The member's strengths and interests;

2.9.6.6.2.4.4 Person-centered goals and objectives, including employment (as applicable) and integrated community living goals, and desired wellness, health, functional, and quality of life outcomes for the member, and how CHOICES or ECF CHOICES services are intended to help the member achieve these goals;

2.9.6.6.2.4.5 Risk factors for the member and measures in place to minimize them, including for any modification regarding the conditions set forth in the federal HCBS setting rule at 42 C.F.R. §§ 441.301(c)(4)(vi)(A) through (D), all of the documentation requirements specified at 42 C.F.R. §§ 441.301(c)(2)(xiii)(A-H) and 441.301(c)(4)(vi)(F)(1-8);

2.9.6.6.2.4.5.1 All Care Coordinators and Support Coordinators shall, in consultation with interdisciplinary team experts, as needed (see 2.9.6.6.2.2), complete a Medication Risk Assessment for all members receiving HCBS in CHOICES or ECF CHOICES except members electing and currently receiving hospice services, as prescribed or approved by TennCare, to assess the level of medication complexity and risk to the member due to medication errors. The Medication Risk Assessment shall include but is not limited to the total number of medications the member takes, complexity of medication regimens, frequent changes in medications (new, changed, or discontinued medications), prescribed "high-risk" medications (those having a high risk of causing patient harm and even death when used incorrectly, including but not limited to anti-coagulants, insulin, narcotics, inhalers (excluding albuterol), opiates, sedatives, and anti-arrhythmic), cognitive or physical limitations impacting self-administration of medications, and the availability of natural or paid supports to assist with medication administration (including set-up, reminders, etc.). For any member who scores in the high-risk category on this assessment, Care Coordinators and Support Coordinators shall, in consultation with interdisciplinary team experts, as needed: (1) identify in the PCSP appropriate strategies to support the member's administration of medication and minimize potential risk, which may include but are not limited to medication reconciliation, patient and family education or the use of assistive technology; and (2) review on an ongoing basis to assess the efficacy of these strategies in reducing medication risk and to identify additional supports, as needed.

2.9.6.6.2.4.6 Support, including specific tasks and functions that will be performed by family members and other caregivers;

2.9.6.6.2.4.7 Caregiver training or supports identified through the caregiver assessment that are needed to support and sustain the caregiver's ability to provide care for the member;

2.9.6.6.2.4.8 Home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services;

2.9.6.6.2.4.9 Home health and private duty nursing that will be authorized by the CONTRACTOR;

2.9.6.6.2.4.10 CHOICES or ECF CHOICES HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided; how such services should be delivered, including the member's preferences; (except for services provided through Consumer Direction and pursuant to requirements set forth in Section A.2.9.6.2.5.13 and A.2.9.6.3.27.1 and guidance issued by TENNCARE) the schedule at which such care is needed; and the address or phone number(s) that will be used to log visits into the EVV system, as applicable;

2.9.6.6.2.4.11 A detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan;

2.9.6.6.2.4.12 For CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in A.2.9.6.6.2.4.9 above, and the projected monthly and annual cost of CHOICES HCBS specified in A.2.9.6.6.2.4.10 above, and for CHOICES Group 3 members, the projected total cost of CHOICES HCBS specified in A.2.9.6.6.2.4.10 above, excluding the cost of minor home modifications;

2.9.6.6.2.4.13 Description of the member's overall wellness, current physical and behavioral health conditions and functional status (i.e., areas of functional deficit), and the member's physical, behavioral and functional needs;

2.9.6.6.2.4.14 Description of the member's physical environment and any modifications necessary to ensure the member's health and safety;

2.9.6.6.2.4.15 Description of medical equipment used or needed by the member (if applicable);

2.9.6.6.2.4.16 The primary language spoken by the member and/or his or her primary caregiver, or the use of other means of effective communication, such as, sign language and other auxiliary aids or services, as applicable, and a description of any special communication needs including interpreters or special devices;

2.9.6.6.2.4.17 A description of the member's psychosocial needs, including any housing or financial assistance needs which could impact the member's ability to maintain a safe and healthy living environment and how such needs will be addressed in order to ensure the member's ability to live safely in the community;

2.9.6.6.2.4.18 For persons receiving community-based residential alternative services other than companion care, a description of the member's capabilities and desires regarding

personal funds management; the extent to which personal funds will be managed by the provider agency or the member's representative (as applicable); whether the member will have a separate bank account rather than an agency-controlled account for personal funds; any training or assistance that will be provided to support the member in managing personal funds or to develop skills needed to increase independence with managing personal funds; goals and objectives involving use of the member's personal funds; and any health, safety or exploitation issues that require limitations on the member's access to personal funds and strategies to remove limitations at the earliest possible time;

2.9.6.6.2.4.19 A person-centered statement of goals, objectives and desired wellness, health, functional and quality of life outcomes for the member and how CHOICES or ECF CHOICES services are intended to help the member achieve these goals;

2.9.6.6.2.4.20 Description of other services that will be provided to the member, including (1) covered physical health services, including population health services, that will be provided by the CONTRACTOR to help the member maintain or improve his or her physical health status or functional abilities and maximize independence; (2) covered behavioral health services that will be provided by the CONTRACTOR to help the member maintain or improve his or her behavioral health status or functional abilities and maximize independence; (3) other psycho/social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement; and (4) any non-covered services including services provided by other community resources, including plans to link the member to financial assistance programs including but not limited to housing, utilities, food as needed, and employment support from other entities (e.g., Vocational Rehabilitation);

2.9.6.6.2.4.21 Relevant information regarding the member's physical health condition(s), including treatment and medication regimen, that is needed by a long-term care provider, caregiver or the Care Coordinator or Support Coordinator, as applicable, to ensure appropriate delivery of services or coordination of care;

2.9.6.6.2.4.22 Frequency of planned Care Coordinator or Support Coordinator contacts needed, which shall include consideration of the member's individualized needs and circumstances, and which shall at minimum meet required contacts as specified in Section A.2.9.6.10.4 (unplanned Care Coordinator or Support Coordinator contacts shall be provided as needed);

2.9.6.6.2.4.23 Additional information for members who elect consumer direction of eligible CHOICES or ECF CHOICES HCBS, including but not limited to whether the member requires a representative to participate in consumer direction and the specific services that will be consumer directed;

2.9.6.6.2.4.24 For CHOICES members, if the member chooses to self-direct any health care tasks, the type of tasks that will be self-directed;

2.9.6.6.2.4.25 Any steps the member and/or representative should take in the event of an emergency that differ from the standard emergency protocol;

2.9.6.6.2.4.26 Planning what to do during an emergency shall include, but may not be limited to the following:

2.9.6.6.2.4.26.1 Developing an emergency plan including power outages, if applicable;

2.9.6.6.2.4.26.2 Creating a plan to have shelter in place when appropriate;

2.9.6.6.2.4.26.3 Creating a plan to get to another safe place when appropriate; and

2.9.6.6.2.4.26.4 Identifying, when possible, two ways out of every room in case of fire.

2.9.6.6.2.4.27 Identify any additional steps the member and/or representative should take in the event of an emergency including, but not limited to, who to contact in the event of any special considerations regarding medications, supplies and dietary needs or power outages, as applicable;

2.9.6.6.2.4.28 A disaster preparedness plan, including a plan for natural disasters, specific to the member;

2.9.6.6.2.4.29 The member's TennCare eligibility end date; and

2.9.6.6.2.4.30 An attachment listing all of the member's current LTSS providers, updated when there is a change in LTSS provider pursuant to A.2.9.6.6.2.5.4).

2.9.6.6.2.5 The member's Care Coordinator/Care Coordination or Support Coordinator/Support Coordination team, as applicable shall ensure that the member or his/her representative, as applicable, reviews, signs and dates the PCSP, as applicable, as well as any substantive updates, including but not limited to any changes in the amount, duration or type of HCBS that will be provided. The member or his/her representative, as applicable, may sign the PCSP, as well as any substantive updates, electronically based on the member or representative's preference and only when the CONTRACTOR has completed the PCSP via a face-to-face person-centered planning process. A face-to-face visit shall not be required in order to complete minor corrections and updates, such as changes in the schedule at which services are needed. The Care Coordinator or Support Coordinator, as applicable, shall also sign and date the PCSP, as applicable, along with any substantive updates. The PCSP, as applicable, shall be updated and signed by the member or his/her representative, as applicable, and the Care Coordinator or Support Coordinator annually and any time the member experiences a significant change in needs or circumstances (see Section A.2.9.6.10.2.1.17). The Care Coordinator or Support Coordinator shall assess the experience of each member receiving Medicaid HCBS using the Individual Experience Assessment (IEA) as prescribed by TENNCARE: 1) upon initial service initiation 2) as part of the member's annual PCSP review; 3) within 30 days of a change in the mental or physical status of a member that impacts modifications/restrictions in place, as applicable; and 4) anytime a change in residence or provider occurs for a person receiving residential services (including, but not limited to, Community Living Services). In the case of items (1) and (4) above, the IEA shall be completed at the next monthly face-to-face visit (as prescribed in A.2.9.6.10.4.3.14), unless such visit is less than two weeks following the initiation of services in item (1) or the change in residence in provider in item (4), in which case, the IEA shall be completed at the following monthly face-to-face visit. A new IEA is not required when a person continues to receive the same benefit in the same residence from the same provider, even if the level of reimbursement for that service has changed. Nor is an IEA required if a person is receiving services in a time-limited transitional placement, pending transition to a more permanent living arrangement, provided that the CONTRACTOR remains obligated to ensure full compliance

with the federal HCBS Settings Rule in all settings. Any restrictions must follow prescribed person-centered planning processes in the federal HCBS Settings Rule, and be reviewed by the CONTRACTOR's HCBS Settings Committee. All members receiving HCBS must have an IEA completed during a face-to-face visit at least annually. If the CONTRACTOR completes an IEA due to one of the circumstances described in items (3) or (4) above, the next IEA shall be due within one year from the date it is completed, unless an additional change as described in either items (3) or (4) occurs prior to that time. Participants in the IEA shall include the member and his or her family members and/or representative, as appropriate. Service provider staff may participate as requested by the member and his or her family and/or representative. In addition, the member's Care Coordinator or Support Coordinator, as applicable, shall address any issues regarding compliance with the HCBS Settings Rule or other concerns identified during the IEA within thirty (30) days of discovery. Additionally, a member's Care Coordinator or Support Coordinator, as applicable, shall complete the Employment Data Sheet (EDS) within thirty (30) days of a member's initiation of competitive integrated employment and annually, as provided by TENNCARE. The Employment Data Sheet may be completed telephonically by a member's Care or Support Coordinator, as applicable.

2.9.6.6.2.5.1 The CONTRACTOR shall develop policies and procedures that describe the measures taken by the CONTRACTOR to address instances when a member refuses to sign the plan of care or PCSP, as applicable. The policies and procedures shall include a specific escalation process (ultimately to TENNCARE) that includes a review of the reasons for the member's refusal as well as actions taken to resolve any disagreements with the plan of care or PCSP, as applicable, and shall involve the consumer advocate in helping to facilitate resolution.

2.9.6.6.2.5.2 When the refusal to sign is due to a member's request for additional services, including requests for a different type or an increased amount, frequency, scope, and/or duration of services than what is included in the plan of care or PCSP, as applicable, the CONTRACTOR shall, in the case of a new plan of care or PCSP, as applicable, authorize and initiate services in accordance with the plan of care or PCSP, as applicable; and, in the case of an annual or revised plan of care or PCSP, as applicable, ensure continuation of at least the level of services in place at the time the annual or revised plan of care or PCSP, as applicable, was developed until a resolution is reached, which may include resolution of a timely filed appeal, if applicable. The CONTRACTOR shall not use the member's acceptance of services as a waiver of the member's right to dispute the plan of care or PCSP, as applicable, or as cause to stop the resolution process.

2.9.6.6.2.5.3 When the refusal to sign is due to the inclusion of services that the member does not want to receive, either in totality or in the amount, frequency, scope or duration of services in the PCSP, the Care Coordinator shall for CHOICES Group 2 and 3 members note, the associated risks and the measures to mitigate the risks in the member's PCSP. In the event the Care Coordinator determines that the member's needs cannot be safely and effectively met in the community without receiving these services, the CONTRACTOR may request that it no longer provide long-term care services to the member (see Section A.2.6.1.5.7).

2.9.6.6.2.5.4 Instances in which a member's signature is not required are limited to: 1) member-initiated schedule changes to the POC or PCSP, as applicable, that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC or PCSP, as applicable, for the member (however, all schedule

changes must be member-initiated); 2) changes in the provider agency that will deliver services that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC or PCSP, as applicable, for the member; 3) changes in the member's current address and phone number(s) or the phone number(s) or address that will be used to log visits into the EVV system; 4) for ECF CHOICES members, the completion of one employment service and the initiation of another one as the member progresses towards meeting individual employment goals established in the PCSP; or 5) instances as permitted pursuant to TennCare policies and protocols, including emergency circumstances where the member's health and safety necessitate service initiation prior to member or representative signature. Documentation of such changes shall be maintained in the member's records, including an attachment listing all of the member's current LTSS providers. Each time a change in the member's LTSS provider(s) occur(s), the CONTRACTOR shall be responsible for circulating an amended attachment listing the current, updated LTSS provider list to all providers on the attachment within five (5) business days of any such update.

2.9.6.6.2.6 The member's Care Coordinator/care coordination or Support Coordinator/support coordination team shall provide a copy of the member's completed comprehensive assessment and plan of care or PCSP, as applicable, including any updates, to the member, the member's representative, as applicable, the member's community-based residential alternative provider, as applicable, and other providers authorized to deliver services to or for the benefit of the member. The member's Care Coordinator/care coordination or Support Coordinator/support coordination team shall further require that: (a) each provider signs the plan of care or PCSP, as applicable, indicating they have reviewed it in its entirety, they understand and agree to provide the services as described and in accordance with the specific goals, preferences and needs of the member, as outlined in the plan of care or PCSP, as applicable and the comprehensive assessment; and (b) each provider receives the fully completed comprehensive assessment and plan of care or PCSP, as applicable, at least two business days prior to the scheduled implementation of services and prior to any change in such services in order to ensure appropriate and timely training of provider staff. The CONTRACTOR shall have mechanisms in place to ensure that such signatures and confirmation of each provider's agreement to provide services occurs within the timeframes specified in A. 2.9.6.3.12, A.2.9.6.3.20, and A.2.9.6.6.2.7, such that a delay in the initiation of services does not result. Electronic signatures shall be accepted for providers who are not present during the care or support planning process or as needed to facilitate timely implementation, including updates to the plan of care or PCSP, as applicable, based on the member's needs.

2.9.6.6.2.7 Within five (5) business days of completing a reassessment of a member's needs, the member's Care Coordinator or Support Coordinator, as applicable, shall update the member's plan of care or PCSP, as appropriate, and the CONTRACTOR shall authorize and initiate CHOICES or ECF CHOICES HCBS in the updated plan of care or PCSP, as applicable, except when such service(s) may be initiated only upon completion of an adverse action such that advance notice is required. In such case, HCBS in the updated plan of care or PCSP, as applicable, shall be initiated upon expiration of the advance notice period or upon resolution of any timely filed appeal requiring continuation of the existing benefits. The CONTRACTOR shall comply with requirements for service authorization in Section A.2.9.6.2.5.12, change of provider in Section A.2.9.6.2.5.13, and notice of service delay in Section A.2.9.6.2.5.14.

2.9.6.6.2.7.1 Within three (3) business days of updating the member's plan of care or PCSP, as applicable, the member's Care Coordinator/care coordination or Support Coordinator/support coordination team shall provide a copy of all relevant changes to the FEA, as applicable, and to other providers authorized to deliver care to the member. Relevant information shall include any information needed to ensure the provision of quality care for the member and to help ensure the member's health, safety, and welfare, including but not limited to any changes in the tasks and functions to be performed.

2.9.6.6.2.8 The member's Care Coordinator or Support Coordinator, as applicable, shall inform each member of his/her eligibility end date (if known) and educate members regarding the importance of maintaining TennCare CHOICES or ECF CHOICES eligibility, that eligibility must be redetermined at least once a year, and that members receiving CHOICES or ECF CHOICES HCBS can receive assistance from the CONTRACTOR in completing an annual renewal packet (e.g., collecting appropriate documentation and completing the necessary forms), as part of the annual PCSP process and/or when a packet has been mailed and such process has not been completed timely, placing the member at risk of losing eligibility.

2.9.6.7 Nursing Facility Diversion

2.9.6.7.1 The CONTRACTOR shall develop and implement a nursing facility diversion process that complies with the requirements in this Section A.2.9.6.7 and is prior approved in writing by TENNCARE. The diversion process shall not prohibit or delay a member's access to nursing facility services when these services are medically necessary and requested by the member, provided that for persons who have an intellectual or developmental disability, the CONTRACTOR shall make every effort to provide services in the community and may admit a person to a nursing facility only in accordance with federal PASRR requirements.

2.9.6.7.2 At a minimum the CONTRACTOR's diversion process shall target the following groups for diversion activities:

2.9.6.7.2.1 Members who are waiting for placement in a nursing facility;

2.9.6.7.2.2 CHOICES or ECF CHOICES members residing in their own homes who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services;

2.9.6.7.2.3 CHOICES or ECF CHOICES members residing in adult care homes or other community-based residential alternative settings who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services;

2.9.6.7.2.4 CHOICES, ECF CHOICES and non-CHOICES and non-ECF CHOICES members admitted to an inpatient hospital or inpatient rehabilitation who are not residents of a nursing facility; and

2.9.6.7.2.5 CHOICES, ECF CHOICES and non-CHOICES and non-ECF CHOICES members who are placed short-term in a nursing facility regardless of payer source.

2.9.6.7.3 The CONTRACTOR's nursing facility diversion process shall be tailored to meet the needs of each group identified in Section A.2.9.6.7.2 above.

2.9.6.7.4 The CONTRACTOR's nursing facility diversion process shall include a detailed description of how the CONTRACTOR will work with providers (including hospitals regarding notice of admission and discharge planning; see Sections A.2.9.6.3.5 and A.2.9.6.3.18) to ensure appropriate communication among providers and between providers and the CONTRACTOR, training for key CONTRACTOR and provider staff, early identification of members who may be candidates for diversion (CHOICES, ECF CHOICES and non-CHOICES and non-ECF CHOICES members), and follow-up activities to help sustain community living.

2.9.6.7.5 The CONTRACTOR's nursing facility diversion process shall include specific timelines for each identified activity.

2.9.6.8 Nursing Facility-to-Community Transition

2.9.6.8.1 The CONTRACTOR shall develop and implement methods for identifying members who may have the ability and/or desire to transition from a nursing facility to the community. Such methods shall include, at a minimum:

2.9.6.8.1.1 Referrals, including but not limited to, treating physician, nursing facility, other providers, community-based organizations, family, and self-referrals;

2.9.6.8.1.2 Identification through the care coordination and support coordination process, including but not limited to: assessments, information gathered from nursing facility staff, participation in at least quarterly coordination meetings/phone calls which may be conducted by phone, between Care or Support Coordinators and designated nursing facility staff, or review and assessment of members whose nursing facility level of care is ending and who appear to meet the at-risk level of care for CHOICES Group 3 or ECF CHOICES Groups 4 or 5.

2.9.6.8.1.3 Review and analysis of members identified by TENNCARE based on Minimum Data Set (MDS) data from nursing facilities.

2.9.6.8.1.4 Identification of members in a nursing facility who have an intellectual or developmental disability and can be served in a more integrated home and community based setting in ECF CHOICES.

2.9.6.8.2 Members in CHOICES Group 1 (who are residents of a nursing facility) and who are under the age of twenty-one (21) and have requested to transition home will be provided coordination of care by the CONTRACTOR's CHOICES and Population Health staff.

2.9.6.8.3 Notwithstanding the nursing facility-to-community transition requirements set forth in this Section (A.2.9.6.8), the CONTRACTOR shall be responsible for monitoring all Group 1 members' level of care eligibility (see Section A.2.9.6.8.1.2) and for completing the process to re-establish nursing facility level of care or transition to Group 3, 4, or 5 HCBS, as appropriate, prior to expiration of nursing facility level of care.

2.9.6.8.4 For transition referrals by or on behalf of a nursing facility resident, regardless of referral source, the CONTRACTOR shall ensure that within fourteen (14) days of the referral a Care Coordinator or Support Coordinator conducts an in-facility visit with the member to determine the member's interest in and potential ability to transition to

the community, and provide orientation and information to the member regarding transition activities. The member's Care Coordinator/care coordination team or Support Coordinator/support coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition from Group 1 to Group 2 when the member expresses a desire to continue receiving nursing facility services.

2.9.6.8.5 For identification by the CONTRACTOR by means other than referral or the care coordination process of a member who may have the ability and/or desire to transition from a nursing facility to the community, the CONTRACTOR shall ensure that within ninety (90) days of such identification a Care Coordinator or Support Coordinator conducts an in-facility visit with the member to determine whether or not the member is interested in and potential ability to pursue transition to the community. The member's Care Coordinator/care coordination team or Support Coordinator/support coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.

2.9.6.8.6 If the member wishes to pursue transition to the community, within fourteen (14) days of the initial visit (see Sections A.2.9.6.8.3 and A.2.9.6.8.4 above) or within fourteen (14) days of identification through the care coordination or support coordination process, the Care Coordinator or Support Coordinator shall conduct an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or prior approved in writing by TENNCARE. This assessment shall include the identification of any barriers to a safe transition.

2.9.6.8.7 As part of the transition assessment, the Care Coordinator shall conduct a risk assessment in accordance with protocols developed by TENNCARE, discuss with the member the risk involved in transitioning to the community and shall include, as applicable for members who would transition into CHOICES Group 2 or Group 3, any 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 as part of the PCSP. The risk mitigation strategy in the PCSP shall include the frequency and type of Care Coordinator contacts that exceed the minimum contacts required (see Section A.2.9.6.10.4), to mitigate any additional risks associated with transition and shall address any special circumstances due to transition. For members transitioning to Group 2, the member's Care Coordinator/care coordination team shall also make a determination regarding whether the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. The member's Care Coordinator shall explain to the member the individual cost neutrality cap and obtain a signed acknowledgement of understanding by the member or his/her representative that a change in a member's 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 a 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 CONTRACTOR will assist with transition to a more appropriate care delivery setting. For members transitioning to Group 3, the Care Coordinator shall explain the expenditure cap. For members transitioning to ECF CHOICES, the Support Coordinator shall identify risks and strategies to mitigate risks as part of the transition plan and PCSP.

2.9.6.8.8 For those members whose transition assessment indicates that they are not candidates for transition to the community, the Care Coordinator or Support Coordinator shall notify them in accordance with the specified transition assessment protocol.

2.9.6.8.9 For those members whose transition assessment indicates that they are candidates for transition to the community, the Care Coordinator or Support Coordinator shall facilitate the development of and complete a transition plan within fourteen (14) days of the member's transition assessment.

2.9.6.8.10 The Care Coordinator or Support Coordinator shall include other individuals such as the member's family and/or caregiver in the transition planning process if the member requests and/or approves, and such persons are willing and able to participate.

2.9.6.8.11 As part of transition planning, prior to the member's physical move to the community, the Care Coordinator or Support Coordinator shall visit the residence where the member will live to conduct an on-site evaluation of the physical residence and meet with the member's family or other caregiver who will be residing with the member (as appropriate). The Care Coordinator or Support Coordinator shall include in the transition plan activities and/or services needed to mitigate any perceived risks in the residence including but not limited to an increase in face-to-face visits beyond the minimum required contacts in Sections A.2.9.6.8.19 and A.2.9.6.8.20.

2.9.6.8.12 The transition plan shall address all services necessary to safely transition the member to the community and include at a minimum member needs related to housing, transportation, availability of caregivers, and other transition needs and supports. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers.

2.9.6.8.13 The CONTRACTOR shall approve the transition plan and authorize any covered or cost effective alternative services included in the plan within ten (10) business days of completion of the plan. The transition plan shall be fully implemented within ninety (90) days from approval of the transition plan, except under extenuating circumstances which must be documented in writing.

2.9.6.8.14 The member's Care Coordinator shall also complete a PCSP that meets all criteria described in Section A.2.9.6.6 for members in CHOICES Groups 2 and 3 including but not limited to completing a comprehensive assessment, completing a risk assessment, and making a final determination of cost neutrality. The member's Support Coordinator shall also complete a PCSP that meets all criteria described in Section A.2.9.6.6 for members in ECF CHOICES, including but not limited to completing a comprehensive assessment and shall identify risks and strategies to mitigate risks as part of the transition plan and PCSP. The PCSP shall be authorized prior to and initiated upon the member's transition to the community.

2.9.6.8.14.1 If a transitioning member is enrolled in CHOICES Group 1, any CHOICES HCBS or ECF CHOICES HCBS that must be completed prior to a member's transition from a nursing facility to the community in order to ensure the member's health and safety upon transition (e.g., for a CHOICES member, minor home modifications, adaptive equipment, or PERS installation; or for an ECF CHOICES member, minor home modifications, assistive technology, etc.) shall be completed while the member is enrolled in Group 1, but shall be billed as a Group 2 or ECF CHOICES service once the member is enrolled into Group 2 or ECF CHOICES, as applicable, with the date of service the effective date of enrollment in CHOICES

Group 2 or ECF CHOICES (see State Medicaid Director Letter, Olmstead Update No. 3, July 25, 2000).

2.9.6.8.14.2 If a transitioning member is enrolled in CHOICES Group 2 or 3 or ECF CHOICES Groups 4, 5, or 6, but is receiving short-term nursing facility care, any CHOICES HCBS or ECF CHOICES HCBS that must be completed prior to a member's transition from a nursing facility to the community in order to ensure the member's health and safety upon transition (e.g., for a CHOICES member, minor home modifications, adaptive equipment, or PERS installation; or for an ECF CHOICES member, minor home modifications, assistive technology, etc.) shall be completed while the member resides in the facility and billed as a Group 2 or Group 3 or ECF CHOICES service, as applicable. However, a member shall not be transitioned from CHOICES Group 1 into Group 2 or 3 or ECF CHOICES for receipt of short-term nursing facility services in order to provide these services. Short-term nursing facility care is available only to a CHOICES 2 or CHOICES 3 or ECF CHOICES Groups 4, 5, or 6 participant who was receiving home and community based services upon admission to the short-term nursing facility stay.

2.9.6.8.15 For members requesting transition from Group 1 to Group 2, the CONTRACTOR shall not prohibit a member from transitioning to the community once the member has been counseled regarding risk. However, the CONTRACTOR may determine that the member's needs cannot be safely and effectively met in the community and at a cost that does not exceed nursing facility care. In such case, the CONTRACTOR shall seek written review and approval from TENNCARE prior to denial of any member's request to transition to the community. If TENNCARE approves the CONTRACTOR's request, the CONTRACTOR shall notify the member in accordance with TennCare rules and regulations and the transition assessment protocol, and the member shall have the right to appeal the determination (see Section A.2.19.3.12 of this Contract).

2.9.6.8.16 Once completed, the CONTRACTOR shall submit to TENNCARE documentation, as specified by TENNCARE to verify that for members transitioning to Group 2, the member's needs can be safely and effectively met in the community and within the cost neutrality cap. Before transitioning a member, the CONTRACTOR shall verify that the member has been approved for enrollment in CHOICES Group 2 or Group 3 or ECF CHOICES, as applicable, effective as of the planned transition date.

2.9.6.8.17 Ongoing CHOICES HCBS or ECF CHOICES HCBS and any medically necessary covered home health or private duty nursing services needed by the member shall be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2, CHOICES Group 3, or ECF HCBS) and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and ongoing CHOICES HCBS or ECF CHOICES HCBS.

2.9.6.8.18 The member's Care Coordinator/care coordination team or Support Coordinator/support coordination team shall monitor all aspects of the transition process and take immediate action to address any barriers that arise during transition.

2.9.6.8.19 For members transitioning to a setting other than a community-based residential alternative setting, the Care Coordinator/care coordination team or Support Coordinator/support coordination team shall upon transition utilize the EVV system to monitor the initiation and daily provision of services in accordance with the member's new plan of care or PCSP, as applicable, and shall take immediate action to resolve any service gaps (see definition in Section A.1).

2.9.6.8.20 For members who will live independently in the community or whose on-site visit during transition planning indicated an elevated risk, within the first twenty-four (24) hours, the Care Coordinator or Support Coordinator shall visit the member in his/her residence. During the initial ninety (90) day post-transition period, the Care Coordinator or Support Coordinator shall conduct monthly face-to-face in-home visits to ensure that the plan of care or PCSP, as applicable, is being followed, that the plan of care or PCSP, as applicable, continues to meet the member's needs, and the member has successfully transitioned to the community.

2.9.6.8.21 For members transitioning to a community-based residential alternative setting or who will live with a relative or other caregiver, within the first twenty-four (24) hours the Care Coordinator or Support Coordinator shall contact the member and within seven (7) days after the member has transitioned to the community, the Care Coordinator or Support Coordinator shall visit the member in his/her new residence. During the initial ninety (90) day post-transition period, the Care Coordinator or Support Coordinator shall (1) at a minimum, contact the member by telephone each month to ensure that the plan of care or PCSP, as applicable is being followed, that the plan of care or PCSP, as applicable, continues to meet the member's needs, and the member has successfully transitioned to the community; and (2) conduct additional face-to-face visits as necessary to address issues and/or concerns and to ensure that the member's needs are met.

2.9.6.8.22 The CONTRACTOR shall monitor hospitalizations and nursing facility re-admission for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes.

2.9.6.8.23 2.9.6.8.23 The CONTRACTOR shall be permitted to coordinate or subcontract with local community-based organizations to assist in the identification, planning and facilitation processes related to nursing facility-to-community transitions that are not specifically assigned to the Care Coordinator or Support Coordinator.

2.9.6.8.24 The CONTRACTOR shall develop and implement any necessary assessment tools, transition plan templates, protocols, or training necessary to ensure that issues that may hinder a member's successful transition are identified and addressed. Any tool, template, or protocol must be prior approved in writing by TENNCARE.

2.9.6.8.25 To facilitate nursing facility to community transition, the CONTRACTOR shall, effective July 1, 2015, maintain at least one (1) dedicated staff person without a caseload who meets the qualifications of a Care Coordinator specified in Section A.2.9.6.12, in each Grand Region in which the CONTRACTOR serves TennCare members. The dedicated staff person(s) shall not be reported in the Care Coordinator or Support Coordinator ratios specified in Section A.2.9.6.12. Such staff person(s) shall be responsible for proactively identifying TennCare members in NFs who are candidates to transition to the community, and to further assist with the completion of the transition process specified in Section A.2.9.6.8. All transition activities identified as responsibilities of the Care Coordinator or Support Coordinator shall be completed by an individual who meets all of the requirements to be a Care Coordinator or Support Coordinator.

2.9.6.8.26 Any nursing facility to community transition shall be based on the individualized needs and preferences of the member. The CONTRACTOR shall not establish a minimum number of members on any Care Coordinator's caseload or a minimum number of residents of any facility that must be transitioned to the community. The CONTRACTOR shall ensure that Care Coordinators are screening members' potential

for and interest in transition (see Section A.2.9.6.5.1.1) and when applicable, facilitating transition activities in a timely manner (see Section A.2.9.6.8), but shall not require any Care Coordinator as a condition of employment to identify a minimum number of nursing facility residents for transition to the community. Nor shall the CONTRACTOR pay any Care Coordinator incentive or bonus based on the number of persons transitioned from a nursing facility to the community, unless there are appropriate safeguards, as determined and approved in writing by TENNCARE, to ensure that transitions are appropriate and consistent with the needs and preferences of residents.

2.9.6.8.27 The CONTRACTOR shall implement policies and processes necessary to ensure that it is aware when a member is admitted to or discharged from a NF in order to facilitate care planning and as seamless a transition as possible, and to ensure timely notification to TENNCARE and other entities as appropriate.

2.9.6.8.27.1 The CONTRACTOR shall require NFs to notify the CONTRACTOR of all NF discharges, transfers between NFs, or elections of hospice services in a NF.

2.9.6.8.27.2 The CONTRACTOR shall, in a manner prescribed by TENNCARE notify: a) TENNCARE of all NF discharges and elections of hospice services in a NF and of all NF discharges and transfers between NFs; and b) receiving NFs of all applicable level of care information when a member is transferring between NFs.

2.9.6.8.27.3 The CONTRACTOR shall conduct a census as frequently as deemed necessary by TENNCARE to confirm the residency status and Group assignment of all CHOICES members (i.e., Group 1 receiving services in a NF or Group 2 receiving HCBS or short-term NF services). The CONTRACTOR shall take actions as necessary to address any discrepancies when a CHOICES member is found to no longer be receiving LTSS services, or is receiving services in a different service delivery setting, e.g., NF, HCBS, or hospice in a NF, including, as appropriate, disenrollment from CHOICES and/or enrollment in a different CHOICES Group.

2.9.6.9 <u>Community-Based Residential Alternative (CBRA) Services</u>

2.9.6.9.1 The CONTRACTOR shall authorize CBRA services and shall facilitate a member's transition into a CBRA service and a specific CBRA setting *only* when such service and setting have been selected by the member; the member has been given the opportunity to meet and to choose to reside with any housemates who will also live in the CBRA setting; the setting has been determined to be appropriate for the member based on the member's needs, interests, and preferences; and a transition plan has been developed and fully implemented to ensure that all necessary services and supports (including physical and behavioral health, medications, HCBS, and social supports needed to assure the member's health and safety) are in place prior to the member's transition. The CONTRACTOR shall be responsible for coordinating with the all providers, regardless of payer source, and all agencies and entities necessary to ensure the member's safe and orderly transition and to minimize any potential for disruption, including inpatient admission.

2.9.6.9.2 Prior to transition of any CHOICES Group 2 or 3 or ECF CHOICES member into a community-based residential alternative setting and the initiation of any community-based residential alternative services other than companion care (including assisted care living facility services, adult care homes, community living supports, community living supports-family model, and Intensive Behavioral Community Transition and Stabilization Services, as applicable), and prior to the transition of any CHOICES

Group 2 or 3 or ECF CHOICES member to a new community-based residential alternative services provider, the Care Coordinator or Support Coordinator shall visit the residence where the member will live and shall, in accordance with protocols developed by TENNCARE, conduct an on-site assessment of the proposed community-based residential alternative setting to ensure that the living environment and living situation are appropriate and that the member's needs will be safely and effectively met, and that all necessary services and supports (including physical and behavioral health, medications, HCBS, and social supports needed to assure the member's health and safety) are in place.

2.9.6.9.3 Within the first twenty-four (24) hours of the transition of any CHOICES Group 2 or 3 or ECF CHOICES member into a community-based residential alternative setting and the initiation of any community-based residential alternative services other than companion care (including assisted care living facility services, adult care homes, community living supports, community living supports-family model, and Intensive Behavioral Community Transition and Stabilization Services, as applicable), and within the first twenty-four (24) hours of the transition of any CHOICES Group 2 or 3 or ECF CHOICES member to a new community-based residential alternative services provider, the Care Coordinator or Support Coordinator shall contact the member and within seven (7) days after the member has transitioned, the Care Coordinator or Support Coordinator shall visit the member in his/her new residence to confirm the member's satisfaction with the CBRA provider and services; that a medication reconciliation has been completed (as applicable) and that the member is receiving all necessary services and supports (including physical and behavioral health, medications, HCBS, and social supports needed to assure the member's health and safety), and any follow-up appointments have been arranged; that the plan of care or PCSP is being implemented; that the services are being delivered in a manner that is consistent with the member's preferences and which supports the member in achieving his or her goals and desired outcomes; and that the member's needs are safely and effectively met. Such contacts may be completed by a member of the Transition Team who meets all of the requirements to be a Care Coordinator or Support Coordinator.

2.9.6.9.4 The CONTRACTOR shall not place any CHOICES or ECF CHOICES member in an unlicensed home or residence providing room and board for two (2) or more unrelated individuals, regardless of whether other assistance is provided in the setting.

2.9.6.10 <u>Ongoing Care Coordination and Support Coordination</u>

2.9.6.10.1 *For Members in CHOICES Group 1*

2.9.6.10.1.1 The CONTRACTOR shall provide for the following ongoing care coordination to CHOICES members in Group 1:

2.9.6.10.1.1.1 Develop protocols and processes to work with nursing facilities to coordinate the provision of care. At minimum, a Care Coordinator or Support Coordinator assigned to a resident of the nursing facility shall participate in at least quarterly coordination meetings/phone calls with designated nursing facility staff with relevant and current knowledge of members' needs and circumstances and shall identify and address any member who 1) has experienced a potential significant change in needs or circumstances (see Section A.2.9.6.10.1.1.5); 2) the nursing facility or MCO has expressed concerns; or 3) is under the age of twenty-one (21);

2.9.6.10.1.1.2 Develop and implement targeted strategies to improve health, functional, or quality of life outcomes, e.g., related to Population Health or pharmacy management, or to increase and/or maintain functional abilities;

2.9.6.10.1.1.3 Coordinate with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the member's acute and/or chronic health conditions, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit;

2.9.6.10.1.1.4 Intervene and address issues as they arise regarding payment of patient liability amounts and assist in interventions to address untimely or non-payment of patient liability in order to avoid the consequences of non-payment;

2.9.6.10.1.1.5 In the manner prescribed by TENNCARE and in accordance with this Contract and TENNCARE policies and protocols pertaining thereto: 1) facilitate transfers between nursing facilities which, at a minimum, includes notification to the receiving facility of the member's level of care, and notification to TENNCARE; and 2) facilitate transitions to CHOICES Group 2 which shall include (but is not limited to) timely notification to TENNCARE; and

2.9.6.10.1.1.6 At a minimum, the CONTRACTOR shall consider the following a potential significant change in needs or circumstances for CHOICES Group 1 members who are residing in a nursing facility and contact the nursing facility to determine if a visit and reassessment is needed:

2.9.6.10.1.1.6.1 Pattern of recurring falls;

2.9.6.10.1.1.6.2 Incident, injury or complaint;

2.9.6.10.1.1.6.3 Report of abuse or neglect;

2.9.6.10.1.1.6.4 Frequent hospitalizations;

2.9.6.10.1.1.6.5 Frequent emergency department utilization; or

2.9.6.10.1.1.6.6 Prolonged or significant change in health and/or functional status.

2.9.6.10.1.1.7 Develop protocols and processes for Care Coordinators to escalate and report as appropriate concerns regarding NF quality.

2.9.6.10.2 *For Members in CHOICES Groups 2 and 3 and ECF CHOICES*

2.9.6.10.2.1 The CONTRACTOR shall provide for the following ongoing care coordination to CHOICES members in Groups 2 and 3 and ongoing support coordination to ECF CHOICES members, which shall comport with person centered planning requirements set forth in 42 C.F.R. § 441.301(c):

2.9.6.10.2.1.1 Coordinate a care/support planning team, develop a PCSP, as applicable, and update the plan as needed;

2.9.6.10.2.1.2 During the development of the member's PCSP, as applicable, and as part of the annual updates, the care/Support Coordinator shall discuss with the member

his/her interest in consumer direction when eligible CHOICES or ECF CHOICES HCBS are included in the PCSP, as applicable;

2.9.6.10.2.1.3 During the development of the member's PCSP, as applicable, the care/Support Coordinator shall educate the member about his/her ability to use advance directives and document the member's decision in the member's file;

2.9.6.10.2.1.4 Ensure the PCSP, as applicable, addresses the member's desired outcomes, needs and preferences. For ECF CHOICES members receiving the following employment services – exploration, discovery, situational observation and assessment, or job development plan or self-employment plan – the member's Support Coordinator shall, as part of ongoing coordination responsibilities, contact the member telephonically to re-assess service needs upon the completion of one of the above services within five (5) days of completion of the service (which shall be defined as the date the report, profile or plan is submitted) in order to initiate the next employment service that is needed;

2.9.6.10.2.1.5 Document and confirm the applicant's current address and phone number(s) or appropriate alternative phone number(s) that the member's service provider will use to log visits into the EVV system, and assist the member in updating his or her address with TENNCARE or the Social Security Administration, if applicable.

2.9.6.10.2.1.6 For members in CHOICES Group 2, each time a member's PCSP is updated to change the level or type of service, document in accordance with TENNCARE policy that the projected total cost of CHOICES HCBS, home health care and private duty nursing is less than the member's cost neutrality cap. If a member's medical condition has changed such that a different cost neutrality cap may be appropriate, the CONTRACTOR shall, in the manner prescribed by TENNCARE, submit to TENNCARE a request to update the member's cost neutrality cap, including documentation specified by TENNCARE to support such request. The CONTRACTOR shall monitor utilization to identify members who may exceed the cost neutrality cap and to intervene as necessary to maintain the member's community placement. The CONTRACTOR shall also educate members in CHOICES Group 2 about the cost neutrality cap and what will happen if the cap is met;

2.9.6.10.2.1.7 For members in CHOICES Group 3 or ECF CHOICES, determine whether the cost of CHOICES or ECF CHOICES HCBS, excluding minor home modifications for persons in CHOICES Group 3 and ECF CHOICES Group 4, will exceed the member's expenditure cap. The CONTRACTOR shall continuously monitor a member's expenditures and work with the member when he/she is approaching the limit including identifying non-Long Term Services and Supports services that will be provided when the limit has been met to prevent/delay the need for institutionalization. Each time the PCSP for a member in CHOICES Group 3 is updated, or the PCSP for ECF CHOICES members, the CONTRACTOR shall educate the member about the expenditure cap, as applicable;

2.9.6.10.2.1.8 For new services in an updated PCSP, as applicable, the care/Support Coordinator shall provide the member with information about potential providers for each CHOICES HCBS or ECF CHOICES HCBS that will be provided by the CONTRACTOR and assist members with any requests for information that will help the member in choosing a provider and, if applicable, in changing providers, subject to the provider's capacity and willingness to provide service;

2.9.6.10.2.1.9 Upon the scheduled initiation of services identified in the PCSP, as applicable, the member's Care Coordinator/care coordination team or Support Coordinator/support coordination team, as applicable, shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized and in accordance with the member's PCSP, as applicable. This shall include ongoing monitoring via electronic visit verification to ensure that services are provided in accordance with the member's PCSP, as applicable, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule; and that services continue to meet the member's needs. It shall also include in-person monitoring of the quality of such services, the member's satisfaction with the services, and whether the services are being delivered in a manner that is consistent with the member's preferences and which supports the member in achieving his or her goals and desired outcomes;

2.9.6.10.2.1.9.1 In order to capture members' satisfaction with services, the CONTRACTOR shall ensure members have access to the established Point of Service Satisfaction Survey, which shall be completed after each visit that includes hands on services. The Point of Service Satisfaction Survey should be completed electronically through the EVV system utilizing the member's tablet. The member may choose to complete the survey after each visit, or at the member's desired frequency. If the member chooses not to complete the Point of Service Satisfaction Survey on their own, at a minimum, the Care Coordinator or Support Coordinator shall offer to assist the member with completing the survey during each monthly, quarterly, semi-annual, or change in condition face-to-face visit. If the member refuses such assistance, the Care Coordinator or Support Coordinator shall document the refusal in the case notes, including the stated reason for the member's refusal. If the member has previously been identified as ineligible for a tablet, the Care Coordinator or Support Coordinator may capture the survey information via other available methods for purposes of including it in the quarterly Point of Service Satisfaction Report.

2.9.6.10.2.1.10 Identify and address service gaps, ensure that back-up plans are implemented and effectively working, and evaluate service gaps to determine their cause and to minimize gaps going forward. The CONTRACTOR shall describe in policies and procedures the process for identifying, responding to, and resolving service gaps in a timely manner;

2.9.6.10.2.1.11 Identify changes to member's risk, address those changes and for CHOICES members in Groups 2 and 3, update the member's PCSP as necessary;

2.9.6.10.2.1.12 Reassess a member's needs and update a member's PCSP, as applicable, in accordance with requirements and timelines specified in Sections A.2.9.6.5 and A.2.9.6.6, including reviewing of the appropriateness of any modifications to a member's rights under the HCBS Settings Rule in a provider-owned or controlled residential setting during each 365 day assessment in A.2.9.6.10.3.1.1;

2.9.6.10.2.1.13 Maintain appropriate on-going communication with community and natural supports to monitor and support their ongoing participation in the member's care;

2.9.6.10.2.1.14 For services not covered by the CONTRACTOR, coordinate with community organizations that provide services that are important to the health, safety and well-being of members, including opportunities for employment. This may include but shall not be limited to referrals to other agencies for assistance and assistance as

needed with applying for programs, but the CONTRACTOR shall not be responsible for the provision or quality of non-covered services provided by other entities;

2.9.6.10.2.1.15 Notify TENNCARE immediately, in the manner specified by TENNCARE, if the CONTRACTOR determines that the needs of a member in CHOICES Group 2 cannot be met safely in the community and within the member's cost neutrality cap or that the needs of a member in CHOICES Group 3 or ECF CHOICES cannot be met safely in the community and within the member's expenditure cap;

2.9.6.10.2.1.16 Perform additional requirements for consumer direction of eligible CHOICES HCBS or ECF CHOICES HCBS as specified in Section A.2.9.6.11;

2.9.6.10.2.1.17 At a minimum, the CONTRACTOR shall consider the following a significant change in needs or circumstances for members in CHOICES Groups 2 and 3 or ECF CHOICES residing in the community:

2.9.6.10.2.1.17.1 Change of residence or primary caregiver or loss of essential social supports;

2.9.6.10.2.1.17.2 Significant change in physical or behavioral health and/or functional status, including any change that results in the member's level of care and transition between CHOICES Groups or ECF CHOICES Groups, e.g., transitions from Group 2 to Group 3 or Group 3 to Group 2 or between ECF CHOICES Groups;

2.9.6.10.2.1.17.3 Loss of mobility;

2.9.6.10.2.1.17.4 An event that significantly increases the perceived risk to a member;

2.9.6.10.2.1.17.5 Member has been referred to APS or DCS, as applicable, because of abuse, neglect or exploitation; or

2.9.6.10.2.1.17.6 Loss of employment or change in employment status.

2.9.6.10.2.1.18 When, due to a change in circumstances, a member is approved for transition from Group 2 to Group 3 or from Group 3 to Group 2 or between ECF CHOICES Groups, within five (5) business days of scheduled initiation of new or modified CHOICES HCBS in the updated PCSP or ECF CHOICES in the updated PCSP, the member's Care Coordinator/care coordination team or Support Coordinator/support coordination team, as applicable, shall contact members in CHOICES Groups 2 and 3 or ECF CHOICES to confirm that new or modified services are being provided in accordance with the PCSP, as applicable, and that the member's needs are being met (such initial contact may be conducted by phone).

2.9.6.10.2.1.19 Identify and immediately respond to problems and issues including but not limited to circumstances that would impact the member's ability to continue living in the community;

2.9.6.10.2.1.20 In the manner prescribed by TENNCARE, and in accordance with this Contract and TENNCARE policies and protocols pertaining thereto, facilitate transition to CHOICES Group 1, which shall include (but is not limited to) timely notification to TENNCARE;

2.9.6.10.2.1.21 In the manner prescribed by TENNCARE, and in accordance with this Contract and TENNCARE policies and protocols pertaining thereto, facilitate transition planning when the CONTRACTOR has identified an ECF CHOICES Group 7 or 8 member who is appropriate to transition to another ECF CHOICES Group which shall include (but is not limited to) timely notification to TENNCARE; and

2.9.6.10.2.1.22 As part the annual reassessment and PCSP review, as applicable, the Care Coordinator or Support Coordinator, as applicable, shall conduct, in a format prescribed by TENNCARE, an Individual Experience Assessment in order to ensure that the member's services and supports are provided in a manner that comports with the HCBS Setting Rule in 42 C.F.R. § 441.301(c)(4)-(5). The Care Coordinator or Support Coordinator, as applicable, shall be responsible for one hundred percent (100%) remediation of any instance in which the member's services do not comport with requirements set forth in the HCBS Settings Rule, and the CONTRACTOR shall analyze data from the Individual Experience Assessments by provider and by setting as part of its ongoing quality monitoring and re-credentialing processes.

2.9.6.10.3 *For ALL CHOICES and ECF CHOICES Members*

2.9.6.10.3.1 The CONTRACTOR shall provide for the following ongoing care coordination or support coordination to all CHOICES and ECF CHOICES members:

2.9.6.10.3.1.1 In the manner prescribed by TENNCARE, conduct a level of care reassessment at least once every three hundred sixty-five (365) days and within five (5) business days of the CONTRACTOR becoming aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. Upon written notification by TENNCARE, and in a manner consistent with TennCare protocol, the CONTRACTOR shall be responsible at the time of the annual level of care reassessment for assisting the member as needed in completing a renewal packet and in gathering and submitting to TENNCARE the renewal packet and any verification documents necessary for TENNCARE to determine ongoing financial eligibility. The CONTRACTOR shall be responsible only for the provision of assistance as needed by the CHOICES or ECF CHOICES member, which may include assistance in submitting the information to TENNCARE, in accordance with guidance provided by TENNCARE. The member is responsible for actions required to establish continued eligibility for the program. Assistance provided by the CONTRACTOR to CHOICES Group 1 members shall include notification as directed by TENNCARE to a nursing facility of its residents due for redetermination and its residents to whom a packet has been mailed and such process has not been completed timely, placing the member at risk of losing eligibility, as well as providing direct assistance when needed and requested by the member to help the member complete the redetermination process.

2.9.6.10.3.1.1.1 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 within five (5) business days of the reassessment for determination.

2.9.6.10.3.1.1.2 Except as specified in Section A.2.9.6.10.3.1.1.1, if the level of care assessment indicates no change in level of care, the CONTRACTOR shall document the date the level of care assessment completed in the member's file and shall report in the manner prescribed by TENNCARE the results of the

LOC reassessment within ten (10) calendar days of the LOC reassessment completion ; any level of care assessments prompted by a request for a change in level of services shall be submitted to TENNCARE for determination. Additionally, for any LOC reassessment that indicates a possible change in the member's medical eligibility, the CONTRACTOR shall notify TENNCARE within ten (10) calendar days by a PAE submission via the PAE Tracking System.

2.9.6.10.3.1.1.3 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:

2.9.6.10.3.1.1.3.1 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.

2.9.6.10.3.1.1.3.2 The CONTRACTOR shall also, for purposes of complying with the Terms and Conditions of the State's Waiver, assess once every 365 days the member's LOC eligibility based on the new LOC criteria in place as of July 1, 2012. The CONTRACTOR shall report in the manner prescribed by TENNCARE the results of the LOC reassessment within ten (10) calendar days of the LOC reassessment completion. This information will be used by the State in its expenditure reporting to CMS.

2.9.6.10.3.1.2 Track and monitor all members whose LOC eligibility has an expiration date and ensure that a LOC reassessment (i.e., PAE) is completed and submitted to TENNCARE at least eight (8) business days prior to expiration of the member's current LOC eligibility segment, including all required supporting documentation needed to appropriately determine the member's LOC eligibility going forward;

2.9.6.10.3.1.3 In the manner prescribed by TENNCARE, request a level of need reassessment for any member enrolled in ECF CHOICES Group 6 within five (5) business days of a request by or on behalf of the member or upon the CONTRACTOR's becoming aware that the member's functional or medical status has changed in a way that may materially affect level of need.

2.9.6.10.3.1.4 Facilitate access to physical and/or behavioral health services as needed, including transportation to services as specified in Section A.2.6.1 and Attachment XI; except as provided in Sections A.2.11.1.8 or A.2.6.5, transportation for HCBS is not included;

2.9.6.10.3.1.5 Monitor and ensure the provision of covered physical health, behavioral health, and/or long-term care services as well as services provided as a cost-effective alternative to other covered services and ensure that services provided meet the member's needs;

2.9.6.10.3.1.6 Provide assistance in resolving concerns about service delivery or providers;

2.9.6.10.3.1.7 Coordinate with a member's PCP, specialists and other providers, such as the member's mental health case manager, to facilitate a comprehensive, holistic, person-centered approach to care;

2.9.6.10.3.1.8 Assist members in establishing and achieving personal wellness goals;

2.9.6.10.3.1.9 Contact providers and workers on a periodic basis and coordinate with providers and workers to collaboratively address issues regarding member service delivery and to maximize community placement strategies;

2.9.6.10.3.1.10 Share relevant information with and among providers and others when information is available and it is necessary to share for the well-being of the member;

2.9.6.10.3.1.11 Determine the appropriate course as specified herein upon (1) receipt of any contact made by or on behalf of a member, regardless of source, which asserts that the member's needs are not met by currently authorized services; (2) the member's hospitalization; or (3) other circumstances which warrant review and potential modification of services authorized for the member;

2.9.6.10.3.1.12 When the CONTRACTOR is facilitating a member's admission to a nursing facility, ensure that all PASRR requirements have been met prior to the member's admission to a nursing facility, including a PASRR level I screening and as applicable, a level II PASRR evaluation, whether the screening is completed by the nursing facility, the CONTRACTOR, or another entity;

2.9.6.10.3.1.12.1 The CONTRACTOR shall coordinate with the nursing facility to help ensure that current information regarding the member's mental health or intellectual disabilities needs (as available) is reflected in the PASRR screening in order to support an appropriate PASRR determination.

2.9.6.10.3.1.13 Update consent forms as necessary; and

2.9.6.10.3.1.14 Assure that the organization of and documentation included in the member's file meets all applicable CONTRACTOR standards.

2.9.6.10.3.2 The CONTRACTOR shall provide to contract providers, including but not limited to hospitals, nursing facilities, physicians, and behavioral health providers, and caregivers information regarding the role of the Care Coordinator or Support Coordinator, and shall request providers and caregivers to notify a member's Care Coordinator or Support Coordinator, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations for additional services. The CONTRACTOR shall provide training to key providers and caregivers regarding the value of this communication and remind them that the member identification card indicates if a member is enrolled in CHOICES or ECF CHOICES.

2.9.6.10.3.3 The CONTRACTOR shall have systems in place to facilitate timely communication and information exchange between internal departments and the Care Coordinator or Support Coordinator to ensure that each Care Coordinator or Support Coordinator receives all relevant information regarding his/her members, e.g., member services, Population Health, utilization management, and claims processing. For dual eligible members, the CONTRACTOR shall ensure that all available Medicare claims data, including data from the CONTRACTOR's D-SNP, and Medicare claims data made available by TennCare, is loaded into the case management system described in 2.9.6.13.11, for purposes of care coordination or support coordination. The Care Coordinator or Support Coordinator, as applicable, shall follow-up on this information as appropriate, e.g.,

documentation in the member's plan of care or PCSP, monitoring of outcomes, and, as appropriate, needs reassessment and updating the plan of care or PCSP.

2.9.6.10.3.4 The CONTRACTOR shall monitor and evaluate a member's emergency department and behavioral health crisis service utilization to determine the reason for these visits. The Care Coordinator or Support Coordinator shall take appropriate action to address physical and behavioral health needs and facilitate appropriate utilization of these services, e.g., communicating with the member's providers, educating the member, conducting a needs reassessment, updating the member's plan of care or PCSP and to better manage the member's physical health or behavioral health condition(s) and/or for persons in ECF CHOICES, referral for Behavioral Crisis Prevention, Intervention, and Stabilization Services (*see 2.7.2.8.4.)* if medically necessary. For any member with I/DD receiving such services in the System of Support (SOS) model, the Support Coordinator shall participate as a member of the SOS team, and shall ensure that the Crisis Prevention, Intervention and Stabilization Plan developed in the SOS model is incorporated into the PCSP, as appropriate.

2.9.6.10.3.5 The CONTRACTOR shall develop policies and procedures to ensure that Care Coordinators and Support Coordinators are actively involved in discharge planning when a CHOICES or ECF CHOICES member is hospitalized, regardless of the payer for such hospitalization. The CONTRACTOR shall define circumstances that require that hospitalized CHOICES or ECF CHOICES members receive a face-to-face visit to complete a needs reassessment and an update to the member's plan of care or PCSP as needed.

2.9.6.10.3.6 The CONTRACTOR shall ensure that at each face-to-face visit the Care Coordinator or Support Coordinator makes the following observations and documents the observations in the member's file:

2.9.6.10.3.6.1 Member's physical condition including observations of the member's skin, weight changes and any visible injuries;

2.9.6.10.3.6.2 Member's physical environment;

2.9.6.10.3.6.3 Member's satisfaction with services and care;

2.9.6.10.3.6.4 Member's upcoming appointments;

2.9.6.10.3.6.5 Member's mood and emotional well-being;

2.9.6.10.3.6.6 Member's falls and any resulting injuries;

2.9.6.10.3.6.7 A statement by the member regarding any concerns or questions; and

2.9.6.10.3.6.8 A statement from the member's representative or caregiver regarding any concerns or questions (when the representative/caregiver is available).

2.9.6.10.3.7 For members receiving community-based residential alternative services, other than assisted care living facility services or companion care, including adult care homes, community living supports and community living supports-family model, the CONTRACTOR shall ensure that at each face-to-face visit the Care Coordinator or Support Coordinator makes the following observations, in addition to those observations required in Section A.2.9.6.10.3.6, documents such

observations in the member's file, takes immediate actions necessary to address any concern(s) identified based on such observations, and documents resolution of the concern(s) in the member's file:

2.9.6.10.3.7.1 A copy of the plan of care or PCSP is accessible in the home to all caregivers;

2.9.6.10.3.7.2 The plan of care or PCSP is being implemented and services are being delivered in a manner that is consistent with the member's preferences and which supports the member in achieving his or her goals and desired outcomes;

2.9.6.10.3.7.3 The member is able to make his or her own choices and maintains control of his or her home and environment;

2.9.6.10.3.7.4 The member is supported in participating fully in community life, including faith-based, social, and leisure activities selected by the individual;

2.9.6.10.3.7.5 The member maintains good relationships with housemates, and there are no major, unresolved disputes;

2.9.6.10.3.7.6 There is an adequate food supply for the member that is consistent with the member's dietary needs and preferences;

2.9.6.10.3.7.7 All utilities are working and in proper order;

2.9.6.10.3.7.8 For members whose plan of care or PCSP reflects that the provider will manage the member's personal funds, review financial records and statements to ensure member's bills have been paid timely and are not overdue, and that there are adequate funds remaining for food, utilities, and any other necessary expenses;

2.9.6.10.3.7.9 For members who require 24/7 staff, that such staff are in the residence during the visit and attentive to the member's needs and interests;

2.9.6.10.3.7.10 The member has been properly supported in scheduling and attending any medical appointments, as applicable;

2.9.6.10.3.7.11 Any medications administered by the staff pursuant to T.C.A. §§ 68-1-904 and 71-5-1414 are documented in a Medication Administration Record in accordance with the member's prescriptions, and that any medication errors have been reported;

2.9.6.10.3.7.12 The member's chronic health conditions, as applicable, are being properly managed, and in the case of members receiving CLS 3 or CLS-FM 3, nurse oversight and monitoring, and skilled nursing services are being provided, as appropriate, and as reflected in the member's plan of care for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.; and

2.9.6.10.3.7.13 Any other requirements specified in TennCare policies and protocols.

2.9.6.10.3.8 The CONTRACTOR shall identify and immediately respond to problems and issues including but not limited to:

2.9.6.10.3.8.1 Service gaps; and

2.9.6.10.3.8.2 Complaints or concerns regarding the quality of care rendered by providers, workers, or care coordination staff.

2.9.6.10.4 *Minimum Care Coordinator and Support Coordinator Contacts*

2.9.6.10.4.1 The Care Coordinator shall conduct all comprehensive assessment and care planning activities, and shall make all minimum Care Coordinator contacts as specified below in the member's place of residence, except under extenuating circumstances (such as assessment and care planning conducted during the member's hospitalization, or upon the member's request), which shall be documented in writing.

2.9.6.10.4.1.1 While the CONTRACTOR may grant a member's request to conduct certain care coordination activities outside his or her place of residence, the CONTRACTOR is responsible for assessing the member's living environment in order to identify any modifications that may be needed and to identify and address, on an ongoing basis, any issues which may affect the member's health, safety and welfare. Repeated refusal by the member to allow the Care Coordinator to conduct visits in his or her home may, subject to review and approval by TENNCARE, constitute grounds for disenrollment from CHOICES Groups 2 or 3, or ECF CHOICES Groups, if the CONTRACTOR is unable to properly perform monitoring and other contracted functions and to confirm that the member's needs can be safely and effectively met in the home setting.

2.9.6.10.4.2 A member may initiate a request to opt out of some of the minimum face-to-face contacts, but only with TENNCARE review of circumstances and approval. The CONTRACTOR shall not encourage a member to request a reduction in face-to-face visits by the Care Coordinator.

2.9.6.10.4.3 The CONTRACTOR shall ensure that Care Coordinators assess each member's need for contact with the Care Coordinator, to meet the member's individual need and ensure the member's health and welfare. At a minimum, CHOICES and ECF CHOICES members shall be contacted by their Care Coordinator or Support Coordinators according to the following timeframes:

2.9.6.10.4.3.1 Members shall receive a face-to-face visit from their Care Coordinator in their residence within the timeframes specified in Sections A.2.9.6.2.4, A.2.9.6.2.5 and A.2.9.6.3.

2.9.6.10.4.3.2 Members who are newly admitted to a nursing facility when the admission has not been authorized or arranged by the CONTRACTOR, shall receive a face-to-face visit from their Care Coordinator within ten (10) days of notification of admission.

2.9.6.10.4.3.3 Members in CHOICES Group 2 or Group 3 who have transitioned from a nursing facility to the community shall be contacted per the applicable timeframe specified in Section A.2.9.6.8.

2.9.6.10.4.3.4 Within five (5) business days of scheduled initiation of services, the member's Care Coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 who begin receiving CHOICES HCBS after the date of enrollment in CHOICES to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).

2.9.6.10.4.3.5 Within five (5) business days of scheduled initiation of CHOICES HCBS in the updated PCSP, the member's Care Coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).

2.9.6.10.4.3.5.1 When a member is approved for transition from Group 2 to Group 3 or from Group 3 to Group 2, within five (5) business days of scheduled initiation of new or modified CHOICES HCBS in the updated PCSP, the member's Care Coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 to confirm that new or modified services are being provided in accordance with the PCSP, and that the member's needs are being met (such initial contact may be conducted by phone).

2.9.6.10.4.3.6 Members in CHOICES Group 1 (who are residents of a nursing facility) and who are twenty-one (21) years of age and older shall receive a face-to-face visit from their Care Coordinator at least once every one-hundred and eighty (180) calendar days. Members in CHOICES Group 1 (who are residents of a nursing facility) who are under the age of twenty-one (21) shall receive a face-to-face visit from their Care Coordinator at least once every ninety (90) calendar days. The member's Care Coordinator must complete each subsequent visit within either one-hundred and eighty (180) or ninety (90) calendar days, respectively, from the previous visit.

2.9.6.10.4.3.7 Except as specified in A.2.9.6.10.4.3.9 below, members in CHOICES Group 2 shall be contacted by their Care Coordinator at least monthly either in person or by telephone (i.e., the member's Care Coordinator must complete each subsequent contact in person or by telephone within thirty (30) calendar days of the previous in-person or telephone contact) . These members shall be visited in their residence face-to-face by their Care Coordinator at least quarterly (i.e., within ninety (90) calendar days of the previous face-to-face visit).

2.9.6.10.4.3.8 Except as specified in A.2.9.6.10.4.3.9 below, members in CHOICES Group 3 shall be contacted by their Care Coordinator at least quarterly either in person or by telephone (more frequently when appropriate based on the member's needs and/or request which shall be documented in the PCSP). For purposes of this section, quarterly means that each subsequent in person or telephone contact must occur within ninety (90) calendar days from the previous contact. These members shall be visited in their residence face-to-face by their Care Coordinator at least semi-annually (more frequently when appropriate based on the member's needs and/or request which shall be documented in the PCSP). For purposes of this section semi-annually means that each subsequent face-to-face visit must occur within one hundred-eighty (180) calendar days of the previous face-to-face visit.

2.9.6.10.4.3.9 Members in CHOICES Group 2 or 3 receiving community-based residential alternative services, other than assisted care living facility services or companion care, including adult care homes, community living supports, and community living supports-family model, shall be visited in their residence face-to-face by their Care Coordinator at least monthly (i.e., the member's Care Coordinator must complete each subsequent face-to-face visit within thirty (30) calendar days of the previous visit) to ensure that the PCSP is being followed and that the PCSP continues to meet the member's needs, unless more frequent contacts are required based on the member's needs and circumstances and as reflected in the member's PCSP, based on a significant change in circumstances (see Sections

A.2.9.6.10.2.1.17 and A.2.9.8.4.5), or a short-term nursing facility stay (see Sections A.2.9.8.8.5 and A.2.9.8.8.7).

2.9.6.10.4.3.10 Members in ECF CHOICES Group 4 shall be contacted by their Support Coordinator in person or by telephone at least quarterly (i.e., the member's Support Coordinator must complete each subsequent contact within ninety (90) calendar days of the previous contact). These members shall be visited in their residence face-to-face by their Support Coordinator at least semi-annually (i.e., the member's Support Coordinator must complete each subsequent face-to-face visit within one hundred and eighty (180) calendar days of the previous visit). Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the member's needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances.

2.9.6.10.4.3.11 Except as provided in A.2.9.6.10.4.3.14, members in ECF CHOICES Group 5, shall be contacted by their Support Coordinator in person or by telephone at least monthly (i.e., the member's Support Coordinator must complete each subsequent contact within thirty (30) calendar days of the previous contact). These members shall be visited in their residence face-to-face by their Support Coordinator at least quarterly (i.e., the member's Support Coordinator must complete each subsequent face-to-face visit within ninety (90) calendar days of the previous visit). Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the member's needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances.

2.9.6.10.4.3.12 Except as provided in A.2.9.6.10.4.3.14, members in ECF CHOICES Group 6 determined by an objective assessment to have low to moderate need and not to have exceptional medical or behavioral needs shall be contacted by their Support Coordinator at least monthly either in person or by telephone (i.e., the member's Support Coordinator must complete each subsequent in person or telephone contact within thirty (30) calendar days of the previous contact). These members shall be visited in their residence face-to-face by their Support Coordinator at least bi-monthly (i.e., the member's Support Coordinator must complete each subsequent face-to-face visit within sixty (60) calendar days of the previous visit). Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the member's needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances.

2.9.6.10.4.3.13 Members in ECF CHOICES Group 6 determined by an objective assessment to have high need and members in CHOICES Group 6 determined by an objective assessment to have exceptional medical or behavioral needs (including members with low to moderate need who have exceptional medical or behavioral needs) shall be visited in their residence face-to-face by their Support Coordinator at least once a month (i.e., the member's Support Coordinator must complete each subsequent face-to-face visit within thirty (30) calendar days of the previous visit). More frequent face-to-face and/or telephone contacts shall be conducted when appropriate based on the member's needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances.

2.9.6.10.4.3.14 Members in ECF CHOICES Group 5 or 6 receiving community-based residential alternative services, including community living supports and community living supports-family model, shall also be visited in their residence face-to-face by their Support Coordinator at least monthly (i.e., the member's Support Coordinator must complete each subsequent face-to-face visit within thirty (30) calendar days of the previous visit) to ensure that the PCSP is being followed and that the PCSP continues to meet the member's needs, unless more frequent contacts are required based on the member's needs and circumstances and as reflected in the member's PCSP, based on a significant change in circumstances (see SectionA.2.9.6.10.2.1.17).

2.9.6.10.4.3.15 During at least the first month of enrollment in ECF CHOICES Group 7, the thirty (30) days leading up to any planned transition out of ECF CHOICES Group 7, and the thirty (30) days following transition out of ECF CHOICES Group 7 into another ECF CHOICES Group, members shall be contacted by their Integrated Support Coordination Team (ISCT) at least weekly either in person or by telephone or other form of audio/visual communication requested by and available to the member (i.e., the member's ISCT must complete each subsequent contact within seven (7) calendar days of the previous contact). A minimum of at least one weekly contact shall continue until IBFCTSS services are in place and for at least the first two weeks following the initiation of IBFCTSS services. These members shall be visited in their residence face-to-face by their ISCT at least monthly (i.e., the member's ISCT must complete each subsequent face-to-face visit within thirty (30) calendar days of the previous visit). Face-to-face and/or telephonic or other non-in-person contacts as requested by the member shall be conducted more frequently when appropriate based on the member's needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances. The Support Coordinator and the Behavior Supports Director (or similarly qualified member of the ISCT) shall be present for all minimum face-to-face contacts.

2.9.6.10.4.3.16 During at least the first month of enrollment in ECF CHOICES Group 8, during the thirty (30) days leading up to any planned transition out of ECF CHOICES Group 8 and the thirty (30) days following transition out of ECF CHOICES Group 8 into another ECF CHOICES Group, members shall be contacted by their ISCT at least weekly either in person or by telephone or other form of audio/visual communication requested by and available to the member (i.e., the member's ISCT must complete each subsequent contact within thirty (30) calendar days of the previous contact). A minimum of at least one weekly contact shall continue until IBCTSS are in place and for at least the first two weeks following the initiation of IBCTSS. These members shall be visited in their residence face-to-face by their ISCT at least monthly (i.e., the member's ISCT must complete each subsequent face-to-face visit within thirty (30) calendar days of the previous visit). Face-to-face and/or telephonic or other non-in-person contacts as requested by the member shall be conducted more frequently when appropriate based on the member's needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances. The Support Coordinator and the Behavior Supports Director (or similarly qualified member of the ISCT) shall be present for all minimum face-to-face contacts.

2.9.6.10.5 The CONTRACTOR shall ensure a member's Care Coordinator/care coordination team coordinates with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare (see Section A.2.9.12).

2.9.6.10.6 *Member Case Files*

2.9.6.10.6.1 The Care Coordinator/care coordination team shall maintain individual files for each assigned CHOICES member.

2.9.6.10.6.2 For members in CHOICES Group 1, the files shall contain at a minimum:

2.9.6.10.6.2.1 Pertinent demographic information regarding the member including the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information, and the member and/or primary caregivers primary spoken language, including the use of sign language or non-verbal forms of communication and any needed assistive technology or any other auxiliary aids or services used to facilitate effective communication;

2.9.6.10.6.2.2 Any supplements to the nursing facility plan of care, as applicable;

2.9.6.10.6.2.3 A signed acknowledgement of the member's patient liability amount and the member's understanding regarding his/her responsibility with respect to payment of patient liability, including the potential consequences for non-payment; and

2.9.6.10.6.2.4 Transition assessment and transition plan, if applicable.

2.9.6.10.6.3 For members in CHOICES Groups 2 or 3, the files shall contain at a minimum:

2.9.6.10.6.3.1 The most current PCSP, including the detailed plan for back-up providers in situations when regularly scheduled providers are unavailable or do not arrive as scheduled;

2.9.6.10.6.3.2 List of providers who will be providing home health, private duty nursing and HCBS paid for by other payors;

2.9.6.10.6.3.3 For members whose PCSP includes eligible CHOICES HCBS, written confirmation of the member's decision regarding participation in consumer direction of eligible CHOICES HCBS;

2.9.6.10.6.3.4 Complete a risk assessment and incorporate any identified risk and corresponding mitigation strategies into the PCSP; and

2.9.6.10.6.3.5 For members in CHOICES Group 2, the cost neutrality cap provided by TENNCARE, and a determination by the CONTRACTOR that the projected cost of CHOICES HCBS, home health, and private duty nursing services will not exceed the member's cost neutrality cap.

2.9.6.10.6.4 For all CHOICES members, files shall contain at a minimum:

2.9.6.10.6.4.1 For CHOICES members age 21 and older in Groups 1 and 2, a Freedom of Choice form signed and dated by the member or his/her representative;

2.9.6.10.6.4.2 Evidence that a Care Coordinator provided the member with CHOICES member education materials (see Section A.2.17.7 of this Contract), reviewed the materials, and provided assistance with any questions;

2.9.6.10.6.4.3 Evidence that a Care Coordinator provided the member with education about the member's ability to use an advance directive and documentation of the member's decision;

2.9.6.10.6.4.4 The most recent level of care assessment and comprehensive assessment (if applicable);

2.9.6.10.6.4.5 Documentation of the member's choice of contract providers for long-term care services;

2.9.6.10.6.4.6 Signed consent forms as necessary in order to share confidential information with and among providers consistent with all applicable state and federal laws and regulations;

2.9.6.10.6.4.7 A list of emergency contacts approved by the member;

2.9.6.10.6.4.8 Documentation of observations completed during face-to-face contact by the Care Coordinator; and

2.9.6.10.6.4.9 The member's TennCare eligibility end date.

2.9.6.11 <u>Additional Requirements for Care Coordination Regarding Consumer Direction of eligible CHOICES HCBS and for Support Coordination Regarding Consumer Direction of eligible ECF CHOICES HCBS</u>

2.9.6.11.1 In addition to the roles and responsibilities otherwise specified in this Section A.2.9.6, the CONTRACTOR shall ensure that the following additional care coordination or support coordination functions related to consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS are fulfilled.

2.9.6.11.2 The CONTRACTOR shall be responsible for providing all needed eligible CHOICES HCBS or eligible ECF CHOICES HCBS using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section A.2.9.7.6.1 of this Contract); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.

2.9.6.11.3 If a member elects not to receive eligible CHOICES HCBS or eligible ECF CHOICES using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS:

2.9.6.11.3.1 The CONTRACTOR shall document this decision, including date and member/member's representative's signature, in the manner specified by TENNCARE (see Section A.2.9.7.4.3.2 of this Contract).

2.9.6.11.3.2 The member's Care Coordinator or Support Coordinator shall visit the member face to face at least monthly to ensure that the member's needs are met, and shall continue to offer eligible CHOICES HCBS or eligible ECF CHOICES through contract providers (See Section A.2.9.7.4.3.3).

2.9.6.11.3.3 If eligible CHOICES HCBS or eligible ECF CHOICES HCBS are not initiated within sixty (60) days following referral to the FEA, the CONTRACTOR shall notify the member that eligible CHOICES HCBS or eligible ECF CHOICES HCBS must be initiated by contract providers unless these HCBS are not needed on an ongoing basis in order to safely meet the member's needs in the community, in which case, the CONTRACTOR shall submit documentation to TENNCARE to begin the process of disenrollment from CHOICES Group 2 or Group 3 or ECF CHOICES, as applicable.

2.9.6.11.4 If a member is interested in participating in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS and the member does not intend to appoint a representative, the Care Coordinator or Support Coordinator shall determine the extent to which the member may require assistance to direct his/her services (see Section A.2.9.7.4.5). If the Care Coordinator or Support Coordinator determines that the member requires assistance to direct his/her services, based upon the results of a completed self-assessment instrument developed by TENNCARE, the Care Coordinator or Support Coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf (see Section A.2.9.7.4.5.1).

2.9.6.11.5 The member's Care Coordinator/care coordination team or Support Coordinator/support coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section A.2.9.7.2.1) and that a representative agreement is completed and signed by the member prior to forwarding a referral to the FEA (see Section A.2.9.7.4.7).

2.9.6.11.5.1 The member or member's representative must retain authority and responsibility for consumer direction.

2.9.6.11.6 For members electing to participate in consumer direction, forward to the FEA a referral initiating the member's participation in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS: (1) within two (2) business days of signing the representative agreement; or (2) if a representative is not designated by the member, within two (2) business days of completion of the self-assessment instrument and the Care Coordinator or Support Coordinator determines that the member does not require a representative to assist the member in directing his/her care.

2.9.6.11.7 For members electing to participate in consumer direction, the member's Care Coordinator or Support Coordinator shall integrate the member's back-up plan for consumer-directed workers (including any updates thereto) into the member's back-up plan for services provided by contract providers, as applicable, and the member's plan of care or PCSP. The Care Coordinator or Support Coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member's needs. The Care Coordinator or Support Coordinator shall, upon notification that the scheduled worker failed to report for service provision, assist the member in implementing the back-up plan as needed, and as part of ongoing care coordination or support coordination activities to ensure that the member is receiving services as specified in the plan of care or PCSP, shall monitor that that the back-up plan is being implemented timely, when applicable, and that the member's needs are being met.

2.9.6.11.8 For members electing to participate in consumer direction, the member's Care Coordinator or Support Coordinator, as applicable, shall reassess the adequacy of the member's back-up plan for consumer direction on at least an annual basis or as

frequently as needed, which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or eligible ECF CHOICES HCBS or the schedule at which such services are needed, changes in consumer-directed workers (when such workers also serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care.

2.9.6.11.9 For members electing to participate in consumer direction of eligible CHOICES HCBS, the member's Care Coordinator shall conduct a risk assessment 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, and shall include this information in the member's PCSP. The member's representative (if applicable) shall participate in the risk assessment process. For members electing to participate in consumer direction of eligible ECF CHOICES HCBS, any risks associated with participation in consumer direction and strategies to mitigate such risks shall be incorporated into the PCSP.

2.9.6.11.10 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care or PCSP occur per requirements specified in Sections A.2.9.6.11 of this Contract. The Care Coordinator or Support Coordinator shall ensure that, for members participating in consumer direction, the FEA is invited to participate in these meetings as appropriate.

2.9.6.11.11 Within three (3) business days of updating the member's plan of care or PCSP, the member's Care Coordinator/care coordination team or Support Coordinator/support coordination team shall provide a copy of all relevant changes to the FEA (see Section A.2.9.6.6.2.7.1. of this Contract).

2.9.6.11.12 Within two (2) business days of receipt of the notification from the FEA indicating that all requirements have been fulfilled and the date that the consumer direction can begin for a member, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services for that member. Each authorization for CHOICES consumer directed services shall include authorized service, authorized units of service, start and end dates, and service code(s). Each authorization for ECF CHOICES consumer directed services shall include authorized services, the dollar amount for each month of service authorized (i.e., the monthly budget for that service), or for respite services, the dollar amount (applicable for hourly respite) or days (applicable for daily respite) for the year of service authorized (i.e., the annual budget); and start and end dates and service code(s).

2.9.6.11.13 The member's Care Coordinator/care coordination team or Support Coordinator/support coordination team shall work with and coordinate with the FEA in implementing consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS (see Section A.2.9.7.3.4).

2.9.6.11.14 The member's Care Coordinator or Support Coordinator, as applicable, shall monitor consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS.

2.9.6.11.15 The CONTRACTOR shall establish a process that allows for the efficient exchange of all relevant member information between the CONTRACTOR and the FEA.

2.9.6.11.16 The Care Coordinator or Support Coordinator shall determine a member's interest in enrolling in or continuing to participate in consumer direction annually and shall document the member's decision in the member's plan of care or PCSP.

2.9.6.11.17 If at any time abuse or neglect is suspected, the member's Care Coordinator or Support Coordinator or the FEA shall report the allegations to the CONTRACTOR within twenty-four (24) hours for CHOICES members and in accordance with timeframes set forth in TennCare protocol for ECF CHOICES members and with the CONTRACTOR's abuse and neglect plan protocols. The CHOICES notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. For ECF CHOICES, notification shall be provided in a form and format prescribed by TENNCARE. If the allegation is in reference to a worker or representative and concerns physical or sexual abuse, the FEA shall contact the member/representative to determine if the member/representative wants to place the worker or representative on administrative leave until DIDD or the MCO, as applicable, has completed its investigation. If the representative is the subject of the allegation, the representative shall not be allowed to decide whether to take leave, and such a decision shall solely be up to the member. The member/representative may additionally decide to remove staff at their discretion for allegations concerning other Tier 1 or Tier 2 incidents in ECF CHOICES (see Section A.2.15.7.6) or critical incidents in CHOICES, as applicable. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative's decision. The Care Coordinator or Support Coordinator shall work with the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation and result in placement on any registry included in Section A.2.29.2.2, then the representative or worker shall no longer be allowed to participate in the CHOICES or ECF CHOICES program as a representative or worker. If the investigation does not result in such placement, then the member may elect to retain the worker or representative. The member's Care Coordinator or Support Coordinator, with assistance from the FEA as appropriate, shall make any updates to the member's PCSP deemed necessary to help ensure the member's health and safety after a risk assessment is conducted, and shall provide, at least annually, education to the member and his/her representative of the risk of, and signs and symptoms of, abuse and neglect. The CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction.

2.9.6.12 <u>Care Coordination and Support Coordination Staff</u>

2.9.6.12.1 The CONTRACTOR shall establish qualifications for Care Coordinators for CHOICES members. At a minimum, Care Coordinators for members enrolled in CHOICES Groups 1, 2, or 3 shall be an RN or LPN or have a bachelor's degree in social work, nursing or other health care profession.

2.9.6.12.2 A Care Coordinator's direct supervisor shall be a licensed social worker or registered nurse with a minimum of two (2) years of relevant health care (preferably long-term care) experience.

2.9.6.12.3 The CONTRACTOR shall establish qualifications for Support Coordinators for ECF CHOICES members. At a minimum, Support Coordinators shall meet at least one of the following:

2.9.6.12.3.1 Be an RN or LPN, with a preference that such individuals also have current Certification from the Developmental Disabilities Nurses Association as a Certified Developmental Disabilities Nurse (CDDN) for RNs or a Developmental Disabilities Nurse (DDC) for LPNs, as applicable;

2.9.6.12.3.2 Have a bachelor's degree in social work, nursing, education, rehabilitation counseling, or other human service (e.g. psychology, sociology) or health care profession or other related field as approved by TENNCARE;

2.9.6.12.3.3 Meet the federal requirements for a Qualified Developmental Disabilities Professional (QDDP) or Qualified Intellectual Disabilities Professional (QIDP); or

2.9.6.12.3.4 Have five (5) or more years' experience as an independent Support Coordinator or case manager for service recipients in a 1915(c) HCBS Waiver and have completed Personal Outcome Measures Introduction and Assessment Workshop trainings as established by the Council on Quality and Leadership and are prior approved by TennCare on a case-by-case basis.

2.9.6.12.4 A Support Coordinator's direct supervisor shall be a licensed social worker, registered nurse, or QDDP/QIDP with a minimum of two (2) years of relevant health care case management (preferably long-term care) experience which must include case management for individuals with I/DD.

2.9.6.12.5 If the CONTRACTOR elects to use a care/support coordination team, the CONTRACTOR's policies and procedures shall specify the qualifications, experience and training of each member of the team and ensure that functions specific to the assigned Care Coordinator are performed by the member's qualified Care Coordinator and that functions specific to the assigned Support Coordinator are performed by the member's qualified Support Coordinator (see Sections A.2.9.6.4.3).

2.9.6.12.6 The CONTRACTOR shall ensure that an adequate number of Care Coordinators and Support Coordinators are available and ensure that the required staffing ratios as detailed in this section are maintained to address the needs of CHOICES and ECF CHOICES members and meet all the requirements described in this Contract. A single staff person may serve as a Care Coordinator for members enrolled in CHOICES and as a Support Coordinator for members enrolled in ECF CHOICES, so long as all applicable requirements, including qualifications and ratios, are met.

2.9.6.12.7 The required average weighted Care Coordinator-to-CHOICES member staffing ratio is no more than 1:125. Effective July 1, 2015, the required average weighted Care Coordinator-to-CHOICES member staffing ratio shall be no more than 1: 115. Such average shall be derived by dividing the total number of full-time equivalent Care Coordinators by the total weighted value of CHOICES members as delineated below.

2.9.6.12.8 The required maximum caseload for any individual Care Coordinator is a weighted value of no more than one hundred seventy-five (175) CHOICES members. Effective July 1, 2015, the required maximum caseload for any individual Care Coordinator is a weighted value of no more than one hundred sixty-five (165) CHOICES members.

2.9.6.12.9 The CONTRACTOR shall use the following methodology to calculate weighted Care Coordinator-to-CHOICES member staffing ratios and Care Coordinator caseloads:

2.9.6.12.9.1 Each CHOICES Group 1 member shall be factored into the weighted Care Coordinator-to-CHOICES member staffing ratio and weighted caseload calculations utilizing an acuity level of one (1), EXCEPT that:

2.9.6.12.9.1.1 Upon completion of a Transition Assessment, which indicates that a Group 1 member is a candidate for transition to the community, such member shall be factored into the weighted caseload and staffing ratio calculations using an acuity level of two and one-half (2.5) until such time as the member is transitioned to CHOICES Group 2 or Group 3 or the member is no longer a candidate for transition;

2.9.6.12.9.1.2 CHOICES Group 1 members under twenty-one (21) years of age shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two and one-half (2.5).

2.9.6.12.9.2 Each CHOICES Group 2 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two and one-half (2.5), except for Group 2 members who receive CBRA services in an adult care home, or CLS, or CLS-FM setting, who shall have an acuity level of three (3);

2.9.6.12.9.3 Each CHOICES Group 3 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of one and three quarters (1.75). Effective July 1, 2015, each CHOICES Group 3 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two (2), except for Group 3 members who receive CBRA services in a CLS or CLS-FM setting, who shall have an acuity level of three (3);

2.9.6.12.9.4 Each ECF CHOICES Group 4 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two (2);

2.9.6.12.9.5 Each ECF CHOICES Group 5 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two and one half (2.5), except for Group 5 members who receive CBRA services in a CLS or CLS-FM setting, who shall have an acuity level of three (3); and

2.9.6.12.9.6 Each ECF CHOICES Group 6 member shall be factored into the weighted caseload and staffing ratio calculations in accordance with their objectively assessed level of need as follows:

2.9.6.12.9.6.1 ECF CHOICES Group 6 members determined by an objective assessment to have low to moderate need and not to have exceptional medical or behavioral needs shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of three (3).

2.9.6.12.9.6.2 ECF CHOICES Group 6 members determined by an objective assessment to have low to moderate need and to have exceptional medical needs shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of three and one quarter (3.25).

2.9.6.12.9.6.3 ECF CHOICES Group 6 members determined by an objective assessment to have low to moderate need and to have exceptional behavioral needs (with or without

exceptional medical needs) and ECF CHOICES Group 6 members determined by an objective assessment to have high need and not to have exceptional medical or behavioral needs shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of three and one half (3.5).

2.9.6.12.9.6.4 ECF CHOICES Group 6 members determined by an objective assessment to have high need and to have exceptional medical needs shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of three and three quarters (3.75).

2.9.6.12.9.6.5 ECF CHOICES Group 6 members determined by an objective assessment to have high need and to have exceptional behavioral needs (with or without exceptional medical needs) shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of four (4).

2.9.6.12.9.6.6 ECF CHOICES Group 7 members shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of six (6).

2.9.6.12.9.6.7 ECF CHOICES Group 8 members shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of six (6).

2.9.6.12.10 The CONTRACTOR shall proactively plan for staff turnover and shall monitor caseload assignments and weighted Care Coordinator-to-CHOICES or Support Coordinator-to-ECF CHOICES member staffing ratios and adjust hiring practices and Care Coordinator or Support Coordinator assignments as necessary to meet the requirements of this Contract and to address members' needs.

2.9.6.12.11 Upon request, the CONTRACTOR shall provide to TENNCARE documentation of such monitoring, including an itemized list by Care Coordinator/Support Coordinator of the total number of members assigned, and the number of Group 1 members (including members in transition and children under age 21), Group 2, Group 3 and ECF CHOICES members that comprise each Care Coordinator/Support Coordinator's caseload.

2.9.6.12.12 In the event that the CONTRACTOR is determined to be deficient with any requirement pertaining to care coordination as set forth in this Contract, the amount of financial sanctions assessed shall take into account whether or not the CONTRACTOR has complied with the required average weighted Care Coordinator to CHOICES member staffing ratio or Support Coordinator to ECF CHOICES staffing ratio and the maximum weighted Care Coordinator/Support Coordinator caseload amounts set forth in Sections A.2.9.6.12.7 and A.2.9.6.12.8, based on the most recent monthly CHOICES and ECF CHOICES Caseload and Staffing Ratio Report (see Section A.2.30.6.7). All applicable sanctions set forth in Sections E.29.2.2.6, E.29.2.2.7.A.16, E.29.2.2.7.A.19, E.29.2.2.7.A.20, E.29.2.2.7.A.21, E.29.2.2.7.A.22, E.29.2.2.7.A.23, E.29.2.2.7.A.24, E.29.2.2.7.A.29, E.29.2.2.7.A.30, E.29.2.2.7.A.31, E.29.2.2.7.A.32, E.29.2.2.7.A.33, E.29.2.2.7.A.34, E.29.2.2.7.A.35, E.29.2.2.7.A.36, E.29.2.2.7.A.38, E.29.2.2.7.B.20, and E.29.2.2.7.C.7 of this Contract shall be multiplied by two (2) when the CONTRACTOR has not complied with these requirements.

2.9.6.12.13 TENNCARE will reevaluate Care Coordinator/Support Coordinator-to-CHOICES/ECF CHOICES member staffing ratio requirements on at least an annual basis and may make adjustments based on the needs of CHOICES and ECF CHOICES members, CHOICES and ECF CHOICES program requirements and MCO performance.

2.9.6.12.14 TENNCARE may request changes in the CONTRACTOR's Care Coordinator/Support Coordination Staffing Plan at any time it determines that the CONTRACTOR does not have sufficient Care Coordinator/support coordination staff to properly and timely perform its obligations under this Contract.

2.9.6.12.15 The CONTRACTOR shall establish a system to assign Care Coordinators and Support Coordinators and to notify the member of his/her assigned Care Coordinator's or assigned Support Coordinator's name and contact information in accordance with Section A.2.9.6.4.2.

2.9.6.12.16 The CONTRACTOR shall ensure that members have a telephone number to call to directly contact (without having to disconnect or place a second call) their Care Coordinator or Support Coordinator or a member of their care coordination or support coordination team (if applicable) during normal business hours. If the member's Care Coordinator or Support Coordinator or a member of the member's care coordination or support coordination team is not available, the call shall be answered by another qualified staff person in the care coordination unit or support coordination unit, as applicable. If the call requires immediate attention from a Care Coordinator or Support Coordinator, the staff member answering the call shall immediately transfer the call to the member's Care Coordinator or Support Coordinator (or another Care Coordinator or Support Coordinator if the member's Care Coordinator or Support Coordinator is not available) as a "warm transfer" (see definition in Section A.1). After normal business hours, calls that require immediate attention by a Care Coordinator or Support Coordinator shall be transferred to a Care Coordinator or Support Coordinator as specified in Section A.2.18.1.6.

2.9.6.12.17 The CONTRACTOR shall permit members to change to a different Care Coordinator or Support Coordinator if the member desires and there is an alternative Care Coordinator or Support Coordinator available. Such availability may take into consideration the CONTRACTOR's need to efficiently deliver care coordination and support coordination in accordance with requirements specified herein, including for example, the assignment of a single Care Coordinator or Support Coordinator, as applicable, to all CHOICES members receiving nursing facility or community-based residential alternative services from a particular provider. Subject to the availability of an alternative Care Coordinator or Support Coordinator, the CONTRACTOR may impose a six (6) month lock-in period with an exception for cause after a member has been granted one (1) change in Care Coordinators or Support Coordinators.

2.9.6.12.18 In order to ensure quality and continuity of care, the CONTRACTOR shall make efforts to minimize the number of changes in the Care Coordinator or Support Coordinator assigned to a member. A CONTRACTOR initiated change in Care Coordinators or Support Coordinators may be appropriate in the following circumstances:

2.9.6.12.18.1 Care coordinator or Support Coordinator is no longer employed by the CONTRACTOR;

2.9.6.12.18.2 Care coordinator or Support Coordinator has a conflict of interest and cannot serve the member;

2.9.6.12.18.3 Care coordinator or Support Coordinator is on temporary leave from employment; and

2.9.6.12.18.4 Care coordinator or Support Coordinator caseloads must be adjusted due to the size or intensity of an individual Care Coordinator's or Support Coordinator's caseload.

2.9.6.12.19 The CONTRACTOR shall develop policies and procedures regarding notice to members of Care Coordinator or Support Coordinator changes initiated by either the CONTRACTOR or the member, including advance notice of planned Care Coordinator or Support Coordinator changes initiated by the CONTRACTOR.

2.9.6.12.20 The CONTRACTOR shall ensure continuity of care when Care Coordinator or Support Coordinator changes are made whether initiated by the member or by the CONTRACTOR. The CONTRACTOR shall demonstrate use of best practices by encouraging newly assigned Care Coordinators or Support Coordinators to attend a face-to-face transition visit with the member and the out-going Care Coordinator or Support Coordinators when possible.

2.9.6.12.21 The CONTRACTOR shall provide initial training to newly hired Care Coordinators and ongoing training to Care Coordinators. Initial training topics shall include at a minimum:

2.9.6.12.21.1 The CHOICES program including a description of the CHOICES groups; eligibility for CHOICES enrollment; enrollment in CHOICES; enrollment targets for Groups 2 and 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3;

2.9.6.12.21.2 Facilitating CHOICES enrollment for current members;

2.9.6.12.21.3 Level of care and comprehensive assessment and reassessment, development of a person-centered PCSP, and updating the PCSP including training on the tools and protocols;

2.9.6.12.21.4 Development and implementation of back-up plans;

2.9.6.12.21.5 Risk assessment and incorporating identified risk and risk mitigation strategies into the member's PCSP;

2.9.6.12.21.6 Consumer direction of eligible CHOICES HCBS;

2.9.6.12.21.7 Self-direction of health care tasks;

2.9.6.12.21.8 Coordination of care for duals;

2.9.6.12.21.9 Electronic visit verification;

2.9.6.12.21.10 Conducting a home visit and use of the monitoring checklist;

2.9.6.12.21.11 How to immediately identify and address service gaps;

2.9.6.12.21.12 Management of critical transitions (including hospital discharge planning);

2.9.6.12.21.13 Nursing facility diversion;

2.9.6.12.21.14 Nursing facility to community transitions, including training on tools and protocols;

2.9.6.12.21.15 Management of transfers between nursing facilities and CBRA, including adult care homes, community living supports, and community living supports-family model;

2.9.6.12.21.16 Facilitation of transitions between CHOICES Groups;

2.9.6.12.21.17 For all CHOICES members, as applicable, members' responsibility regarding patient liability, including the consequences of not paying patient liability;

2.9.6.12.21.18 Alzheimer's, dementia and cognitive impairments;

2.9.6.12.21.19 Traumatic brain injury;

2.9.6.12.21.20 Physical disabilities;

2.9.6.12.21.21 Population health;

2.9.6.12.21.22 Behavioral health;

2.9.6.12.21.23 Evaluation and management of risk;

2.9.6.12.21.24 Identifying and reporting abuse/neglect (see Section A.2.25.4);

2.9.6.12.21.25 Critical incident reporting (see Section A.2.15.7);

2.9.6.12.21.26 Fraud and abuse, including reporting fraud and abuse;

2.9.6.12.21.27 Advance directives and end of life care;

2.9.6.12.21.28 HIPAA/HITECH;

2.9.6.12.21.29 Cultural competency;

2.9.6.12.21.30 Disaster planning;

2.9.6.12.21.31 Available community resources for non-covered services;

2.9.6.12.21.32 Information on the beneficiary support system, including but not limited to how to obtain assistance with choice counseling, filing complaints or appeals, finding the status of a complaint or appeal, and resolving issues related to rights and responsibilities;

2.9.6.12.21.33 The Care Coordinator's role and responsibility in assessing members who have been approved for At-Risk level of care, and have expressed interest in enrollment into CHOICES Group 3, and coordinating with the nursing facility to facilitate timely transition, enrollment into CHOICES Group 3, and initiation of HCBS when appropriate;

2.9.6.12.21.34 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); and

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

2.9.6.12.22 The CONTRACTOR shall establish an ongoing training program for Care Coordinators. Topics to be covered shall be determined by the CONTRACTOR based on its monitoring of care coordination (see Section A.2.9.6.13) and the CHOICES program, and feedback from TENNCARE.

2.9.6.12.23 The CONTRACTOR shall establish roles and job responsibilities for Care Coordinators and Support Coordinators. The job responsibilities shall include a description of activities and required timeframes for completion. These activities shall include the requirements specified in this Section A.2.9.6.

2.9.6.12.24 The CONTRACTOR shall provide initial training to newly hired Support Coordinators and to new or existing Care Coordinators who will serve individuals with I/DD enrolled in ECF CHOICES. The initial training shall be completed by each Support Coordinator (or by each Care Coordinator who will serve individuals with I/DD enrolled in ECF CHOICES) prior to serving individuals with I/DD enrolled in ECF CHOICES. The CONTRACTOR shall also provide ongoing training and assistance to Support Coordinators and to Care Coordinators who will serve individuals with I/DD enrolled in ECF CHOICES.

2.9.6.12.25 The CONTRACTOR's initial and ongoing training program shall be approved by TENNCARE and shall include training topics as specified by TENNCARE in this Contract or in policy or protocol. At a minimum, the CONTRACTOR's initial training program shall include:

2.9.6.12.25.1 Orientation to individuals with I/DD, which shall include an introduction to intellectual and developmental disabilities, and shall be provided by a person or entity with recognized expertise in intellectual and other kinds of developmental disabilities;

2.9.6.12.25.2 Disability awareness and cultural competency, which at a minimum shall include:

2.9.6.12.25.2.1 Person-first language;

2.9.6.12.25.2.2 Applicable professional standards of conduct when meeting and supporting a person with a disability; and

2.9.6.12.25.2.3 Working with individuals who use alternative forms of communication, such as, auxiliary aids or services, including sign language or non-verbal communication, or who may rely on assistive devices for communication, which shall be provided by a qualified allied health professional, i.e., speech language pathologist or occupational therapist with expertise in working with individuals with I/DD who rely on such alternative forms of communication; and cultural competency, in order to effective communication with individuals;

2.9.6.12.25.3 Ethics and confidentiality training, including HIPAA and HI-TECH;

2.9.6.12.25.4 Orientation to Employment and Community First CHOICES, which at a minimum shall include:

2.9.6.12.25.4.1 A description of the ECF CHOICES groups;

2.9.6.12.25.4.2 Eligibility requirements for ECF CHOICES enrollment;

2.9.6.12.25.4.3 Enrollment procedures for ECF CHOICES;

2.9.6.12.25.4.4 Enrollment targets for ECF CHOICES, including reserve capacity and administration of waiting lists;

2.9.6.12.25.4.5 ECF CHOICES benefits, including benefit limits and expenditure caps;

2.9.6.12.25.4.6 Facilitating denial of enrollment into or termination of enrollment from ECF CHOICES when a determination has been made that the applicant or member (as applicable) cannot be safely served within the applicable expenditure cap; and

2.9.6.12.25.4.7 The member's responsibility regarding patient liability, including the consequences of not paying patient liability;

2.9.6.12.25.5 Person-centered practices, which at a minimum shall include the following:

2.9.6.12.25.5.1 A comprehensive training program on person-centered thinking, planning, and service delivery, including training on assessing a member's strengths and goals and identifying, developing and accessing community and natural resources;

2.9.6.12.25.5.2 Federal person-centered planning and HCBS setting requirements and the importance of the member's experience;

2.9.6.12.25.5.3 Planning and implementing HCBS to support employment and community integration and participation;

2.9.6.12.25.5.4 Supporting members in directing the person-centered planning process;

2.9.6.12.25.5.5 Facilitating individual choice and control, including the use of supported decision making;

2.9.6.12.25.5.6 Working with family members and/or conservators, while respecting individual choice;

2.9.6.12.25.6 Supporting family caregivers, which at a minimum shall include the following: The *Supporting Families* initiative and approach the family caregiver comprehensive assessment and support planning processes;

2.9.6.12.25.7 Understanding guardianship, and alternatives to guardianship, including supported decision making, and understanding guardians' and conservators' legal role and working with family members, guardians or conservators on assisting an individual with supported decision making processes when applicable;

2.9.6.12.25.8 Training on Medicaid and Medicare, which at a minimum shall include the following:

2.9.6.12.25.8.1 An introduction to Medicaid services, including covered physical and behavioral health services, processes for authorizing such services, as applicable; expectations for integration of service planning and delivery for individuals enrolled in ECF CHOICES, and the Support Coordinator/Care Coordinator's role and responsibility in facilitating access to other TennCare covered benefits, including home health and behavioral health services; and

2.9.6.12.25.8.2 An introduction to Medicare services, including the CONTRACTOR's D-SNP, and coordination of care for dual eligible members;

2.9.6.12.25.9 Training on coordination of physical and behavioral health needs, which at a minimum shall include the following:

2.9.6.12.25.9.1 An introduction to the unique physical health challenges individuals with I/DD may face, which shall be provided by the LTSS Medical Director or other licensed medical professional;

2.9.6.12.25.9.2 An introduction to the unique behavioral health, including behavior support challenges, individuals with I/DD may face; understanding behavior as communication; potential causes of behavior, including physiological or environmental factors; person-centered assessment and support planning for individuals with challenging behaviors, including positive behavior supports (e.g., supported employment); and Behavioral Health Crisis Prevention, Intervention and Stabilization Services and the System of Support, and the role of the Support Coordinator on the System of Support Team. These topics shall be presented by the Behavioral Health Director, Behavior Supports Director, or other licensed behavioral health professional with expertise in serving individuals with I/DD; and

2.9.6.12.25.9.3 The Support Coordinator's responsibility in promoting healthy lifestyle choices, including assisting the member in finding and maintaining employment, and in supporting self-management of chronic health conditions, including integration of population health and support coordination activities;

2.9.6.12.25.10 Training on essential support services, which at a minimum shall include the following:

2.9.6.12.25.10.1 Extensive training in assessing, planning and implementing employment services and supports for individuals with I/DD, including coordination of employment supports with Vocational Rehabilitation, American Job Centers, and for school age students, the local school district, as applicable;

2.9.6.12.25.10.2 Developing and accessing housing supports and resources including home ownership and other innovative affordable housing options;

2.9.6.12.25.10.3 The importance of proper positioning and the use of assistive technology to support greater independence, which shall be provided by an appropriately licensed allied health professional, i.e., occupational therapist or physical therapist with expertise in working with individuals with I/DD in community settings and with the most currently available forms of assistive technology;

2.9.6.12.25.10.4 Assessing and coordinating social support needs; and

2.9.6.12.25.10.5 Developing and accessing community supports, and identifying, facilitating, and sustaining informal/natural supports;

2.9.6.12.25.11 Training on the responsibility of the Support Coordinator, which at a minimum shall include the following:

2.9.6.12.25.11.1 Level of care and comprehensive assessment and reassessment, including timelines for reassessment, especially when a PAE is end-dated;

2.9.6.12.25.11.2 Development of a person-centered support plan , and updating the person-centered support plan, including training on health plan tools and processes and TennCare protocols that facilitate person-centered planning and service delivery;

2.9.6.12.25.11.3 Helping members select providers;

2.9.6.12.25.11.4 Consumer direction of eligible ECF CHOICES HCBS;

2.9.6.12.25.11.5 Individualized risk assessment and risk mitigation planning;

2.9.6.12.25.11.6 Development and implementation of back-up plans;

2.9.6.12.25.11.7 Implementing the PCSP, including service authorization processes;

2.9.6.12.25.11.8 Monitoring implementation of the PCSP, including progress in achieving member goals;

2.9.6.12.25.11.9 Electronic visit verification, including expectations for assisting members with completion of member surveys and ongoing monitoring and immediate resolution of potential gaps in services;

2.9.6.12.25.11.10 Support Coordination contact requirements, including purpose and expected outcomes of a contact;

2.9.6.12.25.11.11 Conducting a home visit and use of the monitoring checklist, including when to take action;

2.9.6.12.25.11.12 Management of critical transitions (including, but not limited to, hospital discharge planning, transitions from ICFs/IID, and transitions into or between CBRA settings);

2.9.6.12.25.11.13 Facilitation of transitions from an HCBS waiver to ECF CHOICES and between ECF CHOICES Groups;

2.9.6.12.25.12 Training on health, safety and welfare, which at a minimum shall include the following:

2.9.6.12.25.12.1 Dignity of risk and minimizing restrictions on individual freedom;

2.9.6.12.25.12.2 Identifying and reporting abuse, neglect or financial exploitation;

2.9.6.12.25.12.3 Reportable Event reporting and management;

2.9.6.12.25.12.4 Fraud, waste, and abuse, including reporting fraud, waste, and abuse;

2.9.6.12.25.12.5 Disaster planning; and

2.9.6.12.25.12.6 Advance directives and end of life care.

2.9.6.12.25.13 The Supporting Families philosophy and approach: working with families help them support self-determination, independence, productivity, integration, and inclusion in all facets of community life for their family member with a disability;

2.9.6.12.25.14 Transition planning for employment, including coordination with the local education authority; and

2.9.6.12.25.15 Transition planning and service coordination for adults turning age twenty-one (21).

2.9.6.12.26 The CONTRACTOR's training program shall encompass an array of training methodologies in order to accommodate a variety of learning styles, the opportunity to interact with individuals with I/DD and family members or conservators, and to practice skills, competency assessments, and opportunities for peer mentoring and assistance.

2.9.6.12.27 The CONTRACTOR shall also ensure that each Support Coordinator or Care Coordinator who will serve individuals with I/DD enrolled in ECF CHOICES shall complete all PAE training required by TENNCARE in order to become a Certified Assessor.

2.9.6.12.28 The CONTRACTOR shall establish an ongoing training program for Support Coordinators and Care Coordinators who will serve individuals with I/DD enrolled in ECF CHOICES. Ongoing training shall include at least monthly training updates and at least quarterly face-to-face training events for at least the first year following implementation of ECF CHOICES. The training updates and events may be conducted regionally and may be extended as determined appropriate by TENNCARE. Each quarterly training event shall include at least one (1) activity on person-centered thinking; opportunities for peer discussion and assistance; and timely access to SMEs. Topics to be covered shall be determined by the CONTRACTOR based on its monitoring of support coordination/ care coordination and the ECF CHOICES program, and feedback from TENNCARE.

2.9.6.12.29 The CONTRACTOR shall evaluate its training program annually and shall make adjustments to improve the training process and outcomes based on staff performance, in order to provide highly qualified support coordination staff for ECF CHOICES participants.

2.9.6.13 Care Coordination and Support Coordination Monitoring

2.9.6.13.1 The CONTRACTOR shall develop and submit to TENNCARE for review and approval a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its care coordination and support coordination processes, including ongoing quality reviews of an acceptable volume of PCSPs for each care/support coordinator to ensure accuracy, completeness, quality and consistency with quality standards as specified by TENNCARE. The CONTRACTOR shall immediately remediate all individual findings identified through its monitoring process, and shall also track and trend such findings and remediation to identify systemic issues of poor performance and/or non-compliance, implement strategies to improve care coordination and support coordination processes and resolve areas of non-compliance, and shall measure the success of such strategies in addressing identified issues. The CONTRACTOR shall provide detailed information regarding its care/support coordination monitoring processes in a form and format specified by TENNCARE (see A.2.30.6.7 and A.2.30.6.8. At a minimum, the CONTRACTOR shall ensure that:

2.9.6.13.1.1 PCSPs are, complete, appropriate and adequate to address the member needs, and provide sufficient information to guide the delivery of person-centered supports for the member;

2.9.6.13.1.1.1 Person-centered goals are documented in the PCSP for CHOICES and ECF CHOICES members;

2.9.6.13.1.1.2 Ongoing monitoring is conducted to measure progress toward achieving goals;

2.9.6.13.1.2 Assessment and planning processes are person-centered, and conform with best practices and with quality standards as specified by TENNCARE;

2.9.6.13.1.3 Care coordination and support coordination tools and protocols are consistently and objectively applied and outcomes are continuously measured to determine effectiveness and appropriateness of processes;

2.9.6.13.1.4 Level of care assessments and level of care reassessments occur on schedule and are submitted to TENNCARE in accordance with requirements in Section A.2.9.6.10.3.1.1;

2.9.6.13.1.5 Comprehensive assessments and reassessment, as applicable, occur on schedule and in compliance with this Contract;

2.9.6.13.1.6 PCSPs for CHOICES and ECF CHOICES members are developed and updated on schedule and in compliance with this Contract;

2.9.6.13.1.7 PCSPs for CHOICES and ECF CHOICES members reflect needs identified in the comprehensive assessment and reassessment process;

2.9.6.13.1.8 PCSPs for CHOICES and ECF CHOICES members are appropriate and adequate to address member needs;

2.9.6.13.1.9 Services are delivered as described in the plan of care or PCSP and authorized by the CONTRACTOR;

2.9.6.13.1.10 Services are appropriate to address the member's needs;

2.9.6.13.1.11 Services are delivered in a timely manner;

2.9.6.13.1.12 Service utilization is appropriate;

2.9.6.13.1.13 Service gaps are identified and addressed in a timely manner;

2.9.6.13.1.14 Minimum Care Coordinator and Support Coordinator contacts are conducted;

2.9.6.13.1.15 Care coordinator-to-member and Support Coordinator-to-member ratios are appropriate;

2.9.6.13.1.16 The cost neutrality cap for members in CHOICES Group 2 and the expenditure cap for members in CHOICES Group 3 and ECF CHOICES are monitored and appropriate action is taken if a member is nearing or exceeds his/her cost neutrality or expenditure cap; and

2.9.6.13.1.17 Benefit limits are monitored and appropriate action is taken if a member is nearing or exceeds a benefit limit.

2.9.6.13.2 The CONTRACTOR shall provide to TENNCARE the reports required by Section A.2.30.

2.9.6.13.3 The CONTRACTOR shall oversee its selected EVV vendor to ensure the EVV system operates in compliance with this Contract, with policies and protocols established by TENNCARE, and with the requirements of the 21st Century Cures Act, which requires electronic (not manual) verification of the type of service performed, the individual receiving the service, the date of the service, location of service delivery, the individual providing the service, and time the service begins and ends. The CONTRACTOR shall notify TENNCARE within five (5) business days of the identification of any issue affecting EVV system operation which impacts the CONTRACTOR's performance of this Contract, including actions that will be taken by the CONTRACTOR to resolve the issue and the specific timeframes within which such actions shall be completed.

2.9.6.13.4 The CONTRACTOR shall monitor all manual confirmations and take action to eliminate manual confirmations to ensure compliance with 21st Century Cures Act EVV system requirements by January 1, 2020, and on an ongoing basis, and to assure overall program integrity and that members are receiving necessary services. At minimum, the CONTRACTOR shall conduct audits and generate reports as prescribed by TENNCARE, including the report in Section A.2.30 of this Contract regarding manual confirmation, and shall monitor and take appropriate remedial action against providers and workers who repeatedly fail to use the EVV system when required to do so. The CONTRACTOR shall not deny payment to providers for services provided except upon written direction or approval from TENNCARE.

2.9.6.13.5 The CONTRACTOR shall establish business processes and procedures which shall include a standard process by which providers may notify the CONTRACTOR of exceptions for which an action by the CONTRACTOR is required for resolution and

shall maintain an adequate number of qualified, trained staff to support the operation of the EVV system. These staff will ensure that:

2.9.6.13.5.1 Authorizations as defined pursuant to Section A.2.9.6.2.5.13 are entered into the EVV system timely and accurately, including any changes in such authorizations based on changes in the member's plan of care or PCSP.

2.9.6.13.5.2 Authorizations provided by the CONTRACTOR outside the EVV system are consistent with authorizations entered by the CONTRACTOR into the EVV system and with the member's currently approved plan of care or PCSP.

2.9.6.13.5.3 Any actions required by the CONTRACTOR to resolve exceptions in the EVV system, e.g., a change in the service authorization, are completed within three (3) business days so that claims for services can be submitted for payment.

2.9.6.13.5.4 The CONTRACTOR monitors on an ongoing basis and reports to TENNCARE upon request, the total volume of CHOICES HCBS and ECF CHOICES HCBS that have been provided but not reimbursed due to issues with the EVV system or due to individual exceptions, and proactively works with providers and the FEA to ensure that issues are corrected and exceptions are resolved as expeditiously as possible and within the timeframes specified above in order to provide payment as appropriate for services delivered.

2.9.6.13.5.5 Worker Social Security Numbers are entered into the EVV system upon each worker's hire date.

2.9.6.13.6 The CONTRACTOR shall develop or purchase and implement an electronic visit verification system to monitor member receipt and utilization of CHOICES HCBS including at a minimum, personal care, attendant care, in-home respite and home-delivered meals and ECF CHOICES HCBS including at a minimum personal assistance, including supportive home care, and respite. The CONTRACTOR shall select its own electronic visit verification vendor, as applicable, and shall ensure, in the development of its EVV system, the following minimal functionality:

2.9.6.13.6.1 The ability to receive and store service authorizations for individual members;

2.9.6.13.6.2 The ability to log the arrival and departure of an individual provider staff person or worker, through the use of a static GPS device provided to the member for the sole purpose of this program;

2.9.6.13.6.3 The ability to capture the arrival and departure of an individual provider staff person or worker through the member's phone number in the event there is a malfunction with the GPS device;

2.9.6.13.6.3.1 This information shall include the workers SSN, so that the system can report in real time, or at minimum, within twenty-four (24) hours when a worker has clocked into multiple visits at the same time, even if the worker works for multiple agencies and the person supported is not within the same MCO.

2.9.6.13.6.4 The ability to verify in accordance with business rules that services are being delivered in the correct location (e.g., the member's home);

2.9.6.13.6.5 The ability to verify the identity of the individual provider staff person or worker providing the service to the member;

2.9.6.13.6.6 The ability to match services provided to a member with services authorized in the plan of care;

2.9.6.13.6.7 The ability to ensure that the provider/worker delivering the service is authorized to deliver such services;

2.9.6.13.6.8 The ability to create a schedule of services from the service authorizations entered for each member which identifies the amount, frequency, duration and scope of each service, and any schedule specified in the PCSP at which services are needed or preferred by the member; to ensure that workers are scheduled by providers in accordance with such authorization, including any schedule of services specified; and to ensure providers' adherence to the established schedule;

2.9.6.13.6.9 The ability to establish schedules that allow for flexibility of arrival time when such schedule is authorized with a "window of time" and systemically confirm such visits appropriately;

2.9.6.13.6.10 The ability to establish worker schedules when a member has opted for more flexible scheduling in the development of the PCSP, identify gaps in care based on such schedule, and systematically confirm such visits appropriately;

2.9.6.13.6.11 The ability to provide system-generated reporting regarding each provider's compliance with scheduling requirements, late and missed visits, and other data specified by TennCare for purposes of a provider report card and value-based payment approach;

2.9.6.13.6.12 The ability to allow more flexible scheduling options, including the option for open scheduling while still performing all remaining system functions;

2.9.6.13.6.13 The ability to receive and store updated authorizations, including those requiring changes to existing schedules, systematically cancel existing schedules that are no longer authorized, and immediately notify the provider of such updates;

2.9.6.13.6.14 The ability to confirm visits that occur per the authorized services schedule;

2.9.6.13.6.15 The ability to provide immediate (i.e., "real time") notification to the CONTRACTOR, provider and FEA, as applicable, if a provider or worker does not arrive as scheduled or otherwise deviates from the authorized schedule or the schedule created by the provider with the CONTRACTOR and the member when the member has elected a more flexible scheduling approach, so that service gaps and the reason the service was not provided as scheduled, are immediately identified and addressed, including through the implementation of back-up plans, as appropriate;

2.9.6.13.6.16 The ability to automate contact with the member to address late visits that could signal a potential gap in care in order to identify and target intervention as needed;

2.9.6.13.6.17 The ability for a provider of home-delivered meals to log in and enter the meals that have been delivered during the day, including the member's name, time delivered and the reason a meal was not delivered (when applicable);

2.9.6.13.6.18 The ability to capture worker notes per service provided and provide such notes to the provider, CONTRACTOR and FEA as appropriate, upon request;

2.9.6.13.6.19 The ability to engage the provider or consumer directed worker, as applicable, as a member of the care planning team through submission of routine feedback to the CONTRACTOR and FEA as appropriate, regarding the member, including any change in status or the member's needs;

2.9.6.13.6.20 The ability to collect real-time data regarding the member's experience of care, including member Point of Service Satisfaction surveys, and to aggregate such data for purposes of a provider report card and value-based payment approach;

2.9.6.13.6.21 The ability to leverage the member-based technology for health education and self-management of chronic conditions, including monitoring, reminders and documentation of self-care (e.g., glucose checks, blood pressure checks, etc.);

2.9.6.13.6.22 Access to the EVV system and a dashboard for TennCare to conduct real-time monitoring of the CONTRACTOR's performance with these requirements;

2.9.6.13.6.23 The CONTRACTOR shall ensure that the EVV system creates and makes available to providers and to the FEA on at least a daily basis an electronic claims submission file in the 837 format, including exceptions which have been resolved, which may be submitted to the CONTRACTOR for claims processing at the appropriate frequency;

2.9.6.13.6.24 The CONTRACTOR shall ensure providers and the FEA receive an electronic reconciliation report for all submitted claims.

2.9.6.13.6.25 The ability to store each worker's Social Security Number within the system;

2.9.6.13.6.26 The ability to share and transfer information with each MCO EVV system in real time, or at minimum, within twenty-four (24) hours. Such information shall include the worker's Social Security Number in order for the system to report in real time, or at minimum, within twenty-four (24) hours

2.9.6.13.7 The CONTRACTOR shall require and shall conduct readiness review activities as necessary to confirm that the EVV system vendor has a plan in place and will be compliant with all Version 5010 and ICD-10 coding requirements in a timely manner.

2.9.6.13.8 Notwithstanding the address and/or phone number in the 834 file, the CONTRACTOR shall use the address or phone number or alternative phone number listed on the member's PCSP, as confirmed during each care coordination or support coordination visit for all HCBS beginning and/or ending at the member's residence that must be logged into the EVV system. If HCBS begins and/or ends at a location other than the member's residence, an approved EVV check in and out that reflect the physical location of services is acceptable for purposes of logging the service location into the EVV system.

2.9.6.13.9 The CONTRACTOR shall not require that provider staff delivering home-delivered meals log in at arrival and departure. Instead, the provider may opt to log in on a daily basis after meals have been delivered and enter information on all the meals that were delivered that day (see Section A.2.9.6.13.6.16 above).

2.9.6.13.10 The CONTRACTOR shall monitor and use information from the electronic visit verification system to verify that services are provided as specified in the PCSP, and in accordance with the established schedule, including the amount, frequency,

duration, and scope of each service, and that services are provided by the authorized provider/worker; and to identify and immediately address service gaps, including late and missed visits. The CONTRACTOR shall monitor services anytime a member is receiving services, including after the CONTRACTOR's regular business hours.

2.9.6.13.11 The CONTRACTOR shall develop and maintain an electronic case management system that includes the functionality to ensure and document compliance with all requirements specified in the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Contract, and TennCare policies and protocols, including but not limited to the following:

2.9.6.13.11.1 The ability to capture and track key dates and timeframes specified in this Contract, e.g., as applicable, date of referral for potential CHOICES or ECF CHOICES enrollment, date the level of care assessment and plan of care or PCSP were submitted to TENNCARE, date of CHOICES or ECF CHOICES enrollment, date of development of the plan of care or PCSP, date of authorization of the plan of care or PCSP, date of initial service delivery for each service in the plan of care or PCSP, date of each level of care and needs reassessment, date of each update to the plan of care or PCSP, and dates regarding transition from a nursing facility to the community;

2.9.6.13.11.2 The ability to capture and track compliance with minimum care coordination or support coordination contacts as specified in Section A.2.9.6.10.4 of this Contract;

2.9.6.13.11.3 The ability to notify the Care Coordinator or Support Coordinator about key dates, e.g., TennCare eligibility end date, date for annual level of care reassessment, date of needs reassessment, and date for update to the plan of care or PCSP;

2.9.6.13.11.4 The ability to capture and track eligibility/enrollment information, level of care assessments and reassessments, and comprehensive assessments and reassessments;

2.9.6.13.11.5 The ability to capture and monitor the plan of care or PCSP;

2.9.6.13.11.6 The ability to track requested and approved service authorizations, including covered long-term care services and any services provided as a cost-effective alternative to other covered services;

2.9.6.13.11.7 The ability to document all referrals received by the Care Coordinator or Support Coordinator on behalf of the member for covered long-term services and supports; home health and private duty nursing services; other physical or behavioral health services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and other social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement, including notes regarding how such referral was handled by the Care Coordinator or Support Coordinator;

2.9.6.13.11.8 The ability to establish a schedule of services for each member not participating in consumer direction, which identifies the time at which each service is needed and for all members which identifies the amount, frequency, duration and scope of each service;

2.9.6.13.11.9 The ability to provide, via electronic interface with the electronic visit verification system, service authorizations on behalf of a CHOICES or ECF CHOICES member, including the schedule at which each service is needed;

2.9.6.13.11.10 The ability to provide, via electronic interface with the FEA, referrals and service authorizations;

2.9.6.13.11.11 The ability to track service delivery against authorized services and providers;

2.9.6.13.11.12 The ability to track actions taken by the Care Coordinator or Support Coordinator to immediately address service gaps; and

2.9.6.13.11.13 The ability to document case notes relevant to the provision of care coordination or support coordination.

2.9.6.13.12 The CONTRACTOR shall also monitor the EVV system to validate that any given worker is not clocked into multiple shifts at the same time, and shall have a process in place to address this with the provider(s) as needed, and to ensure that overlapping visits by the same worker are not paid.

2.9.6.14 PAE Tracking System

2.9.6.14.1 The CONTRACTOR shall use the TENNCARE PAE Tracking System, the system of record for CHOICES and ECF CHOICES level of care determinations, to facilitate submission of all PreAdmission Evaluation (i.e., level of care) applications, including required documentation pertaining thereto, and to facilitate enrollments into and transitions between LTSS programs, including CHOICES and ECF CHOICES. The CONTRACTOR shall comply with all data entry and tracking processes and timelines established by TENNCARE in policy or protocol in order to ensure efficient and effective administration and oversight of the CHOICES and ECF CHOICES programs.

A.2.9.7 **Consumer Direction of Eligible CHOICES HCBS and Eligible ECF CHOICES HCBS**

2.9.7.1 General

2.9.7.1.1 The CONTRACTOR shall offer consumer direction of eligible CHOICES HCBS and eligible ECF CHOICES HCBS to all CHOICES Group 2 and 3 and ECF CHOICES members who are determined by a Care Coordinator or Support Coordinator, as applicable, through the comprehensive assessment/reassessment process, to need (for CHOICES) attendant care, personal care, in-home respite, companion care services and (for ECF CHOICES) personal assistance, including supportive home care, respite, and community transportation and/or any other service specified in TennCare rules and regulations as available for consumer direction. (Companion care is only available for persons in Group 2 electing consumer direction of eligible CHOICES HCBS.) A service that is not specified in TennCare rules and regulations as available for consumer direction or that is not a CHOICES or ECF CHOICES HCBS shall not be consumer directed. Consumer direction in CHOICES or ECF CHOICES affords members the opportunity to have choice and control over how eligible CHOICES HCBS and eligible ECF CHOICES HCBS are provided, who provides the services and how much workers are paid for providing care, up to a specified maximum amount established by TENNCARE (see Section A.2.9.7.6.11). Members in ECF CHOICES shall have modified budget authority. Once a budget has been established based on the member's needs and the units of service necessary to meet the member's needs, the budget for personal assistance or supportive home care services and a separate budget

for community transportation services shall be allocated on a monthly basis and the budget for respite services shall be allocated on an annual basis. For persons electing to receive the hourly respite benefit (up to two hundred sixteen (216) hours per year), the annual respite budget will be a dollar amount. For persons electing to receive the daily respite benefit (up to thirty (30) days per year), the respite budget will be thirty (30) dates of service. For purposes of this Section, a date of service means a distinct, calendar day in which a person receives respite, regardless of the amount of respite that person receives on that day. The member may direct each service budget available through Consumer Direction so long as the applicable budget is not exceeded. For hourly services, this may include purchasing more units of a particular service than was used by the CONTRACTOR to establish the budget for that service (i.e., based on the wages set by the member for their worker(s)). Such services shall be a cost-effective alternative to services that would otherwise be provided by an agency. For members in Group 6, the CONTRACTOR may elect, as part of determining the budget, to include units of personal assistance services in excess of the monthly benefit limit as a cost-effective alternative service; however, once established, the monthly budget for personal assistance shall not be exceeded. Member participation in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS at any time, service by service, without affecting their enrollment in CHOICES or ECF CHOICES. To the extent possible, the member shall provide his/her Care Coordinator or Support Coordinator ten (10) days advance notice regarding his/her intent to no longer direct one or more eligible CHOICES HCBS or eligible ECF CHOICES HCBS or to withdraw from participation in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS entirely. The CONTRACTOR shall respond to the member's request in keeping with the timeframes and processes set forth in this Section, in order to facilitate a seamless transition to appropriate service delivery. TENNCARE may establish reasonable limitations on the frequency with which members may opt into and out of consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS. In limited circumstances, as prescribed by TennCare rules, policy, and guidance, the CONTRACTOR may authorize, as a cost-effective alternative, a higher rate of payment to workers for services provided through Consumer Direction. These are instances in which a member requires the performance of frequent intermittent or continuous skilled nursing tasks that will be self-directed to the worker or otherwise performed within the scope of the worker's professional license, or where the member's behavior support needs necessitate the hiring of staff with professional licensure, advanced education and training, qualifications, and/or expertise. Limited circumstances in which the CONTRACTOR may authorize a higher level of as a cost-effective alternative include only those which meet all of the following criteria:

2.9.7.1.1.1 The frequency or complexity of the person's skilled nursing needs or the complexity and intensity of the member's behavior support needs necessitate the hiring of staff with professional licensure, advanced education and training, qualifications and/or expertise (e.g. a licensed nurse);

2.9.7.1.1.2 Absent the rate of a higher rate of reimbursement in order to employ workers with such advanced training, qualifications, and/or expertise, the person's needs cannot be safely met in the community, resulting in institutional placement; and

2.9.7.1.1.3 A higher rate of reimbursement can be paid for consumer directed service, while ensuring the total cost of the HCBS (including HH and PDN, as applicable), does not exceed the member's Cost Neutrality Cap in CHOICES or Expenditure Cap in ECF CHOICES.

2.9.7.1.2 Consumer direction is a process by which eligible CHOICES HCBS or eligible ECF CHOICES HCBS are delivered; it is not a service. If a member chooses not to direct his/her care, he/she shall receive authorized CHOICES HCBS or ECF CHOICES HCBS through contract providers. While the denial of a member's request to participate in consumer direction or the termination of a member's participation in consumer direction gives rise to due process including the right to fair hearing, such appeals shall be processed by the TennCare Division of Long Term Services and Supports rather than the TennCare Solutions Unit, which manages medical appeals pertaining to TennCare benefits (i.e., services).

2.9.7.1.3 Members who participate in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS choose either to serve as the employer of record of their workers or to designate a representative (see definition below in Section A.2.9.7.2.1) to serve as the employer of record on his/her behalf. As the employer of record the member or his/her representative is responsible for the following:

2.9.7.1.3.1 Recruiting, hiring and firing workers;

2.9.7.1.3.2 Determining workers' duties and developing job descriptions;

2.9.7.1.3.3 Scheduling workers;

2.9.7.1.3.4 Supervising workers;

2.9.7.1.3.5 Evaluating worker performance and addressing any identified deficiencies or concerns;

2.9.7.1.3.6 Setting wages from a range of rates established by TENNCARE;

2.9.7.1.3.7 Training workers to provide personalized care based on the member's needs and preferences;

2.9.7.1.3.8 Ensuring that workers deliver only those services authorized, and reviewing and approving hours worked by consumer-directed workers;

2.9.7.1.3.9 Reviewing and ensuring proper documentation for services provided; and

2.9.7.1.3.10 Developing and implementing as needed a back-up plan to address instances when a scheduled worker is not available or fails to show up as scheduled.

2.9.7.1.4 The CONTRACTOR's operating systems shall have the ability to implement the model of Consumer Direction or Self-Direction currently employed in CHOICES, ECF CHOICES, and the 1915c Statewide HCBS Waiver (including employer authority, budget authority, and modified budget authority), and the flexibility to transition from an employer authority model to a budget authority or modified budget authority model if necessary to meet programmatic change requirements within timeframes specified by the State, allowing a reasonable period for any systems modifications required to accomplish such changes.

2.9.7.2 Representative for Consumer Direction

2.9.7.2.1 A member may designate, or have appointed by a guardian, a representative to assume the consumer direction responsibilities on his/her behalf. A representative shall meet, at minimum the following requirements: be at least 18 years of age, have a personal relationship with the member and understand his/her support needs; knows the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each worker.

2.9.7.2.2 In order to participate in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS with the assistance of a representative, one of the following must apply: (1) the member must have the ability to designate a person to serve as his/her representative or (2) the member has a legally appointed representative who may serve as the member's representative.

2.9.7.2.3 The Care Coordinator or Support Coordinator shall, based on a self-assessment completed by the member, determine if the member requires assistance in carrying out the responsibilities required for consumer direction and therefore requires a representative. The member's Care Coordinator/care coordination team or Support Coordinator/support coordination team shall verify that a representative meets the qualifications as described in Section A.2.9.7.2.1 above.

2.9.7.2.4 A member's representative shall not receive payment for serving in this capacity and shall not serve as the member's worker for any consumer directed service. The CONTRACTOR shall use a representative agreement developed by TENNCARE to document a member's choice of a representative for consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS and the representative's contact information, and to confirm the individual's agreement to serve as the representative and to accept the responsibilities and perform the associated duties defined therein. The CONTRACTOR shall notify the FEA within three (3) business days when it becomes aware of any changes to a representative's contact information.

2.9.7.2.5 The representative agreement shall be signed by the member (or person authorized to sign on member's behalf) and the representative in the presence of the Care Coordinator. The Care Coordinator shall include the representative agreement in the member's file and provide copies to the member and/or the member's representative and the FEA.

2.9.7.2.6 A member may change his/her representative at any time. The member shall immediately notify his/her Care Coordinator or Support Coordinator and the FEA when he/she intends to change representatives. The Care Coordinator or Support Coordinator shall verify that the new representative meets the qualifications as described above. A new representative agreement shall be completed and signed, in the presence of a Care Coordinator or Support Coordinator, prior to the new representative assuming their respective responsibilities. The Care Coordinator or Support Coordinator shall immediately notify the FEA in writing when a member changes his/her representative and provide a copy of the representative agreement. The CONTRACTOR shall facilitate a seamless transition to the new representative, and ensure that there are no interruptions or gaps in services. As part of the comprehensive assessment and plan of care or PCSP process, the Care Coordinator or Support Coordinator shall educate the member about the importance of notifying the Care Coordinator or Support Coordinator prior to changing a representative.

2.9.7.2.7 The FEA shall ensure that the new representative signs all service agreements (see Section A.2.9.7.6.6).

2.9.7.3 Fiscal Employer Agent (FEA)

2.9.7.3.1 The CONTRACTOR shall enter into a contract with the FEA specified by TENNCARE to provide assistance to members choosing consumer direction.

2.9.7.3.2 The FEA shall fulfill, at a minimum, the following financial administration and supports brokerage functions, as specified in the CONTRACTOR's contract with the FEA and the FEA's contract with TENNCARE, for all CHOICES members electing consumer direction of eligible CHOICES HCBS and all ECF CHOICES members electing consumer direction of eligible ECF CHOICES HCBS:

2.9.7.3.2.1 Assign a supports broker to each CHOICES or ECF CHOICES member electing to participate in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS. The supports broker shall be responsible for assisting the member with enrollment into consumer direction and with the enrollment of new workers;

2.9.7.3.2.2 Notify the member's Care Coordinator or Support Coordinator upon becoming aware of any additional risk associated with the member participating in consumer direction that may need to be addressed in the risk assessment (as applicable) and plan of care or PCSP processes;

2.9.7.3.2.3 Provide initial and ongoing training to members and their representatives (as applicable) on consumer direction and other relevant issues (see Section A.2.9.7.7 of this Contract);

2.9.7.3.2.4 Verify worker qualifications, including, as specified by TENNCARE, conduct background checks on workers, enroll workers into Medicaid, assign provider Medicaid ID numbers, and hold Medicaid provider agreements (see Section A.2.9.7.6.1 of this Contract);

2.9.7.3.2.5 Provide initial and ongoing training to workers on consumer direction and other relevant issues (see Section A.2.9.7.7 of this Contract);

2.9.7.3.2.6 Assist the member and/or representative in developing and updating service agreements (see Section A.2.9.7.6.6);

2.9.7.3.2.7 Receive, review and process timesheets;

2.9.7.3.2.8 Resolve discrepancies regarding timesheets;

2.9.7.3.2.9 Develop and implement a process to support members or their representatives in ensuring that consumer directed workers maintain in the member's home (or alternative location or format approved by TENNCARE) documentation of service delivery to support payments for services provided through consumer direction, and periodically monitor such documentation;

2.9.7.3.2.10 Withhold, file and pay applicable: federal, state and local income taxes; employment and unemployment taxes; and worker's compensation;

2.9.7.3.2.11 Pay workers for authorized services rendered within authorized timeframes;

2.9.7.3.2.12 Facilitate resolution of any disputes regarding payment to workers for services rendered; and

2.9.7.3.2.13 Notify the CONTRACTOR within no more than twenty-four (24) hours of identification of critical incidents and Reportable Events, and notify the CONTRACTOR within four (4) hours of any Tier 1 Reportable Events (see Section A.2.15.7).

2.9.7.3.3 The FEA shall also fulfill, at a minimum, the following financial administration and supports brokerage functions for CHOICES members electing consumer direction of eligible CHOICES HCBS and ECF CHOICES members electing consumer direction of eligible ECF CHOICES HCBS on an as needed basis:

2.9.7.3.3.1 As needed, assist the member and/or representative in developing job descriptions;

2.9.7.3.3.2 As needed, assist the member and/or representative in locating and recruiting workers;

2.9.7.3.3.3 As needed, assist the member and/or representative in interviewing workers (developing questions, evaluating responses);

2.9.7.3.3.4 Assist the member and/or representative in developing (as part of the onboarding process for new workers) a schedule for the member's workers that comports with the schedule at which services are needed by the member as reflected in the PCSP;

2.9.7.3.3.5 Assist the member and/or representative in managing and monitoring payments to workers; and

2.9.7.3.3.6 Assist the member/representative in identification and training of new workers, as needed.

2.9.7.3.4 The CONTRACTOR's care coordination or support coordination functions shall not duplicate the supports brokerage functions performed by the FEA or its subcontractor. A member's Care Coordinator or Support Coordinator shall be responsible for monitoring the member's services through consumer direction.

2.9.7.3.5 The CONTRACTOR's contract with the FEA shall include the provisions specified by TENNCARE in the model CONTRACTOR-FEA contract.

2.9.7.3.6 The CONTRACTOR in collaboration with the FEA shall establish a process that allows for the efficient exchange of all relevant member information regarding members electing to participate in consumer direction between the CONTRACTOR and the FEA.

2.9.7.3.7 The CONTRACTOR and FEA shall develop a protocol for interfaces and transfers of customer service inquiries per the requirements of Section A.2.18 of this Contract.

2.9.7.3.8 The CONTRACTOR shall provide to the FEA copies of all relevant initial and updated member documents, including at a minimum, PCSPs and representative agreements. The CONTRACTOR shall provide to the FEA all relevant documentation prior to service delivery.

2.9.7.3.9 The FEA shall screen monthly to determine if workers have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. If a worker has been excluded, the FEA shall notify the member regarding the worker's status and work with the member to find a replacement worker. The FEA shall notify the CONTRACTOR regarding the worker status. The CONTRACTOR shall work with the member to obtain a replacement contract provider until a replacement worker can be found and all worker requirements are fulfilled and verified.

2.9.7.3.10 The CONTRACTOR shall assist the FEA in maintaining an updated list of Care Coordinators and Support Coordinators for members participating in Consumer Direction. Within two (2) business days of a CHOICES or ECF CHOICES member experiencing a change in Care or Support Coordinator, as applicable, the CONTRACTOR shall contact the FEA and provide the FEA with the name of the member who has experienced a change in Care or Support Coordinator along with the name and contact information of the member's new Care or Support Coordinator.

2.9.7.3.11 *FEA Training*

2.9.7.3.11.1 The CONTRACTOR shall provide education and training to the FEA and its staff and subcontracted supports brokers (as applicable) regarding key requirements of this Contract and the contract between the CONTRACTOR and the FEA.

2.9.7.3.11.2 The CONTRACTOR shall provide to the FEA, in electronic format (including but not limited to CD or access via a web link), a member handbook and updates thereafter annually or any time material changes are made.

2.9.7.3.11.3 The CONTRACTOR shall conduct initial education and training to the FEA and its staff at least thirty (30) days prior to implementation in each Grand Region covered by this Contract. This education and training shall include, but not be limited to, the following:

2.9.7.3.11.3.1 The role and responsibilities of the Care Coordinator or Support Coordinator, including as it relates to members electing to participate in consumer direction;

2.9.7.3.11.3.2 CHOICES and ECF CHOICES comprehensive assessment and plan of care or PCSP development, implementation, and monitoring processes, including the development and activation of a back-up plan for members participating in consumer direction;

2.9.7.3.11.3.3 The FEA's responsibilities for communicating with the CONTRACTOR, members, representatives and workers and TENNCARE, and the process by which to do this;

2.9.7.3.11.3.4 Customer service requirements;

2.9.7.3.11.3.5 Requirements and processes regarding referral to the FEA;

2.9.7.3.11.3.6 Requirements and processes, including timeframes for authorization of consumer directed eligible CHOICES HCBS or eligible ECF CHOICES HCBS;

2.9.7.3.11.3.7 Requirements and processes, including timeframes, for claims submission and payment and coding requirements;

2.9.7.3.11.3.8 Systems requirements and information exchange requirements;

2.9.7.3.11.3.9 Requirements and role and responsibility regarding abuse and neglect plan protocols, and critical incident and Reportable Event reporting and management;

2.9.7.3.11.3.10 The FEA's role and responsibility in implementing the CONTRACTOR's fraud, waste, and abuse plan;

2.9.7.3.11.3.11 CHOICES and ECF CHOICES program quality requirements; and

2.9.7.3.11.3.12 The CONTRACTOR's member complaint and appeal processes.

2.9.7.3.11.4 The CONTRACTOR shall provide ongoing FEA education, training and technical assistance as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Contract and the contract between the CONTRACTOR and the FEA.

2.9.7.3.11.5 The FEA shall provide training to the CONTRACTOR's Care Coordinators and Support Coordinators regarding consumer direction of HCBS and the role and responsibilities of the FEA (including financial administration and supports brokerage functions).

2.9.7.4 <u>Comprehensive Assessment/Plan of Care Process or PCSP Process</u>

2.9.7.4.1 A CHOICES or ECF CHOICES member may choose to direct needed eligible CHOICES HCBS or eligible ECF CHOICES HCBS at any time: during intake or enrollment, through the comprehensive assessment/reassessment and plan of care or PCSP and update processes; and outside of these processes. The Care Coordinator or Support Coordinator shall assess the member's needs for eligible CHOICES HCBS or eligible ECF CHOICES HCBS per requirements in Sections A.2.9.6.2.5, A.2.9.6.3 and A.2.9.6.5, as applicable. The Care Coordinator or Support Coordinator shall use the plan of care or PCSP process (including updates) to identify the eligible services that the member will direct and to facilitate the member's enrollment in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS.

2.9.7.4.2 The CONTRACTOR shall obtain from the member a signed statement regarding the member's decision to participate in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS.

2.9.7.4.2.1 The Care Coordinator or Support Coordinator shall assist the member in identifying which of the needed eligible CHOICES HCBS or eligible ECF CHOICES HCBS shall be consumer directed, provided by contract providers or a combination of both, in which case, there must be a set schedule which clearly defines when contract providers will be utilized. The CONTRACTOR shall not be expected or required to maintain contract providers "on standby" to serve in a back-up capacity for services a member has elected to receive through consumer direction.

2.9.7.4.3 If the member intends to direct one or more needed eligible CHOICES HCBS or eligible ECF CHOICES HCBS, throughout the period of time that consumer direction is being initiated, the CONTRACTOR shall arrange for the provision of needed

CHOICES HCBS or ECF CHOICES HCBS through contract providers in accordance with Section A.2.9.6. The Care Coordinator or Support Coordinator shall obtain from the member his/her choice of contract providers who will provide CHOICES HCBS or ECF CHOICES HCBS until such time as workers are secured and ready to begin delivering services through consumer direction.

2.9.7.4.3.1 If a CHOICES member has been assessed to need companion care services, the CONTRACTOR shall identify non-residential services that will offer interim support to address the member's needs and assist the member in obtaining contract providers for these services.

2.9.7.4.3.2 If a member electing to participate in consumer direction refuses to receive eligible CHOICES HCBS or eligible ECF CHOICES HCBS from contract providers while services are initiated through consumer direction, the decision must be documented on a signed and dated Consumer Direction Participation Form. The CONTRACTOR shall not encourage a member to forego receipt of eligible CHOICES HCBS or eligible ECF CHOICES HCBS from contract providers while these HCBS are being initiated through consumer direction.

2.9.7.4.3.3 For any CHOICES Group 2 or Group 3 or ECF CHOICES member electing to participate in consumer direction that refuses to receive eligible CHOICES HCBS or eligible ECF CHOICES HCBS from contract providers while services are initiated through consumer direction, the member's Care Coordinator or Support Coordinator shall visit the member face to face at least monthly to ensure that the member's needs are safely met, and shall continue to offer eligible CHOICES HCBS or eligible ECF CHOICES HCBS through contract providers.

2.9.7.4.3.4 If eligible CHOICES HCBS or eligible ECF CHOICES HCBS are not initiated within sixty (60) days following referral to the FEA, the CONTRACTOR shall notify the member that eligible CHOICES HCBS or eligible ECF CHOICES HCBS must be initiated by contract providers unless these HCBS are not needed on an ongoing basis in order to safely meet the member's needs in the community, in which case, the CONTRACTOR shall submit documentation to TENNCARE to begin the process of disenrollment from CHOICES or ECF CHOICES. Even if services are initiated by contract providers, if consumer directed services are not initiated within ninety (90) days of FEA referral, the CONTRACTOR shall assess whether consumer direction is appropriate for the member at this time or whether the member should be disenrolled from consumer direction. Disenrollment from consumer direction does not preclude the member from initiating consumer directed services at a later point.

2.9.7.4.4 Except as specified in Section A.2.9.7.4.3.2. and in accordance with requirements pertaining thereto, the CONTRACTOR shall be responsible for providing all needed eligible CHOICES HCBS or eligible ECF CHOICES HCBS using contract providers, including a back-up plan for such services, until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section A.2.9.7.6.1 of this Contract); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.

2.9.7.4.5 The Care Coordinator or Support Coordinator shall determine if the member will appoint a representative to assume the consumer direction functions on his/her behalf. If the member does not intend to appoint a representative, the Care Coordinator or Support Coordinator shall determine the extent to which a member requires assistance to participate in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS, based upon the results of the member's responses to the self-assessment instrument developed by TENNCARE. The self-assessment instrument shall be completed by the member with assistance from the member's Care Coordinator or Support Coordinator as appropriate. The Care Coordinator or Support Coordinator shall file the completed self-assessment in the member's file and provide a copy to the FEA.

2.9.7.4.5.1 If, based on the results of the self-assessment the Care Coordinator or Support Coordinator determines that a member requires assistance to direct his/her services, the Care Coordinator or Support Coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf.

2.9.7.4.5.2 The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to deny participation in consumer direction because a Care Coordinator or Support Coordinator has determined that the health, safety and welfare of the member would be in jeopardy if the member participates in consumer direction without a representative but the member does not want to appoint a representative to assist in directing his/her services. The CONTRACTOR shall abide by TENNCARE's decision.

2.9.7.4.6 The member's Care Coordinator/care coordination team or Support Coordinator/support coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section A.2.9.7.2.1 of this Contract) and that a representative agreement is completed and signed by the member and the person prior to forwarding a referral to the FEA (see Section A.2.9.7.4.7 below).

2.9.7.4.7 Within two (2) business days of signing the representative agreement or completion of the self-assessment instrument if the member has not designated a representative and the Care Coordinator or Support Coordinator determines that the member does not require a representative to assist the member in directing his/her care, the CONTRACTOR shall forward to the FEA a referral initiating the member's participation in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS. The referral shall include at a minimum: the date of the referral; the member's name, address, telephone number, and social security number (SSN); the name of the representative and telephone number (if applicable); member's MCO ID number; member's CHOICES or ECF CHOICES enrollment date; eligible selected HCBS, including for CHOICES members, amount, frequency and duration of each by type, and for ECF CHOICES members, each service type and monthly or annual amount (as applicable) of the budget for each service; and Care Coordinator's or Support Coordinator's name and contact information. The CONTRACTOR shall also forward to the FEA a copy of the written confirmation of the member's decision to participate in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS, the signed POC or PCSP, and the representative agreement, if applicable. Referrals shall be submitted electronically on a daily basis using the agreed upon data interface (either a standard electronic file transfer or the FEA's web portal technology or both) and process. Referrals shall be submitted on a member-by-member basis.

2.9.7.4.8 Within two (2) business days of receipt of the referral, the FEA shall assign a supports broker to the member, notify the Care Coordinator or Support Coordinator of the assignment and provide the name and contact information of the supports broker.

2.9.7.4.9 Within five (5) days of receipt of the referral, the FEA shall contact the member to inform the member of his/her assigned supports broker, provide contact information for the supports broker, and to begin the process of initiating consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS.

2.9.7.4.10 *Back-up Plan for Consumer Direction and Conducting a Risk Assessment as applicable*

2.9.7.4.10.1 The member/representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services. The FEA shall assist the member/representative as needed in developing and verifying the initial back-up plan for consumer direction that adequately identifies how the member/representative will address situations when a scheduled worker is not available or fails to show up as scheduled. The Care Coordinator or Support Coordinator shall assist the member as needed with implementing the back-up plan and shall update and verify the back-up plan annually and as needed.

2.9.7.4.10.2 The member/representative (as applicable) may not elect, as part of the back-up plan, to go without services.

2.9.7.4.10.3 The back-up plan for consumer direction shall include the names and telephone numbers of contacts (workers, agency staff, organizations, supports) for alternate care, the order in which each shall be notified and the services to be provided by contacts. Back-up contacts may include paid and unpaid supports; however, it is the responsibility of the member electing consumer direction and/or his/her representative to secure paid (as well as unpaid) back-up contacts who are willing and available to serve in this capacity. The CONTRACTOR shall not be expected or required to maintain contract providers “on standby” to serve in a back-up capacity for services a member has elected to receive through consumer direction.

2.9.7.4.10.4 All persons and/or organizations noted in the back-up plan for consumer direction shall be contacted by the member/representative to determine their willingness and availability to serve as back-up contacts. For the initial back-up plan, the FEA shall confirm with these persons and/or organizations their willingness and availability to provide care when needed, document confirmation in the member’s file and forward a copy of the documentation to the CONTRACTOR. The Care Coordinator or Support Coordinator shall be responsible for updating and verifying the back-up plan on an ongoing basis.

2.9.7.4.10.5 The member's Care Coordinator or Support Coordinator shall integrate the member's back-up plan for consumer-directed workers (including any updates thereto) into the member's back-up plan for services provided by contract providers, as applicable, and the member's plan of care or PCSP. The Care Coordinator or Support Coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member's needs, and as part of ongoing care coordination or support coordination activities to ensure that the member is receiving services as specified in the plan of care or PCSP, shall monitor that the back-up plan was implemented timely, when applicable, and that the member's needs are being met.

2.9.7.4.10.6 The Care Coordinator or Support Coordinator shall assist the member or his/her representative (as applicable) in implementing the back-up plan for consumer direction as needed, monitor to ensure that the back-up plan is implemented and effectively working to meet the member's needs, and immediately address any concerns with the back-up plan or the member's care.

2.9.7.4.10.7 The Care Coordinator or Support Coordinator shall assist the member or his/her representative (as applicable) in reviewing and updating the back-up plan for consumer direction at least annually and as frequently as necessary, which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or eligible ECF CHOICES HCBS or the schedule at which such services are needed, changes in workers (when such workers also serve as a back-up to other workers) and changes in the availability of paid or unpaid back-up workers to deliver needed care. As part of the annual review of the back-up plan, the member or his/her representative and the Care Coordinator or Support Coordinator shall confirm that each person specified in the back-up plan continues to be willing and available to serve as back-up workers to deliver needed care and to perform the tasks and functions needed by the member. Any updates to the back-up plan for consumer direction shall be provided to the FEA.

2.9.7.4.10.8 The FEA and the CONTRACTOR shall each file a copy of the back-up plan for consumer direction in the member's file.

2.9.7.4.10.9 The member's Care Coordinator or Support Coordinator shall reassess the adequacy of the member's back-up plan for consumer direction on at least an annual basis which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or eligible ECF CHOICES HCBS or the schedule at which such services are needed, changes in consumer-directed workers (when such workers also serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care.

2.9.7.4.10.10 For members in CHOICES, the Care Coordinator shall conduct a risk assessment 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 risks, as well as measures to mitigate these risks to incorporate into the member's PCSP. The member/representative shall participate in the process. The member's representative (if applicable) shall participate in the risk assessment process. The CONTRACTOR, member/representative, and FEA shall receive a copy of the updated PCSP. The CONTRACTOR and the FEA shall each file a copy of the updated PCSP in the member's file. For members in ECF CHOICES, risks

associated with participation in consumer direction and mitigation strategies are addressed in the PCSP.

2.9.7.4.10.11 The FEA shall notify the member's Care Coordinator or Support Coordinator immediately if they become aware of changes in the member's needs and/or circumstances which warrant a reassessment of needs and/or risk or changes to the PCSP.

2.9.7.4.10.12 The FEA shall assist the CONTRACTOR in identifying and addressing in the risk assessment and plan of care or PCSP processes any additional risk associated with the member participating in consumer direction.

2.9.7.4.10.13 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care or PCSP occur per requirements specified in Sections A.2.9.7.9 of this Contract. The Care Coordinator or Support Coordinator shall ensure that the FEA is invited to participate in these meetings as appropriate.

2.9.7.5 Authorizations for Consumer Directed Services and Service Initiation

2.9.7.5.1 Consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS shall not be initiated until all requirements are fulfilled including but not limited to the following: (1) the FEA verifies that the member's employer and related documentation is in order; (2) the FEA verifies that workers meet all qualifications, including completion of required training which shall include training regarding worker's willingness and ability to utilize the designated EVV system and comply with all EVV requirements as prescribed by the 21st Century Cures Act; (3) there is a signed service agreement specific to each individual worker (see Section A.2.9.7.6.6 of this Contract); and (4) the CONTRACTOR issues to the FEA an authorization for consumer directed services (see Section A.2.9.7.5.6 below) for each service.

2.9.7.5.2 The FEA shall work with the member to determine the appropriate level of assistance necessary to recruit, interview and hire workers and provide the assistance.

2.9.7.5.3 Once potential workers are identified, the FEA shall verify that a potential worker meets all applicable qualifications (see Section A.2.9.7.6.1 of this Contract).

2.9.7.5.4 The FEA shall ensure that a service agreement is signed between the member or member's representative and his/her worker within five (5) business days following the FEA's verification that a worker meets all qualifications.

2.9.7.5.5 On a weekly basis the FEA shall update the member's Care Coordinator or Support Coordinator of the status of completing required functions necessary to initiate consumer direction, including obtaining completed paperwork from the member/representative and obtaining workers for each identified consumer directed service and any anticipated timeframes by which qualified workers shall be secured and consumer directed services may begin.

2.9.7.5.6 The provision of consumer directed services shall begin as soon as possible but not longer than sixty (60) days from the date of the CONTRACTOR's referral to the FEA, except due to circumstances beyond the control of the FEA. Prior to beginning the provision of consumer directed services, the FEA shall notify the

CONTRACTOR that all requirements have been fulfilled, including verification of all worker qualifications, criminal background checks, signed service agreements, completion of EVV training including the worker's willingness and ability to utilize the EVV system and comply with all EVV requirements as prescribed by the 21st Century Cures Act, and that the member is ready to begin consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS. Within two (2) business days of receipt of the notification from the FEA, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services. For CHOICES members, each authorization for consumer directed services shall include authorized service, authorized units of service, start and end dates, and service code(s). For ECF CHOICES members, each authorization for consumer directed services shall include authorized service, authorized budget for service(s), start and end dates, and service code(s). For ECF CHOICES members, each authorization for consumer directed services shall include authorized service; the dollar amount for each month of service authorized (i.e., the monthly budget for that service), or for respite services, the dollar amount (applicable for hourly respite) or days (applicable for daily respite) for the year of service authorized (i.e., the annual budget); Services provided through consumer direction shall be authorized in accordance with the PCSP. A CHOICES member participating in consumer direction shall have authority to manage the schedule at which authorized services provided through consumer direction are needed, including personal care visits and attendant care, and to modify such schedule based on needs and preferences. Should this flexibility in scheduling result in a CHOICES member utilizing all of their authorized personal care visits or attendant care hours before the end of the month, (e.g., because one or more service encounters originally anticipated to be less than four hours exceeded four hours), the member shall be permitted to utilize the remaining units of the other service interchangeably, as needed, with such units billed and paid as the service for which authorized units remain for that month. A member shall not be permitted to utilize more than the authorized total units of personal care visits and attendant care during the month. Authorized units of service in a service authorization should reflect the units of measure specified by TENNCARE for the benefit (e.g. visits, hours, days). An ECF CHOICES member participating in consumer direction shall have authority to manage the schedule at which each of the authorized services provided through consumer direction are needed, including respite and personal assistance or supportive home care and to modify such schedule based on needs and preferences within the monthly or annual budget for that service. A member shall not be permitted to utilize more than the authorized budget for personal assistance or supportive home care, or more than the authorized annual budget for respite. Community transportation shall also be authorized on a monthly basis as a separate budgeted amount; the monthly transportation budget shall not be exceeded. The CONTRACTOR shall submit authorizations electronically on at least a daily basis using the agreed upon data interface (which may include a standard electronic file transfer, the FEA's web portal technology, or any combination thereof).

2.9.7.5.7 If initiation of consumer directed services does not begin within sixty (60) days from the date of the CONTRACTOR's referral to the FEA, the FEA shall contact the CONTRACTOR regarding the cause of the delay and provide appropriate documentation to demonstrate efforts to meet the timeframe. The CONTRACTOR shall determine the appropriate next steps, including but not limited to whether additional time is needed or if the member is still interested in participating in

consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS.

2.9.7.5.8 Upon the scheduled start date of consumer directed services, the member's Care Coordinator/care coordination team or Support Coordinator/support coordination team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized. This shall include ongoing monitoring via service utilization reports to ensure that services are provided in accordance with the member's PCSP. Upon the identification of any gaps in care, the member's Care Coordinator/care coordination team or Support Coordinator/support coordination team shall assist the member or his/her representative upon request in implementing the member's back-up plan for consumer direction, and shall continue to monitor service utilization on an ongoing basis.

2.9.7.5.9 Within five (5) business days of the scheduled start date of consumer directed services as specified in the authorization of consumer directed services, a member of the Care Coordinator or Support Coordinator team shall contact the member or his/her representative to confirm that services are being provided and that the member's needs are being met.

2.9.7.5.10 On an ongoing basis, in addition to requirements specified above in Sections A.2.9.7.5.3 – A.2.9.7.5.9 above:

2.9.7.5.10.1 The CONTRACTOR shall develop and forward to the FEA a new authorization for consumer directed services when the following occur: (1) a change in the number of service units for CHOICES members; a change in the monthly or annual (as applicable) budget for any service for ECF CHOICES members, which shall be based solely on a change in the member's needs or circumstances and not on the member's management of the authorized budget for such service and shall not exceed any established benefit limit except for personal assistance authorized by the CONTRACTOR as a cost-effective alternative service; budget based on needed service units for ECF CHOICES members; or (2) a change in the services to be provided through consumer direction, including the provision of a new service through consumer direction or termination of a service through consumer direction. Absent a change in circumstances, a reassessment of the member's needs as a result of such change in circumstances, and any necessary changes to the plan of care or PCSP, the CONTRACTOR shall not authorize additional services due to member exhaustion of approved services or service hours.

2.9.7.6 <u>Worker Qualifications</u>

2.9.7.6.1 As prescribed in the FEA's contract with TENNCARE, the FEA shall ensure that workers meet all requirements prior to the worker providing services. The FEA shall ensure that workers: meet all TENNCARE established requirements for consumer directed services including the worker's willingness and ability to utilize the designated EVV system and comply with all EVV requirements as prescribed by the 21st Century Cures Act; complete a background check which includes criminal background check (including fingerprinting), or, as an alternative, a background check from a licensed private investigation company, verification that the person's name does not appear on the State abuse registry, verification that the person's name does not appear on the State and national sexual offender registries and licensure verification, as applicable; complete all required training, including the training specified in Section A.2.9.7.7 of this Contract; complete all required applications to become a TennCare

provider; sign an abbreviated Medicaid agreement; are assigned a Medicaid provider ID number; and sign a service agreement.

2.9.7.6.1.1 A member cannot waive a background check for a potential worker. A background check may reveal a potential worker's past criminal conduct that may pose an unacceptable risk to the member. The following findings may place the member at risk and may disqualify a person from serving as a worker:

2.9.7.6.1.1.1 Conviction of an offense involving physical, sexual or emotional abuse, neglect, financial exploitation or misuse of funds, misappropriation of property, theft from any person, violence against any person, or manufacture, sale, possession or distribution of any drug; and

2.9.7.6.1.1.2 Entering of a plea of nolo contendere or when a jury verdict of guilty is rendered but adjudication of guilt is withheld with respect to a crime reasonably related to the nature of the position sought or held.

2.9.7.6.1.2 If a potential worker's background check includes past criminal conduct, the member must review the past criminal conduct with the help of the FEA. The member, with the assistance of the FEA, will consider the following factors:

2.9.7.6.1.2.1 Whether or not the evidence gathered during the potential worker's individualized assessment shows that the criminal conduct is related to the job in such a way that could place the member at-risk;

2.9.7.6.1.2.2 The nature and gravity of the offense or conduct, such as whether the offense is related to physical or sexual or emotional abuse of another person, if the offense involves violence against another person or the manufacture, sale or distribution of drugs; and;

2.9.7.6.1.2.3 The time that has passed since the offense or conduct and/or completion of the sentence;

2.9.7.6.1.3 After considering the above factors and any other evidence submitted by the potential worker, the member must decide whether to hire the potential worker.

2.9.7.6.1.4 If a member decides to hire the potential worker, the FEA shall assist the member in notifying the CONTRACTOR of this decision and shall collaborate with the CONTRACTOR to amend identified risks and mitigation strategies for CHOICES Group 2 and 3 members in the member's PCSP to reflect that the member voluntarily chose to take on the risk associated with hiring an individual with a criminal history and is solely responsible for any negative consequences stemming from that decision, or collaborate on a risk mitigation strategy for ECF CHOICES members.

2.9.7.6.2 Workers are not required to be contract providers. The CONTRACTOR shall not require a worker to sign a provider agreement or any other agreement not specified by TENNCARE.

2.9.7.6.3 Members shall have the flexibility to hire persons with whom they have a close personal relationship to serve as a worker, such as a neighbor or a friend.

2.9.7.6.4 Members may hire family members, excluding spouses, to serve as a worker. A family member shall not be reimbursed for a service that he/she would have otherwise provided without pay. The CONTRACTOR shall use the comprehensive assessment process (see Section A.2.9.6.5) to assess the member's available existing supports, including supports provided by family members.

2.9.7.6.5 A member may have multiple workers or both a worker and a contract provider for a given service, in which case, there must be a set schedule which clearly defines when contract providers will be utilized. A member may elect to have a worker provide more than one service.

2.9.7.6.6 A member shall develop a service agreement with each worker. The service agreement template shall be developed by TENNCARE and shall include, at a minimum: the roles and responsibilities of the worker and the member; the worker's schedule (as developed by the member and/or representative), including hours and days, which may be changed by the member based on needs and preferences (see A.2.9.7.5.6); the scope of each service, i.e., the specific tasks and functions the worker is to perform; the service rate; the worker's obligation to use the designated EVV system to check in and out of visits and the member's responsibility to ensure that the worker complies with EVV requirements; and the requested start date for services. The service agreement shall serve as the worker's written confirmation of his/her commitment to initiate services on or before the date specified and to provide services in accordance with specified terms (including the tasks and functions to be performed and the schedule at which care is needed). If necessary, the FEA shall assist in this process. Service agreements shall be updated anytime there is a change in any of the terms or conditions specified in the agreement. Service agreements shall be signed by the new representative when there is a change in representatives.

2.9.7.6.7 The service agreement shall also stipulate if a worker will provide one or more self-directed health care tasks, the specific task(s) to be performed, and the frequency of each self-directed health care task (see Section A.2.7 3).

2.9.7.6.8 The FEA shall ensure that a service agreement is in place for each worker prior to the worker providing services.

2.9.7.6.9 A copy of each service agreement shall be provided to the member and/or representative. The FEA shall give a copy of the service agreement to the worker and shall maintain a copy for its files.

2.9.7.6.10 A member may terminate a worker at any time if he/she feels that the worker is not adhering to the terms of the service agreement and/or is not providing quality services. If the FEA or Care Coordinator or Support Coordinator has concerns that a worker is unable to deliver appropriate care as prescribed in the service agreement and the PCSP, but the member and/or representative chooses to continue to employ the worker, the Care Coordinator or Support Coordinator shall note the concern and the member's choice to continue using the worker in the member's PCSP, and shall conduct a risk assessment as applicable and appropriate. The FEA and Care Coordinator or Support Coordinator shall collaborate to develop strategies to address identified issues and concerns. The FEA shall inform the member and/or representative of any potential risks associated with continuing to use the worker. The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to disenroll the member from consumer direction because a Care Coordinator

or Support Coordinator has determined that the health, safety and welfare of the member may be in jeopardy if the member continues to employ a worker but the member and/or representative does not want to terminate the worker. The CONTRACTOR and FEA shall abide by TENNCARE's decision.

2.9.7.6.11 A member shall have the flexibility to choose from a range of TENNCARE specified reimbursement levels for all eligible consumer directed HCBS, excluding companion care services which shall be reimbursed at the rate specified by TENNCARE.

2.9.7.6.12 In order to receive payment for services rendered, all workers must:

2.9.7.6.12.1 Deliver services in accordance with the member's plan of care or PCSP and the MCO's service authorization, and in accordance with worker assignments and the schedule determined by the member or his/her representative.

2.9.7.6.12.2 Maintain and submit documentation of service delivery (i.e., documentation of the tasks and functions performed during the provision of services), and any other documentation, as required, for units of service delivered.

2.9.7.6.12.3 Provide no more than forty (40) hours of services within a Sunday to Saturday work week, except as specified in Section A.2.9.7.6.12.4 below.

2.9.7.6.12.4 An ECF CHOICES member participating in consumer direction shall have the authority to assign a worker to provide services in accordance with the member's PCSP for more than forty (40) hours per week within a Sunday to Saturday week (work week) only under one of the following circumstances: (1) the number of units of service needed by the member can be handled with minimal overtime pay, and the member chooses to provide overtime pay in lieu of additional hours of service that could otherwise be provided within the member's approved consumer direction budget; or (2) the member chooses to have a worker previously scheduled to work no more than forty (40) hours cover additional time that another scheduled worker is unable to provide which shall be in lieu of additional hours of service that could otherwise be provided within the member's consumer direction budget. The CONTRACTOR shall ensure that the member understands that, should the member elect to allow a worker to provide services for more than forty (40) hours per work week, no additional funding will be allocated to the member's monthly budget for personal assistance or supportive home care, as applicable, or for persons receiving hourly respite, the member's annual budget, to cover the overtime pay.

2.9.7.7 <u>Training</u>

2.9.7.7.1 The CONTRACTOR shall require all members electing to enroll in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS and/or their representatives to receive relevant training. The FEA shall be responsible for providing or arranging for initial and ongoing training of members/representatives. When training is not directly provided by the FEA, the FEA shall validate completion of training. Initial training shall be completed prior to initiation of consumer-directed services.

2.9.7.7.2 At a minimum, consumer direction training for members and/or representatives shall address the following issues:

2.9.7.7.2.1 Understanding the role of members and representatives in consumer direction;

2.9.7.7.2.2 Understanding the role of the Care Coordinator or Support Coordinator and the FEA;

2.9.7.7.2.3 Selecting workers;

2.9.7.7.2.4 Abuse and neglect prevention and reporting;

2.9.7.7.2.5 Being an employer, evaluating worker performance and managing workers;

2.9.7.7.2.6 Fraud, waste, and abuse prevention and reporting;

2.9.7.7.2.7 Performing administrative tasks such as reviewing and approving timesheets;

2.9.7.7.2.8 The requirement that all consumer directed workers must utilize the designated EVV system to log in and out of all consumer directed visits, and that the member or representative must ensure their workers' compliance with the EVV system requirements in order for the member to receive services through consumer direction;

2.9.7.7.2.9 Scheduling workers and back-up planning; and

2.9.7.7.2.10 Ensuring workers maintain daily communication notes for authorized services provided.

2.9.7.7.3 Ongoing training shall be provided by the FEA to members and/or representatives upon request and/or if a Care Coordinator or Support Coordinator or FEA, through monitoring, determines that additional training is warranted.

2.9.7.7.4 The FEA shall be responsible for providing or arranging for initial and ongoing training of all workers. When training is not directly provided by the FEA, the FEA shall validate completion of training. Initial training shall be completed prior to initiation of services. At a minimum, training shall consist of the following required elements:

2.9.7.7.4.1 Overview of the CHOICES program and consumer direction of eligible CHOICES HCBS or overview of the ECF CHOICES program and consumer direction of eligible ECF CHOICES HCBS, as applicable;

2.9.7.7.4.2 Providing person-centered support for older adults, adults with physical disabilities or individuals with intellectual or developmental disabilities, as applicable;

2.9.7.7.4.3 Abuse and neglect identification and reporting;

2.9.7.7.4.4 Fraud, waste, and abuse identification and reporting;

2.9.7.7.4.5 Critical incident and Reportable Event reporting;

2.9.7.7.4.6 Submission of required documentation and withholdings;

2.9.7.7.4.7 Use of the time keeping system;

2.9.7.7.4.8 As appropriate and only for members in CHOICES, administration of self-directed health care task(s). The member or his/her representative shall be responsible for training the worker(s) regarding individualized service needs and preferences and for specific training regarding health care tasks the member or his/her representative elects to self-direct (as applicable); and

2.9.7.7.4.9 Universal precautions and blood borne pathogens training.

2.9.7.7.5 The FEA shall assist the member/representative in determining to what extent the member/representative shall be involved in the above-specified training. The member/ representative) shall provide additional training to the worker regarding individualized service needs and preference.

2.9.7.7.6 The FEA shall verify that workers have successfully completed all required training prior to service initiation and payment for services.

2.9.7.7.7 The FEA shall be responsible for verifying and validating the worker's completion of required CPR and First Aid training from an approved provider prior to initiation of services and payment for services. Ongoing, the FEA shall ensure that workers maintain CPR and first aid certification and receive required refresher training as a condition of continued employment. The FEA may assist workers in locating appropriate courses for initial certification and recertification as appropriate. Additional training components may be provided to a worker to address issues identified by the FEA, Care Coordinator or Support Coordinator, member and/or the representative or at the request of the worker.

2.9.7.7.8 Refresher training may be provided more frequently if determined necessary by the FEA, Care Coordinator or Support Coordinator, member and/or representative or at the request of the worker.

2.9.7.8 <u>Monitoring</u>

2.9.7.8.1 The CONTRACTOR shall monitor the quality of service delivery and the health, safety and welfare of members participating in consumer direction through the CHOICES care coordination or ECF CHOICES support coordination functions.

2.9.7.8.2 The CONTRACTOR shall monitor service utilization by consumer-directed members.

2.9.7.8.3 The CONTRACTOR shall monitor implementation of the back-up plan by the member or his/her representative.

2.9.7.8.4 The CONTRACTOR shall monitor a member's participation in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS to determine, at a minimum, the success and the viability of the service delivery model for the member. The CONTRACTOR shall note any patterns, such as frequent turnover of representatives or workers, habitual mismanagement of authorized services, failure to cooperate with the FEA and changing between consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS and contract providers that may warrant intervention by the CONTRACTOR. The CONTRACTOR may submit a request to TENNCARE, pursuant to TennCare policy, to involuntarily withdraw the member from consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS if the CONTRACTOR has concerns about its ability to protect the

health, safety and welfare of the member (see Section A.2.9.7.9.4). The FEA may submit a request to the CONTRACTOR to involuntarily withdraw the member from consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS due to concerns regarding the member's health, safety and welfare if the member continues in consumer direction. The CONTRACTOR must submit copies of all such requests to TENNCARE with documentation of its decision.

2.9.7.8.5 If at any time abuse or neglect is suspected, the member's Care Coordinator or Support Coordinator or the FEA shall report the allegations to the CONTRACTOR within twenty-four (24) hours in accordance with the abuse and neglect plan protocols developed by the CONTRACTOR for CHOICES members and in accordance with timeframes set forth in TennCare's Reportable Events protocol for ECF CHOICES members. The CHOICES notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. For ECF CHOICES, notification shall be provided in a form and format prescribed by TENNCARE. If the allegation concerns physical or sexual abuse and is in reference to a worker or representative, the FEA shall contact the member/representative to determine if the member/representative wants to place the worker on unpaid leave until DIDD or the MCO, as applicable, has completed its investigation. If the representative is the subject of the allegation, the representative shall not be allowed to decide whether to take leave, and such a decision shall solely be up to the member. The member/representative may additionally decide to remove staff at their discretion for allegations concerning other Tier 1 or Tier 2 incidents in ECF CHOICES (see Section A.2.15.7.6) or critical incidents in CHOICES, as applicable as those incidents are defined in this Contract in Section A.2.15.7. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative's decision. The Care Coordinator or Support Coordinator shall work with the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, and result in placement on any registry included in Section A.2.29.2.2, then the representative and/or worker shall no longer be allowed to participate in the CHOICES or ECF CHOICES program in any capacity. If the investigation does not result in such placement, then the member may elect to retain the worker or representative. The member's Care Coordinator or Support Coordinator, with appropriate assistance from the FEA, shall conduct a risk assessment and make any needed updates to the member's PCSP deemed necessary to help ensure the member's health and safety, and the CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction. In the event a representative of a member who does not have decision-making capacity is alleged to have committed abuse, neglect, or exploitation against the member, the representative shall immediately be removed from his or her representative capacity during the investigation. During such removal, the member's participation in Consumer Direction shall be suspended. If the investigation concludes the allegations against the representative are unsubstantiated, both the member's and the representative's participation in Consumer Direction shall be reinstated. However, if the allegations against the representative are substantiated, the CONTRACTOR shall work with the member to identify a replacement representative for Consumer Direction. If a replacement representative cannot be identified within ten (10) business days from completion of the investigation, the member shall be disenrolled from Consumer Direction.

2.9.7.9 Withdrawal from Consumer Direction of Eligible CHOICES HCBS

2.9.7.9.1 A member may voluntarily withdraw from consumer direction of eligible CHOICES HCBS at any time. The member and/or representative shall notify the Care Coordinator or Support Coordinator as soon as he/she determines that he/she is no longer interested in participating in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS.

2.9.7.9.2 Upon receipt of a member's request to withdraw from consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS, the CONTRACTOR shall conduct a face-to-face visit and update the member's plan of care or PCSP, as appropriate, to initiate the process to transition the member to contract providers.

2.9.7.9.3 In the event that the FEA or Care Coordinator or Support Coordinator has concerns that a worker is unable to deliver appropriate care as prescribed in the service agreement and the PCSP, but the member and/or representative chooses to continue to employ the worker, note the concern and the member's choice to continue using the worker in the member's PCSP, and shall include any updates to identified risks and corresponding mitigation strategies as applicable and needed.

2.9.7.9.4 The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to disenroll a member from consumer direction. The CONTRACTOR may initiate involuntary withdrawal of a member from consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS:

2.9.7.9.4.1 If a member's representative fails to perform in accordance with the terms of the representative agreement and the health, safety and welfare of the member is at risk, and the member wants to continue to use the representative.

2.9.7.9.4.2 If a member has consistently demonstrated that he/she is unable to manage, with sufficient supports (including appointment of a representative) his/her services and the Care Coordinator or Support Coordinator or FEA has identified health, safety and/or welfare issues.

2.9.7.9.4.3 A Care Coordinator or Support Coordinator has determined that the health, safety and welfare of the member may be in jeopardy if the member continues to employ a worker but the member and/or representative does not want to terminate the worker.

2.9.7.9.4.4 Other significant concerns regarding the member's participation in consumer direction which jeopardize the health, safety or welfare of the member.

2.9.7.9.4.5 If a member's worker(s) fail(s) to consistently follow EVV procedures, utilize designated EVV system, and comply with all EVV requirements prescribed by the 21st Century Cures Act including, but not limited to, the use of appropriate EVV methods to check in and out of each consumer directed visit.

2.9.7.9.5 If TENNCARE approves the CONTRACTOR's request, the CONTRACTOR shall notify the member in accordance with TennCare rules and regulations, and the member shall have the right to appeal the determination (see Section A.2.19.3.12 of this Contract).

2.9.7.9.6 The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition from workers to contract providers and ensure there are no interruptions or gaps in services.

2.9.7.9.7 Voluntary or involuntary withdrawal of a member from consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS shall not affect a member's eligibility for long-term services and supports or enrollment in CHOICES or ECF CHOICES.

2.9.7.9.8 The CONTRACTOR shall notify the FEA within one business day of processing the outbound 834 enrollment file when a member voluntarily withdraws from consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS, when a member is involuntarily withdrawn from consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS, and when a member is disenrolled from CHOICES or ECF CHOICES or from TennCare. The notification should include the effective date of withdrawal and/or disenrollment, as applicable.

2.9.7.9.9 Members who have been involuntarily withdrawn may request to be reinstated in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS. The Care Coordinator or Support Coordinator shall work with the FEA to ensure that the issues previously identified as reasons for withdrawal have been adequately addressed prior to reinstatement. All members shall be required to participate in consumer direction training programs prior to re-instatement in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS.

2.9.7.9.10 Claims Submission and Payment

2.9.7.9.10.1 The CONTRACTOR shall reimburse the FEA for authorized eligible CHOICES HCBS or authorized eligible ECF CHOICES HCBS provided by workers at the appropriate rate for the consumer-directed services, which includes applicable payroll taxes.

2.9.7.9.10.2 The CONTRACTOR shall process and pay claims submitted by the FEA within fourteen (14) calendar days of receipt.

A.2.9.8 **Coordination and Collaboration for Members with Behavioral Health Needs**

2.9.8.1 General

As provided in Section A.2.6.1 of this Contract, the CONTRACTOR shall be responsible for providing a full continuum of physical health, behavioral health, and long-term services and supports. The CONTRACTOR shall also be responsible for ensuring continuity and coordination between covered physical health, behavioral health, and long-term services and supports and ensuring collaboration between physical health, behavioral health, and long-term services and supports 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 services and supports needs, exchange of information, confidentiality, assessment, treatment plan and PCSP development and implementation, collaboration, care coordination (for CHOICES

members), support coordination (for ECF CHOICES members) and Population Health, provider training, and monitoring implementation and outcomes.

2.9.8.2 Subcontracting for Behavioral Health Services

If the CONTRACTOR subcontracts for the provision of behavioral health services, the CONTRACTOR shall develop and implement a written agreement with the subcontractor regarding the coordination of services provided by the CONTRACTOR and those provided by the subcontractor. The agreement shall address the responsibilities of the CONTRACTOR and the subcontractor regarding, at a minimum, the items identified in Section A.2.9.8.1 as well as prior authorization, claims payment, claims resolution, contract disputes, and reporting. The subcontract shall comply with all of the requirements regarding subcontracts included in Section A.2.26 of this Contract.

2.9.8.3 Screening for Behavioral Health Needs

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

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

2.9.8.3.3 As part of the care coordination and support coordination processes (see Section A.2.9.6), the CONTRACTOR shall ensure that behavioral health needs of CHOICES and ECF CHOICES members are identified and addressed.

2.9.8.4 Referrals to Behavioral Health Providers

The CONTRACTOR shall ensure through screening that members with a need for behavioral health services, particularly priority enrollees are appropriately referred to behavioral health providers. The CONTRACTOR shall develop provider education and training materials to ensure that physical health and long-term services and supports providers know when and how to refer members who need specialty behavioral health services. This shall include education about behavioral health services, including the recovery process and resilience for children. The CONTRACTOR shall develop a referral process to be used by its providers, including what information must be exchanged and when to share this information, as well as notification to the member's Care Coordinator or Support Coordinator.

2.9.8.5 Referrals to PCPs

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

2.9.8.6 Referrals to CHOICES and ECF CHOICES

The CONTRACTOR shall ensure that members with both long-term services and supports and behavioral health needs are referred to the CONTRACTOR for CHOICES or ECF CHOICES screening and intake (see Section A.2.9.6.3). The CONTRACTOR shall develop provider education and training materials to ensure that behavioral health providers know when and how to refer members who need long-term services and supports to the CONTRACTOR.

2.9.8.7 Behavioral Health Assessment and Treatment Plan

The CONTRACTOR's policies and procedures shall identify the role of physical health and behavioral health providers in assessing a member's behavioral health needs and developing an individualized treatment plan. For members with chronic physical conditions that require ongoing treatment who also have behavioral health needs, the CONTRACTOR shall encourage participation of both the member's physical health provider (PCP or specialist) and behavioral health provider in the assessment and individualized treatment plan development process as well as the ongoing provision of services. For CHOICES members in Groups 2 and 3 and ECF CHOICES with behavioral health needs, the member's Care Coordinator or Support Coordinator shall encourage participation of the member's behavioral health provider in the care planning or PCSP process and shall incorporate relevant information from the member's behavioral health treatment plan (see Section A.2.7.2.1.4) in the member's plan of care or PCSP (see Section A.2.9.6.6). For any member with I/DD receiving such services in the System of Support (SOS) model, the Support Coordinator shall participate as a member of the SOS team, and shall ensure that the Crisis Prevention, Intervention and Stabilization Plan developed in the SOS model is incorporated into the PCSP, as appropriate.

2.9.8.8 MCO Case Management, Disease Management, and CHOICES Care Coordination or ECF CHOICES Support Coordination

The CONTRACTOR shall use its Population Health, and CHOICES care coordination or ECF CHOICES support coordination programs (see Sections A.2.8, and A.2.9.6) to support the continuity and coordination of covered physical health, behavioral health, and long-term services and supports and the collaboration between physical health, behavioral health, and long-term services and supports 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 A.2.8.3), to be enrolled in an appropriate level Population Health Program (see Section A.2.8.4 of this Contract). For CHOICES and ECF CHOICES members, Population Health activities shall be integrated with the care coordination or support coordination process (see Section A.2.9.6.1.9).

2.9.8.9 Monitoring

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

A.2.9.9 **Coordination and Collaboration Among Behavioral Health Providers**

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

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

2.9.9.1.2 Determination of the method of mental health screening to be completed by substance abuse service providers; screening and assessment tools to be designated by TENNCARE;

2.9.9.1.3 Determination of the method of substance abuse screening to be completed by mental health service providers; screening and assessment tools to be designated by TENNCARE;

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

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

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

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

2.9.9.3.1 The outpatient provider shall be involved in the admissions process when possible; if the outpatient provider is not involved, the outpatient provider shall be notified promptly of the member's hospital admission;

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

2.9.9.3.3 An evaluation shall be performed prior to discharge to determine what if any mental health or substance abuse services are medically necessary. Once deemed medically necessary, the referring outpatient provider shall be involved in the discharge planning; and

2.9.9.3.4 A procedure to ensure continuity of care regarding medication shall be developed and implemented.

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

2.9.9.5 The CONTRACTOR is responsible for providing a discharge plan as outlined in Section A.2.9.9.3.2.

A.2.9.10 **Coordination of Pharmacy Services**

2.9.10.1 Except as provided in Section A.2.6.1.3, the CONTRACTOR is not responsible for the provision of pharmacy benefits; TENNCARE contracts with a pharmacy benefits manager (PBM) to provide these services. However, the CONTRACTOR shall maintain an agreement with the PBM for the purpose of making payment to the PBM on behalf of TENNCARE for TennCare covered services. This requirement does not impose any further responsibilities on the CONTRACTOR regarding the provider's and/or provider's claims that are reimbursed through this payment structure. The CONTRACTOR shall not be at risk for payment made to the TennCare contracted PBM (see Section C.3). The CONTRACTOR shall coordinate with the PBM as necessary to ensure that members receive appropriate pharmacy services without interruption. The CONTRACTOR shall monitor and manage its contract providers as it relates to prescribing patterns and its members as it relates to utilization of prescription drugs. The CONTRACTOR shall participate in regularly scheduled meetings with the PBM and TENNCARE to discuss operational and programmatic issues.

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

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

2.9.10.3.1 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; if a CHOICES or ECF CHOICES member is identified as a high-utilizer or as inappropriately using pharmacy services, including psychotropic medications, relevant prescription drug data and/or reports for the member shall be provided to the member's Care Coordinator or Support Coordinator, and the Care Coordinator or Support Coordinator shall take appropriate next steps, which may include coordination with the member's PCP or other licensed prescriber;

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

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

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

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

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

2.9.10.4.3 Support drug utilization review program that meets the requirements of Section 1902(oo) of the Social Security Act. Support of drug utilization review program shall include:

2.9.10.4.3.1 Pharmacy claims review relating to subsequent fills of opioid prescriptions and a claims review automated process that indicates when a member is prescribed a subsequent fill of opioids in excess of limits specified by the State;

2.9.10.4.3.2 Pharmacy claims review relating to the maximum daily morphine equivalent that can be prescribed for treatment of chronic pain and a claims review automated process that indicates when a member is prescribed MME in excess of limitations specified by the State; and

2.9.10.4.3.3 Pharmacy claims review automated process that monitors concurrent prescribing of opioids and benzodiazepines and concurrent prescribing of opioids and antipsychotics.

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

A.2.9.11 **Coordination of Dental Benefits**

2.9.11.1 <u>General</u>

2.9.11.1.1 The CONTRACTOR is not responsible for the provision and payment of dental benefits, including dental benefits in ECF CHOICES; TENNCARE contracts with a dental benefits manager (DBM) to provide these services.

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

2.9.11.1.3 The CONTRACTOR may require prior authorization for services related to dental services including the facility, anesthesia, and/or medical services related to the dental service. However, the CONTRACTOR may waive authorization of said services based upon authorization of the dental services by the dental benefits manager. The CONTRACTOR shall approve and arrange transportation to and from dental services in accordance with this Contract, including but not limited to Attachment XI.

2.9.11.2 Services and Responsibilities

The CONTRACTOR shall coordinate with the DBM and/or the ID HCBS waiver contractor for dental services. Coordination of dental services, at a minimum, includes establishing processes for:

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

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

2.9.11.2.3 Report to TENNCARE all facilities (Inpatient and/or Outpatient) that provide available time in their operating room(s) for Dentists and Oral Surgeons on a regular basis and on a case by case basis in a form and format described by TENNCARE;

2.9.11.2.4 Provide the DBM with the name and contact information of a facility willing to take a specific case within ten (10) days of a request by the DBM;

2.9.11.2.5 Maintenance of confidentiality;

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

2.9.11.2.7 Cooperation with the DBM regarding training activities provided by the DBM such as fluoride varnish, silver diamine fluoride (SDF), training related to the importance of oral health during pregnancy, etc.;

2.9.11.2.8 Notifying the DBM when dental services have been approved as part of the PCSP, as well as the amount approved in the PCSP for such services; and

2.9.11.2.9 Ensuring that the cost of dental services provided by the DBM are accounted for when determining the cost of ECF CHOICES HCBS provided to a member that must be counted against the member's expenditure cap.

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

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

2.9.11.3 Operating Principles

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

2.9.11.4 Resolution of Requests for Prior Authorization

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

2.9.11.4.2 The CONTRACTOR shall assign staff members to serve on a coordination committee with DBM staff members. This committee shall be responsible for addressing all issues of dental care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Contract. The CONTRACTOR and the DBM shall attempt in good faith to resolve any dispute and communicate the decision to the provider requesting prior authorization of a service. In the event the CONTRACTOR and the DBM cannot agree within ten (10) calendar days of the provider's request for prior authorization, the party who first received the request from the provider shall be responsible for prior authorization and payment to the contract provider within the time frames designated by TENNCARE. The CONTRACTOR and the DBM are responsible for enforcing hold harmless protection for the member. The CONTRACTOR shall ensure that any response to a request for authorization shall not exceed fourteen (14) calendar days and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations.

2.9.11.5 Claim Resolution Processes

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

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

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

2.9.11.5.4 If the Claims Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) calendar days of the initial referral to the Claims Coordination Committee, said claim shall be referred to both the CONTRACTOR's and the DBM's CEO or the CEO's designee, for resolution immediately. A meeting shall be held among the CEOs or their designee(s) as soon as possible, but not longer than ten (10) calendar days after the meeting of the Claims Coordination Committee.

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

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

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

2.9.11.5.8 The State or its designee shall make a decision in writing regarding who is responsible for the payment of services within ten (10) calendar days of the receipt of the required information ("Decision"). The Decision may reflect a split payment responsibility that designates specific proportions to be paid by the MCO and the DBM. The Decision shall be determined solely by the State or its designee based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the State, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars ($1,000), for each Request for Resolution. The amount of the DBM's or MCO's payment responsibility shall be contained in the State's Decision. These payments may be made with reservation of rights regarding any judicial resolution. If a party fails to pay the State for the party's payment responsibility as described in this Section, Section A.2.9.11.5.8, within thirty (30) calendar days of the date of the State's Decision, the State may deduct amounts of the payment responsibility from any current or future amount owed the party by the State.

2.9.11.6 <u>Denial, Delay, Reduction, Termination or Suspension</u>

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

2.9.11.7 <u>Emergencies</u>

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

2.9.11.8 Claims Processing Requirements

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

2.9.11.9 Appeal of Decision

Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, TCA 4-5-201 *et seq*. Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section, Section A.2.9.11.9

2.9.11.10 Duties and Obligations

The existence of any dispute under this Contract shall in no way affect the duty of the CONTRACTOR and the DBM to continue to perform their respective obligations, including their obligations established in their respective contracts with the State pending resolution of the dispute under this Section, Section A.2.9.11.10. In accordance with TCA 56-32-126(b), a provider may elect to resolve the claims payment dispute through independent review.

2.9.11.11 Confidentiality

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

2.9.11.11.2 The DBM and MCO shall ensure all materials and information directly or indirectly identifying any current or former member which is provided to or obtained by or through the MCO's or DBM's performance of this Contract, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of TCA 33-4-22, Section E.6 of this Contract, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, unless required by applicable law, shall not be disclosed except in accordance with those requirements or to TENNCARE, and CMS, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former member or potential member.

2.9.11.12 Access to Service

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

A.2.9.12 **Coordination with Medicare**

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

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

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

A.2.9.13 **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**

2.9.13.1 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.

2.9.13.2 The CONTRACTOR shall coordinate with a FBDE member's D-SNP regarding discharge planning from any inpatient setting or observation stay 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.

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

2.9.13.2.2 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.

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

2.9.13.2.4 The CONTRACTOR shall establish processes to ensure that all required notifications from the member's D-SNP to the CONTRACTOR of inpatient admission, including planned and unplanned admissions to the hospital or a SNF, as well as all required notifications of observation days and any reported emergency room visits, are timely and appropriately triaged.

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

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

2.9.13.3 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.

2.9.13.3.1 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 or ECF CHOICES LTSS from a FBDE member's D-SNP, including communication with the member's Care Coordinator or Support 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.

2.9.13.4 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 or ECF CHOICES program.

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

2.9.13.5 The CONTRACTOR shall request, when appropriate, the D-SNP's participation in comprehensive assessments and/or the development of an integrated PCSP for a TennCare CHOICES member or PCSP for an ECF CHOICES member, encompassing Medicare benefits provided by the CONTRACTOR as well as Medicaid benefits provided by the TennCare MCO. When the D-SNP is participating in the comprehensive assessment and/or development of an integrated PCSP for a CHOICES or ECF CHOICES member, the CONTRACTOR shall submit the PCSP for such CHOICES and ECF CHOICES members enrolled in a D-SNP to the member's D-SNP within two (2) business days of developing the PCSP and within two (2) business days of any substantive updates to the member's PCSP.

2.9.13.5.1 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 or ECF CHOICES comprehensive assessment/care planning process for a FBDE member, including the roles/responsibilities of the TennCare MCO and the D-SNP.

2.9.13.6 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.

2.9.13.6.1 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.

2.9.13.7 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.

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

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

2.9.13.8 The CONTRACTOR shall, pursuant to Section A.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.

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

2.9.13.9 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 and ECF CHOICES.

2.9.13.10 For dual eligible members aligned in the CONTRATOR's MCO for Medicaid benefits and the CONTRACTOR's D-SNP for Medicare benefits, the CONTRACTOR shall manage all Medicaid and Medicare benefits locally (i.e., in Tennessee) and in an integrated manner.

2.9.13.10.1 There shall be a single point of coordination for aligned full benefit dual eligible members across the member's Medicaid and Medicare benefits.

2.9.13.10.2 The Care Coordinator of any dual eligible member enrolled in CHOICES and in the CONTRACTOR's D-SNP and the Support Coordinator of any dual eligible member enrolled ECF CHOICES and in the CONTRACTOR's D-SNP shall be responsible for coordinating the full range of Medicaid, including LTSS, and Medicare benefits, have access to all of the information needed to do so, and the CONTRACTOR's systems and business process shall support an integrated approach to care coordination and service delivery. The CONTRACTOR shall ensure that all available Medicare claims data, including data from the CONTRACTOR's D-SNP, and Medicare claims data made available by TennCare, is loaded into the case management system described in 2.9.6.13.11, for purposes of care coordination or support coordination.

2.9.13.10.3 The CONTRACTOR's systems shall be configured and the CONTRACTOR's operations shall be structured to facilitate the coordination of Medicaid and Medicare services in an integrated way. This includes the availability of consistent data for care coordination or support coordination purposes across both the Medicaid and D-SNP plans. This is particularly crucial for CHOICES and ECF CHOICES members and members identified for CHOICES or ECF CHOICES screening.

A.2.9.14 **ICF/IID Services and Alternatives to ICF/IID Services**

2.9.14.1 The CONTRACTOR is not responsible for services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or for services provided through Section 1915(c) Home and Community Based Services (HCBS) waivers operated by the Department of Intellectual and Developmental Disabilities as an alternative to ICF/IID services (hereinafter referred to as "HCBS ID waiver"). However, to the extent

that services available to a member through a HCBS ID waiver are also covered services pursuant to this Contract, the CONTRACTOR shall be responsible for providing all medically necessary covered services. HCBS ID waiver services may supplement, but not supplant, medically necessary covered services. ICF/IID services and HCBS ID waiver services shall be provided to qualified members as described in TennCare rules and regulations through contracts between TENNCARE and appropriate providers.

2.9.14.2 The CONTRACTOR is responsible for covered services for members residing in an ICF/IID or enrolled in a HCBS ID waiver. For members residing in an ICF/IID, the CONTRACTOR is responsible for providing covered services that are not included in the per diem reimbursement for institutional services (e.g., certain items of durable medical equipment, non-emergency ambulance transportation, and non-emergency transportation). Except as provided below for NEMT, for members enrolled in a HCBS ID waiver, the CONTRACTOR shall provide all medically necessary covered services, including covered services that may also be provided through the HCBS ID waiver. The HCBS ID waiver is the payor of last resort. However, the CONTRACTOR is not responsible for providing non-emergency medical transportation (NEMT) to any service that is being provided to the member through the HCBS ID waiver.

2.9.14.3 The CONTRACTOR shall coordinate the provision of covered services with services provided by ICF/IID and HCBS ID waiver providers to minimize disruption and duplication of services.

2.9.14.3.1 If a member receiving home health or private duty nursing services will be subject to a reduction in covered services provided by the CONTRACTOR upon turning twenty-one (21) years of age and the member also receives 1915(c) HCBS Waiver services, the CONTRACTOR, DIDD, and the Independent Support Coordinator (ISC) as applicable shall, pursuant to policies and processes established by TENNCARE, coordinate benefits to implement any changes in 1915(c) HCBS Waiver Services at the same time that MCO services are reduced to ensure as seamless a transition as possible. If a member is enrolled in a 1915(c) HCBS Waiver and has a need for supports not available in that Waiver or requests transition to CHOICES or ECF CHOICES, the CONTRACTOR shall refer that member to TENNCARE for transition as appropriate.

2.9.14.4 The CONTRACTOR shall be responsible for the ECF CHOICES HCBS provided to a member with intellectual or developmental disabilities enrolled in ECF CHOICES.

A.2.9.15 **Inter-Agency Coordination**

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

2.9.15.1 Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) and Tennessee Department of Intellectual and Developmental Disabilities (DIDD) for the purpose of interfacing with and assuring continuity of care, for coordination of specialized services in accordance with federal PASRR requirements, and for avoiding inappropriate admission of individuals with I/DD to an RMHI and/or coordinating timely discharge of individuals with I/DD from an RMHI, which shall include:

2.9.15.1.1 2.9.15.1.1 Ongoing tracking and coordination of members with I/DD experiencing a behavioral health crisis and referred for placement in an RMHI in order to divert the member from placement in an RMHI unless it is the most appropriate treatment setting;

2.9.15.1.2 2.9.15.1.2 Immediate engagement and coordinated post-discharge planning for any member with I/DD admitted to an RMHI to facilitate timely transition to the appropriate sub-acute or community placement, with follow-up as appropriate to ensure stabilization and avoid readmission;

2.9.15.1.3 2.9.15.1.3 Weekly case conferences between the CONTRACTOR's Behavioral Health Director, Behavior Supports Director, and other Behavioral Health leads, as appropriate, and each RMHI, TENNCARE and DIDD regarding the CONTRACTOR's members with I/DD referred to or receiving services in an RMHI; and

2.9.15.1.4 2.9.15.1.4 Monthly reporting to TENNCARE as described in Section A.2.30.6.10 regarding the CONTRACTOR's performance as it relates to avoiding inappropriate admission of individuals with I/DD to an RMHI and/or coordinating timely discharge of individuals with I/DD from an RMHI.

2.9.15.2 Tennessee Department of Children's Services (DCS) for the purpose of interfacing with and assuring continuity of care;

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

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

2.9.15.5 Tennessee Department of Intellectual Disabilities Services (DIDD), for the purposes of coordinating physical and behavioral health services with HCBS available for members who are also enrolled in a Section 1915(c) HCBS waiver for persons with intellectual disabilities, for purposes of ECF CHOICES, intake, critical incident reporting and management, quality monitoring, and programmatic leadership, oversight, and statewide coordination of ECF Groups 7 and 8; and building the statewide capacity and continuum of the behavioral health system to meet the needs of individuals with I/DD who have co-occurring mental health conditions or behavioral support needs in a person-centered way.

2.9.15.5.1 Programmatic leadership, oversight and statewide coordination of Groups 7 and 8, and development of statewide behavioral health capacity shall include:

2.9.15.5.1.1 Review and approval (or denial) of referrals for enrollment into Groups 7 and 8 as a part of the Interagency Review Committee;

2.9.15.5.1.2 Leadership, coordination and direction of Interagency Review Committee processes for Groups 7 and 8;

2.9.15.5.1.3 Review of MCO referrals for admission of any member with I/DD to an inpatient behavioral health setting, and consultation with MCO behavioral health and behavior supports staff regarding the most appropriate treatment setting;

2.9.15.5.1.4 Leadership, oversight, and support of the CONTRACTOR's coordination responsibilities between the CONTRACTOR and DMHSAS to facilitate timely discharge of individuals with I/DD from an RMHI, as described in 2.9.15.1.1 through 2.9.15.1.4;

2.9.15.5.1.5 Review, consultation, and approval of discharge plans for a member with I/DD from an RMHI or other inpatient behavioral health setting, including, but not limited to members enrolled in Groups 7 and 8;

2.9.15.5.1.6 Review, consultation, and approval of the CONTRACTOR's provider network for the provision of IBFCTSS in Group 7 and IBCTSS in Group 8, and broader network capacity for transition and ongoing support once stabilization is achieved, as well as direct assistance in developing the capacity of such networks;

2.9.15.5.1.7 Statewide support, technical assistance, coordination and oversight of the CONTRACTOR's development of statewide capacity for behavioral crisis and stabilization response specific to the needs of individuals with I/DD, leveraging telehealth with in-person backup as needed. To the extent service is provided directly by DIDD, the CONTRACTOR shall contract with DIDD for the provision of this service at a rate to be determined by TENNCARE;

2.9.15.5.1.8 Statewide support, technical assistance, coordination, and oversight of the CONTRACTOR's development of statewide capacity for rapid placement, intensive therapeutic behavioral stabilization, medication management (as applicable), and comprehensive person-centered assessment specifically targeted to the needs of individuals with I/DD, including person-centered transition planning with the HCBS provider and/or family caregiver (as applicable); program development and implementation (including training), and post-transition stabilization placement support (telehealth and in-person). To the extent this service is provided directly by DIDD, the CONTRACTOR shall contract with DIDD for the provision of this service at a rate to be determined by TENNCARE;

2.9.15.5.1.9 Ongoing monitoring, technical assistance, and support of the quality of services delivered by contracted providers to members enrolled in Group 7 or Group 8, with a primary focus on IBFCTSS and IBCTSS, Such activities shall include, but is not limited to: monthly review of data submitted by the MCO to TENNCARE, onsite review by a qualified I/DD professional with sufficient experience to adequately monitor the quality of care delivered by contracted providers to each of the CONTRACTOR's members enrolled in these Groups, and ongoing training, technical assistance and support of the CONTRACTOR and its contracted providers to help ensure quality and cost efficiency of services delivered to members in these Groups and to improve quality outcomes;

2.9.15.5.1.10 Review and approval of plans for transition of a Group 7 or Group 8 member to a different benefit group, and the support and oversight of the timely and effective implementation of such plans;

2.9.15.5.1.11 Post-transition stabilization review, monitoring, support and assistance as needed to ensure the adequacy of ongoing behavior supports;

2.9.15.5.1.12 Any other responsibility as defined in the Interagency Agreement between TENNCARE and DIDD and/or set forth by TENNCARE in policies or protocols.

2.9.15.5.2 In addition, the CONTRACTOR shall partner with TENNCARE and DIDD to:

2.9.15.5.2.1 Embed person-centered thinking, planning, and practices and align key requirements and processes across Medicaid programs and authorities in order to create a single, seamless person-centered system of service delivery for people with I/DD, including: critical incident management, quality assurance and improvement, direct support workforce training and qualifications, provider qualifications and enrollment/credentialing processes, value-based reimbursement approaches aligned with system values and outcomes;

2.9.15.5.2.2 Increase the capacity, competency and consistency of the direct support workforce, including a reduction in workforce turnover and the ability to consistently demonstrate compliance in the timely initiation of services and the ongoing provision of services as specified in the person-centered support plan;

2.9.15.5.2.3 Support the independence, integration, and competitive, integrated employment of individuals with I/DD through the use of effective person-centered planning, enabling technology, and the development of natural supports, including the implementation of a Technology First approach across the CHOICES and ECF HCBS programs; training and support for care and support coordinators in person-centered assessment and planning for independence; engaging occupational and physical therapists and/or certified Assistive Technology Professionals, as needed, as a member of the care team (whether contracted or employed by the CONTRACTOR) to provide in-home assessments and recommendations pertaining to the use of technology to support safety, independence and integration; displacement prevention; and supporting transformation of contracted providers to a Technology First approach in providing services and supports;

2.9.15.5.2.4 Build the statewide capacity and continuum of the behavioral health system to meet the needs of individuals with I/DD who have co-occurring mental health conditions or behavior support needs in a person-centered way (moving toward independence and integration to the maximum extent appropriate), including:

2.9.15.5.2.5 The successful implementation of Groups 7 and 8 in Employment and Community First CHOICES;

2.9.15.5.2.6 The development and engagement of statewide HCBS provider networks, including workforce capacity, to serve people with I/DD and co-occurring behavior support needs;

2.9.15.5.2.7 The development of statewide capacity for behavioral crisis response and stabilization, leveraging telehealth with in-person backup as needed;

2.9.15.5.2.8 The development of statewide capacity for rapid placement, stabilization and assessment, including person-centered transition planning with the HCBS provider and/or family caregiver (as applicable); program development and implementation (including training), and post-transition stabilization placement support (telehealth and in-person);

2.9.15.5.2.9 Observation, and upon request and as appropriate, participation in DIDD Human Rights Committee and likewise, inviting DIDD to observe and as appropriate, participate in the CONTRACTOR's HCBS Settings Compliance Committee to promote learning and a consistent person-centered approach to reviewing restrictions in PCSPs; and

2.9.15.5.2.10 Other opportunities for collaboration as determined by TENNCARE in order to develop and enhance the service delivery system for individuals with I/DD, improve person-centered outcomes, and provide services in a cost-efficient manner.

2.9.15.6 Area Agencies on Aging and Disability (AAADs) regarding intake of members new to both TENNCARE and CHOICES;

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

2.9.15.7.1 The CONTRACTOR is responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers to manage the care of students with special needs. DOE and local education agencies are responsible to document when a school-aged child has a need for medical services in an Individualized Education Plan (IEP). If the child is enrolled in TennCare, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO in a manner required by the MCO. The CONTRACTOR shall determine whether it chooses to receive the IEP and parental consent prior to providing and paying for identified medically necessary covered services or upon request during a post payment audit.

2.9.15.7.2 The CONTRACTOR may choose to provide the medically necessary covered services identified either within the school setting or outside the school setting. The CONTRACTOR may require a school based provider billing for covered services be a participating provider in the CONTRACTOR's network.

2.9.15.7.3 The CONTRACTOR may choose not to require DOE to send eligible students' IEPs to the CONTRACTOR prior to the CONTRACTOR being responsible to pay for the medically-necessary covered services.

2.9.15.7.3.1 If the CONTRACTOR has chosen not to receive an IEP in advance of paying for covered services in the school based setting, the CONTRACTOR shall, at a minimum, conduct regular post payment sample audits of IEPs and all other documentation to support the medical necessity of the school based services reimbursed by the CONTRACTOR. When the CONTRACTOR requests a copy of an IEP, the provider must also include a copy of the appropriate parental consent.

2.9.15.7.4 If the CONTRACTOR requires DOE submit an IEP to the CONTRACTOR as a request for covered services, DOE shall include a copy of parental consent and the CONTRACTOR shall:

2.9.15.7.4.1 Either accept the IEP as indication of a medical problem and treat the IEP as a request for service or assist in making an appointment to have the child evaluated by the child's PCP or another contract provider. If the CONTRACTOR does not

accept the documentation provided with the IEP as indication of a medical problem, the CONTRACTOR shall have the child re-evaluated in order to make a decision about the appropriateness of the requested service.

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

2.9.15.7.4.3 Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery) within fourteen (14) days of the CONTRACTOR's receipt of the IEP.

2.9.15.7.5 The CONTRACTOR shall designate a contact person to whom correspondence concerning children with medical services included in their IEPs will be directed.

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

2.9.15.9 Tennessee Department of Intellectual and Developmental Disabilities (DIDD) and TENNCARE for the purpose of participating in the Abuse Registry Referral Committee (ARRC) which shall be responsible for reviewing Tier 1 Reportable Events/Critical Incident investigation findings involving ECF CHOICES members. The ARRC shall consist of one representative for DIDD, one representative for TennCare, and one representative for the applicable MCO whose member was the alleged victim in the investigation. All ARRC proceedings shall be conducted pursuant to the requirements of the Interagency Agreement between TENNCARE and DIDD, as well as the processes detailed in TennCare protocol.

A.2.10 SERVICES NOT COVERED

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

A.2.11 PROVIDER NETWORK

A.2.11.1 General Provisions

2.11.1.1 The CONTRACTOR shall provide or ensure the provision of all covered services specified in Section A.2.6.1 of this Contract. Accessibility of covered services, including geographic access and appointments and wait times shall be in accordance with the access and network adequacy standards set forth in the applicable federal regulations and the CRA requirements, including, but not limit to the requirements set forth in: CRA Sections A.2.30.8.4 and A.2.11.7; in Attachment III; the Specialty Network Standards in Attachment IV; the Access and Availability for Behavioral Health Services in Attachment V; and the applicable federal requirements. These minimum requirements shall not release the CONTRACTOR from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members, whether specified above or not.

2.11.1.2 The CONTRACTOR may provide covered physical health and behavioral health services directly or may enter into written agreements with providers and provider subcontracting entities or organizations that will provide covered physical health and

behavioral health services to the members in exchange for payment by the CONTRACTOR for services rendered. The CONTRACTOR shall enter into written agreements with providers to provide covered long-term care services. The CONTRACTOR shall not directly provide long-term care services.

2.11.1.3 When the CONTRACTOR contracts with providers, the CONTRACTOR shall:

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

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

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

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

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

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

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.

2.11.1.4 Section A.2.11.1.3 shall not be construed to:

2.11.1.4.1 Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its members and the access standards of this Contract; however, the CONTRACTOR shall contract with nursing facilities pursuant to the requirements of Section A.2.11.7 of this Contract and shall contract with at least two (2) providers for each CHOICES HCBS to cover each county in the Grand Region, as specified in Section A.2.11.7.3;

2.11.1.4.2 Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different providers in the same specialty; however, the CONTRACTOR shall reimburse long-term care services in accordance with Sections A.2.13.3 and A.2.13.4; or

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

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

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

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

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

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

2.11.1.6 Prior to including a provider on the *Provider Enrollment File* (see Section A.2.30.8.1) and/or paying a provider's claim, the CONTRACTOR shall ensure that the provider has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE.

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

2.11.1.8 If the CONTRACTOR is unable to meet the access standard for a covered service for which the CONTRACTOR is responsible for providing non-emergency transportation to a member, the CONTRACTOR shall provide transportation regardless of whether the member has access to transportation.

2.11.1.8.1 In the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III), the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity.

2.11.1.8.2 The CONTRACTOR is not required to provide non-emergency transportation for HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities and HCBS provided through the CHOICES program, except as provided in Section A.2.11.1.8.1 above.

2.11.1.9 If the CONTRACTOR is unable to provide medically necessary covered services to a particular member using contract providers, the CONTRACTOR shall adequately and timely cover these services for that member using non-contract providers, for as long as the CONTRACTOR's provider network is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the member can be safely transferred, the CONTRACTOR may transfer the member to an appropriate contract provider as specified in Section A.2.9.5.

2.11.1.10 The CONTRACTOR shall monitor provider compliance with access requirements specified in Attachment III, including but not limited to appointment and wait times and take corrective action for failure to comply. The CONTRACTOR shall maintain an emergency/contingency plan in the event that a large provider of services collapses or is otherwise unable to provide needed services and shall conduct surveys and office visits to monitor compliance with appointment waiting time standards and shall report findings and corrective actions to TENNCARE in accordance with Section A.2.30.8.2.

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

2.11.1.12 TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify any provider agreement when TENNCARE determines it to be in the best interest of the State.

2.11.1.13 To demonstrate sufficient accessibility and availability of covered services, the CONTRACTOR shall comply with all reporting requirements specified in Section A.2.30.8.

A.2.11.2 **Primary Care Providers (PCPs)**

2.11.2.1 With the exception of members dually eligible for Medicare and TennCare, the CONTRACTOR shall ensure that each member has an assigned PCP, as defined in Section A.1, who is responsible for coordinating the covered services provided to the member. For CHOICES members, the CONTRACTOR shall develop and implement protocols that address, at a minimum, the roles and responsibilities of the PCP and Care Coordinator and collaboration between a member's PCP and Care Coordinator.

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

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

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

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

2.11.2.6 The CONTRACTOR shall establish policies and procedures to enable member's reasonable opportunities to change PCPs. Such policies and procedures may not specify a length of time greater than twelve (12) months between PCP changes under normal circumstances. If the ability to change PCPs is limited, the CONTRACTOR shall include provisions for more frequent PCP changes with good cause. The policies and procedures shall include a definition of good cause as well as the procedures to request a change and must allow members to call or fax a change request that will facilitate an immediate change to the assigned PCP. The criteria for PCP change limitations must be approved by TENNCARE.

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

2.11.2.8 The CONTRACTOR agrees to implement Primary Care Transformation strategies, inclusive of PCMH (comprehensive primary care program) and Tennessee Health Link (integrated care coordination for members with the highest behavior health needs), consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TENNCARE.

A.2.11.3 **Specialty Service Providers**

2.11.3.1 <u>Essential Hospital Services and Centers of Excellence</u>

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

2.11.3.1.1.1 Neonatal services;

2.11.3.1.1.2 Perinatal services;

2.11.3.1.1.3 Pediatric services;

2.11.3.1.1.4 Trauma services; and

2.11.3.1.1.5 Burn services.

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

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

2.11.3.2 Physician Specialists

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

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

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

2.11.3.3 TENNCARE Monitoring

2.11.3.3.1 TENNCARE will monitor CONTRACTOR compliance with specialty network standards on an ongoing basis. TENNCARE will use data from the monthly *Provider Enrollment File* required in Section A.2.30.8.1, to verify compliance with the specialty network requirements. TENNCARE will use these files to confirm the CONTRACTOR has a sufficient number and distribution of physician specialists and in conjunction with MCO enrollment data to calculate member to provider ratios. TENNCARE will also periodically phone providers listed on these reports to confirm that the provider is a contract provider as reported by the CONTRACTOR. TENNCARE shall also monitor appeals data for indications that problems exist with access to specialty providers.

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

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

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

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

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

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

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

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

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

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

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

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

A.2.11.4 **Medication Assisted Treatment (MAT) Network**

2.11.4.1 Buprenorphine Treatment

2.11.4.1.1 The CONTRACTOR shall establish a provider network for Medication Assisted Treatment (MAT) for members with opioid use disorder (OUD). The CONTRACTOR shall engage all contracted MAT providers, at the individual NPI level, as described below.

2.11.4.1.1.1 For the first two (2) calendar years of a provider's participation in the MAT network, the CONTRACTOR shall provide at minimum three (3) engagements as described below with the contracted MAT provider. These three (3) engagements shall include, at a minimum, the in-person check in, the in-person audit meeting, and the virtual education session as described below.

2.11.4.1.1.1.1 The CONTRACTOR shall conduct at minimum one (1) in-person check-in, at individual NPI-level, with each contracted MAT provider per calendar year. The CONTRACTOR must have the appropriate representative present to discuss the following with the provider in-person:

2.11.4.1.1.1.1.1 Billing or processing questions;

2.11.4.1.1.1.1.2 Provide education (programmatic and clinical);

2.11.4.1.1.1.1.3 Quality metrics;

2.11.4.1.1.1.1.4 Program description and opportunities for additional supports.

2.11.4.1.1.1.2 The CONTRACTOR shall conduct one (1) in-person audit meeting, at individual NPI-level, per calendar year for each contracted MAT provider. The CONTRACTOR shall use the audit tool template as prescribed by TENNCARE to ensure that the providers are accurately and consistently implementing the program description and providing high-quality care. The CONTRACTOR shall review a minimum of ten (10) member charts per provider. If the provider has less than ten (10) members, the CONTRACTOR shall review all members treated with buprenorphine Medication Assisted Treatment (MAT) by that provider.

2.11.4.1.1.1.2.1 The CONTRACTOR may collaborate with the other TennCare MCOs to allow a provider to only be audited by one CONTRACTOR during a calendar year. If the CONTRACTOR decides to partner with another MCO, this shall fulfill the requirements for the CONTRACTOR.

2.11.4.1.1.1.3 The CONTRACTOR shall conduct at minimum one (1) virtual education session for all contracted MAT providers per calendar year. The virtual education session shall be for MAT providers and staff to receive additional training, education, or necessary general updates to the MAT network requirements. The CONTRACTOR shall share all topics for the virtual education sessions with TENNCARE, at least ninety (90) days in advance of the meeting and shall receive approval by TENNCARE prior to using the virtual education session.

2.11.4.1.1.1.3.1 The CONTRACTOR may collaborate with other TennCare MCOs to provide a single virtual education session for providers. If the CONTRACTOR decides to partner with another MCO, this shall fulfill the requirements for the CONTRACTOR.

2.11.4.1.1.1.3.2 The CONTRACTOR shall record the virtual education session and make the recording available to contracted MAT providers for future viewings.

2.11.4.1.1.1.3.3 The CONTRACTOR shall facilitate all aspects of the virtual education session, including but not limited to, communicating to providers, RSVPs, hosting the webinar platform, and developing webinar content.

2.11.4.1.1.1.3.4 The CONTRACTOR shall track attendance and share the attendance data with TENNCARE within ten (10) calendar days of the virtual education session.

2.11.4.1.1.2 After two (2) calendar years of a provider participating in the MAT network, the CONTRACTOR shall provide at minimum two (2) engagements with the contracted MAT provider.

2.11.4.1.1.2.1 Each CONTRACTOR shall conduct one (1) in-person meeting, at individual NPI-level, per contracted MAT provider per calendar year to function as a check-in and audit.

2.11.4.1.1.2.2 The CONTRACTOR shall conduct one (1) virtual education session per calendar year for all contracted MAT providers.

2.11.4.1.1.2.2.1 The CONTRACTOR may collaborate with other TennCare MCOs to provide a single virtual education session for providers. If the CONTRACTOR decides

to partner with another MCO, this shall fulfill the requirements for the CONTRACTOR.

2.11.4.1.1.2.2.2 The CONTRACTOR shall record the virtual education session and make the recording available to contracted MAT providers for future viewings.

2.11.4.1.1.2.2.3 The CONTRACTOR shall facilitate all aspects of the virtual education session, including but not limited to, communicating to providers, RSVPs, hosting the webinar platform, and developing webinar content.

2.11.4.1.1.2.2.4 The CONTRACTOR shall track attendance and share the attendance data with TENNCARE within ten (10) calendar days of the virtual education session

2.11.4.1.1.3 The CONTRACTOR shall distribute quarterly MAT Network Quality Metrics Reports to all contracted MAT providers on an NPI-level as described by TENNCARE. Reports shall be distributed in a format described by TENNCARE no later than one hundred twenty (120) calendar days following the end of each calendar year quarter unless otherwise described by TENNCARE. The one hundred twenty (120) day period includes three (3) months for claims-runout and a thirty (30) days for report processing.

2.11.4.1.1.4 The CONTRACTOR shall submit to TENNCARE a *MAT Network Quality Metrics Summary Report* on a quarterly basis, in a manner described by TENNCARE. Reports will assess MAT providers and collect aggregate data indicative of provider performance, outcomes, and activity.

2.11.4.2 Methadone Treatment

2.11.4.2.1 The CONTRACTOR shall establish a provider network by July 1, 2020 for Methadone Medication Assisted Treatment (MAT) for members with opioid use disorder (OUD) as outlined by TENNCARE. The CONTRACTOR shall comply with all guidance set forth by the TennCare Methadone Program Description.

2.11.4.2.2 The CONTRACTOR shall reimburse the Methadone Medication Assisted Treatment providers at a rate specified by TENNCARE through December 31, 2021. The CONTRACTOR shall also use the payment methodology as specified by TENNCARE.

2.11.4.2.3 The CONTRACTOR shall meet with each TDMHSAS licensed Opioid Treatment Program and offer each facility a contract for Methadone Medication Assisted Treatment. If the CONTRACTOR has quality of care concerns that may prevent contracting with the Opioid Treatment Program, the CONTRACTOR shall inform TENNCARE of this finding.

A.2.11.5 **Special Conditions for Prenatal Care Providers**

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

2.11.5.2 Regardless of whether prenatal care is provided by a PCP, physician extender or an obstetrician who is not the member's PCP, the access standards for PCP services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible for TennCare. For women who are past their first trimester of pregnancy on the day they are determined to be eligible, a first prenatal care appointment shall occur within fifteen (15) calendar days of the day they are determined to be eligible. Failure to do so shall be considered a material breach of the provider's provider agreement with the CONTRACTOR (see Sections A.2.7.5.2 and A.2.11.5).

A.2.11.6 **Special Conditions for Behavioral Health Services**

2.11.6.1 At the direction of the State, the CONTRACTOR shall divert new admissions to other inpatient facilities as appropriate, utilizing the Regional Mental Health Institutes only when no other option is available.

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

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

2.11.6.4 The CONTRACTOR shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification.

2.11.6.5 The CONTRACTOR shall build the statewide capacity and continuum of the behavioral health system to meet the needs of individuals with I/DD who have co-occurring mental health conditions or behavior support needs in a person-centered way (moving toward independence and integration to the maximum extent appropriate), including:

2.11.6.5.1 The successful implementation of Groups 7 and 8 in Employment and Community First CHOICES, including network adequacy to timely provide services to any member meeting the requirements for participation in these Groups, and broader network capacity for transition and ongoing support once stabilization is achieved;

2.11.6.5.2 The development and engagement of statewide HCBS provider networks, including workforce capacity, to serve people with I/DD and co-occurring behavior support needs;

2.11.6.5.3 The development of statewide capacity for behavioral crisis and stabilization response specific to the needs of individuals with I/DD, leveraging telehealth with in-person backup as needed;

2.11.6.5.4 The development of state capacity for rapid placement, intensive therapeutic behavioral stabilization, medication management (as applicable), and comprehensive

person-centered assessment specifically targeted to the needs of individuals with I/DD, including person-centered transition planning with the HCBS provider and/or family caregiver (as applicable); program development and implementation (including training), and post-transition stabilization placement support (telehealth and in-person);

2.11.6.5.4.1 Inpatient psychiatric hospitalization settings targeted to the general population, including RMHIs, shall not meet this requirement.

2.11.6.5.5 As prescribed in Section A.2.9.15.5 of this Contract, the CONTRACTOR shall partner with TENNCARE and DIDD in developing this continuum; however, it shall be the CONTRACTOR's responsibility to ensure the development of the statewide continuum and to ensure timely access to appropriate behavioral health services for individuals with I/DD.

2.11.6.5.6 The CONTRACTOR shall develop and submit to TENNCARE for review and approval in consultation with DIDD a specific network development plan related to this requirement, including specific actions and timelines to ensure that these actions are completed and that the requirements are met no later than January 2, 2023. The plan shall be due no later than October 1, 2020. Upon approval, the implementation of the plan shall be monitored by TENNCARE and DIDD on an ongoing basis

A.2.11.7 **Special Conditions for Long-Term Services and Supports Providers**

In addition to the requirements in Section A.2.11.1 of this Contract and the access standards specified in Attachment III of this Contract, the CONTRACTOR shall meet the following requirements for long-term services and supports providers.

2.11.7.1 The CONTRACTOR shall, pursuant to TCA 71-5-1412 contract with any licensed and certified nursing facility willing to contract with the MCO to provide that service under the same terms and conditions as are offered to any other participating facility contracted to provide that service under any policy, contract or plan that is part of the TennCare managed long-term care service delivery system. Terms and conditions shall not include the rate of reimbursement. This does not prevent the CONTRACTOR from enforcing the provisions of its contract with the facility.

2.11.7.2 For community-based residential alternatives, the CONTRACTOR shall demonstrate good faith efforts to develop the capacity to have a travel distance of no more than sixty (60) miles between a member's community-based residential alternative placement and the member's residence before entering the facility.

2.11.7.3 Except as specified by TENNCARE in writing, at a minimum, the CONTRACTOR shall contract with at least two (2) providers for each CHOICES and each ECF CHOICES HCBS, other than community-based residential alternatives to cover each county in each Grand Region covered under this Contract unless otherwise specified by TENNCARE. For CHOICES and ECF CHOICES HCBS provided in a member's place of residence, the provider does not need to be located in the county of the member's residence but must be willing and able to serve residents of that county. For adult day care, the provider does not have to be located in the county of the member's residence but must meet the access standards for adult day care specified in Attachment III.

2.11.7.4 In addition, the CONTRACTOR shall maintain a network of CHOICES and ECF CHOICES HCBS providers that is adequate to meet the needs of each and every

CHOICES member in Group 2 and 3 and in any ECF CHOICES Group, and to provide authorized CHOICES or ECF CHOICES HCBS within the timeframe prescribed in Sections A.2.9.2, A.2.9.3, and A.2.9.6 of this Contract. This includes initiating CHOICES or ECF CHOICES HCBS in the member's person centered supports plan, as appropriate, within the timeframes specified in this Contract and continuing services in accordance with the member's person centered supports plan, as appropriate, including the amount, frequency, duration and scope of each service in accordance with the member's service schedule.

2.11.7.4.1 The CONTRACTOR shall not delay or fail to identify a service on a member's PCSP because the CONTRACTOR's network of qualified providers (including the providers' workforce) is not sufficient to timely initiate such service. The CONTRACTOR shall not ask nor encourage a member (or his/her representative, as applicable) to omit a service from the PCSP because the CONTRACTOR cannot timely initiate the service. All covered, medically necessary benefits should be identified on a CHOICES or ECF CHOICES member's PCSP; any delays in the timely initiation of a service shall be reported pursuant to Sections 2.30.6.7, 2.30.6.8, 2.30.6.25, and 2.30.6.26.

2.11.7.4.2 The CONTRACTOR shall not delay nor fail to refer an individual for enrollment into ECF CHOICES Groups 7 or 8 because the CONTRACTOR's network of qualified providers is not sufficient to timely initiate services in the Group or because the CONTRACTOR does not have adequate network capacity for the member's transition and ongoing support once stabilization is achieved.

2.11.7.4.3 If the CONTRACTOR determines that a member's referral for enrollment into ECF CHOICES Groups 7 or 8 is not appropriate because other behavioral health services will more appropriately meet the member's needs, the CONTRACTOR shall be responsible for the timely coordination and initiation of such services. DIDD shall review and advise on all such determinations as part of its oversight responsibilities.

2.11.7.4.4 In developing and maintaining its network of ECF CHOICES providers, the CONTRACTOR shall consider the following as preferred contracting standards for participating providers:

2.11.7.4.4.1 The provider currently participates in one or more of the Section 1915(c) waiver programs for individuals with I/DD and has a consistent Quality Assurance (QA) performance rating of "proficient" or "exceptional performance." Providers with "exceptional performance" shall be given additional consideration. For the purpose of this Section, consistent QA performance shall mean that the provider receives the ratings of performance described above for at least two (2) consecutive years, including the most recent survey results.

2.11.7.4.4.2 The provider has or is actively seeking (meaning applied for and has financially invested in the process) accreditation from a nationally recognized accrediting body, e.g., Commission on Accreditation of Rehabilitation Facilities (applicable only if accredited for the specific services the provider will provide in ECF CHOICES), Council on Quality and Leadership (CQL), and the Council On Accreditation (COA). Acceptance of accreditation from other entities not listed must be prior approved by TENNCARE.

2.11.7.4.4.3 The provider has a Vocational Rehabilitation Letter of Agreement with the Tennessee Department of Human Services, Division of Rehabilitation Services.

2.11.7.4.4.4 The provider has completed DIDD person-centered organization training.

2.11.7.4.4.5 The provider is START-Certified or has completed START training.

2.11.7.4.4.6 The provider has achieved documented success in helping individuals with I/DD achieve employment opportunities in integrated community settings at a competitive wage. Such success may be based on the number or percent of persons served that the provider has successfully placed in integrated employment settings who are earning a competitive wage; success in developing customized employment options for individuals with more significant physical or behavior support needs; or other employment successes the CONTRACTOR determines merit additional contracting consideration;

2.11.7.4.4.7 The provider has demonstrated leadership in employment service delivery and community integration, e.g., designing and implementing plans to transition away from facility-based day services to integrated employment services with community-based wraparound supports.

2.11.7.4.4.8 The provider can demonstrate longstanding community relationships that can be leveraged to assist members in pursuing and achieving employment and integrated community living goals, including commitments from community-based organizations and employers to work with the provider in order to help persons supported by the provider to achieve such goals.

2.11.7.4.4.9 The provider has assisted persons supported by the agency in successfully transitioning into more independent living arrangements, such as Semi-Independent Living or CLS-1 or CLS-2, and also into arrangements that are not owned or controlled by a provider, and/or has experience facilitating home ownership for individuals.

2.11.7.4.4.10 The provider has policies and systems in place to support member selection of staffing and consistent staffing assignment, which are implemented and monitored.

2.11.7.4.4.11 The provider has capacity and willingness to function as a health partner with choice agency in order to support member participation in staff selection and supervision, including appropriate clinical and case management staffing to support ongoing assurance of appropriate preventive care and management of chronic conditions.

2.11.7.4.4.12 The provider is willing and able to assign staff who are linguistically competent in spoken languages other than English that may be the primary language of individuals enrolled in ECF CHOICES and/or their primary caregivers. The provider is able to assign staff that are trained in the use of auxiliary aids or services in order to achieve effective communication with individuals enrolled in ECF CHOICES and/or their primary caregivers.

2.11.7.4.4.13 The provider employs a Certified Work Incentive Coordinator (CWIC) who is available to counsel members on benefits and employment.

2.11.7.4.4.14 The provider employs or contracts with appropriately licensed professionals in one (1) or more specialty areas (behavior services, occupational therapy, physical therapy, speech language pathology, nutrition, orientation and mobility, or nurse education, training and delegation) to assist paid staff in supporting individuals who have long-term intervention needs, consistent with the ISP, therefore

increasing the effectiveness of the specialized therapy or service, and allows such professionals to be an integral part of the person-centered planning team, as needed, to participate in team meetings and provide additional intensive consultation for individuals whose functional, medical or behavioral needs are determined to be complex.

2.11.7.4.4.15 The provider meets other standards established by TENNCARE in policy or protocol that are intended to confer preferred contracting status.

2.11.7.4.5 Additional contracting consideration shall be given for each preferred contracting standard satisfied by a potential provider. The CONTRACTOR shall not be obligated to contract with every provider who meets one or more of these preferred contracting standards; nor shall the CONTRACTOR be prohibited from contracting with providers who do not meet any of these preferred contracting standards. However, the CONTRACTOR shall be able to demonstrate to TENNCARE that these standards are being thoughtfully considered in developing an adequate network of qualified providers for the ECF CHOICES program and shall include in its network reporting information regarding which, if any, preferred contracting standards have been met.

2.11.7.5 The CONTRACTOR shall develop and maintain a network development plan to ensure the adequacy and sufficiency of its provider network. The network development plan shall be submitted to TENNCARE annually, monitored by TENNCARE per the requirements in Section A.2.25 of the Contract, and include the following minimum elements:

2.11.7.5.1 Summary of nursing facility provider network, by county.

2.11.7.5.2 Summary of CHOICES and ECF CHOICES HCBS provider networks, including community-based residential alternatives, by service and county.

2.11.7.5.3 Demonstration of and monitoring activities to ensure that access standards for long-term services and supports are met, including requirements in Attachment III and in this Section A.2.11.7.

2.11.7.5.4 Demonstration of the CONTRACTOR's ongoing activities to track and trend every time a member does not receive initial or ongoing long-term services and supports in accordance with the requirements of this Contract due to inadequate provider capacity, identify systemic issues, and implement remediation and quality improvement (QI) activities. This shall include a summary of provider network capacity issues by service and county, the CONTRACTOR's remediation and QI activities and the targeted and actual completion dates for those activities.

2.11.7.5.5 CHOICES and ECF CHOICES HCBS network deficiencies (in addition to those specified in Section A.2.11.7.5.4 above) by service and by county and interventions to address the deficiencies.

2.11.7.5.6 Demonstration of the CONTRACTOR's efforts to develop and enhance existing community-based residential alternatives (including adult care homes, community living supports, and community living supports-family model) capacity for elders and/or adults with physical disabilities and individuals with intellectual and developmental disabilities. The CONTRACTOR shall specify related activities, including provider recruitment activities, and provide a status update on capacity building.

2.11.7.5.7 Demonstration of the CONTRACTOR's efforts to develop and enhance employment services capacity for elders and/or adults with physical disabilities and individuals with intellectual and developmental disabilities. The CONTRACTOR shall specify related activities, including provider recruitment activities, and provide a status update on capacity building.

2.11.7.5.8 Ongoing activities for CHOICES or ECF CHOICES HCBS provider development and expansion taking into consideration identified provider capacity, network deficiencies, and service delivery issues and future needs relating to growth in membership and long-term needs.

2.11.7.6 The CONTRACTOR shall, as part of its network management responsibilities, oversee the development of its contracted provider workforce, and shall take specific and measurable actions to help ensure a qualified, competent, and sufficient workforce to consistently deliver needed services in a timely manner. Responsibilities shall include the following: collection, analysis, and reporting of data about the contracted provider workforce; sufficient operational infrastructure to lead workforce development activities; the integration of workforce management responsibilities into policies and procedures for network management and support; the development and implementation of an annual workforce development plan; working with TennCare, other MCOs and/or providers to establish Statewide WFD goals, and to collaboratively plan and implement workforce development initiatives; the recruitment and employment of CHOICES and ECF CHOICES members into the workforce when appropriate; and direct assistance, support, investments, and incentives to contracted providers in order to develop the quality, competency, and sufficiency of their workforce.

2.11.7.6.1 The CONTRACTOR shall designate a staff member located within the State of Tennessee with experience and expertise in workforce development to oversee the CONTRACTOR's workforce development responsibilities.

2.11.7.6.2 The CONTRACTOR shall ensure that sufficient resources are available to collect, analyze and report contracted provider workforce data; develop, implement, and monitor an annual workforce development plan; lead workforce development activities; monitor, on an ongoing basis, the CONTRACTOR's policies and procedures that include workforce management responsibilities, including policies and procedures for network management and support; work with TennCare, other MCOs and/or providers to collaboratively plan and implement statewide workforce development initiatives; lead the recruitment and employment of CHOICES and ECF CHOICES members into the workforce when appropriate; provide direct assistance, support, investments and incentives to providers in order to develop the quality, competency, and sufficiency of their workforce; and monitor provider workforce development activities. Provider technical assistance may include but is not limited to the following:

2.11.7.6.2.1 Provider workforce development data collection and analysis;

2.11.7.6.2.2 Provider workforce development planning;

2.11.7.6.2.3 Talent identification and acquisition (recruitment);

2.11.7.6.2.4 Competency based training and development programs, systems and incentives;

2.11.7.6.2.5 Workforce retention and promotion strategies; and

2.11.7.6.2.6 Workplace culture and business model development.

2.11.7.6.3 Workforce Development Plan and Implementation Progress Report

The CONTRACTOR shall produce a Workforce Development (WFD) Plan in collaboration with providers, members, and their families, as well as other stakeholders, including but not limited to other CONTRACTORS, and industry, education and community groups. The WFD Plan shall describe the CONTRACTOR's goals, objectives, tasks, and timelines to develop the CONTRACTOR'S provider workforce. The initial WFD Plan shall be submitted by March 1, 2020, and shall upon approval by TENNCARE, be implemented beginning June 1, 2020. The CONTRACTOR's WFD Plan shall include the following:

2.11.7.6.3.1 Analysis of currently available workforce data, including workforce capacity (size, job types, etc.) and competency (skills and workplace support);

2.11.7.6.3.2 Forecast of anticipated workforce capacity (size, job types, etc.) and competency (skills and workplace support) needs, taking into account program and population growth;

2.11.7.6.3.3 Short and long-term strategic workforce development (WFD) capacity and competency objectives (e.g. addressing network adequacy, quality, direct support and health professional shortage areas, and integrated care). These objectives shall include a focus on helping enrollees and potential employers address and work through the employment barriers created by bias and discrimination based on class, race, color, national origin, age, disability, creed, religion, sex, and other protected statuses;

2.11.7.6.3.4 Standardized baseline workforce metrics in order to track improvement over time;

2.11.7.6.3.5 Description of the actions to be taken to achieve WFD goals, including specific initiatives and timelines;

2.11.7.6.3.6 Description of how the implementation of the plan and its impact on WFD will be monitored and measured; and

2.11.7.6.3.7 Description of how stakeholders, members, families and the general public have been involved in the development and will be involved in the implementation of the WFD Plan.

2.11.7.6.3.8 The CONTRACTOR shall routinely monitor and evaluate the implementation and progress of all initiatives and activities specified in its WFD Plan and shall formally assess and submit a semi-annual written WFD Implementation Progress Report of overall progress as specified in Contract. The WFD Implementation Progress Report shall include (at a minimum):

2.11.7.6.3.8.1 A summary of actions taken and progress being made toward the achievement of Statewide WFD goals as well as CONTRACTOR specific provider network identified WFD goals, including the current status of each initiative and each short and long-term strategic WFD capacity and competency objective;

2.11.7.6.3.8.2 At least annual updates to standardized baseline workforce metrics;

2.11.7.6.3.8.3 A summary of direct assistance, support, investments, and incentives to providers during the reporting period in order to develop the quality, competency, and sufficiency of their workforce;

2.11.7.6.3.8.4 A summary of monitoring processes and activities by the CONTRACTOR to evaluate the implementation and progress of all initiatives and activities specified in its WFD Plan; and

2.11.7.6.3.8.5 A description of how stakeholders, members, families, and the general public have been involved in in the implementation of the WFD Plan during the reporting period.

2.11.7.6.3.9 The CONTRACTOR shall update its WFD Plan at least annually based on progress, key learnings, and new insights regarding contracted provider WFD needs. The CONTRACTOR shall involve stakeholders, members, and families in this process.

2.11.7.6.3.10 The CONTRACTOR may partner with other MCOs in developing one consolidated WFD Plan or alternatively may partner with other MCOs on specific WFD objectives or initiatives; however, the CONTRACTOR shall be responsible for compliance with all of the WFD requirements specified in this contract.

2.11.7.7 The CONTRACTOR, in collaboration with TENNCARE, shall develop a strategy to strengthen networks with housing providers and develop access to affordable housing. The CONTRACTOR shall actively participate with TENNCARE, other TennCare managed care contractors, and other stakeholders to develop and implement strategies for the identification of resources to assist in transitioning CHOICES and ECF CHOICES members to affordable housing. To demonstrate this strategy, the CONTRACTOR shall report annually to TENNCARE on the status of any affordable housing development and networking strategies it elects to implement (See Section A.2.30.6.14).

2.11.7.8 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.

2.11.7.8.1 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.

A.2.11.8 **Special Conditions for Persons with Intellectual or Developmental Disabilities (I/DD)**

2.11.8.1 The CONTRACTOR's provider network must have adequate capacity to deliver covered physical and behavioral health services that meet the needs of persons with I/DD. Indicators of an adequate network include, but are not limited to:

2.11.8.1.1 The CONTRACTOR meets guidelines established in this Contract for a provider network;

2.11.8.1.2 The CONTRACTOR has sufficient types and numbers of providers to be able to consistently deliver services in a timely manner; and

2.11.8.1.3 The CONTRACTOR has within its network specialized health providers with sufficient expertise to deliver covered physical and behavioral health needed by persons with I/DD.

2.11.8.2 The CONTRACTOR shall identify and/or recruit and contract with physical and behavioral health care providers, in particular PCPs, who have the qualifications, capabilities and resources to work with persons with I/DD.

2.11.8.3 The CONTRACTOR shall develop policies and procedures for assigning members with I/DD to PCPs, and other medical and behavioral health specialists, with I/DD expertise.

2.11.8.4 The CONTRACTOR shall, in collaboration with TennCare and the Department of Intellectual and Developmental Disabilities, implement, distribute and train, and monitor PCPs and specialists regarding the use of best practice guidelines for acute and chronic conditions common to persons with I/DD.

2.11.8.5 The CONTRACTOR shall, in collaboration with TennCare and the Department of Intellectual and Developmental Disabilities, provide training opportunities for PCPs and other providers regarding the unique needs of persons with I/DD, how to improve the quality of service delivery, and effective collaboration with persons with I/DD, their family members and conservators.

A.2.11.9 **Safety Net Providers**

2.11.9.1 Federally Qualified Health Centers (FQHCs)

2.11.9.1.1 The CONTRACTOR is encouraged to contract with FQHCs and other safety net providers (e.g., rural health clinics) in the CONTRACTOR's service area to the extent possible and practical. However, the CONTRACTOR must contract with at least one (1) FQHC and RHC in each of the service areas authorized by this Contract. Where FQHCs are not utilized, the CONTRACTOR shall demonstrate to DHHS, the Tennessee DHS and TENNCARE that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in the CONTRACTOR's entire service area without contracting with FQHCs.

2.11.9.1.2 FQHC reporting information shall be submitted to TENNCARE as described in Section A.2.30.8.8 of this Contract.

2.11.9.2 Community Mental Health Agencies (CMHAs)

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

2.11.9.3 Local Health Departments

The CONTRACTOR shall contract with each local health department in each Grand Region(s) served by the CONTRACTOR for the provision of TennCare Kids screening services until such time as the CONTRACTOR achieves a TennCare Kids screening percentage of eighty percent (80%) or greater. Payment to local health departments shall be in accordance with Section A.2.13.7.

A.2.11.10 **Credentialing and Other Certification**

2.11.10.1 Credentialing of Contract Providers

2.11.10.1.1 Except as provided in Sections A.2.11.10.3 and A.2.11.10.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

2.11.10.1.2 The CONTRACTOR shall completely process credentialing applications from all types of providers (physical health, behavioral health and long-term care providers) within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.10.1.3 To the extent the CONTRACTOR has delegated credentialing agreements in place with any approved delegated credentialing agency, the CONTRACTOR shall ensure all providers submitted to the CONTRACTOR from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.

2.11.10.1.4 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

2.11.10.2 Credentialing of Non-Contract Providers

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

2.11.10.2.2 The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.10.2.3 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

2.11.10.3 Credentialing of Behavioral Health Entities

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

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

2.11.10.4 Credentialing of Long-Term Services and Supports Providers

2.11.10.4.1 The CONTRACTOR shall work with TENNCARE and contracted providers to develop and implement a consolidated process for credentialing and recredentialing long-term services and supports providers, including CHOICES and ECF CHOICES, that seeks to minimize MCO and provider burden resulting from duplicative review processes when a provider is contracted with more than one MCO. The consolidated process shall, as applicable, meet the minimum NCQA requirements as specified in the NCQA Standards and Guidelines for the Accreditation of MCOs and ensure that all long-term services and supports providers, including those credentialed/recredentialed in accordance with NCQA Standards and Guidelines for the Accreditation of MCOs, meet applicable State requirements, as specified by TENNCARE in State Rule, this Contract, or in policies or protocols. The consolidated process for credentialing and recredentialing LTSS providers shall not preclude the CONTRACTOR from establishing and/or reviewing criteria that are unique from other MCOs, but shall seek to avoid duplicative review of criteria that are the same across MCOs.

2.11.10.4.1.1 The CONTRACTOR shall develop policies that specify by HCBS provider type the credentialing process, the recredentialing process including frequency, and ongoing provider monitoring activities.

2.11.10.4.1.1.1 Ongoing CHOICES and ECF CHOICES HCBS providers must be recredentialed at least annually;

2.11.10.4.1.1.2 All other CHOICES and ECF CHOICES HCBS providers (e.g., pest control and assistive technology), must be recredentialed, at a minimum, every three (3) years.

2.11.10.4.1.2 At a minimum, credentialing of LTSS providers shall include the collection of required documents, including disclosure statements, and verification that the provider:

2.11.10.4.1.2.1 Has a valid license or certification for the services it will contract to provide as required pursuant to State law or rule, or TENNCARE policies or protocols;

2.11.10.4.1.2.2 Is not excluded from participation in the Medicare or Medicaid programs;

2.11.10.4.1.2.3 Has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE.

2.11.10.4.1.2.4 Has policies and processes in place to conduct, in accordance with Federal and State law and rule and TENNCARE policy, criminal background checks and registry checks, which shall include a check of the Tennessee Abuse Registry, National and Tennessee Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE), as required in Section A.29.2.2 and to document these in the worker's employment record or otherwise maintain these records on volunteers, as applicable;

2.11.10.4.1.2.4.1 Has completed criminal background checks, including registry checks, as applicable, pursuant to the requirements of Section A.2.29.2.2.

2.11.10.4.1.2.4.2 Has a policy and process in place for conducting an individualized assessment for workers whose criminal background check reveals past criminal conduct (see Section A.2.9.7.6 for further details about the individualized assessment).

2.11.10.4.1.2.5 Has a process in place to provide and document initial and ongoing education to its employees who will provide services to CHOICES members that includes, at a minimum (as applicable based on the service(s) the provider will be contracted to deliver):

2.11.10.4.1.2.5.1 Orientation to the population that the staff will support (e.g., elderly and adults with physical disabilities);

2.11.10.4.1.2.5.2 Disability awareness and cultural competency training, including person-first language; etiquette when meeting and supporting a person with a disability; and working with individuals who use alternative forms of communication, such as sign language or non-verbal communication, or who may rely on assistive devices for communication or who may need auxiliary aids or services in order to effectively communicate;

2.11.10.4.1.2.5.3 Ethics and confidentiality training, including HIPAA and HI-TECH;

2.11.10.4.1.2.5.4 Delivering person-centered services and supports, including;

2.11.10.4.1.2.5.4.1 Federal HCBS setting requirements and the importance of the member's experience;

2.11.10.4.1.2.5.4.2 Supporting community integration and participation in the delivery of HCBS;

2.11.10.4.1.2.5.4.3 Facilitating individual choice and control; and

2.11.10.4.1.2.5.4.4 Working with family members and/or conservators, while respecting individual choice.

2.11.10.4.1.2.5.5 An introduction to behavioral health, including behavior support challenges or other cognitive limitations (including Alzheimer's Disease, dementia, etc.) may face; understanding behavior as communication; potential causes of behavior, including physiological or environmental factors; and person-centered supports for individuals with challenging behaviors, including positive behavior supports;

2.11.10.4.1.2.5.6 The paid caregiver's responsibility in promoting healthy lifestyle choices and in supporting self-management of chronic health conditions;

2.11.10.4.1.2.5.7 Abuse and neglect prevention, identification and reporting;

2.11.10.4.1.2.5.8 Critical incident management and reporting;

2.11.10.4.1.2.5.9 Documentation of service delivery;

2.11.10.4.1.2.5.10 Use of the EVV System;

2.11.10.4.1.2.5.11 Any other training requirements specified by TENNCARE in State Rule, this Contract, or in policies or protocols; and

2.11.10.4.1.2.5.12 The CONTRACTOR shall submit to TENNCARE for review and approval a listing of applicable training requirements by service type.

2.11.10.4.1.2.6 Has policies and processes in place to ensure:

2.11.10.4.1.2.6.1 Compliance with the CONTRACTOR's critical incident reporting and management process; and

2.11.10.4.1.2.6.2 Appropriate use of the EVV system.

2.11.10.4.1.2.7 Is compliant with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

2.11.10.4.1.3 The CONTRACTOR shall ensure that ECF CHOICES providers have a process in place to provide and document initial and ongoing education to their employees who will provide services to ECF CHOICES members as specified by TENNCARE.

2.11.10.4.1.4 At a minimum, recredentialing of HCBS providers shall include verification of continued licensure and/or certification (as applicable); compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident and Reportable Event reporting and management, and use of the EVV; and compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

2.11.10.4.1.4.1 The CONTRACTOR shall also verify that any persons required to have background checks, including registry checks, as applicable, who have been employed or have begun volunteering since the last credentialing visit have had criminal background checks, including registry checks, as applicable, performed pursuant to the requirements in Section A.29.2.2 The CONTRACTOR shall also verify that any persons required to have background checks, including registry checks, as applicable, who have been employed or have begun volunteering since the last credentialing visit have had criminal background checks, including registry checks, as applicable, performed pursuant to the requirements in Section A.29.2.2.

2.11.10.4.1.5 For both credentialing and recredentialing processes, the CONTRACTOR shall conduct a site visit, unless the provider is located out of state, in which case the CONTRACTOR may waive the site visit and document the reason in the provider file.

2.11.10.4.1.6 At a minimum, the CONTRACTOR shall reverify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid, and/or SCHIP programs.

2.11.10.4.1.7 Except as provided in A.2.11.10.4.1.9, the CONTRACTOR shall be responsible for tracking and obtaining copies of current licensure and/or certification (as applicable) for all of the CONTRACTOR's CHOICES and ECF CHOICES HCBS providers. The CONTRACTOR shall be required to present this current licensure and/or certification to TENNCARE upon request. Except as provided in A.2.11.10.4.1.9, the CONTRACTOR shall further require all of the CONTRACTOR's CHOICES and ECF CHOICES HCBS providers to submit copies of current licensure and/or certification (as applicable) to the CONTRACTOR.

2.11.10.4.1.8 Whenever the CONTRACTOR executes a provider agreement with a new provider for an ECF CHOICES service, the CONTRACTOR shall notify DIDD of the new provider via data exchange as specified in TennCare protocol.

2.11.10.4.1.9 For ECF CHOICES providers, the CONTRACTOR shall, pursuant to processes established or approved by TENNCARE, accept verification from DIDD or TENNCARE that a provider contracted with DIDD and with TENNCARE to deliver services pursuant to a Section 1915(c) HCBS waiver operated by DIDD, meets certain credentialing or re-credentialing requirements applicable to ECF CHOICES providers, including licensure and/or certification (as applicable), and shall not require the provider to submit duplicate information to the CONTRACTOR.

2.11.10.4.1.10 The CONTRACTOR shall work with TENNCARE to develop specific credentialing processes pertaining to a change of ownership for LTSS providers, when the new provider will continue to provide services to members enrolled in CHOICES or ECF CHOICES. The purpose of this process shall be to assist the provider in completing the credentialing and contracting process, including obtaining a new Medicaid ID, prior to the effective date of the ownership change.

2.11.10.5 <u>CHOICES and ECF CHOICES Quality Monitoring</u>

2.11.10.5.1 Quality monitoring of ECF CHOICES services by DIDD shall include select ECF CHOICES services as determined by TENNCARE and established in TennCare protocol and interagency agreement. Quality monitoring of CHOICES services shall include only CLS and CLS-FM.

2.11.10.5.2 Upon the first initiation of services by a CHOICES CLS or CLS-FM or ECF CHOICES provider to one or more CHOICES or ECF CHOICES members (i.e., the first time the provider begins delivering services in the program), the CONTRACTOR shall notify DIDD of service initiation within ten (10) business days of the initiation of services for purposes of scheduling consultative quality monitoring surveys, as applicable, with DIDD. The data transfer process shall be developed with and approved by TENNCARE and DIDD. Upon completion of consultative surveys, the providers shall be placed on the annual survey schedule.

2.11.10.5.3 Following each consultative and annual survey involving the CONTRACTOR's members, the CONTRACTOR and DIDD shall meet to discuss the survey results and findings prior to presenting the results and finding to the provider surveyed. The CONTRACTOR shall attend the exit survey, where in DIDD explains the results of

the survey with the provider. The CONTRACTOR shall be responsible for appropriate actions based on final survey results for consultative and annual surveys conducted by DIDD and follow-up visits conducted by DIDD, which may include as appropriate and specified by TENNCARE in quality monitoring protocols: onsite monitoring pending resolution of Reportable Events requiring immediate attention, corrective action plan a moratorium on new referrals.

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

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

2.11.10.7 Weight Watchers Centers or Other Weight Management Program

The CONTRACTOR is not required to credential Weight Watchers centers(s) or another weight management program used as a cost effective alternative service pursuant to Section A.2.8 of this Contract.

A.2.11.11 **Network Notice Requirements**

2.11.11.1 Member Notification

The CONTRACTOR must ensure that all enrollee notices are written and issued in adherence with applicable state and federal regulation. To this end, TENNCARE and the CONTRACTOR agree to collaborate in designing TENNCARE approved notice templates. Effective January 1, 2018, enrollee notices must comply with the notice content, timing, format, readability and language requirements set forth in 42 C.F.R. §438.10 and §438.404.

2.11.11.1.1 *Change in PCP*

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

2.11.11.1.2 *PCP Termination*

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

2.11.11.1.3 *Physical Health or Behavioral Health Providers Providing Ongoing Treatment Termination*

If a member is in a prior authorized ongoing course of treatment with any other contract provider who becomes unavailable to continue to provide services to such member and the CONTRACTOR is aware of such ongoing course of treatment, the CONTRACTOR shall provide written notice to each member as soon as possible but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2.11.11.1.4 *Non-PCP Provider Termination*

If a non-PCP provider, including but not limited to a specialist or hospital, ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice to members who have been seen and/or treated by the non-PCP provider within the last six (6) months. Notice shall be issued no less than thirty (30) days prior to the effective date of the termination of the non-PCP provider when possible or immediately upon the CONTRACTOR becoming aware of the termination.

2.11.11.1.5 *Long-Term Care Provider Termination*

If a long-term care provider ceases participation in the CONTRACTOR's MCO the CONTRACTOR shall provide written notice as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who has chosen or is authorized to receive long-term care services from that provider. Notices regarding termination by a nursing facility shall comply with state and federal requirements. The requirement in this Section A.2.11.11.1.5 to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances. See Section A.2.9.5 of this Contract regarding requirements for transitioning from a terminating provider to a new provider.

2.11.11.1.6 *Network Deficiency*

Upon notification from TENNCARE that a corrective action plan designed to remedy a network deficiency has not been accepted, the CONTRACTOR shall immediately provide written notice to members living in the affected area of a provider shortage in the CONTRACTOR's network.

2.11.11.2 TENNCARE Notification

2.11.11.2.1 *Subcontractor Termination*

When a subcontract that relates to the provision of services to members or claims processing is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCI. Said notices shall include, at a minimum: a CONTRACTOR's intent to change to a new subcontractor for the provision of said services; an effective date for termination and/or change; and any other pertinent information that may be needed to access services. In addition to prior written notice, the CONTRACTOR shall also provide a transition plan to TENNCARE within fifteen (15) calendar days, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition and how continuity of care will be maintained for the members.

2.11.11.2.2 *Hospital Termination*

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

2.11.11.2.3 *Other Provider Terminations*

2.11.11.2.3.1 The CONTRACTOR shall notify TENNCARE of any provider termination and shall submit an Excel spreadsheet that includes the provider's name, TennCare provider identification number, NPI number, and the number of members affected within five (5) business days of the provider's termination. If the termination was initiated by the provider, the notice to TENNCARE shall include a copy of the provider's notification to the CONTRACTOR. The CONTRACTOR shall maintain documentation of all information, including a copy of the actual member notice(s), on-site. Upon request, the CONTRACTOR shall provide TENNCARE a copy of the following: one or more of the actual member notices mailed, an electronic listing in Excel identifying each member to whom a notice was sent, a transition plan for the members affected, and documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity and date member notices were mailed as proof of compliance with the member notification requirements.

2.11.11.2.3.2 If termination of the CONTRACTOR's provider agreement with any PCP or physician group or clinic or long-term care provider, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Section A.2.11 and Attachments III, IV and V, such termination shall be reported by the CONTRACTOR in writing to TENNCARE, in the standard format provided by TENNCARE to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

A.2.12 PROVIDER AGREEMENTS

A.2.12.1 Provider agreements, as defined in Section A.1 of this Contract, shall be administered in accordance with this Contract and shall contain or incorporate by reference to the provider manual all of the items listed in this Section A.2.12.

A.2.12.2 All template provider agreements and revisions thereto must be approved in writing in advance by TDCI in accordance with statutes regarding the approval of a certificate of authority (COA) and any material modifications thereof.

A.2.12.3 The CONTRACTOR shall revise provider agreements as directed by TENNCARE.

A.2.12.4 No provider agreement terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Contract are carried out. It shall be the responsibility of the CONTRACTOR to provide all necessary training and information to providers to ensure satisfaction of all CONTRACTOR responsibilities as specified in this Contract.

A.2.12.5 The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program.

A.2.12.6 The CONTRACTOR shall not include covenant-not-to-compete requirements in its provider agreements. The CONTRACTOR shall not execute provider agreements that require that a provider not provide services for any other TennCare MCO.

A.2.12.7 The CONTRACTOR shall not execute provider agreements that contain compensation terms that discourage providers from serving any specific eligibility category or population covered by this Contract.

A.2.12.8 No other terms or conditions agreed to by the CONTRACTOR and the provider shall negate or supersede the requirements listed in Section A.2.12.9 below.

A.2.12.9 All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, shall, except as otherwise provided in Section A.2.12.12, at a minimum, meet the following requirements:

2.12.9.1 Be in writing. All new provider agreements and existing provider agreements as they are renewed, shall include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties. Signed agreements may include a wet or handwritten signature or valid binding electronic signature as required by the CONTRACTOR. Agreements kept on file in an electronic format must be immediately accessible in a printable version upon request by TENNCARE or any authorized party as described in Section A.2.12.9;

2.12.9.2 Specify the effective dates of the provider agreement;

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

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;

2.12.9.5 Identify the population covered by the provider agreement;

2.12.9.6 Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Contract for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

2.12.9.7 Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;

2.12.9.8 Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section A.2.10 of this Contract and the TennCare rules and regulations;

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

2.12.9.10 Require compliance with applicable access requirements, including but not limited to appointment and wait times as referenced in Section A.2.11 of the CONTRACTOR's Contract with TENNCARE;

2.12.9.11 Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR and include the definition of unreasonable delay as described in Section A.2.7.5.2.3 of this Contract;

2.12.9.12 If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

2.12.9.13 Require the provider to have and maintain documentation necessary to demonstrate that covered services were provided in compliance with state and federal requirements. Paper records must be signed by rendering provider, electronic records must have capability of affixing an electronic signature to notes added by rendering provider;

2.12.9.14 Require that an adequate record system be maintained and that all records be maintained for ten (10) years from the termination of the provider agreement or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions);

2.12.9.15 Include a statement that as a condition of participation in TennCare, enrollees and providers shall give TENNCARE or its authorized representative, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCD, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider in either paper or electronic form, at no cost to the requesting party, for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCD, the DHHS OIG and the DOJ. Said records are to be provided by the provider at no cost to the requesting agency;

2.12.9.16 Include medical records requirements found in Section A.2.24.8 of this Contract;

2.12.9.17 Contain the language described in Section A.2.25.6 of this Contract regarding Audit Requirements and Section A.2.25.5 of this Contract regarding Availability of Records;

2.12.9.18 Provide that TENNCARE, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCD, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Contract including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Such records are to be provided at no charge to the requesting agency. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCD, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, TBI MFCD, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions;

2.12.9.19 Provide for monitoring, whether announced or unannounced, of services rendered to members;

2.12.9.20 Provide for the participation and cooperation in any internal and external QM/QI, monitoring, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE;

2.12.9.21 Specify CONTRACTOR's responsibilities under this Contract and its agreement with the provider, including but not limited to, provision of a copy of the member handbook and provider manual whether via web site or otherwise and requirement that the CONTRACTOR notice a provider of denied authorizations;

2.12.9.22 Specify that the CONTRACTOR shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or long-

term care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;

2.12.9.23 Require that the provider comply with corrective action plans initiated by the CONTRACTOR;

2.12.9.24 Provide for the timely submission of all reports and clinical information required by the CONTRACTOR;

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

2.12.9.26 Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR. However, the agreement shall not include rate methodology that provides for an automatic increase in rates;

2.12.9.27 Specify that the CONTRACTOR shall only pay providers for services (1) provided in accordance with the requirements of this Contract, the CONTRACTOR's policies and procedures implementing this Contract, and state and federal law and (2) provided to TennCare enrollees who are enrolled with the CONTRACTOR; and specify that the provider is responsible for (1) ensuring that any applicable authorization requirements are met and (2) verifying that a person is eligible for TennCare on the date of service;

2.12.9.28 Provide for prompt submission of information needed to make payment. Specify that a provider shall have one hundred twenty (120) calendar days from the date of rendering a covered service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the MCO with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment;

2.12.9.29 Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in TCA 56-32-126 and Section A.2.22.4 of this Contract;

2.12.9.30 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus the amount of any applicable TennCare cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable TennCare cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the enrollee being served;

2.12.9.31 Specify that in the event that TENNCARE deems the CONTRACTOR unable to timely process and reimburse claims and requires the CONTRACTOR to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the CONTRACTOR's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;

2.12.9.32 Specify the provider's responsibilities and prohibited activities regarding cost sharing as provided in Section A.2.6.7 of this Contract;

2.12.9.33 Specify the provider's responsibilities regarding third party liability (TPL) , including the provider's obligation to identify third party liability coverage, including Medicare and long-term care insurance as applicable, and, except as otherwise provided in the CONTRACTOR's Contract with TENNCARE, to seek such third party liability payment before submitting claims to the CONTRACTOR;

2.12.9.34 For those agreements where the provider is compensated via a capitation arrangement, language which requires:

2.12.9.34.1 That if a provider becomes aware for any reason that he or she is not entitled to a capitation payment for a particular enrollee (a patient dies, for example), the provider shall immediately notify both the CONTRACTOR and TENNCARE by certified mail, return receipt requested; and

2.12.9.34.2 The provider shall submit utilization or encounter data as specified by the CONTRACTOR so as to ensure the CONTRACTOR's ability to submit encounter data to TENNCARE that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims;

2.12.9.35 Require the provider to comply with fraud, waste, and abuse requirements described in Section A.2.20 of this Contract;

2.12.9.36 Require that the provider comply with the Affordable Care Act and TennCare policies and procedures regarding recovery of overpayments, including written notification to the CONTRACTOR and TennCare Office of Program Integrity (OPI) of overpayments identified by the provider and, when applicable, returning the overpayment to the CONTRACTOR within sixty (60) days from the date the overpayment is identified., Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law;

2.12.9.37 Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements, including timeframes, specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures. The timeframes for this requirement shall include, at a minimum, at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at any time upon request. This requirement may be satisfied through TENNCARE's provider registration process;

2.12.9.38 Any reassignment of payment must be made in accordance with 42 CFR 447.10. All tax-reporting provider entities shall not be permitted to assign TennCare funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (SAM)

screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited;

2.12.9.39 Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider shall be required to immediately report to the CONTRACTOR any exclusion information discovered. The provider shall be informed by the CONTRACTOR that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members;

2.12.9.40 The provider, subcontractor or any other entity agrees to abide by the Medicaid laws, regulations and program instructions that apply to the provider. The provider, subcontractor or any other entity understands that payment of a claim by TennCare or a TennCare Managed Care Contractor and/or Organization is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and is conditioned on the provider's, subcontractor's or any other entity's compliance with all applicable conditions of participation in Medicaid. The provider, subcontractor or any other entity understands and agrees that each claim the provider, subcontractor or any other entity submits to TennCare or a TennCare Managed Care Contractor and/or Organization constitutes a certification that the provider, subcontractor or any other entity has complied with all applicable Medicaid laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), in connection with such claims and the services provided therein;

2.12.9.41 Require the provider to conduct criminal background checks and registry checks in accordance with state law and TennCare policy;

2.12.9.42 Require the provider to report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 and to report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605;

2.12.9.43 Require that, for CHOICES and ECF CHOICES members, the provider facilitate notification of the member's care/supports coordinator by notifying the CONTRACTOR, in accordance with the CONTRACTOR's processes, as expeditiously as warranted by the member's circumstances, of any known significant changes in the member's condition or care, hospitalizations, or recommendations for additional services;

2.12.9.44 Require hospitals, including psychiatric hospitals, to cooperate with the CONTRACTOR in developing and implementing protocols as part of the CONTRACTOR's nursing facility diversion plan (see Section A.2.9.6.7), which shall, include, at a minimum, the hospital's obligation to promptly notify the CONTRACTOR upon admission of an eligible member regardless of payor source for the hospitalization; how the hospital will identify members who may need home health, private duty nursing, nursing facility, or CHOICES or ECF CHOICES HCBS upon discharge, and how the hospital will engage the CONTRACTOR in the discharge planning process to ensure that members receive the most appropriate and cost-effective medically necessary services upon discharge;

2.12.9.45 As a condition of reimbursement for global procedures codes for obstetric care, the provider shall submit utilization or encounter data as specified by the CONTRACTOR in a timely manner to support the individual services provided;

2.12.9.46 Except as otherwise specified in Sections A.2.12.10 or A.2.12.11, require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CONTRACTOR's members and the CONTRACTOR under the provider agreement. The provider shall maintain such insurance coverage at all times during the provider agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;

2.12.9.47 Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the CONTRACTOR and the provider. Provide that the agreement incorporates by reference all applicable federal law and regulations and state laws, TennCare rules and regulations, consent decrees or court orders, and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the provider agreement, as they become effective;

2.12.9.48 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the provider agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, then the terms shall include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc.);

2.12.9.49 Include provisions that allow the CONTRACTOR to suspend, deny, refuse to renew or terminate any provider agreement in accordance with the terms of the CONTRACTOR's Contract with TENNCARE (see Section E.14) and applicable law and regulation;

2.12.9.50 Specify that TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify the provider agreement when TENNCARE determines it to be in the best interest of the State;

2.12.9.51 Specify that both parties recognize that in the event of termination of this Contract between the CONTRACTOR and TENNCARE for any of the reasons described in Section E.14 of this Contract, the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the CONTRACTOR/provider agreement. The provision of such records shall be at no expense to TENNCARE;

2.12.9.52 Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the CONTRACTOR as provided at TCA 56-32-126(b);

2.12.9.53 Include a Conflict of Interest clause as stated in Section E.28 of this Contract, Gratuities clause as stated in Section E.30 of this Contract, and Lobbying clause as stated in Section E.8 of this Contract between the CONTRACTOR and TENNCARE;

2.12.9.54 Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Contract between TENNCARE and the CONTRACTOR. This indemnification may be accomplished by incorporating Section E.36 of the TENNCARE/CONTRACTOR Contract in its entirety in the provider agreement or by use of other language developed by the CONTRACTOR and approved in writing by TENNCARE;

2.12.9.55 Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Sections A.2.27 and Section E.6. of this Contract;

2.12.9.56 Require the provider to comply with 42 CFR Part 438, Managed care, including but not limited to 438.3, compliance with the requirements mandating provider identification of provider-preventable conditions as a condition of payment. At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the CONTRACTOR and TENNCARE;

2.12.9.57 Specify provider actions to improve patient safety and quality;

2.12.9.58 Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider shall comply with the appeal process, including but not limited to the following:

2.12.9.58.1 Assist an enrollee by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review; and

2.12.9.58.2 Require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization or change or cancel the prescription when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.);

2.12.9.59 Require the provider to coordinate with the TennCare PBM regarding authorization and payment for pharmacy services;

2.12.9.60 Specify in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing;

2.12.9.61 Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CONTRACTOR's request for information, the request to provide medical records, credentialing information, etc.; at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial consequences against the provider as appropriate;

2.12.9.62 Include language which informs providers of the package of benefits that TennCare Kids offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. TennCare Kids requirements are contained in Section A.2.7.6 of this Contract. All provider agreements

shall contain language that references the TennCare Kids requirements in this Contract between TENNCARE and the CONTRACTOR, and the provider agreement shall either physically incorporate these sections of the Contract or include language to require that these sections be furnished to the provider upon request;

2.12.9.63 Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical, behavioral, or long-term care services covered by TENNCARE;

2.12.9.64 Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees;

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, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section A.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. The provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and enrollees.

2.12.9.65.2 Specify that the provider have written procedures for the provision of language assistance services to members and/or the member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats for any member and/or the member's representative who needs such services, including but not limited to, members with Limited English Proficiency and individuals with disabilities.

2.12.9.65.3 Require the provider to agree to cooperate with TENNCARE and the CONTRACTOR during discrimination complaint investigations and to report discrimination complaints and allegations to CONTRACTOR including allegations of discrimination set forth in Section 2.12.21.1 and 2.15.7.6.3.2.7.

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;

2.12.9.65.5 For Provider Agreement that include Ethical and Religious Directives provisions, include the following requirements:

2.12.9.65.5.1 The Provider shall provide a list of the services it does not deliver due to the Ethical and Religious Directives to the CONTRACTOR. The CONTRACTOR shall furnish this list to TENNCARE, notating those services that are TennCare covered services. This list shall be used by the CONTRACTOR and TENNCARE to provide information to TennCare members about where and how the members can obtain the services that are not being delivered by the Provider due to Ethical and Religious Directives.

2.12.9.65.5.2 At the time of service, the Provider shall inform TennCare members of the health care options that are available to the TennCare members, but are not being

provided by the Provider due to the Ethical and Religious Directives, but the Provider is not required to make specific recommendations or referrals. In addition, the Provider shall inform TennCare members that the member's MCO has additional information on providers and procedures that are covered by TENNCARE

2.12.9.66 The provider shall not use TennCare's name or trademark for any materials intended for dissemination to their patients unless said material has been submitted to TENNCARE by the CONTRACTOR for review and has been approved by TENNCARE in accordance with Section A.2.17 of this Contract. This prohibition shall not include references to whether or not the provider accepts TennCare; and

2.12.9.67 Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Contract between TENNCARE and the CONTRACTOR, such requirement shall be null and void and all other provisions shall remain in full force and effect.

2.12.9.68 Require that all staff employed by contracted providers and delivering employment services to ECF CHOICES members obtain certification and training pursuant to TENNCARE guidance and as required for compliance in the ECF CHOICES program.

A.2.12.10 The provider agreement with a nursing facility shall meet the minimum requirements specified in Section A.2.12.9 above and shall also include, at a minimum, the following requirements:

2.12.10.1 Require the nursing facility provider to promptly notify the CONTRACTOR, and/or State entity as directed by TENNCARE, of a member's admission or request for admission to the nursing facility regardless of payor source for the nursing facility stay, or when there is a change in a member's known circumstances and to notify the CONTRACTOR, and/or State entity as directed by TENNCARE, prior to a member's discharge;

2.12.10.2 Require the nursing facility provider to provide written notice to TENNCARE and the CONTRACTOR in accordance with state and federal requirements before voluntarily terminating the agreement and to comply with all applicable state and federal requirements regarding voluntary termination;

2.12.10.3 Require the nursing facility provider to notify the CONTRACTOR immediately if the nursing facility is considering discharging a member and to consult with the member's Care Coordinator to intervene in resolving issues if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate;

2.12.10.4 Require the nursing facility to notify the member and/or the member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements;

2.12.10.5 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the member's third party payer) plus the amount of any applicable patient liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of payment from the member in excess of the amount of applicable patient liability responsibilities. Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the member being served;

2.12.10.6 Specify the nursing facility provider's responsibilities regarding patient liability (see Sections A.2.6.7 and A.2.21.5 of this Contract), which shall include but not be limited to collecting the applicable patient liability amounts from CHOICES Group 1 members, notifying the member's Care Coordinator if there is an issue with collecting a member's patient liability, and making good faith efforts to collect payment;

2.12.10.7 Specify the role of the nursing facility provider regarding timely certification and recertification (as applicable) of the member's level of care eligibility for nursing facility care, and require the nursing facility provider to cooperate fully with the CONTRACTOR in the completion and submission of the level of care assessment;

2.12.10.8 Require the nursing facility to submit complete and accurate PAEs that satisfy all technical requirements specified by TENNCARE, and accurately reflect the member's current medical and functional status, including Safety Determination Requests. The nursing facility shall also submit all supporting documentation required in the PAE and *Safety Determination Request Form*, as applicable and required pursuant to TennCare Rules.

2.12.10.9 Require the nursing facility to notify the CONTRACTOR of any change in a member's medical or functional condition that could impact the member's level of care eligibility for the currently authorized level of nursing facility services;

2.12.10.10 Require the nursing facility provider to comply with state and federal laws and regulations applicable to nursing facilities as well as any applicable federal court orders, including but not limited to those that govern admission, transfer, and discharge policies;

2.12.10.11 Require the nursing facility to comply with federal Preadmission Screening and Resident Review (PASRR) requirements applicable to all nursing facility residents, regardless of payor source, including ensuring that a level I screening has been completed prior to admission, a level II evaluation has been completed prior to admission when indicated by the level I screening, and a review is completed based upon a significant physical or mental change in the resident's condition that might impact the member's need for or benefit from specialized services. The facility shall collaborate with the CONTRACTOR and with other providers as needed to help ensure that current information regarding the member's mental health or intellectual disabilities needs (as available) is reflected in the PASRR screening in order to support an appropriate PASRR determination;

2.12.10.12 Require the nursing facility to cooperate with the CONTRACTOR in developing and implementing protocols as part of the CONTRACTOR's nursing facility diversion and transition plans (see Section A.2.9.6.7), which shall, include, at a minimum, the nursing facility's obligation to promptly notify the CONTRACTOR upon admission or request for admission of an eligible member regardless of payor source for the nursing facility stay; how the nursing facility will assist the CONTRACTOR in identifying residents who may want to transition from nursing facility services to home and community-based care; the nursing facility's obligation to promptly notify the CONTRACTOR regarding all such identified members; and how the nursing facility will work with the CONTRACTOR in assessing the member's transition potential and needs, and in developing and implementing a transition plan, as applicable;

2.12.10.13 Require the nursing facility provider to coordinate with the CONTRACTOR in complying with the requirements in 42 CFR 483.75 regarding written transfer

agreements and shall use contract providers when transfer is medically appropriate, except as authorized by the CONTRACTOR or for emergency services;

2.12.10.14 Require the nursing facility provider to have on file a system designed and utilized to ensure the integrity of the member's personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations;

2.12.10.15 Require that nursing facilities specify whether the provider will be contracted to provide SNF services at an ERC rate for Ventilator Weaning, Chronic Ventilator Care, and/or Tracheal Suctioning in addition to standard NF and SNF services (each level of ERC reimbursement must be uniquely identified).

2.12.10.16 Prior to entering into an agreement with a NF for SNF services at an enhanced rate for ventilator weaning, chronic ventilator care, and/or tracheal suctioning, the CONTRACTOR shall verify that the NF has been licensed by the Tennessee Department of Health to provide such specialized ERC, is certified by CMS for program participation, and is compliant with threshold standards of care for the applicable type of ERC and requirements for ERC reimbursement established by TENNCARE.

2.12.10.17 Require the nursing facility provider to immediately notify the CONTRACTOR of any change in its license to operate as issued by the Tennessee Department of Health as well as any deficiencies cited during the federal certification process;

2.12.10.18 Provide that if the nursing facility provider is involuntarily decertified by the Tennessee Department of Health or the Centers for Medicare and Medicaid Services, the provider agreement will automatically be terminated in accordance with federal requirements; and

2.12.10.19 Include language requiring that the provider agreement shall be assignable from the CONTRACTOR to the State, or its designee, at the State's discretion upon written notice to the CONTRACTOR and the affected nursing facility provider. Further, the provider agreement shall include language by which the nursing facility provider agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the CONTRACTOR.

2.12.10.20 Notwithstanding the requirements provided in Section A.2.11.10.4.1.10, when there is a change of ownership with any Nursing Facility, the new provider shall provide to TENNCARE documents sufficient to obtain a Medicaid ID based on appropriate documentation submitted by the new provider. The CONTRACTOR shall, subject to the provisions set forth in T.C.A. § 71-5-1412, enter into a provider agreement with the new provider prior to the effective date of the change of ownership. A new provider with a Medicaid ID and a provider agreement with the CONTRACTOR, which shall include, but not be limited to, the assumption of the previous owner's agreement, a new agreement with the CONTRACTOR, or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. For purposes of nursing facility changes of ownership only, the CONTRACTOR may provisionally credential the new provider based on credentialing completed for the previous provider to enable execution of an agreement prior to the change of ownership. In cases where the CONTRACTOR utilizes provisional credentialing, the CONTRACTOR must subsequently conduct credentialing of the provider in accordance with Section A.2.11.10 of this Contract once the change of ownership process has fully concluded (including any actions related to licensure

and/or certification). A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

2.12.10.21 Require that, in the event the contract is terminated because of a change of ownership, the CONTRACTOR shall remain obligated to pay for reimbursable services rendered prior to termination of the contract and that become due after the contract is terminated subject to timely filing requirements.

A.2.12.11 Prior to executing a provider agreement with any CHOICES or ECF CHOICES HCBS provider seeking Medicaid reimbursement for CHOICES or ECF CHOICES HCBS, the CONTRACTOR shall verify that the provider is compliant with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5). The provider agreement with a CHOICES or ECF CHOICES HCBS provider shall meet the minimum requirements specified in Section A.2.12.9 above and shall also include, at a minimum, the following requirements:

2.12.11.1 Require the CHOICES or ECF CHOICES HCBS provider to provide at least thirty (30) days advance notice to the CONTRACTOR when the provider is no longer willing or able to provide services to a member, including the reason for the decision, and to cooperate with the member's Care Coordinator to facilitate a seamless transition to alternate providers;

2.12.11.2 In the event that a CHOICES or ECF CHOICES HCBS provider change is initiated for a member, require that, regardless of any other provision in the provider agreement, the transferring HCBS provider continue to provide services to the member in accordance with the member's person-centered support plan, as appropriate until the member has been transitioned to a new provider, as determined by the CONTRACTOR, or as otherwise directed by the CONTRACTOR, which may exceed thirty (30) days from the date of notice to the CONTRACTOR unless the member refuses continuation of services, the member's health and welfare would be otherwise at risk by remaining with the current provider or if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm. The CONTRACTOR shall document clearly any member refusal of services, and all concerns and actions taken to remediate the concerns if the welfare and safety of either the member and/or the staff will result in services not being delivered. Prior to discontinuing service to the member or prior to Provider termination of its Provider Agreement, as applicable, the Provider shall be required to:

2.12.11.2.1 Provide a written notification of the planned service discontinuation to the member, his/her conservator or guardian, and his/her support coordinator, no less than thirty (30) days prior to the proposed date of service or Provider Agreement termination;

2.12.11.2.2 Obtain the CONTRACTOR's approval, in the form of a signed PCSP, to discontinue the service and cooperate with transition to any subsequent, authorized service provider as is necessary; and

2.12.11.2.3 Consult and cooperate with the CONTRACTOR in the preparation of a discharge plan for all members receiving care and service from the Provider in the event of a proposed termination of service. Also, when appropriate, as part of the discharge plan, the terminating provider shall meet, consult and cooperate with any new providers to ensure continuity of care and as smooth a transition as possible.

2.12.11.3 Specify that reimbursement of a CHOICES or ECF CHOICES HCBS provider shall be contingent upon the provision of services to an eligible member in accordance with applicable federal and state requirements and the member's plan of care or person-centered support plan, as appropriate as authorized by the CONTRACTOR, and must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific HCBS provided, the name of the member receiving the service, the name of the staff person who delivered the service, the detailed tasks and functions performed as a component of each service, notes for other caregivers (whether paid or unpaid) regarding the member or his/her needs (as applicable), and the initials or signature of the staff person who delivered the service;

2.12.11.4 Require CHOICES or ECF CHOICES HCBS providers to immediately report any deviations from a member's service schedule that would affect service authorizations to the member's Care Coordinator;

2.12.11.5 Require CHOICES and ECF CHOICES HCBS providers, as applicable, to use the electronic visit verification system specified by the CONTRACTOR in accordance with the CONTRACTOR's requirements;

2.12.11.6 Require that upon acceptance by the CHOICES or ECF CHOICES HCBS provider to provide approved services to a member as indicated in the member's plan of care or person-centered support plan, as appropriate, the provider shall ensure that it has staff sufficient to provide the service(s) authorized by the CONTRACTOR in accordance with the member's plan of care or person-centered support plan, as appropriate, including the amount, frequency, duration and scope of each service in accordance with the member's service schedule;

2.12.11.7 Require CHOICES and ECF CHOICES HCBS providers to provide back-up for their own staff if they are unable to fulfill their assignment for any reason and ensure that back-up staff meet the qualifications for the authorized service;

2.12.11.8 Prohibit CHOICES and ECF CHOICES HCBS providers from requiring a member to choose the provider as a provider of multiple services as a condition of providing any service to the member;

2.12.11.9 Prohibit CHOICES and ECF CHOICES HCBS providers from soliciting members to receive services from the provider including:

2.12.11.9.1 Referring an individual for CHOICES or ECF CHOICES screening and intake with the expectation that, should CHOICES or ECF CHOICES enrollment occur, the provider will be selected by the member as the service provider;

2.12.11.9.2 Communicating with existing CHOICES or ECF CHOICES members via telephone, face-to-face or written communication for the purpose of petitioning the member to change providers;

2.12.11.9.3 Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHOICES or ECF CHOICES members that should instead be referred to the person's MCO, AAAD, or DIDD as applicable;

2.12.11.10 Require CHOICES and ECF CHOICES HCBS providers to comply with critical incident reporting and management requirements as prescribed by TENNCARE, including those requirements in Section A.2.15.7 of this Contract;

2.12.11.11 Prohibit CHOICES and ECF CHOICES providers from altering in any manner official CHOICES, or ECF CHOICES materials unless the CONTRACTOR has submitted a request to do so to TENNCARE and obtained prior written approval from TENNCARE in accordance with Section A.2.17 of this Contract;

2.12.11.12 Prohibit CHOICES providers from reproducing for its own use the CHOICES logos unless the CONTRACTOR has submitted a request to do so to TENNCARE and obtained prior written approval from TENNCARE in accordance with Section A.2.17 of this Contract;

2.12.11.13 The CONTRACTOR shall require all of the CONTRACTOR's CHOICES and ECF CHOICES HCBS providers to submit copies of current licensure and/or certification (as applicable) to the CONTRACTOR; and

2.12.11.14 The CONTRACTOR shall require that all CHOICES and ECF CHOICES HCBS providers maintain compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

2.12.11.15 The CONTRACTOR shall require that all CHOICES and ECF CHOICES HCBS providers utilizing the EVV system ensure that all HCBS workers complete and submit worker surveys upon logging out of each visit using a format and in a manner prior approved by TENNCARE.

2.12.11.16 Notwithstanding the requirements provided in Section A.2.11.10.4.1.10, when there is a proposed change of ownership with any CHOICES or ECF CHOICES provider, the new provider shall provide to TENNCARE documents sufficient to obtain a Medicaid ID based on appropriate documentation submitted by the new provider and any Managed Care Contractor previously contracted with the former owner or operator. CONTRACTOR shall enter into a provider agreement with the new owner/operator. A new provider with a Medicaid ID and an executed contract with the CONTRACTOR, which shall include, but not be limited to, the assumption of the previous owner's contract, a new contract with the CONTRACTOR, or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. A new provider with a Medicaid ID, but without an executed contract with the CONTRACTOR, shall be reimbursed eighty percent (80%) from the effective date of the change of ownership, with a retroactive payment to the effective date of the change of ownership of an additional twenty percent (20%) due after the execution of a contract with the CONTRACTOR. A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

2.12.11.17 The CONTRACTOR shall require that all CHOICES and ECF CHOICES providers for whom DIDD is providing quality monitoring, as specified by TENNCARE, must cooperate with all quality monitoring processes and requirements, as described herein or in TENNCARE quality monitoring protocols.

A.2.12.12 The provider agreement with a CHOICES HCBS provider to provide PERS, assistive technology, minor home modifications, or pest control shall meet the requirements specified in Sections A.2.12.8, A.2.12.9, and A.2.12.11 except that these provider agreements shall not be required to meet the following requirements: Section A.2.12.9.9 regarding emergency services; Section A.2.12.9.11 regarding delay in prenatal care; Section A.2.12.9.12 regarding CLIA; Section A.2.12.9.44 regarding hospital protocols; Section A.2.12.9.45 regarding reimbursement of obstetric care; Section A.2.12.9.58.2 regarding prior authorization of pharmacy; and Section A.2.12.9.59 regarding coordination with the PBM. Exceptions may also be granted to these and other requirements in Section A.2.12 for certain ECF CHOICES HCBS as specified by TENNCARE in writing.

A.2.12.13 The provider agreement with a local health department (see Section A.2.11.9.3) shall meet the minimum requirements specified in Sections A.2.12.8 and A.2.12.9 above and shall also specify for the purpose of TennCare Kids screening services: (1) that the local health department agrees to submit encounter data timely to the CONTRACTOR; (2) that the CONTRACTOR agrees to timely process claims for services in accordance with Section A.2.22.4; (3) that the local health department may terminate the agreement for cause with thirty (30) days advance notice; and (4) that the CONTRACTOR agrees prior authorization shall not be required for the provision of TennCare Kids screening services.

A.2.12.14 In addition to Sections A.2.12.11 through A.2.12.13 above, provider agreements with all ECF CHOICES providers, as well as provider agreements with all CHOICES CLS and CLS-FM providers shall include the following additional requirements:

2.12.14.1 Residential providers shall develop and maintain policies concerning fire evacuation and natural disasters, including ensuring staff are knowledgeable about evacuation procedures and any available safety equipment (e.g., fire extinguishers).

2.12.14.2 Providers shall routinely monitor the maintenance of a sanitary and comfortable living environment and/or program site, and shall develop and maintain policies for staff to identify and report any individual or systemic problems identified. Additionally, all CLS-FM providers must complete a DIDD-compliant home study and a current DIDD Family Model Residential Supports Initial Site Survey prior to member placement.

2.12.14.3 Providers with provider-owned vehicles (including employee-owned vehicles used to transport members) shall develop and maintain policies to routinely inspect such vehicles, including adaptive equipment used in such vehicles, and report and resolve any deficiencies with these vehicles.

2.12.14.4 Providers shall designate a staff member as an Incident Management Coordinator who shall be trained on critical incident and Reportable Event processes by the CONTRACTOR as prescribed by TENNCARE. Such staff member shall be the provider's lead for critical incidents and Reportable Events, be primarily responsible for tracking and analyzing critical incidents and Reportable Events, and be the CONTRACTOR's main point of contact at the provider agency for critical incidents and Reportable Events.

2.12.14.5 Providers shall develop and maintain a crisis intervention policy that is consistent with TennCare requirements and approved by the CONTRACTOR. As applicable, policies shall include instructions for the use of psychotropic medications and behavioral safety interventions.

2.12.14.6 Providers shall develop and maintain a complaint resolution process, which includes, but is not limited to the following: designation of a staff member as the complaint contact person; maintenance of a complaint log; and documentation and trending of complaint activity. The provider's policies and procedures concerning the complaint resolution process shall be available to the CONTRACTOR upon request.

2.12.14.7 As applicable, providers providing assistance to members with medication administration shall develop and maintain policies to ensure any medications are provided and administered by trained and qualified staff consistent with a physician's orders. Such providers shall ensure that medication administration records are properly maintained, and that all medication is properly stored and accessible to members when needed. Such providers shall also develop and maintain policies to track and trend medication variance and omission incidents to analyze trends and implement preventions strategies.

2.12.14.8 Providers shall develop and maintain policies approved by the CONTRACTOR that ensure members are treated with dignity and respect, including training staff on person-centered practices. Such policies shall include, but are not limited to:

2.12.14.8.1 Ensuring members/representatives and family are given the opportunity to participate in the selection and evaluation of their direct support staff, if applicable;

2.12.14.8.2 Soliciting member/representative and family feedback on provider services;

2.12.14.8.3 Ensuring the member/representative has information to make informed choices about available services;

2.12.14.8.4 Ensuring members are allowed to exercise personal control and choice related to their possessions;

2.12.14.8.5 Supporting members in exercising their rights;

2.12.14.8.6 Periodically reviewing members' day services and promoting meaningful day activities, if applicable;

2.12.14.8.7 Supporting the member in pursuing employment goals; and

2.12.14.8.8 Only restricting members' rights as provided in the member's person-centered support plan.

2.12.14.9 Residential providers shall develop and maintain policies to ensure that members have good nutrition while being allowed to exercise personal choice and that members' dietary and nutritional needs are met.

2.12.14.10 Providers shall ensure that staff have appropriate, job-specific qualifications and shall verify prior to and routinely during employment that provider staff have all required licensure and certification. Additionally, all providers shall ensure that staff receive ongoing supervision consistent with staff job functions.

2.12.14.11 Providers shall ensure that the composition of the provider board of directors or community advisor group, as applicable, reflects the diversity of the community that the provider serves and is representative of the people served.

2.12.14.12 Residential providers shall have policies and procedures to manage and protect members' personal funds that comport with all applicable TennCare policies, procedures and protocols.

2.12.14.13 Providers shall agree to carry adequate liability and other appropriate forms of insurance, which shall include, but is not limited to, the following.

2.12.14.13.1 Workers' Compensation/ Employers' Liability (including all States' coverage) with a limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence for employers' liability.

2.12.14.13.2 Comprehensive Commercial General Liability (including personal injury & property damage, premises/operations, independent Provider, contractual liability and completed operations/products coverage) with bodily injury/property damage combined single limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence and one million, five hundred thousand dollars ($1,500,000.00) aggregate.

2.12.14.13.3 Automobile Coverage (including owned, leased, hired, and non-owned vehicles coverage) with a bodily injury/property damage combined single limits not less than one million, five hundred thousand dollars ($1,500,000.00). Employment and Community First CHOICES providers requiring this coverage are limited to those expected to transport the member as a component of service delivery, as follows: individual and small group employment supports (including pre-employment services), personal assistance, supportive home care, community integration support services, community transportation, independent living skills training, community living supports, and community living supports—family model.

2.12.14.14 Notwithstanding the requirements provided in Section A.2.11.10.4.1.10, when there is a proposed change of ownership, the new provider shall provide to TENNCARE documents sufficient to obtain a Medicaid ID based on appropriate documentation submitted by the new provider and any Managed Care Contractor previously contracted with the former owner or operator. CONTRACTOR shall enter into a provider agreement with the new owner/operator. A new provider with a Medicaid ID and an executed contract with the CONTRACTOR, which shall include, but not be limited to, the assumption of the previous owner's contract, a new contract with the CONTRACTOR, or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. A new provider with a Medicaid ID, but without an executed contract with the CONTRACTOR, shall be reimbursed eighty percent (80%) from the effective date of the change of ownership, with a retroactive payment to the effective date of the change of ownership of an additional twenty percent (20%) due after the execution of a contract with the CONTRACTOR. A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

A.2.12.15 The CONTRACTOR shall maintain an agreement with the PBM for the purpose of making payment to the PBM on behalf of TENNCARE for TennCare covered services. The agreement shall be in accordance with an approved template provided by TENNCARE. The CONTRACTOR shall not be at risk for payment made to the TennCare contracted PBM (see Section C.3).

A.2.12.16 The CONTRACTOR shall comply with the Annual Coverage Assessment Act, (T.C.A. 71-5-1003 et seq., 71-5-160 et seq.).

2.12.16.1 The CONTRACTOR shall be prohibited from implementing across the board rate reductions to covered or excluded contract hospitals or physicians either by category or type of provider. These requirements shall also apply to services or settings of care that are ancillary to a covered or excluded hospital, or physician's primary license if the physician or covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate of a covered or excluded hospital or hospital system, holds more than fifty percent (50%) controlling interest in such ancillary services or settings of care, but shall not apply to any other ancillary services or settings of care. For purposes of this Section, covered or excluded contract hospitals or physicians shall be those as defined by the Annual Coverage Assessment Act.

2.12.16.2 The CONTRACTOR shall notice providers regarding across the board rate reductions and shall include language in the notice that describes those providers to be excluded from the across the board rate reduction in accordance with the Annual Coverage Assessment Act. The provider exclusion language shall be conspicuously placed on the front page of the notice and will advise providers who believe they meet the exclusion criteria specified in the Act of the process for demonstrating such to the MCO.

2.12.16.3 For purposes of this requirement, services or settings of care that are "ancillary" shall mean, but not be limited to, ambulatory surgical facilities, outpatient treatment clinics or imaging centers, dialysis centers, home health and related services, home infusion therapy services, outpatient rehabilitation or skilled nursing services. Further, for purposes of this requirement, "physician" includes a physician licensed under title 63, chapter 6 and chapter 9 and a group practice of physicians that hold a contract with the CONTRACTOR.

A.2.12.17 All provider agreements for CLS and CLS-FM providers shall include a requirement that such providers allow DIDD staff access to pertinent CHOICES and ECF CHOICES member documentation as specified in TennCare protocol during 1915(c) waiver critical incident investigations in CLS and CLS-FM blended residences in instances where the critical incident may impact all residents of the home (for example, staff misconduct). For the purpose of this Contract, a CLS or CLS-FM blended residence is one in which at least one (1) CHOICES or ECF CHOICES member and one (1) 1915(c) waiver participant receive services in the same CLS or CLS-FM residence.

A.2.12.18 All provider agreements for CLS and CLS-FM providers shall include a requirement that such providers are required to comply with DIDD investigations as prescribed by TennCare protocol.

A.2.12.19 The CONTRACTOR shall require that contracted providers in CHOICES and ECF CHOICES are responsible for acquiring, developing, and deploying a sufficiently staffed and qualified workforce to capably deliver services to members in a person-centered way. Upon acceptance of an authorization for services, contracted providers shall be obligated to deliver services in accordance with the PCSP, including the amount, frequency, intensity, and duration of services specified in the PCSP, and shall be responsible for arranging back-up staff to address instances when other scheduled staff are not able to deliver services as scheduled. The Provider shall, in any and all circumstances, except member refusal of continuation of services, instances where the member’s health and welfare would be otherwise at risk by remaining with the current provider, if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm, or following termination of the Agreement, continue to provide services that maintain continuity of care to the person supported in accordance with

his/her PCSP until other services are arranged and provided that are of acceptable and appropriate quality. The CONTRACTOR shall document clearly any member refusal of services, and all concerns and actions taken to remediate the concerns if the welfare and safety of either the member and/or the worker will result in services not being delivered.

A.2.12.20 The CONTRACTOR shall require that all contracted ECF CHOICES providers report the following Tier 3 Reportable Events to the member's MCO within two (2) business days of witnessing or discovery of the Tier 3 Reportable Event. Reporting and review of such Tier 3 Reportable Events is secondary to any medical attention required by the person supported.

2.12.20.1 Tier 3 Reportable Medical Events, which include:

2.12.20.1.1 Deaths (other than those that are unexpected/unexplained);

2.12.20.1.2 ER visits;

2.12.20.1.3 Any inpatient observation or admission (acute care, Long-Term Acute Care Hospital, or SNF/NF);

2.12.20.1.4 Use of CPR or an automated external defibrillator (AED);

2.12.20.1.5 Choking episode requiring physical intervention (e.g.., use of abdominal thrust or Heimlich maneuver;

2.12.20.1.6 Fall with injury (including minor or serious);

2.12.20.1.7 Insect or animal bite requiring treatment by a medical professional;

2.12.20.1.8 Stage II and above pressure ulcer;

2.12.20.1.9 Staph infection;

2.12.20.1.10 Fecal impaction;

2.12.20.1.11 Severe dehydration requiring medical attention;

2.12.20.1.12 Seizure progressing to status epilepticus;

2.12.20.1.13 Pneumonia;

2.12.20.1.14 Severe allergic reaction requiring medical attention; and

2.12.20.1.15 Victim of natural disaster (natural disasters affecting multiple individuals do not require multiple individual reports).

2.12.20.2 Tier 3 Reportable Behavioral Events, which include:

2.12.20.2.1 Criminal conduct or incarceration;

2.12.20.2.2 Engagement of law enforcement;

2.12.20.2.3 Sexual aggression;

2.12.20.2.4 Physical aggression;

2.12.20.2.5 Injury to another person as a result of a behavioral incident of a person supported;

2.12.20.2.6 Suicide attempt;

2.12.20.2.7 Self-injurious behavior;

2.12.20.2.8 Property destruction greater than $100;

2.12.20.2.9 Swallow inedible/harmful matter;

2.12.20.2.10 Behavioral crisis requiring protective equipment, manual or mechanical restraints, regardless of type or time used or approved by PCSP (all take-downs and prone restraints are prohibited);

2.12.20.2.11 Behavioral crisis requiring PRN psychotropic medication;

2.12.20.2.12 Behavioral crisis requiring crisis intervention (i.e., call);

2.12.20.2.13 Behavioral crisis requiring in-home stabilization (SOS participants only);

2.12.20.2.14 Behavioral crisis requiring out-of-home therapeutic respite; and

2.12.20.2.15 Psychiatric admission (or observation), including in acute care hospital.

2.12.20.3 For any Reportable Event, the CONTRACTOR shall require that the provider have supervisory staff (including clinical staff, as applicable) review the Reportable Event and determine appropriate follow up. For Tier 3 Reportable Behavioral Events, this may include follow up with the member's PCP or behavioral health provider, as applicable, to provide information and determine any needed treatment adjustments, follow up with the person's Support Coordinator regarding any needed adjustments in the PCSP, and targeted training or assistance for agency staff who support the person. All Tier 3 Reportable Events, any medical attention provided, and follow up shall be documented in the member's record.

2.12.20.4 Both the provider and CONTRACTOR shall be responsible for tracking and trending all Tier 3 Reportable Events above and evaluating such events to determine how to prevent or reduce similar occurrences in the future whenever possible. Such efforts may be targeted to an individual person supported, a particular service setting or location, a particular type of Tier 3 Reportable Event, a particular provider, or may be system-wide.

A.2.12.21 The CONTRACTOR shall require that all contracted ECF CHOICES providers shall be responsible for documenting, addressing, tracking, and trending Non-Reportable Events, which do not rise to the level of Tier 1, Tier 2, or Tier 3 Reportable Events as defined by TENNCARE. The provider shall immediately contact DIDD by appropriate hotline number or the MCO and DIDD within twenty-four (24) hours if during a provider's review of a Non-Reportable Event the provider discovers the Non-Reportable Event should be classified as a Tier 1 or Tier 2 Reportable Event (see Section A.2.15.7.6), respectively. Non-Reportable Events shall be defined as follows:

2.12.21.1 Any instance of disrespectful or inappropriate communication, e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts pertaining to a

person supported that is not directed to or within eyesight or audible range of the person supported and that does not meet the definition of emotional or psychological abuse (the CONTRACTOR shall require providers under this Section to report such complaints to the CONTRACTOR and the CONTRACTOR shall include such complaints in the CONTRACTOR's non-discrimination reporting pursuant to A.2.30.22.3.2.1);

2.12.21.2 Failure to provide goods or services which do not result in injury or probable risk of serious harm (i.e., does not meet neglect threshold);

2.12.21.3 Minor injury not requiring medical treatment beyond first aid by a lay person and is not associated with abuse or neglect; and

2.12.21.4 Staff misconduct that falls outside the definition of Tier 1 or Tier 2 Reportable Events (see Section A.2.15.7.6) or Tier 3 Reportable Medical and Behavioral Events and does not result in serious injury or probable risk of serious injury. An example would include failure to follow the PCSP when such action (or inaction) would not pose a probable risk of serious injury; staff convenience; or minor traffic violation while transporting person.

A.2.12.22 All ECF CHOICES provider agreements shall require that all direct support staff (i.e., provider staff working directly with people in ECF CHOICES) complete required training as prescribed by TENNCARE within thirty (30) days of hire and prior to providing direct support to members.

A.2.12.23 All provider agreements between the CONTRACTOR and a home health agency (HHA) shall require the HHA to comply with the federal regulations delineating the conditions of participation that HHAs must meet in order to participate in the Medicaid program. Each provider agreement must contain a general provision to that effect.

2.12.23.1 Each provider agreement must specify that the contracted HHA supply each enrollee with the following:

2.12.23.1.1 Written and verbal notice of the enrollee's rights and responsibilities as a home health patient as required under 42 CFR §484.50(a);

2.12.23.1.2 Written and verbal notice of the HHA's policy for transfer and discharge as required under 42 CFR §484.50(d), including an explanation in plain language that disruptive, abusive, or uncooperative behaviors could give rise to a "discharge for cause," and the requirements that must be satisfied by the HHA in order for transfer or a discharge to be effectuated;

2.12.23.1.3 Written and verbal notice of the HHA's obligation to accept complaints made by the enrollee about the care that is (or fails to be) furnished, and of the HHA's obligation to investigate, document, and resolve these enrollee complaints (as well as complaints of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, or injuries of unknown source, or misappropriation of the enrollee's property by anyone furnishing care on behalf of the HHA) as required under 42 CFR §484.50(e).

2.12.23.1.4 The HHA must explain to the enrollee the scope of the home health services that the enrollee will be receiving. Afterwards, the HHA must obtain the signature of the enrollee verifying that an HHA staff member has explained the scope of services to the enrollee. Likewise, the HHA must obtain, as required under 42

C.F.R. § 484.50(a)(2), the enrollee's or the legal representative's signature confirming that they received written notice of the enrollee's rights and responsibilities as required by Section A.2.12.23.1.1. The HHA must maintain all signature(s) in their record of the enrollee.

2.12.23.1.5 The HHA must develop a back-up plan for each enrollee to be implemented during missed visits, as defined by Section A.2.15.9.1, or when otherwise necessary.

2.12.23.1.6 When the HHA is notified before a missed visit occurs or as it is occurring, the HHA must contact the enrollee and implement the back-up plan or offer a suitable alternative service. The HHA must report all missed visits to the CONTRACTOR in writing within three calendar days of the missed visit. This report must be submitted on a CONTRACTOR-approved form, which captures all of the information the CONTRACTOR requires, including, but not limited to, the following: the identity of the enrollee; the type of service involved; the date of the missed visit; the cause(s); and, what corrective action was taken to mitigate the cause(s) of the missed visit. The HHA must ensure that the staff member enters notes about the circumstances of a missed visit in every instance in which notes are possible.

2.12.23.1.7 When a conflict arises between an enrollee and an assigned HHA staff member, or when an enrollee refuses to allow an assigned staff member to begin or to complete their assigned visit, the staff member will immediately notify the HHA. Once notified, the HHA will contact the enrollee and offer to either (1) implement the existing back-up plan or (2) staff the care with a qualified alternative staff member. In every instance, the HHA must record these missed visits, as described above, and timely submit them to the CONTRACTOR. All of the aforementioned facts should be included in the reports with as much written explanation as possible regarding the causes and factors contributing to the conflict. If additional conflicts arise between the enrollee and the HHA or alternative staff member (for example, if an enrollee refuses to admit the alternative staff member into enrollee's home), the HHA must notify the CONTRACTOR and must continue making reasonable efforts to staff the approved care with qualified alternative staff members until the HHA, in its discretion, plans to discharge the enrollee for cause. At that point, the HHA must notify the CONTRACTOR of its decision to discharge or transfer the enrollee.

A.2.13 PROVIDER AND SUBCONTRACTOR PAYMENTS

A.2.13.1 General

2.13.1.1 The CONTRACTOR shall agree to reasonable reimbursement standards to providers for covered services, to be determined in conjunction with actuarially sound rate setting. The CONTRACTOR shall not agree to reimbursement rate methodology that provides for an automatic increase in rates. All reimbursement paid by the CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State.

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

2.13.1.3 The CONTRACTOR shall not pay a PCP for services provided to members that have not been assigned to the PCP or the practice within which the PCP is affiliated. However, the CONTRACTOR shall allow members to call or fax a PCP change request that will facilitate an immediate change to the assigned PCP (see Section A.2.11.2.6).

2.13.1.4 If the CONTRACTOR is required to reimburse a non-contract provider pursuant to this Contract, and the CONTRACTOR's payment to a non-contract provider is less than it would have been for a contract provider, and the provider contests the payment amount, the CONTRACTOR shall notify the non-contract provider that the provider may initiate the independent review procedures in accordance with TCA 56-32-126, including but not limited to reconsideration by the CONTRACTOR.

2.13.1.5 The CONTRACTOR shall ensure that the member is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing amounts (described in Section A.2.6.7 and in Attachment II of this Contract) and patient liability amounts.

2.13.1.6 The CONTRACTOR shall ensure that payments are not issued under this Contract for an item or service in accordance with the following:

2.13.1.6.1 To providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements, as applicable, have not been obtained in accordance with 42 CFR 455.100 through 106, Section A.2.12.9.37 of this Contract, and TennCare policies and procedures;

2.13.1.6.2 Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XIX or XX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act;

2.13.1.6.3 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX or XX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

2.13.1.6.4 Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

2.13.1.6.5 With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997;

2.13.1.6.6 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

2.13.1.7 The CONTRACTOR, as well as its subcontractors and tax-reporting provider entities shall not be permitted to assign TennCare funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (SAM) screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited.

2.13.1.8 For any entities to which the CONTRACTOR makes payment via electronic transfers, the CONTRACTOR shall have a signed EFT form that shall have 42 CFR 455.18 and 455.19 statements immediately preceding the "Signature" section.

2.13.1.9 The CONTRACTOR shall implement Episodes of Care (retrospective episode based reimbursement for specialty and acute care) and Primary Care Transformation strategies, inclusive of PCMH (comprehensive primary care program) and Tennessee Health Link (integrated care coordination for members with the highest behavior health needs), consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TENNCARE. This includes but is not limited to:

2.13.1.9.1 Using a retrospective process to administer value-based outcome payments for the initiative's payment reform strategies that is aligned with the models designed by TENNCARE.

2.13.1.9.2 Implementing key design choices as directed by TENNCARE, including the definition of each episode, and the definition of quality measures for the initiative's payment reform strategies.

2.13.1.9.3 Implementation of payment reform strategies and improvements at a pace dictated by the State. This includes actively participating in episodes-related stakeholder conversations.

2.13.1.9.4 Implementation of aligned TennCare PCMH strategy shall include at least thirty-seven percent (37.0%) of the CONTRACTOR's TennCare population beginning January 1, 2019 and at least thirty-seven percent (37.0%) of the population beginning January 1, 2020.

2.13.1.9.4.1 In order for TENNCARE to monitor the CONTRACTOR's compliance, the CONTRACTOR shall track and report PCMH participation and membership in accordance with the following:

2.13.1.9.4.1.1 The CONTRACTOR shall submit PCMH projected membership counts for members attributed to groups that are anticipated to sign and/or renew TennCare PCMH contracts for the following year with the CONTRACTOR.

2.13.1.9.4.1.2 The CONTRACTOR shall submit PCMH actual membership counts for members attributed to groups that are participating in PCMH.

2.13.1.9.4.1.3 PCMH membership counts shall be submitted in accordance with Sections A.2.30.4.8.1 and A.2.30.4.8.2.

2.13.1.9.4.1.4 The Contractor shall notify the State within thirty (30) days of terminating participation with a PCMH provider.

2.13.1.9.4.1.5 PCMH *projected* membership counts shall be calculated using the following formulas:

Target Due Date	Formula
July 31	CONTRACTOR's total TennCare PCMH membership as of June 30 from *anticipated* PCMH TINs as of the June enrollment report
December 31	CONTRACTOR's total TennCare PCMH membership as of November 30 from *anticipated* PCMH TINs for January 1 of following year / CONTRACTOR's total TennCare members as of the November enrollment report

2.13.1.9.4.1.6 PCMH actual membership counts shall be calculated using the following formula:

Target Due Dates	Formula
February 28 May 31 August 31 November 30	CONTRACTOR's total TennCare PCMH membership as of January 31, April 30, July 31, and October 31 from *actual* PCMH TINs/ CONTRACTOR's total TennCare members as of the same month's enrollment report

2.13.1.9.4.1.7 TENNCARE will monitor the CONTRACTOR's progress in accordance with the following timeline:

Target Due Date	Benchmark
May 31, 2019	TENNCARE will verify that the CONTRACTOR is meeting the PCMH membership requirement for 2019
July 31, 2019	TENNCARE will verify that the CONTRACTOR is on track to meet the PCMH membership requirement for 2020
August 31, 2019	TENNCARE will verify that the CONTRACTOR is meeting the PCMH membership requirement for 2019
November 30, 2019	TENNCARE will verify that the CONTRACTOR is meeting the PCMH membership requirement for 2019
December 31, 2019	TENNCARE will verify that the CONTRACTOR is on track to meet the PCMH membership requirement for 2020
February 28, 2020	TENNCARE will verify that the CONTRACTOR is meeting the PCMH membership requirement for 2020

2.13.1.9.4.1.8 If the CONTRACTOR fails to meet and maintain the percentage benchmarks described herein, the CONTRACTOR shall provide a contingency plan to TENNCARE within five (5) business days of TENNCARE's quarterly calculation. This contingency plan will describe efforts to meet the thirty seven percent (37.0%) benchmark which shall be achieved within thirty (30) calendar days of reported deficiency. If the thirty seven percent (37.0%) benchmark is not reached by the thirtieth (30th) calendar day, the CONTRACTOR shall submit a corrective action plan (CAP) and shall be subject to liquidated damages.

2.13.1.9.5 Participate in a State-led process to design, launch and refine the initiative's payment reform strategies, including the seeking of clinical input from payer medical teams and clinical leaders throughout Tennessee for the development of new episodes.

2.13.1.9.6 The CONTRACTOR shall submit to TENNCARE, PCMH and THL attribution files for the Care Coordination Tool in accordance with TENNCARE policy and Section A.2.30.4.10.

2.13.1.9.7 The CONTRACTOR shall submit an annual *Provider Engagement Plan* and quarterly *Provider Engagement Tracker* detailing information and communication plans with the Tennessee Health Link (THL), Patient Centered Medical Home (PCMH) and Episodes of Care providers in accordance with Sections A.2.30.4.6.1 and A.2.30.4.6.2.

2.13.1.9.8 The CONTRACTOR shall provide training and technical assistance for PCMH, THL, and EOC as described in Section A.2.18.6 of this Contract.

2.13.1.9.9 Delivering performance reports for the initiative's payment reform strategies with the same appearance and content as those designed by the State/Payer Coalition.

2.13.1.9.10 The CONTRACTOR shall update cost and quality thresholds annually for all episodes in performance. The updated cost and quality thresholds shall be included in the Episodes of Care Performance Reports.

2.13.1.9.11 The CONTRACTOR shall submit documents related to Payment Reform Initiatives (e.g., data analytics requests) to TENNCARE in a timely manner as requested by the state.

2.13.1.10 The CONTRACTOR shall implement State Budget Reductions and Payment Reform Initiatives, including retrospective episode based reimbursement, as described by TENNCARE. The CONTRACTOR's failure to implement State Budget Reductions and/or Payment Reform Initiatives as described by TENNCARE may, at the discretion of TENNCARE, result in the CONTRACTOR forfeiting savings that would have been realized based on the timely implementation, including the forfeiture of recoupment from providers.

2.13.1.10.1 The CONTRACTOR shall not retroactively adjust payments made to an out of network provider due to budget reductions unless approved by TENNCARE.

2.13.1.11 Effective January 1, 2021, the CONTRACTOR shall reimburse providers for services provided to CoverKids members based on a state provided CoverKids Fee Schedule.

A.2.13.2 **All Covered Services**

2.13.2.1 Except as provided in Sections A.2.13.2.1.1 and A.2.13.2.1.2 below, the CONTRACTOR shall not reimburse providers based on a percentage of billed charges.

2.13.2.1.1 The CONTRACTOR may, at its discretion, pay a percentage of billed charges for covered physical health and behavioral health services for which there is no Medicare reimbursement methodology.

2.13.2.1.2 As part of a stop-loss arrangement with a physical health or behavioral health provider, the CONTRACTOR may, at its discretion, pay the provider a percentage of billed charges for claims that exceed the applicable stop-loss threshold.

2.13.2.2 The CONTRACTOR shall not reimburse providers based on automatic escalators or linkages to other methodologies that escalate such as current Medicare rates or inflation indexes unless otherwise allowed by TENNCARE.

A.2.13.3 **Nursing Facility Services**

2.13.3.1 The CONTRACTOR shall reimburse contract nursing facility providers at the per diem rate specified by TENNCARE, net of any applicable patient liability amount (see Section A.2.6.7).

2.13.3.2 The CONTRACTOR shall reimburse non-contract nursing facility providers as specified in TennCare rules and regulations, net of any applicable patient liability amount (see Section A.2.6.7).

2.13.3.3 The CONTRACTOR shall be responsible for monitoring the member's continued need for and receipt of skilled and/or rehabilitative services in a NF only when approval of NF LOC is conditioned on the receipt of such services, and in such case, when skilled and/or rehabilitative services are no longer medically necessary, shall submit information needed by TENNCARE to reevaluate whether the member continues to meet level of care for nursing facility services (see also Section A.2.14.1.14).

2.13.3.4 The CONTRACTOR shall, upon receipt of notification from TENNCARE of a retrospective adjustment of a nursing facility's per diem rate(s), provide to TENNCARE within one (1) business day written confirmation of the receipt of such adjustment(s), and shall, without requiring any action on the part of the provider, reprocess affected claims and provide any additional payment due within sixty (60) days of receipt of such notification. The CONTRACTOR shall notify TENNCARE within two (2) business days when the adjudication of all affected claims has been completed. The CONTRACTOR shall, upon notification in the outbound 834 enrollment file of retroactive patient liability amounts or retroactive adjustments in patient liability amounts, without requiring any action on the part of the provider, reprocess affected claims and provide any additional payment due within thirty (30) days of receipt of such notification. The CONTRACTOR shall not require that NFs resubmit affected claims in order to process these adjustments.

A.2.13.4 **CHOICES HCBS and ECF CHOICES HCBS**

2.13.4.1 For covered CHOICES and ECF CHOICES HCBS and for CHOICES and ECF CHOICES HCBS that exceed the specified benefit limit and are provided by the CONTRACTOR as a cost effective alternative (see Section A.2.6.5), the CONTRACTOR shall reimburse contract HCBS providers, including community-based residential alternatives, at the rate specified by TENNCARE.

2.13.4.2 The CONTRACTOR shall reimburse non-contract CHOICES and ECF CHOICES HCBS providers as specified in TennCare rules and regulations.

2.13.4.3 For other HCBS that are not otherwise covered but are offered by the CONTRACTOR as a cost effective alternative to nursing facility services (see Section A.2.6.5), the CONTRACTOR shall negotiate the rate of reimbursement.

2.13.4.4 The CONTRACTOR shall reimburse the FEA for payments provided to consumer-directed workers in accordance with Sections A.2.9.7.6.11 and A.2.26 of this Contract.

A.2.13.5 **Hospice**

Hospice services shall be provided and reimbursed in accordance with state and federal requirements, including but not limited to the following:

2.13.5.1 Rates shall be no less than the federally established Medicaid hospice rates (updated each federal fiscal year (FFY)), adjusted by area wage adjustments for the categories described by CMS;

2.13.5.2 The rates described above shall be subject to the annual cap for Medicaid Hospice rates as provided annually by CMS; and

2.13.5.3 If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR shall pay an amount equal to at least ninety-five percent (95%) of the prevailing NF room and board rate to the hospice provider (not subject to the annual cap for Medicaid Hospice rates).

2.13.5.4 If a member in CHOICES Group 2 or Group 3 admits to a nursing facility for receipt of NF services (including a short-term NF stay) and will receive hospice in the NF, the CONTRACTOR shall disenroll such member from CHOICES Group 2 or Group 3. The CONTRACTOR shall be responsible for payment of medically necessary hospice services to the hospice provider (including hospice room and board for dual eligible members) pursuant to TennCare policy.

2.13.5.5 If such a member receiving hospice in an HCBS setting is admitted to a nursing facility for a short-term stay, but does not receive or elect to receive hospice while in the short-term stay, the CONTRACTOR shall not disenroll the member from Group 2 or Group 3 unless it is determined that the stay will not be short-term or the member will not transition back to the community; and prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members. The CONTRACTOR shall be responsible for payment of the NF services pursuant to TennCare rule.

2.13.5.6 If a member in CHOICES Group 2 or Group 3 admits to a nursing for receipt of inpatient respite (and not NF services), the member may receive hospice in the NF without being disenrolled from CHOICES Group 2 or Group 3. The CONTRACTOR shall be responsible for payment of inpatient respite services and hospice (excluding room and board since the member is receiving respite services) pursuant to TennCare policy.

A.2.13.6 **Behavioral Health Crisis Service Teams**

2.13.6.1 The CONTRACTOR shall reimburse crisis mobile teams for their intervention services on a monthly basis at a rate to be determined and set by the State. The rate shall be factored into the CONTRACTOR's capitation payments.

2.13.6.2 The CONTRACTOR shall assume financial liability for crisis respite and crisis stabilization services.

A.2.13.7 **Local Health Departments**

2.13.7.1 The CONTRACTOR shall reimburse contracted local health departments (see Sections A.2.11.9.3 and A.2.12.13) for TennCare Kids screenings to members under age twenty-one (21) at the following rates, unless specified otherwise by TENNCARE. Although the codes include preventive visits for individuals twenty-one (21) and older, this Section only requires the CONTRACTOR to pay local health departments for the specified visits for members under age twenty-one (21).

Preventive Visits	85% of 2001 Medicare
99381 New pt. Up to 1 yr.	$80.33
99382 New pt. 1- 4 yrs.	$88.06
99383 New pt. 5 - 11yrs.	$86.60
99384 New pt. 12 - 17yrs.	$95.39
99385 New pt. 18 - 39 yrs.	$93.93
99391 Estab. pt. Up to 1 yr.	$63.04
99392 Estab. pt. 1 - 4 yrs.	$71.55
99393 Estab. pt. 5 - 11yrs.	$70.96
99394 Estab. pt. 12 - 17yrs.	$79.57
99395 Estab. pt. 18 - 39 yrs.	$78.99

2.13.7.2 The CONTRACTOR shall recognize that public health nurses employed by the local health departments are appropriately trained and practice within a scope of protocols developed by the state. The protocols allow public health nurses from across the licensure spectrum to provide services specific to diagnosis, treatment and delivery of preventive services under the general, but not necessarily onsite, supervision of a physician. These services include, but may not be limited to, EPSDT services for children, immunizations, family planning and sexually transmitted disease treatment. TennCare is a state operated program and is not bound by Medicare policy regarding the interpretation of billing codes, therefore, in accordance with the training and protocols the state's public health nurses practice within, the CONTRACTOR shall allow public health nurses to bill using the same CPT codes, related to the aforementioned services, as would be used if the service was delivered by an advance practice nurse.

2.13.7.3 TENNCARE may conduct an audit of the CONTRACTOR's reimbursement methodology and related processes on an annual basis to verify compliance with this requirement. In addition, the Local Health Department may initiate the independent review procedure at any time it believes the CONTRACTOR's payment is not the required reimbursement rate or that the CONTRACTOR has denied claims inappropriately.

A.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, TennCare MCOs were required to make payments for certain primary care services (as described by CMS) and furnished by primary care providers (as described by CMS) in an amount determined by CMS. If CMS extends this requirement, the CONTRACTOR shall make payments in accordance with CMS and TENNCARE specified requirements.

2.13.8.2 In addition to the routine claims payment reports required by this Contract, the CONTRACTOR shall report to TENNCARE any information related to this requirement in a format described by TENNCARE. At a minimum, the reports shall be sufficient to accomplish the following:

2.13.8.2.1 Assure payments made to specified primary care providers are at the minimum Medicare primary care payment levels as required by 42 CFR 447, subpart G. This includes the assurance that eligible providers receive direct and full benefit of the payment increase for each of the primary care services specified in the final rule implementing this section of The Affordable Care Act regardless of whether the provider is paid directly or through a capitated arrangement;

2.13.8.2.2 Submit any documentation to TENNCARE, sufficient to enable TENNCARE and CMS to ensure that provider payments increase as required by 42 CFR 438.6(c)(5)(vi)(A) are made and to adequately document expenditures eligible for 100% FFP and to support all audit or reconciliation processes. TENNCARE shall report these data to CMS.

A.2.13.9 **Payment to TennCare PBM**

2.13.9.1 The CONTRACTOR shall make payment to the PBM on behalf of TENNCARE for TennCare covered services. The CONTRACTOR shall not be at risk for payment made to the TennCare contracted PBM (see Section C.3). The CONTRACTOR shall adhere to the following process for payments to the PBM:

2.13.9.1.1 The CONTRACTOR shall maintain a separate bank account for the funds transfer from TENNCARE for purposes of payment to the PBM.

2.13.9.1.2 The CONTRACTOR shall receive a weekly invoice from the PBM for services rendered by the PBM.

2.13.9.1.3 The CONTRACTOR shall invoice TENNCARE for the cost of the payments to be made to the PBM based on the weekly PBM invoice as well as any associated regulatory costs.

2.13.9.1.4 The CONTRACTOR shall make payment to the PBM in the full amount of the funds transfer from TENNCARE no later than the Friday following receipt of the funds from TENNCARE unless extended by TENNCARE due to unforeseen circumstances or bank holidays.

A.2.13.10 **Physician Incentive Plan (PIP)**

2.13.10.1 The CONTRACTOR shall notify and make TENNCARE and TDCI aware of any operations or plans to operate a physician incentive plan (PIP). Prior to implementation of any such plans, the CONTRACTOR shall submit to TDCI any provider agreement templates or subcontracts that involve a PIP for review as a material modification.

2.13.10.2 The CONTRACTOR shall not implement a PIP in the absence of TDCI review and written approval.

2.13.10.3 If the CONTRACTOR operates a PIP, the CONTRACTOR shall ensure that no specific payment be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

2.13.10.4 If the CONTRACTOR operates a PIP, upon TENNCARE's request, the CONTRACTOR shall report descriptive information about its incentive plan in sufficient detail to enable TENNCARE to adequately monitor the CONTRACTOR. The information that may be requested shall include, but not be limited to, the following:

2.13.10.4.1 Whether services not furnished by the physician or physician group are covered by the incentive plan;

2.13.10.4.2 The type or types of incentive arrangements, such as, withholds, bonus, capitation;

2.13.10.4.3 The percent of any withhold or bonus the plan uses;

2.13.10.4.4 Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection; and

2.13.10.4.5 The patient panel size and, if the plan uses pooling, the pooling method.

A.2.13.11 **Emergency Services Obtained from Non-Contract Providers**

2.13.11.1 Payments to non-contract providers for emergency services may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care services, as described in Section A.1. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TennCare rules and regulations for emergency services provided by non-contract providers.

2.13.11.2 Payment by the CONTRACTOR for properly documented claims for emergency services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

2.13.11.3 The CONTRACTOR shall review and approve or disapprove claims for emergency services based on the definition of emergency services specified in Section A.1 of this Contract. If the CONTRACTOR determines that a claim requesting payment of emergency services does not meet the definition as specified in Section A.1 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and time frames for reconsideration. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency services, the provider may pursue the independent review process for disputed claims as provided by TCA 56-32-126, including but not limited to reconsideration by the CONTRACTOR.

A.2.13.12 **Medically Necessary Services Obtained from Non-Contract Provider when MCO Assignment is Unknown**

2.13.12.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a non-contract provider when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service. Examples of when this may occur include, but are not limited to, (i) when an enrollee receives services during a retroactive eligibility period (see Section A.2.4.5) and the enrollee did not select an MCO and is assigned to an MCO by TENNCARE, or (ii) the enrollee was assigned to an MCO other than the one that he/she requested (see Section A.2.4.4.5). In these cases, the effective date of enrollment may occur prior to the CONTRACTOR or the enrollee being notified of the enrollee becoming a member of the CONTRACTOR's MCO.

2.13.12.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services provided during this period of eligibility for lack of prior authorization or lack of referral; likewise, the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.12.3 The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section A.2.6), as determined by the State and shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

A.2.13.13 **Medically Necessary Services Obtained from Contract Provider without Prior Authorization when MCO Assignment is Unknown**

2.13.13.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a contract provider without prior authorization or referral when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service.

2.13.13.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services for lack of prior authorization or lack of referral; likewise, a CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.13.3 The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section A.2.6), as determined by the State and shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

A.2.13.14 **Medically Necessary Services Obtained from Non-Contract Provider Referred by Contract Provider**

2.13.14.1 The CONTRACTOR shall pay for medically necessary covered services provided to a member by a non-contract provider when referred by a contract provider and in accordance with the following requirements:

2.13.14.1.1 The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the CONTRACTOR if the member had received the services from a contract provider.

2.13.14.1.2 The CONTRACTOR shall only pay for medically necessary covered services for which the member was eligible (see Section A.2.6) and that were authorized by the CONTRACTOR in accordance with the requirements of this Contract.

A.2.13.15 **Medically Necessary Services Obtained from Non-Contract Provider Not Authorized by the CONTRACTOR**

2.13.15.1 When an enrollee has utilized medically necessary non-emergency covered services from a non-contract provider, and the CONTRACTOR has not authorized such use in advance, the CONTRACTOR shall not be required to pay for the service(s) received unless payment is required pursuant to a directive from TENNCARE or an Administrative Law Judge.

2.13.15.2 The CONTRACTOR shall not make payment to non-contract providers for covered services that are not medically necessary or for long-term care services for which the member was not eligible (see Section A.2.6).

A.2.13.16 **Covered Services Ordered by Medicare Providers for Dual Eligibles**

2.13.16.1 Generally, when a TennCare enrollee is dually eligible for Medicare and TennCare and requires services that are covered under this Contract but are not covered by Medicare, and the services are ordered by a Medicare provider who is a non-contract provider, the CONTRACTOR shall pay for the ordered, medically necessary service if it is provided by a contract provider. However, if all of the following criteria are met, the CONTRACTOR may require that the ordering physician be a contract provider:

2.13.16.1.1 The ordered service requires prior authorization; and

2.13.16.1.2 Dually eligible enrollees have been clearly informed of the contract provider requirement and instructed in how to obtain assistance identifying and making an appointment with a contract provider; and

2.13.16.1.3 The CONTRACTOR assists the enrollee in obtaining a timely appointment with a contract provider upon request of the enrollee or upon receipt of an order from a non-contract provider.

2.13.16.2 Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider.

2.13.16.3 The CONTRACTOR shall not pay for non-covered services, services that are not medically necessary, or services ordered and obtained from non-contract providers.

A.2.13.17 **Transition of New Members**

The CONTRACTOR shall pay for the continuation of covered services for new members pursuant to the requirements in Section A.2.9.2 regarding transition of new members.

A.2.13.18 **Transition of CHOICES Members Receiving Long-Term Care Services at the Time of Implementation**

The CONTRACTOR shall pay for the continuation of covered long-term care services for transitioning CHOICES members pursuant to the requirements in Section A.2.9.3 regarding transition of members receiving long-term care services at the time of implementation.

A.2.13.19 **Transition of Care**

In accordance with the requirements in Section A.2.9.5.1 of this Contract, if a provider has terminated participation with the CONTRACTOR, the CONTRACTOR shall pay the non-contract provider for the continuation of treatment through the applicable period provided in Section A.2.9.5.1.

A.2.13.20 **Limits on Payments to Providers and Subcontractors Related to the CONTRACTOR**

2.13.20.1 The CONTRACTOR shall not pay more for similar services rendered by any provider or subcontractor that is related to the CONTRACTOR than the CONTRACTOR pays to providers and subcontractors that are not related to the CONTRACTOR. For purposes of this subsection, "related to" means providers or subcontractors that have an indirect ownership interest or ownership or control interest in the CONTRACTOR, an affiliate (see definition in Section A.1 of this Contract) of the CONTRACTOR, or the CONTRACTOR's management company as well as providers or subcontractors that the CONTRACTOR, an affiliate of the CONTRACTOR or the CONTRACTOR's management company has an indirect ownership interest or ownership or control interest in. The standards and criteria for determining indirect ownership interest, an ownership interest or a control interest are set out at 42 CFR Part 455, Subpart B.

2.13.20.2 Any payments made by the CONTRACTOR that exceed the limitations set forth in this Section shall be considered non-allowable payments for covered services and shall be excluded from medical expenses reported in the MLR report required in Section A.2.30.16.2.1, except that services which exceed a benefit limit and are provided as a cost-effective alternative service to another covered benefit in CHOICES or ECF CHOICES shall be considered medical expenses.

2.13.20.3 As provided in Section A.2.30.10 of this Contract, the CONTRACTOR shall submit information on payments to related providers and subcontractors.

A.2.13.21 **1099 Preparation**

In accordance with federal requirements, the CONTRACTOR shall prepare and submit Internal Revenue Service (IRS) Form 1099s for all providers who are not employees of the CONTRACTOR to whom payment is made.

A.2.13.22 **Payments to the FEA**

The CONTRACTOR shall reimburse the Fiscal Employer Agent (FEA) for authorized eligible CHOICES and ECF CHOICES HCBS provided by consumer-directed workers as specified in the partnership agreement between the CONTRACTOR and the FEA. TENNCARE will pay the FEA the administrative fees specified in the contract between TENNCARE and the FEA.

A.2.14 UTILIZATION MANAGEMENT (UM)

A.2.14.1 **General**

2.14.1.1 The CONTRACTOR shall develop and maintain a utilization management (UM) program which shall be documented in writing. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program.

2.14.1.1.1 In accordance with 42 CFR 438.910(d), the CONTRACTOR shall not impose NQTLs for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the CONTRACTOR as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

2.14.1.2 The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.

2.14.1.2.1 The UM program description, work plan and program evaluation shall be exclusive to TENNCARE and shall not contain documentation from other state Medicaid programs or product lines operated by the CONTRACTOR.

2.14.1.3 The UM program, including the UM program description, associated work plan, and annual evaluation shall address Emergency Department (ED) utilization and ED diversion efforts.

2.14.1.4 The CONTRACTOR's UM program shall include distinct policies and procedures regarding long-term care services and shall specify the responsibilities and scope of authority of Care Coordinators in authorizing long-term care services and in submitting service authorizations to providers and/or the FEA for service delivery.

2.14.1.5 The CONTRACTOR shall notify all contract providers of and enforce compliance with all provisions relating to UM procedures.

2.14.1.6 The UM program shall have criteria that:

2.14.1.6.1 Are objective and based on medical, behavioral health and/or long-term care evidence, to the extent possible;

2.14.1.6.2 Are applied based on individual needs;

2.14.1.6.3 Are applied based on an assessment of the local delivery system;

2.14.1.6.4 Involve appropriate practitioners in developing, adopting and reviewing them;

2.14.1.6.5 Assure family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used; and

2.14.1.6.6 Are annually reviewed and updated as appropriate.

2.14.1.7 For long-term care services, the CONTRACTOR's UM program shall have criteria that are consistent with the guiding principles set forth in TCA 71-5-1402 and shall take into consideration the member's preference regarding cost-effective long-term care services and settings.

2.14.1.8 The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

2.14.1.9 The CONTRACTOR shall use written criteria based on sound clinical evidence to make utilization decisions. The written criteria shall specify procedures for appropriately applying the criteria. The criteria must be in accordance with NCQA standards and requirements. The CONTRACTOR shall apply objective and evidence based criteria and take individual circumstances and the local delivery into account when determining the medical appropriateness of health care services.

2.14.1.10 The CONTRACTOR shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition.

2.14.1.11 The CONTRACTOR shall assure, consistent with 42 CFR 438.3, 42 CFR 422.208 and 422.210, that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

2.14.1.12 As part of the provider survey required by Section A.2.18.7.4, the CONTRACTOR shall assess provider/office staff satisfaction with UM processes to identify areas for improvement.

2.14.1.13 <u>Inpatient Care</u>

The CONTRACTOR shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures and, at a minimum, shall include the items specified in subparagraphs A.2.14.1.13.1 through A.2.14.1.13.5 below:

2.14.1.13.1 Pre-admission certification process for non-emergency admissions;

2.14.1.13.2 A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CONTRACTOR shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a member can be transferred to a contract facility in the network, if presently in a non-contract facility;

2.14.1.13.3 Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;

2.14.1.13.4 Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and

2.14.1.13.5 Prospective review of same day surgery procedures.

2.14.1.14 Nursing Facility

2.14.1.14.1 The CONTRACTOR shall be responsible for monitoring the member's continued need for and receipt of skilled and/or rehabilitative services in a NF only when approval of NF LOC is conditioned on the receipt of such services, and in such case, when skilled and/or rehabilitative services are no longer medically necessary, shall submit information needed by TENNCARE to reevaluate the member's level of care (i.e., reimbursement) for nursing facility services (see also Section A.2.14.1.14).

2.14.1.15 Emergency Department (ED) Utilization

The CONTRACTOR shall utilize the following guidelines in identifying and managing care for members who are determined to have excessive and/or inappropriate ED utilization:

2.14.1.15.1 Review ED utilization data, at a minimum, every six (6) months to identify members with utilization exceeding the threshold defined by TENNCARE as ten (10) or more visits in the defined six (6) month period (January through June and July through December);

2.14.1.15.2 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 A.2.8.4 of this Contract) and may use the information to identify members who may be eligible for CHOICES in accordance with the requirements in Section A.2.9.6.3 if appropriate;

2.14.1.15.3 For CHOICES members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period, the Care Coordinator shall conduct appropriate follow-up to identify the issues causing frequent ED utilization and determine appropriate next steps. For CHOICES members in Group 1, appropriate next steps may include communication with the nursing facility to determine interventions to better manage the member's condition. For CHOICES members in Groups 2 and 3, appropriate next steps may include modifications to the member's PCSP in order to address service delivery needs and better manage the member's condition.

2.14.1.15.4 As appropriate, make contact with members whose utilization exceeded the threshold of ED visits defined by TENNCARE in the previous six (6) month period and their primary care providers for the purpose of providing education on appropriate ED utilization; and

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

2.14.1.16 Hospitalizations and Surgeries

The CONTRACTOR shall comply with any applicable federal and state laws or rules related to length of hospital stay. TENNCARE will closely monitor encounter data related to length of stay and re-admissions to identify potential problems. If indicated, TENNCARE may conduct special studies to assess the appropriateness of hospital discharges.

A.2.14.2 **Prior Authorization for Physical Health and Behavioral Health Covered Services**

2.14.2.1 The CONTRACTOR shall have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The policies and procedures shall provide for consultation with the requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR and the service is provided, payment for the prior authorized service shall not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted.

2.14.2.2 Prior authorization for home health nurse, home health aide, and private duty nursing services shall comply with TennCare rules and regulations, including service definitions in TennCare Rule 1200-13-13-.01, medical necessity requirements at 1200-13-16, and specific prior authorization requirements at 1200-13-13-.04(6).

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. If the CONTRACTOR determines that following the standard authorization timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the CONTRACTOR shall make an expedited service authorization decision and provide notice as expeditiously as the enrollee’s health condition requires and no later than seventy-two (72) hours after receipt of the request for service. See 42 C.F.R. §438.210(d)(2)(i); 42 C.F.R. §438.404(c)(6).

2.14.2.4 The CONTRACTOR’s prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d). TENNCARE may request copies of the CONTRACTOR’s policies and procedures to assure compliance with 42 CFR, Subpart K.

A.2.14.3 **Referrals for Physical Health and Behavioral Health**

2.14.3.1 Except as provided in Section A.2.14.4, the CONTRACTOR may require members to seek a referral from their PCP prior to accessing non-emergency specialty physical health services.

2.14.3.2 If the CONTRACTOR requires members to obtain PCP referral, the CONTRACTOR may exempt certain services, identified by the CONTRACTOR in the member handbook, from PCP referral.

2.14.3.3 For members determined to need a course of treatment or regular care monitoring, the CONTRACTOR shall have a mechanism in place to allow members to directly access a specialist as appropriate for the members' condition and identified needs.

2.14.3.4 The CONTRACTOR shall not require that a woman go in for an office visit with her PCP in order to obtain the referral for prenatal care.

2.14.3.5 Referral Provider Listing

2.14.3.5.1 The CONTRACTOR shall provide all PCPs with information on how to access a current listing of referral providers, including behavioral health providers, as well as the right to request a hard copy at least thirty (30) calendar days prior to the start date of operations. Thereafter the CONTRACTOR shall provide notification to PCPs regarding how to access and request a hard copy of an updated version of the listing on a quarterly basis. The CONTRACTOR shall maintain an updated electronic, web-accessible version of the referral provider listing.

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

2.14.3.5.3 As required in Section A.2.30.11.5, the CONTRACTOR shall submit to TENNCARE a copy of the notification regarding the referral provider listing, a data file of the provider information in a media and format described by TENNCARE, and documentation regarding mailing.

A.2.14.4 **Exceptions to Prior Authorization and/or Referrals for Physical Health and Behavioral Health**

2.14.4.1 Emergency and Post-Stabilization Care Services

The CONTRACTOR shall provide emergency services without requiring prior authorization or PCP referral, as described in Section A.2.7.1, regardless of whether these services are provided by a contract or non-contract provider. The CONTRACTOR shall provide post-stabilization care services (as defined in Section A.1) in accordance with 42 CFR 422.113.

2.14.4.2 TennCare Kids

The CONTRACTOR shall not require prior authorization or PCP referral for the provision of TennCare Kids screening services.

2.14.4.3 Access to Women's Health Specialists

The CONTRACTOR shall allow female members direct access (without requiring a referral) to a women's health specialist who is a contract provider for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

2.14.4.4 Behavioral Health Services

The CONTRACTOR shall not require a PCP referral for members to access a behavioral health provider.

2.14.4.5 Transition of New Members

Pursuant to the requirements in Section A.2.9.2 regarding transition of new members, the CONTRACTOR shall provide for the continuation of medically necessary covered services regardless of prior authorization or referral requirements. However, as provided in Section A.2.9.2, in certain circumstances the CONTRACTOR may require prior authorization for continuation of services beyond the initial thirty (30) days.

A.2.14.5 **Authorization of Long-Term Care Services**

2.14.5.1 The CONTRACTOR shall have in place an authorization process for covered long-term services and supports and cost effective alternative services that is separate from but integrated with the CONTRACTOR's prior authorization process for covered physical health and behavioral health services (See Section A.2.9.6 of this Contract).

2.14.5.2 The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care (i.e., reimbursement, including the duration of such level of reimbursement) approved by TENNCARE (see Section A.2.14.1.14).

2.14.5.3 The CONTRACTOR shall authorize and initiate CHOICES HCBS for CHOICES members and ECF CHOICES HCBS for ECF CHOICES members within the timeframes specified in Sections A.2.9.2, A.2.9.3, and A.2.9.6 of this Contract.

2.14.5.4 The CONTRACTOR shall not require that CHOICES HCBS or ECF CHOICES HCBS except Specialized Consultation and Training services, as applicable be ordered by a treating physician, but may consult with the treating physician as appropriate regarding the member's physical health, behavioral health, and long-term services and supports needs and in order to facilitate communication and coordination regarding the member's physical health, behavioral health, and long-term services and supports. Participation by the Specialized Consultation and Training services provider in the person-centered planning process shall not require a physician's order, except as required pursuant to state law or regulation.

2.14.5.5 The CONTRACTOR may determine the duration of time for which CHOICES or ECF CHOICES HCBS will be authorized. Additionally, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES or ECF CHOICES HCBS in accordance with the PCSP, including transition from the CHOICES or ECF CHOICES HCBS that are immediately needed by the member to CHOICES or ECF CHOICES HCBS in the PCSP that are needed on an ongoing basis, including those immediately needed services that are also needed on an ongoing basis. The CONTRACTOR shall further be responsible for ensuring that service authorizations are consistent with the PCSP, including, except for services provided through consumer direction, the schedule at which services are needed and any updates to the PCSP and/or schedule, and except in the following circumstance, for notifying providers in advance when a service authorization (including a schedule) will be changed. Retroactive entry or adjustments in service authorizations for CHOICES or ECF 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.

2.14.5.6 For non-CHOICES members receiving care in non-contract nursing facilities authorized by the CONTRACTOR as a cost-effective alternative, the CONTRACTOR shall reimburse services in accordance with its authorization until such time that the member is no longer eligible for services, is enrolled in CHOICES, or such care is no longer medically necessary or cost-effective.

2.14.5.7 The CONTRACTOR shall determine medical necessity of ventilator weaning and short term tracheal suctioning for individuals recently weaned from a ventilator, but who still require intensive respiratory intervention. TENNCARE shall determine medical necessity of chronic ventilator care and tracheal suctioning other than short-term tracheal suctioning following recent ventilator weaning through the PAE process.

2.14.5.8 The CONTRACTOR shall provide authorization for Enhanced Respiratory Care (ERC) reimbursement rates based upon medical necessity. Prior to authorizing ERC reimbursement, the CONTRACTOR shall also confirm that the NF has an available bed licensed by the Tennessee Department of Health specifically for the provision of ventilator weaning or chronic ventilator care or tracheal suctioning, as applicable, and that authorizing reimbursement at those rates for a member to receive those services would not cause the facility to exceed the number of beds licensed for such specialized ERC on any given day. The CONTRACTOR must also provide authorizations for ERC reimbursement specific to the service being requested: ventilator weaning, chronic ventilator care, and/or tracheal suctioning. The CONTRACTOR shall not provide a broad ERC authorization that fails to specify which rate is being approved.

A.2.14.6 Transition of CHOICES Members Receiving Long-Term Care Services at the Time of Implementation

For transitioning members enrolled in CHOICES as of the date of implementation, the CONTRACTOR shall be responsible for continuing to provide the long-term care services previously authorized for the member, as specified in Section A.2.9.3 of this Contract.

A.2.14.7 **Notice of Adverse Benefit Determination Requirements**

2.14.7.1 In accordance with 42 C.F.R. 438.210(c), the CONTRACTOR must notify the requesting provider, and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The Notice of Adverse Benefit Determination must meet the requirements set forth in section A.2.19.2.

2.14.7.2 The CONTRACTOR shall comply with all member notice provisions in TennCare rules and regulations.

2.14.7.3 The CONTRACTOR shall issue appropriate notice prior to any CONTRACTOR-initiated decision to reduce or terminate CHOICES or non-CHOICES nursing facility services and shall comply with all federal court orders, and federal and state laws and regulations regarding members' transfer or discharge from nursing facilities.

A.2.14.8 **Medical History Information Requirements**

2.14.8.1 The CONTRACTOR is responsible for eliciting pertinent medical history information from the treating provider(s), as needed, for purposes of making medical necessity determinations. With respect to CHOICES HCBS which are not primarily medical in nature, pertinent medical history shall include assessments, case notes, and documentation of service delivery by HCBS providers. Medical information from the treating physician may also be pertinent in better understanding the member's functional needs. The CONTRACTOR shall take action (e.g., sending a CONTRACTOR representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem if a treating provider is uncooperative in supplying needed information. The CONTRACTOR shall make documentation of such action available to TENNCARE, upon request. Providers who do not provide requested information for purposes of making a medical necessity determination for a particular item or service shall not be entitled to payment for the provision of such item or service.

2.14.8.2 Upon request by TENNCARE, the CONTRACTOR shall provide TENNCARE with individualized medical record information from the treating provider(s). The CONTRACTOR shall take whatever action necessary to fulfill this responsibility within the required appeal time lines as specified by TENNCARE and/or applicable TennCare rules and regulations, up to and including going to the provider's office to obtain the medical record information. Should a provider fail or refuse to respond to the CONTRACTOR's efforts to obtain medical information, and the appeal is decided in favor of the member, at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

A.2.14.9 **PCP Profiling**

The CONTRACTOR shall profile its PCPs. Further, the CONTRACTOR shall investigate the circumstances surrounding PCPs who appear to be operating outside peer norms and shall intervene, as appropriate, when utilization or quality of care issues are identified. As part of these profiling activities, the CONTRACTOR shall analyze utilization data, including but not limited to, information provided to the CONTRACTOR by TENNCARE, and report back information as requested by TENNCARE. PCP profiling shall include, but not be limited to the following areas:

2.14.9.1 Utilization of Non-Contract Providers

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of services provided by non-contract providers by PCP panel.

2.14.9.2 Specialist Referrals

The CONTRACTOR shall maintain a procedure to identify and evaluate member specialty provider utilization by PCP panel.

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 A.2.14.1.15 of this Contract, members who establish a pattern of accessing emergency room services shall be referred to the appropriate Population Health Program for follow-up services.

2.14.9.4 Inpatient Admissions

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of inpatient services by PCP panel.

2.14.9.5 Pharmacy Utilization

At a minimum, the CONTRACTOR shall profile PCP prescribing patterns for generic versus brand name and the number of narcotic prescriptions written. In addition, the CONTRACTOR shall comply with the requirements in Section A.2.9.10 of this Contract.

2.14.9.6 Advanced Imaging Procedures

The CONTRACTOR shall profile the utilization of advanced imaging procedures by PCP panel. Advanced imaging procedures include: PET Scans; CAT Scans and MRIs.

2.14.9.7 PCP Visits

The CONTRACTOR shall profile the average number of visits per member assigned to each PCP.

A.2.15 QUALITY MANAGEMENT/QUALITY IMPROVEMENT

A.2.15.1 Quality Management/Quality Improvement (QM/QI) Program

2.15.1.1 The CONTRACTOR shall have a written Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. Program documents must include all of the elements listed below and shall include a separate section on CHOICES care coordination. This QM/QI program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the CONTRACTOR's plan for improving patient safety. This means at a minimum that the QM/QI program shall:

2.15.1.1.1 Address physical health, behavioral health, and long-term care services;

2.15.1.1.2 Be accountable to the CONTRACTOR's board of directors and executive management team;

2.15.1.1.3 Have substantial involvement of a designated physician and designated behavioral health practitioner;

2.15.1.1.4 Have a QM/QI committee that oversees the QM/QI functions;

2.15.1.1.5 Have an annual work plan;

2.15.1.1.6 Have resources – staffing, data sources and analytical resources – devoted to it;

2.15.1.1.7 Be evaluated annually and updated as appropriate; and

2.15.1.1.8 The QM/QI program description, work plan and program evaluation shall be exclusive to TENNCARE and shall not contain documentation from other state Medicaid programs or product lines operated by the CONTRACTOR.

2.15.1.2 The CONTRACTOR shall make all information about its QM/QI program available to providers and members.

2.15.1.3 As part of the QM/QI program, the CONTRACTOR shall collect information on providers' actions to improve patient safety and make performance data available to providers and members.

2.15.1.4 The CONTRACTOR shall use the results of QM/QI activities to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from providers and members.

2.15.1.5 The CONTRACTOR shall take appropriate action to address service delivery, provider, and other QM/QI issues as they are identified.

2.15.1.5.1 The CONTRACTOR may be required to conduct special focus studies as requested by TENNCARE.

2.15.1.5.2 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.

2.15.1.5.3 The CONTRACTOR shall collect data on race and ethnicity. As part of the QM/QI program description, the CONTRACTOR shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected.

2.15.1.5.4 The CONTRACTOR shall include QM/QI activities to improve healthcare disparities identified through data collection.

2.15.1.6 In addition to QM/QI activities as defined in this Section A.2.15, the CONTRACTOR's QM/QI program shall incorporate all applicable reporting and monitoring requirements and activities, including but not limited to such activities specified in Sections A.2.25, A.2.30, and A.2.9.6.13 of this Contract; and shall include

discovery and remediation of individual findings, as well as identification and implementation of strategies to make systemic improvements in the delivery and quality of care.

A.2.15.2 **QM/QI Committee**

2.15.2.1 The CONTRACTOR shall have a QM/QI committee which shall include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers). This committee shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs.

2.15.2.2 The QM/QI committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA accreditation review.

2.15.2.3 The CONTRACTOR shall provide the Chief Medical Officer of TENNCARE with ten (10) calendar days advance notice of all regularly scheduled meetings of the QM/QI committee. To the extent allowed by law, the Chief Medical Officer of TENNCARE, or his/her designee, may attend the QM/QI committee meetings at his/her option.

A.2.15.3 **Performance Improvement Projects (PIPs)**

2.15.3.1 The CONTRACTOR shall perform at least two (2) clinical and three (3) non-clinical PIPs. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints.

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. The CONTRACTOR shall clearly label each PIP as to the area addressed.

2.15.3.1.2 One (1) of the three (3) non-clinical PIPs shall be in the area of long-term services and supports. The CHOICES special study may not be used as a PIP. The CONTRACTOR shall use existing processes, methodologies, and protocols, including the CMS protocols. The CONTRACTOR shall clearly label the Long-term care PIP as such.

2.15.3.1.3 Based on the State's CMS-416 MCO report, if the CONTRACTOR has an overall rate below eighty percent (80%) the CONTRACTOR shall submit a PIP on EPSDT Screening and Community outreach plans in addition to the above required PIP's. The CONTRACTOR shall use existing processes, methodologies, and protocols, including the CMS protocols. The CONTRACTOR shall clearly label the EPSDT PIP as such.

2.15.3.2 The CONTRACTOR shall ensure that CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for performance improvement projects are documented.

2.15.3.3 The CONTRACTOR shall identify benchmarks and set achievable performance goals for each of its PIPs. The CONTRACTOR shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.

2.15.3.4 The CONTRACTOR shall report on PIPs as required in Section A.2.30.12.1 and A.2.30.12.1.1, Reporting Requirements. For Performance Improvement Project topics that are conducted in more than one region of the State, the CONTRACTOR shall submit one Performance Improvement Project Summary Report that includes region-specific data and information, including *G. Activity VIIa -Include improvement strategies* as required by CMS.

2.15.3.5 After three (3) years, the CONTRACTOR shall, using evaluation criteria established by TENNCARE, determine if one or all of the non-long-term care PIPs should be continued. Prior to discontinuing a non-long-term care PIP, the CONTRACTOR shall identify a new PIP and along with a rationale, shall receive TENNCARE's approval to discontinue the previous PIP and perform the new PIP.

2.15.3.6 The CONTRACTOR shall submit preliminary PIP topics to TENNCARE for approval or denial by March 31 (end of quarter 1). The CONTRACTOR shall clearly categorize and label each PIP into the area that it addresses. In addition, the CONTRACTOR shall indicate the current measurement year (Baseline, Y1, Y2, Y3, Extension Y4, or Extension Y5) for each PIP. The CONTRACTOR shall also include the rationale for selection of each new PIP topic.

A.2.15.4 **Clinical Practice Guidelines**

The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its Population Health Programs (see Section A.2.8.6 of this Contract). The guidelines shall be reviewed and revised whenever the guidelines change and at least every two (2) years. The CONTRACTOR shall provide copies of clinical practice guidelines to enrollees upon request. 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.

A.2.15.5 **NCQA Accreditation**

2.15.5.1 TENNCARE shall require the CONTRACTOR to be NCQA accredited or obtain NCQA accreditation within the timelines specified below. Health plans applying for NCQA accreditation must notify NCQA of the accreditation option they choose. The CONTRACTOR shall choose the first evaluation option which will require the CONTRACTOR to notify NCQA of this option six (6) months prior to submission of HEDIS data. Health Plans providing LTSS shall obtain NCQA Long-Term Services and Supports Distinction by December 31, 2019.

2.15.5.2 If the CONTRACTOR is NCQA accredited for its TennCare product in each Grand Region covered by this Contract as of the start date of this Contract, the CONTRACTOR shall maintain NCQA accreditation throughout the period of this Contract. If the CONTRACTOR is not NCQA accredited for its TennCare product in each Grand Region covered by this Contract as of the start date of this Contract, the CONTRACTOR shall obtain NCQA accreditation no later than the end of the second full calendar year of operation in the initial Grand Region implementation and shall maintain it thereafter. Any accreditation status granted by NCQA under the New Health Plan (NHP) program or the MCO Introductory Survey option shall not be

acknowledged by TENNCARE. Accreditation obtained under the NCQA Full Accreditation Survey or Multiple Product Survey options will be acknowledged by TENNCARE if the TennCare product is specifically included in the NCQA survey. TENNCARE will accept the use of the NCQA Corporate Survey process, to the extent deemed allowable by NCQA, in the accreditation of the CONTRACTOR. In order to ensure that the CONTRACTOR is making forward progress, TENNCARE shall require that, if the CONTRACTOR is not NCQA accredited for its TennCare product in each Grand Region covered by this Contract as of the start date of this Contract, the events described in the table below are completed by the required deadlines.

EVENT	REQUIRED DEADLINE
CALENDAR YEAR 2015	
NCQA Accreditation Survey Application submitted and Pre Survey Fee paid	August 1, **2015**
Submit copy of signed NCQA Survey contract to TENNCARE	September 1, 2015
Purchase NCQA ISS Tool for 2016 MCO Accreditation Survey	November 1, 2015
Copy of signed contract with NCQA approved vendor to perform 2016 CAHPS surveys (Adult, Child and Children with Chronic Conditions) to TENNCARE	November 1, 2015
Copy of signed contract with NCQA approved vendor to perform 2016 HEDIS Audit to TENNCARE (The CONTRACTOR must perform the complete Medicaid HEDIS Data Set with the exception of dental related measures)	November 1, 2015
CALENDAR YEAR 2016	
Notify TENNCARE of date for ISS Submission and NCQA On-site review	January 15, 2016
HEDIS Record of Administration, Data Management and Processes (ROADMAP) completed and submitted to Contracted HEDIS Auditor, TENNCARE, and the EQRO	February 15, 2016
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TENNCARE	June 15, 2016
Finalize preparations for NCQA Survey (final payment shall be submitted to NCQA thirty (30) calendar days prior to submission of ISS)	Notify TENNCARE of final payment within five (5) business days of submission to NCQA.
Submission of ISS to NCQA	Notify TENNCARE within five (5) business days of submission to NCQA.
NCQA Survey Completed	December 31, 2016
Copy of NCQA Final Report to TENNCARE: • Excellent, Commendable, or Accredited • Provisional – Corrective Action required to achieve status of Excellent, Commendable, or Accredited; resurvey within twelve (12) months. • Accreditation Denied – Results in termination of this Contract.	Immediately upon receipt but not to exceed ten (10) days

2.15.5.3 If the CONTRACTOR consistently fails to meet the timelines as described above, the CONTRACTOR shall be considered to be in breach of the terms of this Contract and may be subject to termination in accordance with Section E.14 of this Contract.

2.15.5.4 Failure to obtain NCQA accreditation by the date specified in Section A.2.15.5.2 above and failure to maintain accreditation thereafter shall be considered a breach of this Contract and shall result in termination of this Contract in accordance with the terms set forth in Section E.14 of this Contract. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of notification from NCQA and may result in termination of this Contract in accordance with Section E.14 of this Contract.

2.15.5.5 The CONTRACTOR shall assure the NCQA Accreditation Report is provided to TENNCARE for each accreditation cycle within ten (10) days of receipt of the report from NCQA. Updates of accreditation status, based on annual HEDIS scores must also be submitted within ten (10) days of receipt.

A.2.15.6 **HEDIS and CAHPS**

2.15.6.1 Annually, beginning with HEDIS 2016, the CONTRACTOR shall complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set shall be dental measures. The HEDIS measure results shall be reported separately for each Grand Region in which the CONTRACTOR operates, as well as an overall statewide rate. The CONTRACTOR shall contract with an NCQA certified HEDIS auditor to validate the processes of the CONTRACTOR in accordance with NCQA requirements. Audited HEDIS results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year beginning in 2016.

2.15.6.1.1 Beginning with HEDIS 2016, 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.

2.15.6.1.2 The CONTRACTOR shall submit to TENNCARE by June 15 of each calendar year a detailed explanation for any Medicaid HEDIS measure marked as "Not Reported"

2.15.6.2 Annually, beginning in 2016, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR's vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey using the most current CAHPS version specified by NCQA. Survey results shall be reported to TENNCARE separately for each required CAHPS survey listed above. The survey results shall be reported separately for each Grand Region in which the CONTRACTOR operates, as well as an overall statewide rate. Survey results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year beginning in 2016.

2.15.6.3 Annually, beginning in 2019, the CONTRACTOR shall report the HEDIS 2019 Technical Specifications for LTSS Measures, which shall include, at minimum, the following: (1) Long term Services and Supports Comprehensive Assessment and Update; (2) Long Term Services and Supports Comprehensive Care Plan and Update;

(3) Long Term Services and Supports Shared Care Plan with Primary Care Provider; and (4) Long Term Services and Supports Re-Assessment/Care Plan Update After Inpatient Discharge. The CONTRACTOR is encouraged to participate in the NCQA learning collaborative opportunity in order to receive support in reporting the new HEDIS 2019 Technical Specifications for LTSS Measures. CHOICES Group 1 Members are excluded from the HEDIS 2019 Technical Specifications for LTSS Measures

A.2.15.7 **Critical Incident Reporting and Management**

2.15.7.1 CHOICES Critical Incident Reporting and Management

2.15.7.1.1 The CONTRACTOR shall develop and implement a critical incident reporting and management system for incidents that occur in a home and community-based long-term services and supports service delivery setting, including: community-based residential alternatives; adult day care centers; other CHOICES HCBS provider sites; and a member's home or any other community-based setting. Critical incidents shall include incidents that occur during the provision of covered CHOICES HCBS and incidents that are discovered or witnessed by the CONTRACTOR, provider, or FEA staff, regardless of whether the provider is believed to be responsible for the incident and/or other HCBS system factors are believed to have contributed to the incident.

2.15.7.1.2 The CONTRACTOR shall identify and track critical incidents and shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The CONTRACTOR shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from APS and CPS if available); identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of CHOICES HCBS.

2.15.7.1.3 Critical Incidents, for the purposes of CHOICES, shall be stratified into two groups: Tier 1 and Tier 2. Critical incidents shall include the following incidents when they occur in a home and community-based long-term care service delivery setting (as defined in Section A.2.15.7.1.1. above).

2.15.7.1.3.1 Tier 1 Critical Incidents shall include the following:

2.15.7.1.3.1.1 Any incident involving allegations, suspicions or evidence of any form of abuse, neglect or exploitation including misappropriation of property. For purposes of this section, abuse, neglect, and exploitation shall be defined as in TCA 33-2-402 and implemented as specified in TennCare protocol. Sexual abuse includes sexual battery by an authority figure as defined in TCA 39-13-527;

2.15.7.1.3.1.2 All unexplained or unexpected deaths including suicide;

2.15.7.1.3.1.3 A suspicious injury where abuse or neglect is suspected or the nature of the injury does not coincide with explanation of how the injury was sustained;

2.15.7.1.3.1.4 Serious injury, including serious injury of an unknown cause. For purposes of this section, serious injury is an injury requiring medical treatment beyond first aid by a lay person, and includes but is not limited to fractures, dislocations, concussions, cuts or lacerations requiring sutures, staples or dermabond, torn ligaments (e.g. a severe sprain) or torn muscles or tendons (e.g. a severe strain) requiring surgical repair, second and third degree burns, and loss of consciousness;

2.15.7.1.3.1.5 Theft by provider personnel (employees or volunteers) of more than $1,000 (Class E felony);

2.15.7.1.3.1.6 A serious traffic violation with significant risk of harm (e.g., reckless, careless or imprudent driving, driving under the influence, speeding in excess of fifteen (15) miles per hour over the speed limit); and

2.15.7.1.3.1.7 Medication error which results in the need for face-to-face medical treatment based on injury or probable risk of serious harm, including physician services, emergency assistance, or transfer to an acute care facility for stabilization. Such errors include but are not limited to medication omission, administration of the wrong drug, administration of the wrong dose, administration of a drug to the wrong member, administration of a drug at the wrong time, administration of a drug at the wrong rate, the wrong preparation of a drug, and the wrong route of administration of a drug.

2.15.7.1.3.2 Tier 2 Critical Incidents shall include the following:

2.15.7.1.3.2.1 Allegations that provider personnel (e.g. employees, volunteers) engaged in disrespectful or inappropriate communication about a person [e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures)], or any other similar acts that do not meet the definition of emotional of psychological abuse and which are directed to or within eyesight or audible range of the person supported;

2.15.7.1.3.2.2 Person whose whereabouts are unknown and could likely place him/her in a dangerous situation for self or others. This incident should be reported if the whereabouts of the person are unknown for sixty (60) minutes or more if the absence is unusual, unless a shorter time is specified in the person's PCSP or Behavior Support Plan (BSP), or the absence is a known risk as specified in the person's PCSP or BSP. Reporting that a person's whereabouts are unknown is in addition to, and not a substitute for or priority over, actively looking for the person and contacting law enforcement if necessary. Persons supported shall have the freedom to come and go without staff supervision except when such restrictions are necessary to ensure their health and safety or the safety of others, which must be documented in the PCSP;

2.15.7.1.3.2.3 Minor vehicle accidents resulting in an injury that does not require face-to-face medical treatment by someone other than a lay person;

2.15.7.1.3.2.4 Victim of fire;

2.15.7.1.3.2.5 Medication variance resulting in the need for observation but which does not require any face-to-face medical treatment (including treatment by provider's trained medical staff, physician services, emergency assistance or transfer to an acute inpatient facility for stabilization) because there is no injury or probable risk of serious harm. Such variances include but are not limited to, medication omission, wrong drug, wrong dose, wrong person, wrong time, wrong rate, wrong preparation, and wrong route of administration;

2.15.7.1.3.2.6 Unsafe environment (cleanliness/hazardous conditions not otherwise expected to normally exist in the environment);

2.15.7.1.3.2.7 Use of manual restraint, mechanical restraint and/or protective equipment that has been approved for use in the person's PCSP or BSP, but that has been used incorrectly or other than as intended. Events determined to be completely outside of an approved PCSP or BSP or intentionally inappropriate or intentionally in violation of guidelines specified in the person's PCSP or BSP shall be considered Tier 1 Critical Incidents, and as such, Tier 1 reporting requirements must be followed; and

2.15.7.1.3.2.8 The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of belongings or money valued between $250 and $1,000, i.e. less than the threshold for misappropriation.

2.15.7.1.4 The CONTRACTOR shall require its staff and contract CHOICES HCBS providers and the FEA, as applicable, to report, respond to, and document Tier 1 and Tier 2 critical incidents as specified in this Contract and in TENNCARE protocol. This shall include, but not be limited to the following:

2.15.7.1.4.1 Requiring that the CONTRACTOR's staff and contract CHOICES HCBS providers report Tier 1 and Tier 2 critical incidents to the CONTRACTOR in accordance with applicable requirements.

2.15.7.1.4.2 HCBS providers report all Tier 1 Critical Incidents to the CONTRACTOR within four (4) hours of witnessing or discovering the Tier 1 Critical Incident. The CONTRACTOR shall require such providers to submit a written Critical Incident Form for Tier 1 Critical Incidents by close of business the next business day counting from the date of notification. The CONTRACTOR shall also require that such providers provide initial notification to the CONTRACTOR using the Critical Incident Form for all Tier 2 Critical Incidents by close of the next business day counting from the date of witnessing or discovering the Tier 2 Critical Incident.

2.15.7.1.4.3 Requiring that its staff and contract CHOICES HCBS providers immediately (which shall not exceed twenty-four hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members. If the allegation concerns allegations, suspicions, or evidence of any form of abuse, neglect, or exploitation including misappropriation of property, relating to a CHOICES HCBS worker, the CONTRACTOR shall ensure that the provider either places the worker on administrative leave or in another position in which he or she does not have direct contact with, or supervisory responsibility for, a person supported until the provider's investigation is complete. Providers may, pursuant to agency policies, choose to remove staff concerning other incidents at their discretion, pending completion of the investigation.

2.15.7.1.4.4 Requiring that contract CHOICES HCBS providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by the CONTRACTOR. The timeframe for submitting the report shall be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, shall be no more than thirty (30) days after the date of the incident. The CONTRACTOR shall review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

2.15.7.1.4.5 The CONTRACTOR shall have thirty (30) calendar days from the anchor date to review the provider's investigation report and make one of the following

determinations which must be sent to the provider in writing: (1) Accept the report, (2) Submit the finding to the provider (e.g., sanctions or corrective action), or (3) Request additional information from the provider to make a determination. The CONTRACTOR may request one (1) seven (7) day extension from TENNCARE for completion of its review process only upon extenuating circumstance beyond the CONTRACTOR's control, and such request for an extension must be made within thirty (30) calendar days from the anchor date.

2.15.7.1.4.5.1 If the CONTRACTOR determines that additional information from the provider is necessary to complete the CONTRACTOR's review, the CONTRACTOR shall notify the provider in writing and shall have fourteen (14) calendar days from the date of such notification to complete a review of the provider's investigation and determine whether to accept or make findings on the report and notify the provider.

2.15.7.1.4.5.2 The CONTRACTOR shall submit to TENNCARE, all Tier 1 final investigation reports within twenty (20) calendar days from the date in which the Provider submits the final report. This notification shall include any actions taken by the HCBS Provider and the CONTRACTOR.

2.15.7.1.4.6 Requiring that its staff and contract CHOICES HCBS providers cooperate with any investigation conducted by the CONTRACTOR or outside agencies (e.g., TENNCARE, APS, CPS, and law enforcement).

2.15.7.1.4.7 Defining the role and responsibilities of the fiscal employer agent (see definition in Section A.1) in reporting, any critical incidents, which shall include reporting incidents to the CONTRACTOR using the process developed in a accordance with Section A.2.15.7.1.4.1, and reporting to the CONTRACTOR within 24 hours in accordance with the abuse and neglect plan protocols anytime there is a suspicion of abuse or neglect (see Section A.2.9.7.8.5); training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding reporting, and cooperating with the investigation of any critical incidents; and training consumers and caregivers regarding critical incident reporting and management. Such roles and responsibilities shall be defined in a manner that is consistent with requirements in this Section A.2.15.7.1.4 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.

2.15.7.1.4.8 Reviewing any FEA reports regarding critical incidents and investigate, as appropriate to determine any necessary corrective actions needed by the member and/or his/her representative to help ensure the member's health and safety.

2.15.7.1.4.9 Providing appropriate training and taking corrective action as needed to ensure its staff, contract CHOICES HCBS providers, the FEA, and workers comply with critical incident requirements.

2.15.7.1.4.10 Conducting oversight, including but not limited to oversight of its staff, contract CHOICES HCBS providers, and the FEA, to ensure that the CONTRACTOR's policies and procedures are being followed and that necessary follow-up is being conducted in a timely manner.

2.15.7.1.5 In the manner required by TENNCARE, within one (1) business day of detection or notification, the CONTRACTOR must report to TENNCARE any Tier 1 Critical Incident, unexplained or unexpected death (including suicide), and any incident reported to APS. The timeframe for reporting to TENNCARE shall begin from the

time of detection by a provider or upon receipt of information relative to the incident by CONTRACTOR staff, whichever is sooner.

2.15.7.1.6 In the manner required by TENNCARE, within two (2) business days of detection of notification, the CONTRACTOR must report to TENNCARE any Tier 2 Critical Incidents. The timeframe for reporting to TENNCARE shall begin from the time of detection by a provider or upon receipt of information relative to the incident by CONTRACTOR staff, whichever is sooner.

2.15.7.1.7 As specified in Section A.2.30.12.7, the CONTRACTOR shall submit quarterly reports to TENNCARE regarding CHOICES HCBS critical incidents.

2.15.7.2 Behavioral Health Adverse Occurrences

2.15.7.2.1 Adverse occurrences shall include but not be limited to the following incidents when they occur while the member is in the care of a behavioral health inpatient, residential or crisis stabilization unit:

2.15.7.2.1.1 Suicide death;

2.15.7.2.1.2 Non-suicide death;

2.15.7.2.1.3 Death-cause unknown;

2.15.7.2.1.4 Homicide;

2.15.7.2.1.5 Homicide Attempt with significant medical intervention;

2.15.7.2.1.6 Suicide Attempt with significant medical intervention;

2.15.7.2.1.7 Allegation of Abuse/Neglect (Physical, Sexual, Verbal);

2.15.7.2.1.8 Accidental Injury with significant medical intervention;

2.15.7.2.1.9 Use of Restraints/Seclusion (Isolation) requiring significant medical intervention; or

2.15.7.2.1.10 Treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention.

2.15.7.2.2 The CONTRACTOR's staff and contract providers shall report adverse occurrences to the CONTRACTOR in accordance with applicable requirements. The maximum timeframe for reporting an adverse occurrence to the CONTRACTOR shall be twenty-four (24) hours.

2.15.7.2.3 In the manner prescribed by TENNCARE, within twenty-four (24) hours of detection or notification, the CONTRACTOR must report to TENNCARE any adverse occurrence as described above.

2.15.7.2.4 As specified in Section A.2.30.12.9, the CONTRACTOR shall submit quarterly reports to TENNCARE regarding adverse occurrences.

2.15.7.3 Home Health Agency Critical Incident Reporting

2.15.7.3.1 The CONTRACTOR shall identify, track, and review all significant critical incidents that occur during the provision of Home Health (HH) services. This requirement shall be applied for all members, including CHOICES and Non-CHOICES members. A HH critical incident shall include those significant incidents that are reported to the CONTRACTOR from the Home Health Agency (HHA). Critical incidents include, but are not limited to, the following:

2.15.7.3.1.1 Any unexpected death, regardless of whether the death occurs during the provision of HH;

2.15.7.3.1.2 Major/severe injury;

2.15.7.3.1.3 Safety issues;

2.15.7.3.1.4 Suspected physical, mental or sexual abuse;

2.15.7.3.1.5 Neglect;

2.15.7.3.1.6 Life-threatening medical emergency;

2.15.7.3.1.7 Medication error;

2.15.7.3.1.8 Financial exploitation;

2.15.7.3.1.9 Theft.

2.15.7.3.2 Each incident must be reported using the TENNCARE prescribed HHA Critical Incident report template within twenty-four (24) hours of detection or notification by the CONTRACTOR's QM/QI Program staff receiving information relative to such an incident. An updated report, including results of investigation and next steps must be submitted to TENNCARE within thirty (30) calendar days of notification of the incident.

2.15.7.3.3 The CONTRACTOR shall, as part of its critical incident management system, track, review and analyze critical incident data that takes into consideration all incidents occurring for members supported by an agency, that occur during the provision of HH services, including the identification of trends and patterns, opportunities for improvement, and actions and strategies the CONTRACTOR will take to reduce the occurrence of incidents and improve the quality of HH services received.

2.15.7.3.4 The CONTRACTOR shall identify and track critical incidents and shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The CONTRACTOR shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from APS and CPS if available); identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of HH services.

2.15.7.4 Death of Member Reporting (Not Otherwise Reported in accordance with Section A.2.15.7)

2.15.7.4.1 The CONTRACTOR shall report to TENNCARE any unexpected death of a member that is not otherwise reported in accordance with Section A.2.15.7.

2.15.7.4.2 The CONTRACTOR shall be responsible for reviewing and tracking all unexpected deaths, regardless of circumstances or setting. The CONTRACTOR shall submit an annual report to Quality Improvement regarding all unexpected deaths, in a manner prescribed by TENNCARE.

2.15.7.5 For DIDD-conducted investigations in CLS and CLS-FM blended residences (see Section A.2.12.17), if a DIDD investigation report submitted to TENNCARE indicates a substantiated finding by DIDD, TENNCARE shall notify the MCO, and the MCO shall take actions as necessary to ensure the CLS or CLF-FM resident(s)' health and welfare.

2.15.7.6 ECF CHOICES Reportable Event Management

2.15.7.6.1 The CONTRACTOR shall develop and implement in coordination with DIDD a Reportable Event management system for Reportable Events involving ECF CHOICES members that occur in a home and community-based long-term service and supports delivery setting, if the Reportable Event occurs during the provision of covered ECF CHOICES services or is discovered or witnessed by the CONTRACTOR, provider, or FEA staff, regardless of whether the provider is believed to be responsible for the event and/or other HCBS system factors are believed to have contributed to the event.

2.15.7.6.2 The CONTRACTOR in coordination with DIDD shall identify and track Reportable Events, and the CONTRACTOR shall review and analyze Reportable Events to identify and address potential and actual quality of care and/or health and safety issues. The CONTRACTOR shall regularly review the number and types of Reportable Events (including, for example, the number and type of Reportable Events across settings, providers, and provider types) and findings from investigations (including findings from APS and CPS if available); identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of Reportable Events and improve the quality of ECF CHOICES HCBS.

2.15.7.6.3 Reportable Events for the purposes of ECF CHOICES shall be stratified into two groups: Tier 1 and Tier 2.

2.15.7.6.3.1 Tier 1 Reportable Events shall include the following:

2.15.7.6.3.1.1 Any incident involving allegations, suspicions or evidence of any form of Abuse, Neglect or Exploitation including Misappropriation of Property.

2.15.7.6.3.1.1.1 For purposes of this section, abuse, neglect, and exploitation shall be defined as in TCA 33-2-402 and implemented as specified in TennCare protocol.

2.15.7.6.3.1.1.2 Sexual abuse includes sexual battery by an authority figure as defined in TCA 39-13-527;

2.15.7.6.3.1.2 All unexpected or unexplained deaths, including suicide;

2.15.7.6.3.1.3 A suspicious injury where abuse or neglect is suspected, or the nature of the injury does not coincide with explanation of how injury was sustained;

2.15.7.6.3.1.4 Serious injury, including serious injury of unknown cause;

2.15.7.6.3.1.4.1 For purposes of this section, serious injury is any injury requiring medical treatment beyond first aid by a lay person, and includes, but is not limited to: fractures, dislocations, concussions, cuts or lacerations requiring sutures, staples, or dermabond; torn ligaments (e.g., a severe sprain) or torn muscles or tendons (e.g., a severe strain) requiring surgical repair, second and third degree burns, and loss of consciousness.

2.15.7.6.3.1.5 Theft by provider personnel (employees or volunteers) of more than $1,000 (Class E felony);

2.15.7.6.3.1.6 A serious traffic violation with significant risk of harm (e.g., reckless, careless or imprudent driving; driving under the influence, speeding in excess of fifteen (15) miles per hour over the speed limit);

2.15.7.6.3.1.7 Medication error, which results in the need for face-to-face medical treatment based on injury or probable risk of serious harm, including physician services, emergency assistance, or transfer to an acute care facility for stabilization. Such errors shall include: (1) medication omission; (2) administering the wrong drug; (3) administering the wrong drug dosage; (4) administering the drug to the wrong person; (5) administering the drug at the wrong time; (6) administering the drug at the wrong rate; (7) administering the drug following improper or inadequate preparation; or (8) administering the drug via the incorrect route.

2.15.7.6.3.2 Tier 2 Reportable Events shall include the following:

2.15.7.6.3.2.1 Allegations that provider personnel (employees, volunteers) engaged in disrespectful or inappropriate communication about a person [e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures)], or any other similar acts that do not meet the definition of emotional or psychological abuse, and which are directed to or within eyesight or audible range of the person supported (the CONTRACTOR shall include such complaints in the CONTRACTOR's non-discrimination reporting pursuant to A.2.30.22.3.2.1).

2.15.7.6.3.2.2 Person whose whereabouts are unknown and could likely place him/her in a dangerous situation for self or others. This event is reportable if the whereabouts of the member are unknown for sixty (60) minutes or more if the absence is unusual, unless a shorter time is specified in the person's PCSP or Behavior Support Plan (BSP), or the absence is a known risk as specified in the person's PCSP or the BSP. Reporting that a member's whereabouts are unknown is in addition to, and not a substitute for or priority over, actively looking for the member and contacting law enforcement if necessary.

2.15.7.6.3.2.2.1 Person supported shall have the freedom to come and go without staff supervision, except when such restrictions are necessary to ensure their health and safety or the safety of others, which must be documented in the PCSP.

2.15.7.6.3.2.3 Minor vehicle accident resulting in an injury that does not require face-to-face medical treatment by someone other than a lay person.

2.15.7.6.3.2.4 Victim of fire.

2.15.7.6.3.2.5 Medication variance resulting in the need for observation, but which does not require any face-to-face medical treatment (including treatment by provider's

trained medical staff, physician services, emergency assistance or transfer to an acute inpatient facility for stabilization) because there is no injury or probable risk of serious harm. Such variances shall include: (1) medication omission; (2) administering the wrong drug; (3) administering the wrong drug dosage; (4) administering the drug to the wrong person; (5) administering the drug at the wrong time; (6) administering the drug at the wrong rate; (7) administering the drug following improper or inadequate preparation; or (8) administering the drug via the incorrect route.

2.15.7.6.3.2.6 Unsafe environment (cleanliness/hazardous conditions not otherwise expected to normally exists in the environment).

2.15.7.6.3.2.7 The use of manual or mechanical restraint or protective equipment approved for use in the person's PCSP or BSP, but used incorrectly or in a manner other than intended. Reportable Events determined to be outside of an approved PCSP or BSP or intentionally inappropriate or in violation of guidelines specified in the person's PCSP or BSP shall be referred to DIDD as a Tier 1Reportable Event.

2.15.7.6.3.2.8 The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of belongings or money valued between $250 and $1,000 (i.e., less than the threshold for misappropriation).

2.15.7.6.4 The CONTRACTOR shall require its staff, contract ECF CHOICES HCBS providers, and the FEA, as applicable, to report, respond to, and document Reportable Events as specified in this Contract and in TennCare protocol. This shall include, but not be limited to, the following:

2.15.7.6.4.1 Requiring that ECF CHOICES HCBS providers report all Tier 1 Reportable Events to DIDD verbally within four (4) hours of witnessing or discovery of the Tier 1 Reportable Event. The CONTRACTOR shall provide DIDD with the individual's most recent PCSP as soon as possible, but no later than two (2) hours after request from DIDD following a report or notification of a Tier 1 Reportable Event. The CONTRACTOR shall require such providers to submit a corresponding written Reportable Event Form (REF) as prescribed by TENNCARE to DIDD for Tier 1 Reportable Events by close of the next business day counting from the date of verbal notification. The CONTRACTOR shall also require that such providers provide initial notification to the CONTRACTOR and DIDD using the REF for all Tier 2 Reportable Events by close of the next business day counting from the date of witnessing or discovery of the Reportable Event.

2.15.7.6.4.2 For Tier 2 Reportable Events, provider submission of the Tier 2 Reportable Event on the REF to DIDD and the CONTRACTOR shall be the anchor date for purposes of Tier 2 Reportable Event review timelines. The CONTRACTOR shall require that ECF CHOICES HCBS providers complete all investigations into Tier 2 Reportable Events and submit an investigation report within fourteen (14) calendar days of the anchor date. The CONTRACTOR may at its discretion grant one (1) seven (7)-day extension to the provider. Such extension process shall not apply for Reportable Event investigations in consumer direction in which the MCO, and not the provider, is responsible for investigating.

2.15.7.6.4.3 The CONTRACTOR shall have thirty (30) calendar days from the anchor date to review the provider's investigation report and make one of the following determinations which must be sent to the provider in writing: (1) Accept the report, (2) Submit findings to the provider (e.g., sanctions or corrective action), or (3)

Request additional information from the provider to make a determination. The CONTRACTOR may request one (1) seven (7)-day extension from TENNCARE for completion of its review process only upon extenuating circumstances beyond the CONTRACTOR's control, and such request for an extension must be made within the thirty (30) calendar days from the anchor date.

2.15.7.6.4.3.1 If the CONTRACTOR determines that additional information from the provider is necessary to complete the CONTRACTOR's review, the CONTRACTOR shall notify the provider in writing and shall have fourteen (14) calendar days from the date of such notification to complete a review of the provider's investigation and determine whether to accept or make findings on the report and notify the provider.

2.15.7.6.4.3.2 The CONTRACTOR shall submit a copy of the acceptance or findings sent to the provider to DIDD within seven (7) calendar days of submitting such notification to the provider.

2.15.7.6.4.4 Requiring that if the CONTRACTOR receives notice of a Tier 1 or Tier 2 Reportable Event from an individual who is not CONTRACTOR, FEA, or provider staff (e.g., a caregiver, family member, etc.), then the CONTRACTOR shall notify DIDD of the Tier 1 or Tier 2 Reportable Event as detailed in Section A.2.15.7.6.4.1.

2.15.7.6.4.5 Requiring CONTRACTOR staff to notify DIDD within four (4) hours by phone following discovery that a Tier 2 Reportable Event should be classified as Tier 1 Reportable Event, and submit an amended REF to DIDD and the provider for the Reportable Event by close of the next business day counting from the day of discovery of the incorrectly classified Reportable Event.

2.15.7.6.4.6 Requiring that suspected abuse, neglect, and exploitation of members who are adults is immediately reported in accordance with TCA 71-6-103 and suspected brutality, abuse, or neglect of members who are children is immediately reported in accordance with TCA 37-1-403 or TCA 37-1-605 as applicable.

2.15.7.6.4.7 Requiring that its staff and contract ECF CHOICES HCBS providers immediately take steps to prevent further harm to any and all members and respond to any emergency needs of members. If the allegation concerns a Tier 1 Reportable Event allegation of physical or sexual abuse relating to an ECF CHOICES HCBS worker, the CONTRACTOR shall ensure that the provider either places the worker on administrative leave or in another position in which he or she does not have direct contact with, or supervisory responsibility for, a person supported until DIDD has completed its investigation. Providers may request an exception to this administrative leave policy in a method prescribed by TENNCARE. Providers may additionally decide to remove staff concerning other Tier 1 and Tier 2 Reportable Events at their discretion and pursuant to agency policy.

2.15.7.6.4.8 Requiring that its staff and contract ECF CHOICES HCBS providers cooperate with any investigation conducted by the CONTRACTOR or outside agencies (e.g., TENNCARE, DIDD, APS, CPS, and law enforcement).

2.15.7.6.4.9 Defining the role and responsibilities of the FEA in reporting, any Reportable Events in ECF CHOICES, which shall include reporting Reportable Events to the CONTRACTOR using the process developed in accordance with Section A.2.15.7.6.4.1, and reporting to the CONTRACTOR in accordance with timeframes set forth in TennCare protocol for ECF CHOICES members, as well

as training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding reporting, and cooperating with the investigation of any Reportable Events; and training consumers and caregivers regarding Reportable Event reporting and management. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section A.2.15.7.6.4 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.

2.15.7.6.4.10 Reviewing any FEA reports regarding Reportable Events and investigate, as appropriate to determine any necessary corrective actions needed by the member and/or his/her representative to help ensure the member's health and safety.

2.15.7.6.4.11 Providing appropriate training and taking corrective action as needed to ensure its staff, contract ECF CHOICES HCBS providers, the FEA, and workers comply with Reportable Event requirements.

2.15.7.6.4.12 Conducting oversight, including but not limited to oversight of its staff, contract ECF CHOICES HCBS providers, and the FEA, to ensure that the CONTRACTOR's policies and procedures are being followed and that necessary follow-up is being conducted in a timely manner.

2.15.7.6.4.13 As specified in Section A.2.30.12.8, the CONTRACTOR shall submit quarterly reports to TENNCARE regarding ECF CHOICES HCBS critical incidents.

A.2.15.8 **Provider Preventable Conditions**

The CONTRACTOR shall comply with 42 CFR Part 438 requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR §438.3(g), §434.6(a)(12) and § 447.26. The CONTRACTOR shall submit all identified Provider Preventable Conditions in a form or frequency as described by TENNCARE.

A.2.15.9 **Missed Visits of Home Health Services**

2.15.9.1 "Missed visit," as used herein, refers to a period of one or more hours that a staff member of an HHA does not furnish the home health service that an enrollee is authorized to receive, and which has been implemented. A missed visit may be due to exigent circumstances beyond any party's control. It may also be due to a fault of the HHA, the staff member, or the CONTRACTOR. It may also be due to a fault of the enrollee. For example, the enrollee refuses to allow the staff member to enter the home or to remain there after beginning work; the staff member suspects or witnesses unlawful activity in the home; or, the environment in the enrollee's home is such that the staff member fears for their personal safety.

2.15.9.2 The CONTRACTOR shall collect all missed-visit reports delivered to them by the HHAs and monitor them. As a general practice, the CONTRACTOR shall identify negative trends with regard to particular HHAs or enrollees. The CONTRACTOR shall contact the HHAs and attempt to resolve such negative trends. In its discretion, the CONTRACTOR may contact enrollees in order to remediate such negative trends.

2.15.9.3 The CONTRACTOR shall respond to all inquiries from TENNCARE regarding potential missed visits by submitting timely documentation showing the dates and times of any missed visits, the name of the HHA involved, and the cost of each visit

had it been provided, as well as any other information reasonably requested by TENNCARE.

2.15.9.4 Upon monitoring the missed-visit reports or upon being notified by an HHA of an enrollee's refusal of two (2) or more staff members, the CONTRACTOR shall contact the HHA and the enrollee to attempt a resolution while the HHA remains willing and able to provide services to the enrollee. This may include the CONTRACTOR scheduling a meeting between a member of its management, the enrollee, and HHA personnel. The CONTRACTOR shall document every action taken.

2.15.9.5 If the enrollee has refused two (2) or more staff members, the CONTRACTOR shall assign a case-manager to the enrollee if one is not already assigned. The CONTRACTOR shall also contact the primary care provider to advise him or her of the enrollee's pattern of refusing the authorized services and to discuss a possible solution. The conversation, and any decisions made, shall be documented in the CONTRACTOR'S record for the enrollee.

2.15.9.6 If the HHA plans to discharge the enrollee for cause, the CONTRACTOR shall send the enrollee a letter informing them that the HHA will no longer be providing their care as of a certain date, and that they have either found or are searching for another HHA to replace it. The CONTRACTOR, however, should only seek the services from in-network HHAs. The CONTRACTOR shall also send a delay notice to the enrollee if a delay occurs to the enrollee receiving the service from the new provider.

2.15.9.7 If the enrollee continues to refuse staff members from the newly selected HHA, the CONTRACTOR shall again follow the protocol.

2.15.9.8 If after the CONTRACTOR follows the protocol in Section A.2.15.9.5 twice and the situation is not then resolved, the CONTRACTOR, at its discretion, shall make a reasonable number of attempts (if any) to arrange for further in-network HHAs to provide the enrollee's authorized care taking into account the number of HHAs available in the enrollee's county and/or adjacent counties.

2.15.9.9 When all reasonable attempts have been exhausted, the CONTRACTOR shall move to terminate the enrollee's home health service. When the CONTRACTOR decides to terminate the enrollee's care, it shall, if it has not already done so, collect all of the relevant missed-visit reports. The CONTRACTOR must then, if it has not already done so, make a single record consisting of a list of the names of the agencies used and how many staff members from each agency were refused by the enrollee. The CONTRACTOR shall also offer a covered medically necessary alternative, such as facility-based care, to the enrollee.

2.15.9.10 Once these steps are completed, the CONTRACTOR shall issue a Notice of Adverse Benefit Determination, citing Tenn. Comp. R. & Regs. ("Rule") 1200-13-16-.05(1)(c), and (5) (or other rule(s) as TENNCARE may direct), and the reason for the termination. The notice shall also state the covered medically necessary alternative, if any. The CONTRACTOR shall forward a copy of that notice to TENNCARE.

A.2.15.10 **National Core Indicators and National Core Indicators – Aging and Disability**

2.15.10.1 The CONTRACTOR shall assist TENNCARE in conducting an annual quality of life survey for members enrolled in CHOICES and ECF CHOICES using the National Core Indicators© and National Core Indicators – Aging and Disability© tool and processes.

2.15.10.2 The CONTRACTOR shall collect and report Pre-Survey and Background Information for each member in the sample (including the oversample) into the ODESA database in accordance with instructions and timeframes established by TENNCARE.

2.15.10.3 The CONTRACTOR shall review the results of each survey process by region, identify strengths and opportunities, develop and implement a specific quality improvement plan for each region to address opportunities identified in the survey in order to improve member satisfaction and quality of life, and measure progress that results from these changes in order to inform ongoing quality improvement activities.

A.2.16 MARKETING

A.2.16.1 The CONTRACTOR shall not conduct any enrollee marketing activities, as defined in Section A.1 of this Contract. This prohibition includes, but is not limited to the following information and activities:

2.16.1.1 Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers.

2.16.1.2 Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined, or similar techniques;

2.16.1.3 Offers of gifts or material or financial gain as incentives to enroll;

2.16.1.4 Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;

2.16.1.5 Direct solicitation of prospective enrollees;

2.16.1.6 Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;

2.16.1.7 Assertions or statements (whether oral or written) that the enrollee must enroll with the CONTRACTOR in order to obtain benefits or in order not to lose benefits;

2.16.1.8 Assertions or statements (whether written or oral) that the CONTRACTOR is endorsed by CMS, the federal or state government or similar entity;

2.16.1.9 Use of independent marketing agents in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions;

2.16.1.10 Seeking to influence enrollment in conjunction with the sale or offering of any private insurance; and

2.16.1.11 Distributing marketing materials to select or partial service areas for which the CONTRACTOR is authorized to serve.

A.2.16.2 The CONTRACTOR shall not use the name of the CONTRACTOR's TennCare MCO in any form of general marketing (as defined in Section A.1) without TENNCARE's prior written approval.

A.2.17 MEMBER MATERIALS

A.2.17.1 Prior Approval Process for All Member Materials

2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior written approval all materials that will be distributed to members (referred to as member materials). Should the CONTRACTOR decide to contract with either a subcontractor or its providers to create and/or distribute member materials, the materials shall not be distributed to members unless the materials have been submitted to TENNCARE by the CONTRACTOR for review and prior written approval. Member Materials include, but are not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.

2.17.1.2 All member materials shall be submitted to TENNCARE in electronic file media, unless otherwise approved by TENNCARE, in the format prescribed by TENNCARE. The materials shall be accompanied by a plan that describes the CONTRACTOR's intent and procedure for the use of the materials. Materials developed by a recognized entity having no association with the CONTRACTOR that are related to management of specific types of diseases (e.g., heart, diabetes, asthma, etc.) or general health improvement shall be submitted for approval. The electronic files shall be submitted in a format acceptable to TENNCARE. Electronic files submitted in any other format than those approved by TENNCARE will not be processed.

2.17.1.3 TENNCARE shall review the submitted member materials and either approve or deny them within fifteen (15) calendar days from the date of submission. In the event TENNCARE does not approve the materials TENNCARE may provide written comments, and the CONTRACTOR shall resubmit the materials.

2.17.1.4 Once member materials have been approved in writing by TENNCARE, the CONTRACTOR shall submit to TENNCARE an electronic version (PDF) of the final printed product, unless otherwise specified by TENNCARE, within thirty (30) calendar days from the print date. Should TENNCARE request original prints be submitted in hard copy, photo copies may not be submitted as a final product. Upon request, the CONTRACTOR shall provide additional original prints of the final product to TENNCARE.

2.17.1.5 Prior to modifying any approved member material, the CONTRACTOR shall submit for written approval by TENNCARE a detailed description of the proposed modification. Proposed modifications shall be submitted in accordance with the requirements herein.

2.17.1.6 TENNCARE reserves the right to notify the CONTRACTOR to discontinue or modify member materials after approval.

A.2.17.2 **Written Material Guidelines**

The CONTRACTOR shall comply with the following requirements as it relates to written member materials:

2.17.2.1 All member materials shall be worded at a sixth (6th) grade reading level, unless TENNCARE approves otherwise;

2.17.2.2 All written materials shall be clearly legible and unless otherwise directed by TENNCARE, must be written with a minimum font size of 12pt. with the exception of member I.D. cards and certain taglines that require a minimum font size of 18 pt. Any request from the CONTRACTOR for an exception to the written materials font size requirements shall be approved in writing by TENNCARE prior to use;

2.17.2.3 Articles and/or informational material included in written materials such as newsletters, brochures, etc. shall be limited to approximately 200 words for purposes of readability unless otherwise approved in writing by TENNCARE;

2.17.2.4 All written materials shall be printed with the notice of non-discrimination and taglines as required by TENNCARE and set forth in TENNCARE's tagline template. In addition to any other requirements specified in Section A.2.17, the CONTRACTOR may also provide required member materials/information electronically or on its website pursuant to the specifications set forth in section 2.28.10.3, TENNCARE'S tagline template, and the following requirements: (1) the material/information must be placed on the CONTRACTOR'S website in a location that is prominent and readily accessible for applicants and members to link to from CONTRACTOR'S home page; (2) the material/information must be provided in a format that can be electronically saved and printed; and (3) if a member or applicant requests that the CONTRACTOR mail them a copy of the material/information, the CONTRACTOR must mail free of charge the material/information to them within five (5) days of that request. To the extent that the CONTRACTOR and its providers and/or subcontractors are using electronic and information technology to fulfill its obligations under this Contract, the entities shall comply with section 2.28.10.

2.17.2.5 The following shall not be used on any written materials, including but not limited to member materials, without the written approval of TENNCARE:

2.17.2.5.1 The Seal of the State of Tennessee;

2.17.2.5.2 The TennCare name unless the initials "SM" denoting a service mark, is superscripted to the right of the name (TennCare[sm]);

2.17.2.5.3 The word "free" unless the service is at no cost to all members. If members have cost sharing or patient liability responsibilities, the service is not free. Any conditions of payments shall be clearly and conspicuously disclosed in close proximity to the "free" good or service offer; and

2.17.2.5.4 The use of phrases to encourage enrollment such as "keep your doctor" implying that enrollees can keep all of their providers. Enrollees in TennCare shall not be led to think that they can continue to go to their current provider, unless that particular provider is a contract provider with the CONTRACTOR's MCO;

2.17.2.6 All vital CONTRACTOR documents shall be translated and available in Spanish. Within ninety (90) calendar days of notification from TENNCARE, all vital CONTRACTOR documents shall be translated and available to each Limited English Proficiency group identified by TENNCARE that constitutes five percent (5%) of the TennCare population or one-thousand (1,000) enrollees, whichever is less;

2.17.2.7 All written member materials shall notify enrollees that oral interpretation is available for any language at no expense to them and how to access those services;

2.17.2.8 All written member materials shall ensure effective communication with disabled/handicapped persons at no expense to the member and/or the member's representative. Effective Communication may be achieved by providing aids or services, including, but may not be limited to: Braille, large print and audio and shall be based on the needs of the individual member and/or the member's representative. The CONTRACTOR and its providers and direct service subcontractors shall be required to comply with the Americans with Disabilities Act of 1990 in the provision of auxiliary aids and services to members and/or the member's representative to achieve effective communication;

2.17.2.9 The CONTRACTOR shall provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. The CONTRACTOR shall provide written notice at least thirty (30) days before the effective date of the change;

2.17.2.10 The CONTRACTOR shall use the approved Glossary of Required Spanish Terms in the Spanish translation of all member materials; and

2.17.2.11 All educational materials (brochures, scripts etc.) shall be reviewed and updated concurrently with the update of the Clinical Practice Guidelines to assure the materials reflect current evidence-based information.

A.2.17.3 **Distribution of Member Materials**

2.17.3.1 The CONTRACTOR shall distribute member materials as required by this Contract. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters, identification cards, CHOICES member education materials, and ECF CHOICES member education materials.

2.17.3.2 The CONTRACTOR may distribute additional materials and information, other than those required by this Section, Section A.2.17, to members in order to promote health and/or educate enrollees.

A.2.17.4 **Member Handbooks**

2.17.4.1 The CONTRACTOR shall develop a separate member handbook for TennCare and CoverKids based on a template provided by TENNCARE, and update them periodically (at least annually). Upon notice to TENNCARE of material changes to the member handbooks, the CONTRACTOR shall make appropriate revisions and immediately distribute the revised handbook to members and providers.

2.17.4.2 The CONTRACTOR shall distribute member handbooks to members within thirty (30) calendar days of receipt of notice of enrollment in the CONTRACTOR's MCO or prior to enrollees' enrollment effective date as described in Section A.2.4.5 and at least annually thereafter. In the event of material revisions to the member handbook, the CONTRACTOR shall distribute the new and revised handbook to all members immediately.

2.17.4.3 In situations where there is more than one member in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook to each address listed for the member's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to members. Should a single individual be enrolled and be added into an existing case, a member handbook (new or updated) shall be mailed to that individual regardless of whether or not a member handbook has been previously mailed to members in the existing case.

2.17.4.4 The CONTRACTOR shall distribute a member handbook to all contract providers upon initial credentialing, annually thereafter to all contract providers and the FEA as handbooks are updated, and whenever there are material revisions. For purposes of providing member handbooks to providers and to the FEA, it shall be acceptable to provide handbooks in electronic format, including but not limited to CD or access via a web link.

2.17.4.5 The CONTRACTOR shall print, disseminate and review, or provide to members electronically based on member preference, with each CHOICES or ECF CHOICES member participating in consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS a consumer direction handbook applicable to the specific program in which the member is enrolled, developed by TENNCARE. In the event of material revisions to the consumer direction handbook, the CONTRACTOR shall immediately disseminate and review with each CHOICES or ECF CHOICES member participating in consumer direction key changes as reflected in the revised consumer direction handbook applicable to the specific program in which the member is enrolled.

2.17.4.6 Each member handbook shall, at a minimum, be in accordance with the following guidelines:

2.17.4.6.1 Shall be in accordance with all applicable requirements as described in Section A.2.17.2 of this Contract;

2.17.4.6.2 Shall include a table of contents;

2.17.4.6.3 Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment, of PCP assignment, and of Care Coordinator or Support Coordinator assignment for CHOICES and ECF CHOICES members;

2.17.4.6.4 Shall include an explanation of how members can request to change PCPs;

2.17.4.6.5 Shall include a description of services provided including benefit limits, the consequences of reaching a benefit limit, non-covered services, and use of non-contract providers, including that members are not entitled to a fair hearing about non-covered services and that members shall use contract providers except in specified circumstances. This description shall also include information, if applicable, in the case of a counseling or referral service that the CONTRACTOR does not cover because of

moral or religious objections as well as information on how the counseling or referral service is covered by TENNCARE;

2.17.4.6.6 Shall explain that prior authorization is required for some services, including non-emergency services provided by a non-contract provider, and that service authorization is required for all long-term care services; that such services will be covered and reimbursed only if such prior authorization/service authorization is received before the service is provided; that all prior authorizations/service authorizations are null and void upon expiration of a member's TennCare eligibility; and that the member shall be responsible for payment for any services provided after the member's eligibility has expired;

2.17.4.6.7 Shall include descriptions of the Medicaid Benefits, Standard Benefits, and the covered long-term care services for CHOICES and ECF CHOICES members, by CHOICES and ECF CHOICES group. This shall include information about how transportation is provided, including transportation for any benefits carved out of the CRA and provided by the state;

2.17.4.6.8 Shall include a description of TennCare cost sharing or patient liability responsibilities including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts. Further, the information shall specify the instances in which a member may be billed for services, and shall indicate that the member may not be billed for covered services except for the amounts of the specified TennCare cost sharing or patient liability responsibilities and explain the member's right to appeal in the event that they are billed for amounts other than their TennCare cost sharing or patient liability responsibilities. The information shall also identify the potential consequences if the member does not pay his/her patient liability, including loss of the member's current nursing facility provider, disenrollment from CHOICES or ECF CHOICES, and, to the extent the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare;

2.17.4.6.9 Shall include information about preventive services for adults and children, including TennCare Kids, a listing of covered preventive services, and notice that preventive services are at no cost and without cost sharing responsibilities;

2.17.4.6.10 Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract providers. This shall include an explanation that the CONTRACTOR may not require a member to obtain a referral before choosing a family planning provider. The handbook shall advise members that if they need a service that is not available from a contract provider, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider;

2.17.4.6.11 Shall include information on the CHOICES program, including a description of the CHOICES groups; eligibility for CHOICES; enrollment in CHOICES, including whom to contact at the MCO regarding enrollment in CHOICES; enrollment targets for Group 2 and Group 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3;

2.17.4.6.12 Shall provide information regarding ECF CHOICES as specified in a template provided by TENNCARE.

2.17.4.6.13 Shall include information on care coordination for CHOICES members, including but not limited to the role of the Care Coordinator, level of care assessment and reassessment, comprehensive assessment and reassessment, and care planning, including the development of a PCSP for members in CHOICES Groups 2 and 3;

2.17.4.6.14 Shall include information on the right of CHOICES members to request an objective review by the State of their comprehensive assessment and/or care planning processes and how to request such a review;

2.17.4.6.15 Shall include information regarding consumer direction of eligible CHOICES HCBS, including but not limited to the roles and responsibilities of the member or the member's representative, the services that can be directed, the member's right to participate in or voluntarily withdraw from consumer direction at any time, the role of and services provided by the FEA, as well as a statement that voluntary or involuntary withdrawal from consumer direction will not affect a member's eligibility for CHOICES;

2.17.4.6.16 Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the CONTRACTOR's service area, including but not limited to: an explanation of post-stabilization services, the use of 911, locations of emergency settings and locations for post-stabilization services;

2.17.4.6.17 Shall include information on how to access the primary care provider on a twenty-four (24) hour basis as well as the twenty-four (24) hour nurse line. The handbook may encourage members to contact the PCP or twenty-four (24) hour nurse line when they have questions as to whether they should go to the emergency room;

2.17.4.6.18 Shall include information on how to access a Care Coordinator, including the ability to access a Care Coordinator after regular business hours through the twenty-four (24) hour nurse triage/advice line;

2.17.4.6.19 Shall include information about the civil rights laws as directed by TENNCARE, which shall include, but is not limited to the notice of nondiscrimination, taglines, and the discrimination complaint forms;

2.17.4.6.20 Shall include information about the Long-Term Care Ombudsman Program;

2.17.4.6.21 Shall include information on the beneficiary support system, including but not limited to, help with choice counseling, filing complaints or appeals, finding the status of a complaint or appeal, and resolving related issues related to rights and responsibilities.

2.17.4.6.22 Shall include information about the CHOICES consumer advocate, including but not limited to the role of the consumer advocate in the CHOICES program and how to contact the consumer advocate for assistance;

2.17.4.6.23 Shall include information about how to report suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 *et seq*.) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 *et seq*. and TCA 37-1-601 *et seq*.), including the phone numbers to call to report suspected abuse/neglect;

2.17.4.6.24 Shall include Grievance and Appeal procedures as described in Section A.2.19 of this Contract;

2.17.4.6.25 Shall include notice that the member shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;

2.17.4.6.26 Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs;

2.17.4.6.27 Shall include written information concerning advance directives as described in 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128;

2.17.4.6.28 Shall include notice that enrollment in the CONTRACTOR's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the CONTRACTOR's MCO and notice of continuation of care when entering the CONTRACTOR's MCO as described in Section A.2.9.2 of this Contract;

2.17.4.6.29 Shall include notice to the member that it is the member's responsibility to notify the CONTRACTOR, TENNCARE (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify TENNCARE (or for SSI eligibles, SSA) could result in the member not receiving important eligibility and/or benefit information;

2.17.4.6.30 Shall include notice that a new member may request to change MCOs at any time during the ninety (90) calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;

2.17.4.6.31 Shall include notice that the member may change MCOs at the next choice period as described in Section A.2.4.7.2.2 of this Contract and shall have a ninety (90) calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;

2.17.4.6.32 Shall include notice that the member has the right to ask TENNCARE to change MCOs based on hardship, the circumstances which constitute hardship, explanation of the member's right to file an appeal if such request is not granted, and how to do so;

2.17.4.6.33 Shall include notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TENNCARE for termination forms and additional information on termination;

2.17.4.6.34 Shall include TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line with a statement that the member may contact the CONTRACTOR or TENNCARE regarding questions about the TennCare program, including CHOICES, as well as the service/information that may be obtained from each line;

2.17.4.6.35 Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;

2.17.4.6.36 Shall include information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law;

2.17.4.6.37 Shall include directions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans" (see Section A.2.17.9.2);

2.17.4.6.38 Shall include information that the member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

2.17.4.6.39 Shall include information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

2.17.4.6.40 Shall include notice that member has the right to participate in decisions regarding his or her health care, including the right to refuse treatment;

2.17.4.6.41 Shall include notice that the member has the right to request and receive a copy of their medical records and request that they be amended or corrected;

2.17.4.6.42 Shall include information on appropriate prescription drug usage (see Section A.2.9.10);

2.17.4.6.43 Shall include state-developed definitions as required in 42 CFR 438.10(c)(4)(i) which the CONTRACTOR shall use when communicating with enrollees; and

2.17.4.6.44 Shall include any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

A.2.17.5 **Quarterly Member Newsletter**

2.17.5.1 The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members (TennCare and CoverKids) which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.

2.17.5.2 The CONTRACTOR shall include the following information in each respective newsletter:

2.17.5.2.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;

2.17.5.2.2 Hardcopies shall contain the procedure on how to obtain information in alternative communication formats, such as auxiliary aids or services and how to access language assistance services (i.e., interpretation and translation services) as well as a statement that interpretation and translation services and auxiliary aids or services are free (The notice of non-discrimination and taglines as required by TENNCARE and set forth in TENNCARE's tagline template). Electronic versions of the quarterly member newsletters do not need to contain this information as it is readily available to members on the MCO's website;

2.17.5.2.3 TennCare Kids and/or CoverKids information, including but not limited to, encouragement to obtain screenings and other preventive care services;

2.17.5.2.4 One article on teen health written for teenage enrollees over the age of 12. Each quarter, the teen health article must fall into one of four required categories: medical/physical health, behavioral health, anticipatory guidance, and dental. Each category must be addressed once per calendar year;

2.17.5.2.5 At least one specific article targeted to CHOICES members for Tenncare members;

2.17.5.2.6 At least one specific article targeted to ECF CHOICES members for TennCare members;

2.17.5.2.7 Information about appropriate prescription drug usage;

2.17.5.2.8 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line; and

2.17.5.2.9 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to http://tn.gov/tenncare and click on 'Stop TennCare Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Division (MFCD), call toll-free 1-800-433-5454."

2.17.5.3 The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly general newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. The newsletter may be distributed in alternative formats chosen by the CONTRACTOR and approved by TENNCARE. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, the following proof of distribution:

2.17.5.3.1 Submit a final copy, describe the method/media the CONTRACTOR used to disseminate the newsletter and documentation from the MCO's staff or outside vendor indicating the quantity and date disseminated as proof of compliance by the 30th of the month following each quarter.

A.2.17.6 **Identification Card**

Each member shall be provided an identification card, which identifies the member as a participant in the TennCare program within thirty (30) calendar days of notification of enrollment into the CONTRACTOR's MCO or prior to the member's enrollment effective date. The identification card shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), shall comply with all state and federal requirements and, at a minimum, shall include:

2.17.6.1 The CONTRACTOR's name and issuer identifier, with the company logo;

2.17.6.2 Phone numbers for information and/or authorizations, including for physical health, behavioral health, and long-term care services;

2.17.6.3 Descriptions of procedures to be followed for emergency or special services;

2.17.6.4 The member's identification number;

2.17.6.5 The member's name (First, Last and Middle Initial);

2.17.6.6 The member's date of birth;

2.17.6.7 The member's enrollment effective date;

2.17.6.8 Co-payment information;

2.17.6.9 The Health Insurance Portability and Accountability Act (HIPAA) adopted identifier;

2.17.6.10 The words "Medicaid" or "Standard" based on eligibility;

2.17.6.11 For CHOICES members, the word "CHOICES.";

2.17.6.12 For ECF CHOICES members, the phrase "ECF CHOICES."; and

2.17.6.13 For CoverKids members, the card should be accompanied by a notice regarding cost share benefit changes as described by TENNCARE.

A.2.17.7 **CHOICES and ECF CHOICES Member Education Materials**

2.17.7.1 The CONTRACTOR shall explain and provide member education materials to each CHOICES and ECF CHOICES member (see Section A.2.9.6.10.6.4.2).

2.17.7.2 The CONTRACTOR shall update and re-print the CHOICES and ECF CHOICES member education materials as specified and with advance notice by TENNCARE. The revised materials shall be submitted to TENNCARE for review and approval. Upon TENNCARE approval, the CONTRACTOR shall immediately distribute the updated materials to all CHOICES and ECF CHOICES members.

2.17.7.3 The materials shall comply with all state and federal requirements and, at a minimum, shall include:

2.17.7.3.1 A description of the CHOICES program, including the CHOICES Groups;

2.17.7.3.2 Information on CHOICES groups and the covered long-term care services for each CHOICES group, including CHOICES HCBS benefit limits;

2.17.7.3.3 A general description of care coordination and the role of the Care Coordinator;

2.17.7.3.4 Information about contacting and changing the member's Care Coordinator, including but not limited to how to contact the Care Coordinator, how and when the member will be notified of who the assigned Care Coordinator is, and the procedure for making changes to the assigned Care Coordinator, whether initiated by the CONTRACTOR or requested by the member;

2.17.7.3.5 Information about the CHOICES consumer advocate, including but not limited to the role of the CHOICES consumer advocate and how to contact the consumer advocate for assistance;

2.17.7.3.6 Information and procedures on how to report suspected abuse and neglect (including abuse, neglect and/or exploitation of members who are adults and suspected brutality, abuse, or neglect of members who are children), including the phone numbers to call to report suspected abuse and neglect;

2.17.7.3.7 Information about estate recovery;

2.17.7.3.8 The procedure on how to obtain member materials in alternative formats for members with special needs and how to access oral interpretation services and that both alternative formats and interpretation services are available at no expense to the member. The notice of non-discrimination and taglines as required by TENNCARE shall be set forth in TENNCARE's tagline template;

2.17.7.3.9 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line;

2.17.7.3.10 Information about the member's right to choose between nursing facility and CHOICES HCBS if the member qualifies for nursing home care and if the member's needs can be safely and effectively met in the community and at a cost that does not exceed the member's cost neutrality cap;

2.17.7.3.11 A description of the Care Coordinator's role and responsibilities for CHOICES Group 1 members, which at a minimum shall include:

2.17.7.3.11.1 Performing comprehensive assessments as deemed necessary by the CONTRACTOR;

2.17.7.3.11.2 Participating in the nursing facility's care planning process;

2.17.7.3.11.3 Coordinating the member's physical health, behavioral health, and long-term care needs;

2.17.7.3.11.4 Conducting face-to-face visits every six (6) months;

2.17.7.3.11.5 Conducting level of care reassessments; and

2.17.7.3.11.6 Determining the member's interest in transition to the community and facilitating such transition, as appropriate.

2.17.7.3.12 Information about patient liability responsibilities including the potential consequences of failure to comply with patient liability requirements. For Group 1 members, this may include loss of the member's nursing facility provider; for Group 2 members, loss of the member's CBRA provider; and for all CHOICES members, loss of the member's MCO, disenrollment from CHOICES, and to the extent that the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare;

2.17.7.3.13 Information for Group 1 members about the CONTRACTOR's nursing facility transition process;

2.17.7.3.14 A statement advising members in Groups 2 and 3 that the CONTRACTOR may choose to provide certain non-covered services to a particular member when the CONTRACTOR determines that such services are an appropriate and more cost-effective way of meeting the member's needs than other covered services that would otherwise be provided; a member is not entitled to receive these non-covered services; the decision to provide or not provide these non-covered services to a particular member is at the sole discretion of the CONTRACTOR; and if the CONTRACTOR does not provide one of these non-covered services to a member, the member is not entitled to a fair hearing regarding the decision;

2.17.7.3.15 A statement advising members in Group 2 that the cost of providing CHOICES HCBS, home health, and private duty nursing shall not exceed the member's cost neutrality cap, and that the cost neutrality cap reflects the projected cost of providing nursing facility services to the member;

2.17.7.3.16 A statement advising members in Group 3 that the cost of providing CHOICES HCBS, excluding home modification, to members in CHOICES Group 3 shall not exceed the expenditure cap;

2.17.7.3.17 An explanation for members in Group 2 of what happens when a member is projected to exceed his/her cost neutrality cap, which shall include the following: The CONTRACTOR will first work with the member to modify the member's PCSP to safely and effectively meet the member's needs in the community and at a cost that is less than the member's cost neutrality cap; if that is not possible, the member will be transitioned to a more appropriate setting (a nursing facility); and if the member declines to move to a more appropriate setting, the member may be disenrolled from CHOICES, and to the extent that the member's eligibility depends on receipt of long-term care services, may lose eligibility for TennCare;

2.17.7.3.18 A statement advising CHOICES members in Group 3 that the CONTRACTOR will deny CHOICES HCBS in excess of the expenditure cap;

2.17.7.3.19 A statement advising members that CHOICES HCBS provided by the CONTRACTOR to CHOICES members will 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;

2.17.7.3.20 A description of the Care Coordinator's role and responsibilities for CHOICES Group 2 and 3 members, which at a minimum shall include:

2.17.7.3.20.1 Conducting an individualized, comprehensive assessment;

2.17.7.3.20.2 Coordinating a care plan team and facilitating the development of a PCSP;

2.17.7.3.20.3 Coordinating the identification of the member's physical health, behavioral health and long-term care needs and coordinating services to meet those needs;

2.17.7.3.20.4 Implementing the authorized PCSP, including ensuring the timely delivery of services in accordance with the PCSP;

2.17.7.3.20.5 Providing assistance in resolving any concerns about service delivery or providers;

2.17.7.3.20.6 Explanation of the minimum contacts a Care Coordinator is required to make and a statement that the Care Coordinator may be contacted as often as the member needs to contact the Care Coordinator;

2.17.7.3.20.7 Completing level of care and needs reassessments and updating the PCSP; and

2.17.7.3.20.8 Ongoing monitoring of service delivery to ensure that any service gaps are immediately addressed and that provided services meet the member's needs;

2.17.7.3.21 Information about the right of members in Groups 2 and 3 to request an objective review by the State of his/her comprehensive assessment and/or care planning processes and how to make such a request;

2.17.7.3.22 Information for members in Groups 2 and 3 on consumer direction of eligible CHOICES HCBS, including but not limited to the roles and responsibilities of the member; the ability of the member to select a representative and who can be a representative; the services that can be directed; the member's right to participate in and voluntarily withdraw from consumer direction at any time; how to choose to participate in consumer direction; the role of the FEA; who can/cannot be hired by the member to perform the services, and when a family member can be paid to provide care and applicable limitations thereto; and

2.17.7.3.23 Information for members in Groups 2 and 3 and ECF CHOICES regarding self-direction of health care tasks.

2.17.7.4 The CONTRACTOR shall provide information regarding ECF CHOICES as specified in a template provided by TENNCARE.

2.17.7.5 The CONTRACTOR shall include information on the beneficiary support system in the member education materials to include but not limited to help with filing complaints or appeals, finding the status of a complaint or appeal, and resolving related issues related to rights and responsibilities.

A.2.17.8 **Provider Directories**

2.17.8.1 The CONTRACTOR shall distribute information regarding general provider directories (see Section A.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 and ECF CHOICES provider directory (see Section A.2.17.8.6 below) to each CHOICES or ECF 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 in the CHOICES program, and to ECF CHOICES members during the face-to-face enrollment visit, but not more than thirty (30) days from notice of CHOICES or ECF CHOICES enrollment. Such information shall include how to access the CHOICES or ECF 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 or ECF 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 and ECF CHOICES provider directory. A PDF copy of the hard copy version shall not meet this requirement. The online searchable version shall be available in a machine readable file and format in accordance with federal requirements. The online searchable version of the general provider directory and the CHOICES and ECF CHOICES provider directory shall be updated a minimum of three (3) days a 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 applicants and updated CHOICES or ECF CHOICES provider directory to CHOICES or ECF CHOICES members and applicants, as applicable. The hard copy of the general provider directory and the CHOICES and ECF CHOICES provider directory shall be updated at least on a monthly basis. Individuals 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 or ECF 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 or ECF 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 and ECF CHOICES provider directory), and any revisions thereto, shall be submitted to TENNCARE for written approval prior to distribution to enrollees in accordance with Section A.2.17.1 of this Contract. 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 and applicants. The provider directory shall be posted on the CONTRACTOR's website and provided in hard copy upon request of the individual. Individuals 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. Individuals 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 a minimum of three (3) days a week. The general provider directory shall include the following: names, locations, website, telephone numbers, office hours, and non-English languages spoken cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, whether the provider has completed cultural competence training; whether offices/facilities have accommodations for people with physical disabilities; including offices, exam room(s) and equipment; specialties as appropriate; identification of providers accepting new patients; and identification of whether or not a provider performs TennCare Kids screens; behavioral health providers; any group affiliations; 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/ECF CHOICES members should refer to the CHOICES/ECF CHOICES provider directory for information on long-term care providers and the weblink to those on-line directories.

2.17.8.6 The CONTRACTOR shall develop and maintain a CHOICES and ECF CHOICES provider directory that includes long-term care providers. The CHOICES and ECF CHOICES provider directory, shall be made available to all CHOICES or ECF CHOICES members and applicants, as applicable, 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 and ECF CHOICES HCBS providers with the name, location, telephone number, and type of services by county of each provider. The CHOICES and ECF 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 and ECF 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 or ECF 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 and ECF CHOICES provider directory shall be updated a minimum of three (3) days a week.

A.2.17.9 **Additional Information Available Upon Request**

The CONTRACTOR shall have written policies guaranteeing to provide all other information to members as required by CMS, including but not limited to the following information to any enrollee who requests it:

2.17.9.1 Information regarding the structure and operation of the CONTRACTOR's MCO; and

2.17.9.2 Information regarding physician incentive plans, including but not limited to:

2.17.9.2.1 Whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services;

2.17.9.2.2 The type of incentive arrangement; and

2.17.9.2.3 Whether stop-loss protection is provided.

2.17.9.3 Any reports of transactions between the CONTRACTOR and parties in interest that are provided to the state, or other agencies upon reasonable request.

A.2.18 CUSTOMER SERVICE

A.2.18.1 Member Services Toll-Free Phone Line

2.18.1.1 The CONTRACTOR shall operate a toll-free telephone line (member services information line) to respond to member questions, concerns, inquiries, and complaints from the member, the member's family, or the member's provider.

2.18.1.2 The CONTRACTOR shall develop member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals, including CHOICES referrals from all sources, assistance completing ECF CHOICES self-screening tool, monitoring of calls via recording or other means, and compliance with standards.

2.18.1.3 The member services information line shall handle calls from individuals with LEP and individuals with disabilities, including, but not limited to individuals with hearing and/or speech disabilities.

2.18.1.4 The CONTRACTOR shall ensure that the member services information line is staffed adequately to respond to members' questions, at a minimum, from 8 a.m. to 5 p.m., in the time zone applicable to each Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays.

2.18.1.5 The member services information line shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified nurses to triage urgent care and emergency calls from members and to facilitate transfer of calls to a Care Coordinator or Support Coordinator from or on behalf of a CHOICES or ECF CHOICES member that require immediate attention by a Care Coordinator or Support Coordinator. The CONTRACTOR may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements of this Section, Section A.2.18.1.

2.18.1.6 The CONTRACTOR shall ensure that all calls from CHOICES or ECF CHOICES members to the nurse triage/nurse advice line that require immediate attention are immediately addressed or transferred to a Care Coordinator or Support Coordinator. During normal business hours, the transfer shall be a "warm transfer" (see definition in Section A.1). After normal business hours, if the CONTRACTOR cannot transfer the call as a "warm transfer", the CONTRACTOR shall ensure that a Care Coordinator or Support Coordinator is notified and returns the member's call within thirty (30) minutes and that the Care Coordinator or Support Coordinator has access to the necessary information (e.g., the member's back-up plan) to resolve member issues. The CONTRACTOR shall implement protocols, prior approved by TENNCARE, that describe how calls to the nurse triage/nurse advice line from CHOICES and ECF CHOICES members will be handled.

2.18.1.7 The member services information line shall be adequately staffed with staff trained to accurately respond to member questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, the CHOICES program, the ECF CHOICES program, TennCare Kids, and the CONTRACTOR's provider network.

2.18.1.8 The CONTRACTOR shall implement protocols, prior approved by TENNCARE, to ensure that calls to the member services information line that should be transferred/referred to other CONTRACTOR staff, including but not limited to a member services supervisor or a Care Coordinator or Support Coordinator, or to an external entity, including but not limited to the FEA, are transferred/referred appropriately.

2.18.1.9 The CONTRACTOR shall ensure that calls received during normal business hours that require immediate attention by a Care Coordinator are immediately transferred to a Care Coordinator or Support Coordinator as a "warm transfer"; that calls received after normal business hours that require immediate attention are immediately addressed or transferred to a Care Coordinator or Support Coordinator in accordance with Section A.2.18.1.6; that calls for a member's Care Coordinator or care coordination team or Support Coordinator or support coordination team during normal business hours are handled in accordance with Section A.2.9.6.12.16; that calls transferred to the FEA during business hours are "warm transfers"; that calls to other CONTRACTOR staff, at a minimum, occur without the caller having to disconnect or place a second call; and that messages to Care Coordinators or Support Coordinators and other CONTRACTOR staff are returned by the next business day.

2.18.1.10 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.1.11 The CONTRACTOR shall have an automated system available during non-business hours, including weekends and holidays. This automated system shall provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

2.18.1.12 <u>Performance Standards for Member Services Line/Queue</u>

2.18.1.12.1 The CONTRACTOR shall adequately staff the member services information line to ensure that the line, including the nurse triage/nurse advice line or queue, meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.

2.18.1.12.2 The CONTRACTOR shall submit the reports required in Section A.2.30.13 of this Contract.

A.2.18.2 **Interpreter and Translation Services**

2.18.2.1 The CONTRACTOR shall develop written policies and procedures for the provision of language assistance services, which includes, but is not limited to interpreter and translation services and effective communication assistance in alternative formats, such as, auxiliary aids to any member or the member's representative 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 assistance services, including but not limited to interpreter and translation services and effective communication assistance in alternative formats, such as, auxiliary aids free of charge to members and/or the member's representative.

2.18.2.3 Interpreter services should be available in the form of in-person interpreters, telephone interpretation language line services, sign language or access to telephonic assistance, such as the Telecommunications Relay Services (TRS).

A.2.18.3 **Cultural Competency**

As required by 42 CFR 438.206, the CONTRACTOR and its Providers and Subcontractors that are providing services pursuant to this Contract shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, disabilities and diverse cultural and ethnic backgrounds regardless of an enrollee's sex. This includes the CONTRACTOR emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities.

2.18.3.1 For members in CHOICES or ECF CHOICES, the CONTRATOR shall:

2.18.3.1.1 Ascertain and specify in the plan of care or person-centered support plan (as applicable) the primary language spoken by the member and his or her primary caregiver, which shall include the use of sign language or non-verbal forms of communication and any needed assistive technology and auxiliary aid or services needed to facilitate effective communication (see A.2.9.6.6.2.4.16);

2.18.3.1.2 Assign a Care Coordinator for a CHOICES member or a Support Coordinator for an ECF CHOICES member who is linguistically competent in the member and primary caregiver's primary spoken language or who is trained in the use of auxiliary aids or services including sign language or other non-verbal forms of effective communication, including the use of assistive technology, as applicable (see A. 2.9.6.4.3.2). In instances when such is not available, translation services may be utilized but shall not be the first option.

2.18.3.1.3 If the CONTRACTOR is unable to assign a Care Coordinator for a CHOICES member or a Support Coordinator for an ECF CHOICES member who is linguistically competent in the member and primary caregiver's primary spoken language, or who is trained in the use of sign language or other non-verbal forms of communication, including the use of assistive technology, as applicable, ensure the availability of translation services in the member and primary caregiver's primary spoken language or in sign language, or other forms of effective communication assistance, including auxiliary aids or services, who can facilitate non-verbal forms of communication, including the use of assistive technology, as applicable, for all comprehensive assessment and care planning activities (see A.2.9.6.4.2.3);

2.18.3.1.4 Assist the member in identifying contract providers that may be selected by the member to provide personal care visits, attendant care, respite or community-based residential alternative services, as applicable, that are able to assign staff who are linguistically competent in the member and primary caregiver's primary spoken language or in sign language, or other forms of effective communication assistance, including auxiliary aids or services, or who can facilitate non-verbal forms of

communication, including the use of assistive technology, as applicable, (see A.2.9.6.2.5.10).

A.2.18.4 **Provider Services and Toll-Free Telephone Line**

2.18.4.1 The CONTRACTOR shall establish and maintain a provider services function to timely and adequately respond to provider questions, comments, and inquiries.

2.18.4.2 The CONTRACTOR shall operate a toll-free telephone line (provider service line) to respond to provider questions, comments, and inquiries.

2.18.4.3 The CONTRACTOR shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

2.18.4.4 The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to providers' questions at a minimum from 8 a.m. to 5 p.m., in the time zone applicable to each Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays.

2.18.4.5 The provider service line shall also be adequately staffed to provide appropriate and timely responses regarding authorization requests as described in Section A.2.14 of this Contract. The CONTRACTOR may meet this requirement by having a separate utilization management line.

2.18.4.6 The provider service line shall be adequately staffed with staff trained to accurately respond to questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, the CHOICES program, the ECF CHOICES program, TennCare Kids, prior authorization and referral requirements, care coordination, support coordination, and the CONTRACTOR's provider network. The CONTRACTOR shall maintain a dedicated queue to assist long-term care providers with enrollment, service authorization, or reimbursement questions or issues and shall ensure that long-term care providers are appropriately notified regarding how to access the dedicated queue for assistance.

2.18.4.7 For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the CONTRACTOR shall have a specific process in place whereby the Emergency Department (ED) can contact the CONTRACTOR twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The CONTRACTOR may use the 24/7 nurse triage line described in Section A.2.18.1.5 of this Contract for this purpose or may use another line the CONTRACTOR designates.

2.18.4.8 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.4.9 The CONTRACTOR shall have an automated system available during non-business hours. This automated system shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

2.18.4.10 Performance Standards for Provider Service Line

2.18.4.10.1 The CONTRACTOR shall adequately staff the provider service line to ensure that the line, including the utilization management line/queue, meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.

2.18.4.10.2 The CONTRACTOR shall submit the reports required in Section A.2.30.13 of this Contract.

A.2.18.5 **Provider Manual**

2.18.5.1 The CONTRACTOR shall issue a provider manual to all contract providers. The CONTRACTOR may distribute the provider manual electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider.

2.18.5.2 At a minimum the provider manual shall include the following information:

2.18.5.2.1 Description of the TennCare program;

2.18.5.2.2 Covered services;

2.18.5.2.3 Description of the CHOICES and ECF CHOICES program including but not limited to who qualifies for CHOICES (including the three CHOICES groups and enrollment targets for CHOICES Groups 2 and 3) and ECF CHOICES; how to enroll in CHOICES and ECF CHOICES; long-term care services available to each CHOICES Group (including benefit limits, cost neutrality cap for members in Group 2, and the expenditure cap for members in Group 3) and ECF CHOICES Group; consumer direction of eligible CHOICES and ECF CHOICES HCBS; self-direction of health care tasks for CHOICES and ECF CHOICES; the level of care assessment and reassessment process for CHOICES and ECF CHOICES; the comprehensive assessment and reassessment processes for CHOICES and ECF CHOICES; requirement to provide services in accordance with an approved plan of care or PCSP, as applicable, including the amount, frequency, duration and scope of each service in accordance with the member's service schedule; service authorization requirements and processes; the role of the Care Coordinator, Support Coordinator, or Intensive Support Coordination Team, as applicable; the role and responsibilities of long-term care and other providers; requirements regarding the electronic visit verification system and the provider's responsibility in monitoring and immediately addressing service gaps, including back-up staff; how to submit clean claims; documentation requirements for CHOICES and ECF CHOICES HCBS providers; and quality monitoring processes for CHOICES and ECF CHOICES;

2.18.5.2.4 Emergency service responsibilities;

2.18.5.2.5 TennCare Kids services and standards;

2.18.5.2.6 Information on members' Grievance and Appeal rights;

2.18.5.2.7 Policies and procedures of the provider complaint system;

2.18.5.2.8 Medical necessity standards and clinical practice guidelines;

2.18.5.2.9 PCP responsibilities;

2.18.5.2.10 Coordination with other TennCare contractors or MCO subcontractors;

2.18.5.2.11 Requirements regarding background checks;

2.18.5.2.12 Information on identifying and reporting suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 *et seq.*) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 *et seq*. and TCA 37-1-601 *et seq*.), including reporting to APS, CPS, and the CONTRACTOR;

2.18.5.2.13 Requirements for CHOICES and ECF CHOICES HCBS providers regarding critical incident reporting and management (see Section A.2.15.7);

2.18.5.2.14 Information for CHOICES HCBS providers regarding prohibition of facilitating CHOICES referrals with the expectation of being selected as the service provider or petitioning existing CHOICES members to change CHOICES providers (See Section A.2.12.11.10);

2.18.5.2.15 Requirements regarding the prohibition of the reproduction and/or use of CHOICES and MFP materials and logos (See Sections A.2.12.11.11 and A.2.12.11.12);

2.18.5.2.16 Requirements for nursing facility providers regarding patient liability (see Sections A.2.6.7 and A.2.21.5), including the collection of patient liability and the provider's ability, if certain conditions are met (including providing notice and required documentation to the CONTRACTOR and notice to the member), to refuse to provide services if the member does not pay his/her patient liability, as well as the additional potential consequences to the member of non-payment of patient liability, including disenrollment from CHOICES or ECF CHOICES, and, to the extent the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare;

2.18.5.2.17 Requirement to notify the CONTRACTOR of significant changes in a CHOICES or ECF CHOICES member's condition or care, hospitalizations, or recommendations for additional services (see Section A.2.12.9.43);

2.18.5.2.18 Prior authorization, referral and other utilization management requirements and procedures;

2.18.5.2.19 Protocol for encounter data element reporting/records;

2.18.5.2.20 Medical records standard;

2.18.5.2.21 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;

2.18.5.2.22 Payment policies;

2.18.5.2.23 Member rights and responsibilities;

2.18.5.2.24 Important phone numbers of all departments/staff a contract provider may need to reach at the CONTRACTOR's MCO; and

2.18.5.2.25 How to reach the contract provider's assigned provider relations representative.

2.18.5.2.26 Information about the civil rights laws as directed by TENNCARE, which shall include, but is not limited to the notice of nondiscrimination, taglines, and the discrimination complaint forms.

2.18.5.3 The CONTRACTOR shall disseminate bulletins as needed to incorporate any needed changes to the provider manual.

A.2.18.6 **Provider Education and Training**

2.18.6.1 The CONTRACTOR shall develop an education and training plan and materials for contract providers and provide education and training to contract providers and their staff regarding key requirements of this Contract.

2.18.6.2 The CONTRACTOR shall conduct initial education and training to contract providers at least thirty (30) calendar days prior to the start date of operations.

2.18.6.3 The CONTRACTOR shall conduct initial education and training for long-term care providers no later than thirty (30) days prior to implementation in each Grand Region covered by this Contract. This education and training shall include but not be limited to:

2.18.6.3.1 An overview of the CHOICES program;

2.18.6.3.2 The three CHOICES groups and the enrollment targets for each (as applicable);

2.18.6.3.3 The long-term care services available to each CHOICES group (including benefit limits, cost neutrality cap for CHOICES Group 2, and the expenditure cap for CHOICES Group 3);

2.18.6.3.4 The level of care assessment and reassessment processes;

2.18.6.3.5 The comprehensive assessment and reassessment processes;

2.18.6.3.6 The CHOICES intake process;

2.18.6.3.7 Service authorization requirements and processes;

2.18.6.3.8 The role and responsibilities of the Care Coordinator for members in CHOICES Group 1;

2.18.6.3.9 The role and responsibilities of the Care Coordinator for members in CHOICES Groups 2 and 3;

2.18.6.3.10 Requirement to provide services in accordance with an approved PCSP including the amount, frequency, duration and scope of each service in accordance with the member's service schedule;

2.18.6.3.11 The role and responsibilities of long-term care and other providers;

2.18.6.3.12 Requirements regarding the electronic visit verification system and the provider's responsibility in monitoring and immediately addressing service gaps, including back-up staff;

2.18.6.3.13 The CONTRACTOR shall provide education and training to contracted ECF CHOICES providers as specified by TENNCARE.

2.18.6.3.14 How to submit clean claims;

2.18.6.3.15 Background check requirements;

2.18.6.3.16 Information about abuse/neglect (which includes abuse, neglect and exploitation of members who are adults and suspected brutality, abuse, or neglect of members who are children), including how to assess risk for abuse/neglect, how to identify abuse/neglect, and how to report abuse/neglect to APS/CPS and the CONTRACTOR;

2.18.6.3.17 Critical incident reporting and management for CHOICES HCBS and behavioral health providers;

2.18.6.3.18 The member grievance and appeal processes; and

2.18.6.3.19 The provider complaint system.

2.18.6.4 The CONTRACTOR shall provide training and education to long-term care providers regarding the CONTRACTOR's enrollment and credentialing requirements and processes (see Section A.2.11.10).

2.18.6.5 For a period of at least twelve (12) months following implementation in each Grand Region covered by this Contract, the CONTRACTOR shall conduct monthly education and training for long-term care providers regarding claims submission and payment processes, which shall include but not be limited to an explanation of common claims submission errors and how to avoid those errors. Such period may be extended as determined necessary by TENNCARE.

2.18.6.6 For a period of at least twelve (12) months following implementation in each Grand Region covered by this Contract, the CONTRACTOR shall conduct monthly education and training for CHOICES HCBS providers regarding the use of the EVV system. Such period may be extended as determined necessary by TENNCARE.

2.18.6.7 The CONTRACTOR shall provide education and training on documentation requirements for CHOICES HCBS.

2.18.6.8 The CONTRACTOR shall provide training and technical assistance services for primary care providers (PCPs) and behavioral health providers to assist them in participating in TennCare's Patient-Centered Medical Home (PCMH) program and TennCare's Tennessee Health Link program for members with acute behavioral health needs, respectively. The CONTRACTOR shall comply with the following general requirements:

2.18.6.8.1 Prepare practices to design, execute, and track improvements in practice management, care delivery, and care team effectiveness to achieve PCMH and Health Home goals;

2.18.6.8.2 Prepare practices to proactively coordinate activities and improve relationships with other healthcare stakeholders;

2.18.6.8.3 Assist practices in monitoring and improving performance on select adult and child quality measures for PCMH. The CONTRACTOR shall assist PCMH practices in reducing avoidable utilization and decreasing unnecessary spend;

2.18.6.8.4 In order to effectively train practices, the CONTRACTOR shall have a working knowledge of the Care Coordination Tool (CCT) and be able to communicate about the basic functionality of the tool and how it can be used to meet practice transformation goals. The State shall supply information to the CONTRACTOR on the capabilities and uses of the CCT;

2.18.6.8.5 The CONTRACTOR shall train practices on how to incorporate the CCT in practice to augment transformation efforts (e.g., use of Admission, Discharge, Transfer (ADT) feeds from the hospital to expedite post-discharge follow ups);

2.18.6.8.6 Respond to TennCare provider inquiries regarding training and transformation and, as appropriate, notify the State about those provider concerns and issues.

2.18.6.9 The CONTRACTOR shall maintain qualified trainers and coaches for the PCMH and THL organizations. For PCMH organizations contracted with multiple MCOs, one MCO will be assigned as the primary coach for the practice. By October 1st, the MCOs shall submit to the State each PCMH organization's primary coach for the following program year. The MCO primary coach shall be responsible for sharing updates and information with other contracted MCOs. The primary coach role is to be in regular communication and provide updates to the other contracted MCOs and be responsible for initiating annual reviews. The CONTRACTOR's trainers and coaches shall comply with the following:

2.18.6.9.1 The CONTRACTOR's training and coaching staff shall have strong knowledge of primary care transformation processes;

2.18.6.9.2 The CONTRACTOR's training and coaching staff shall have strong background in behavioral health treatment, service delivery, and care coordination;

2.18.6.9.3 The CONTRACTOR's training and coaching staff shall have strong knowledge of the State's PCMH and Health Home programs;

2.18.6.9.4 The CONTRACTOR's training and coaching staff shall have the skills necessary to effectively train practices, and equip them with best practices and approaches to optimize their population health impact, control total cost of care, and improve the patient experience;

2.18.6.9.5 The CONTRACTOR shall maintain NCQA Certified Content Experts as part of the training and coaching staff. The CONTRACTOR's training and coaching staff shall complete training as required by NCQA and sit for the CCE Exam. At a minimum, the CONTRACTOR shall have three (3) staff with the specified training and sit for the NCQA CCE exam.

2.18.6.10 Initial Assessment of Provider Capabilities - The CONTRACTOR shall conduct an Initial Assessment of each newly participating provider that identifies current capabilities. The Initial Assessment shall be conducted no later than three months after the newly participating provider begins participation in the Patient Centered Medical Home and/or Tennessee Health Link programs. The CONTRACTOR shall use a standard assessment tool approved by the State in order to complete the initial readiness assessment as well as subsequent semi-annual assessments. Consistency across the initial assessment and subsequent assessments shall allow the State to uniformly track providers' progress.

2.18.6.10.1 The initial assessment shall differentiate between the wide ranges of provider readiness in areas including, but not limited to:

2.18.6.10.1.1 Knowledge of practice transformation and quality improvement principles;

2.18.6.10.1.2 Supporting processes and workflows already in place;

2.18.6.10.1.3 Staff capabilities and gaps in workforce;

2.18.6.10.1.4 Already existing clinical activities (e.g., same-day appointment access, care planning, patient risk stratification) relative to future required activities;

2.18.6.10.1.5 Current level of quality improvement capabilities;

2.18.6.10.1.6 Supporting technical capabilities and infrastructure (e.g., EHR use and data sharing, e-prescribing);

2.18.6.10.1.7 Current level of medical/behavioral integration to include referral and coordination activities;

2.18.6.10.1.8 Current use of team-based care;

2.18.6.10.1.9 Current methods of patient engagement;

2.18.6.10.1.10 Awareness of current patient experience performance (i.e., through Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, user ratings, or patient feedback) and knowledge of techniques to improve patient satisfaction;

2.18.6.10.1.11 Initial practice needs and prioritized areas of improvement; and

2.18.6.10.1.12 Presence and perceived enthusiasm of practice staff for practice transformation training.

2.18.6.10.2 The Initial Assessment shall support the CONTRACTOR in tailoring a curriculum for each practice.

2.18.6.10.3 The completed Initial Assessment shall be shared with TennCare via the agreed upon shared platform (i.e., SharePoint or OneDrive).

2.18.6.11 The CONTRACTOR shall conduct an Annual Review of each PCMH and THL organization engaged in coaching. The Annual Review shall be completed at the end of each calendar year for each PCMH and THL organization to assess their progress in the program. The Annual Review shall be shared with TennCare via the agreed upon shared platform (i.e., SharePoint or OneDrive).

2.18.6.12 The CONTRACTOR shall hold large format, in-person conferences quarterly in each of Tennessee's three grand divisions (East, Middle, and West Tennessee). The CONTRACTOR shall work collaboratively with the other MCOs in planning and executing the Large Format In-person Conferences. Each MCO shall be responsible for hosting/payment for a total of three (3) conferences throughout the year. These trainings shall comply with the following requirements:

2.18.6.12.1 The conference sessions shall be non-duplicative material not otherwise covered in webinars;

2.18.6.12.2 The conference sessions shall target audiences of PCMH, THL, and EOC;

2.18.6.12.3 The CONTRACTOR shall facilitate all aspects of the large format trainings including but not limited to communicating to providers, RSVPs, facility rental, logistics, and content;

2.18.6.12.4 All training sessions shall be recorded and posted on the State's website for those practices that are unable to attend;

2.18.6.12.5 The CONTRACTOR shall provide the State with detailed notes on the proceedings of the trainings, including lists of attendees, discussions initiated by the audience, and frequently asked questions;

2.18.6.12.6 The State shall approve the training session topics in writing prior to the training session content being developed and advertised to providers.

2.18.6.13 The CONTRACTOR shall conduct live, hosted webinars with live question and answer sessions on a bi-monthly basis (each MCO shall be responsible for two webinars per year) for both PCMH and Health Homes. The CONTRACTOR shall work collaboratively with the other MCOs in planning an annual schedule for webinars. The webinars shall comply with the following requirements:

2.18.6.13.1 The webinars shall be non-duplicative, including material not otherwise covered in large format conferences;

2.18.6.13.2 The CONTRACTOR shall facilitate all aspects of the webinars including but not limited to, communicating to providers, RSVPs, hosting the webinar platform, and content;

2.18.6.13.3 The CONTRACTOR shall track attendance and share the attendance data with the State;

2.18.6.13.4 The content can be targeted to PCMH providers, Health Home providers, or to both PCMH and Health Home providers;

2.18.6.13.5 All live webinars shall be recorded and posted on the State's website for those practices that are unable to attend, and

2.18.6.13.6 The State shall approve the webinar topics in writing prior to the webinar content being developed and advertised to providers.

2.18.6.14 The CONTRACTOR shall provide documented and routine education and training to providers regarding proper billing.

2.18.6.15 The CONTRACTOR shall conduct ongoing provider education, training and technical assistance as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Contract. This shall include training and technical assistance in person-centered supports and compliance with the HCBS settings rule, as directed and/or approved by TENNCARE.

2.18.6.16 The CONTRACTOR shall distribute on a quarterly basis a newsletter to contract providers to update providers on CONTRACTOR initiatives and communicate pertinent information to contract providers.

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

2.18.6.18 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 contiguous 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 A.2.18.6.18, 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.

A.2.18.7 **Provider Relations**

2.18.7.1 The CONTRACTOR shall establish and maintain a formal provider relations function to provide ongoing troubleshooting and education for contract providers.

2.18.7.2 The CONTRACTOR shall provide one-on-one assistance to long-term care providers (including CHOICES and ECF CHOICES providers) as needed to help long-term care providers submit clean and accurate claims and minimize claim denial. The CONTRACTOR shall develop and implement protocols, prior approved by TENNCARE, that specify the CONTRACTOR's criteria for providing one-on-one assistance to a provider and the type of assistance the CONTRACTOR will provide. At a minimum, the CONTRACTOR shall contact a provider if, during the first year after implementation of CHOICES or ECF CHOICES in each Grand Region covered by this Contract, the CONTRACTOR has or will deny ten percent (10%) or more of the total value of the provider's claims for a rolling thirty (30) day period, and shall, in addition to issuing a remittance advice, contact the provider to review each of the error(s)/reason(s) for denial and advise how the provider can correct the error for resubmission (as applicable) and avoid the error/reason for denial in the future.

2.18.7.3 The CONTRACTOR shall implement policies to monitor and ensure compliance of providers with the requirements of this Contract.

2.18.7.4 The CONTRACTOR shall conduct an annual survey of providers, based on Tax Identification Number, who furnish physical health services, behavioral health services, nursing facility services, CHOICES HCBS, and/or ECF-CHOICES HCBS. All providers or a statistically representative sample of providers shall be surveyed. The CONTRACTOR shall include questions specified by TENNCARE to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, utilization management processes, including medical reviews, and overall satisfaction with the CONTRACTOR. The CONTRACTOR shall submit the survey tool(s) for TENNCARE review at least thirty (30) days prior to use of the survey tool(s). The CONTRACTOR shall submit an annual report on the survey to TENNCARE as required in Section A.2.30.13.3. The CONTRACTOR shall take action to address opportunities for improvement identified through the survey and provide an update on actions taken in the previous year to improve provider satisfaction. The survey shall be structured so that results are separately reported for physical health providers; behavioral health providers; CHOICES (nursing facilities and HCBS) providers; and ECF-CHOICES HCBS providers.

A.2.18.8 **Provider Complaint System**

2.18.8.1 The CONTRACTOR shall establish and maintain a provider complaint system for any provider (contract or non-contract) who is not satisfied with the CONTRACTOR's policies and procedures or a decision made by the CONTRACTOR that does not impact the provision of services to members.

2.18.8.2 The procedures for resolution of any disputes regarding the payment of claims shall comply with TCA 56-32-126(b) (see Section A.2.22.5.2).

A.2.18.9 **FEA Education and Training**

The CONTRACTOR shall provide education and training to the FEA and its staff and subcontracted support brokers (as applicable) regarding key requirement in this Contract and the contract between the CONTRACTOR and the FEA (see Section A.2.9.7.3 of this Contract).

A.2.18.10 **Member Involvement with Behavioral Health Services**

2.18.10.1 The CONTRACTOR shall develop policies and procedures with respect to member, parent, or legally appointed representative involvement with behavioral health. These policies and procedures shall include, at a minimum, the following elements:

2.18.10.1.1 The requirement that all behavioral health treatment plans document member involvement. Fulfilling this requirement means that each treatment plan has a member/family member signature or the signature of a legally appointed representative on the treatment plan and upon each subsequent treatment plan review, where appropriate, and a description of how this requirement will be met;

2.18.10.1.2 The requirement that member education materials include statements regarding the member's, parent's, or legally appointed representative's right to involvement in behavioral health treatment decisions, their ability to choose and change service providers, and a description of how this requirement will be met;

2.18.10.1.3 The requirement that provider education include materials regarding the rights of members, parent(s), or legally appointed representatives to be involved in behavioral health treatment decisions and a description of how this requirement will be met; and

2.18.10.1.4 A description of the quality monitoring activities to be used to measure provider compliance with the requirement for member, parent, or legally appointed representative involvement in behavioral health treatment planning.

2.18.10.2 The CONTRACTOR shall provide an education plan for all members with behavioral health issues; education shall occur on a regular basis. At a minimum, educational materials shall include information on medications and their side effects; behavioral health disorders and treatment options; self-help groups, peer recovery services, family support services, and other community support services available for members and families.

2.18.10.3 The CONTRACTOR shall require providers to inform children and adolescents for whom residential treatment is being considered and their parent(s) or legally appointed representative, and adults for whom voluntary inpatient treatment is being considered, of all their options for residential and/or inpatient placement, and alternatives to residential and/or inpatient treatment and the benefits, risks and limitations of each in order that they can provide informed consent.

2.18.10.4 The CONTRACTOR shall require providers to inform all members being considered for prescription of psychotropic medications of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

A.2.18.11 **Beneficiary Support System**

2.18.11.1 The CONTRACTOR shall, as required by TENNCARE, collaborate with TENNCARE's beneficiary support system contractor for the purpose of addressing member grievances and appeals.

2.18.11.2 The CONTRACTOR shall, as requested by TENNCARE, train TENNCARE's beneficiary support system contractor on the CONTRACTOR's process for addressing member grievances and appeals.

A.2.19 GRIEVANCES AND APPEALS

A.2.19.1 **General**

As permitted under federal and state law, the State, at its sole discretion, may delegate back to the State any portion of this Section A.2.19 that the CONTRACTOR is obligated to perform. The CONTRACTOR understands that the Grievance and Appeal process requirements are always subject to change based on legal developments and on TENNCARE's interpretation of its obligations under new or existing law. CMS has determined that the Reconsideration phase of TENNCARE's existing State Fair Hearing (SFH)/Appeal process satisfies the requirement for a CONTRACTOR-level benefit appeal process. Accordingly, enrollees will not be required to exhaust an appeal with the CONTRACTOR before requesting a SFH/Appeal. In this section A.2.19, the terms "appeal" and "state fair hearing" are synonymous—each refers to the *TennCare* appeal process, and to enrollee requests to engage the *TennCare* state fair hearing process.

2.19.1.1 Grievance System. Although CONTRACTOR shall follow *TENNCARE's* process for handling enrollee appeal requests, the CONTRACTOR shall have its own internal system for processing *grievances* filed with the CONTRACTOR. As distinguished from an "appeal", a "grievance" includes a complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. The CONTRACTOR shall have a formally structured internal Grievance System in place

for handling enrollee grievances in accordance with 42 CFR §438.402(a)-(b), and 42 CFR §438.228(a) and in accordance with the definition of "Grievance" found in section A.1. of this Contract.

2.19.1.2 TENNCARE Appeal System. TENNCARE, on written approval from CMS, has delegated back to itself certain aspects of the benefit appeal process set forth under 42 CFR 438 subpart F. Specifically, CONTRACTOR shall not have its own internal appeal system for enrollee benefit appeals. Enrollees will not exhaust an internal appeal process with CONTRACTOR before being permitted to request a TENNCARE appeal. Therefore, CONTRACTOR shall not operate its own internal appeal process. CONTRACTOR must fulfill its obligations as described in Contract Section A.2.19. CONTRACTOR shall not modify the appeal process except by written direction from TENNCARE. Accordingly, the provisions in 42 CFR § 438.402 that relate to a CONTRACTOR-level appeal system do not apply under this Contract. The enrollee will receive these protections through the Reconsideration phase of the TENNCARE appeal process. Any enrollee who seeks to contest an adverse benefit determination may do so by filing a request with TENNCARE for a TENNCARE appeal.

2.19.1.3 Reasonable Assistance with Grievances and Requests for Appeal. The CONTRACTOR must give enrollees any reasonable assistance in completing grievance and appeal forms and other procedural steps related to a grievance or appeal. This includes availability of enrollee support staff, auxiliary aids and services, such as interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability. See 42 C.F.R. §438.406(a); 42 C.F.R. §438.228(a).

2.19.1.4 Acknowledgment of Grievances and Requests for Appeal.

2.19.1.4.1 Acknowledgment of Grievances. In accordance with 42 CFR §438.406(b) and 42 CFR §438.228(a), CONTRACTOR shall acknowledge receipt of an enrollee grievance.

2.19.1.4.2 Acknowledgment of Requests for SFH/Appeal. In accordance with 42 CFR §438.406(b) and 42 CFR §438.228(a), the CONTRACTOR shall acknowledge receipt of an enrollee grievance. If an enrollee attempts to contest an Adverse Benefit Determination by filing an appeal/SFH request with the CONTRACTOR, the CONTRACTOR shall submit the SFH request to TENNCARE within one (1) business day for expedited SFH requests and within five (5) business days for standard SFH requests. TENNCARE will send the enrollee an acknowledgement letter and inform the enrollee that the matter will be treated as a request for a SFH..

2.19.1.5 Decision-Makers. The CONTRACTOR shall ensure that decision-makers on grievances, and decision-makers responsible for rendering a medical review of CONTRACTOR's proposed adverse benefit determination during the Reconsideration stage of the appeal process, were not either:

2.19.1.5.1 Involved in any previous level of review or decision-making relating to the grievance or benefit appeal, or

2.19.1.5.2 Subordinates of any individual who was involved in a previous level of review or decision-making relating to the grievance or benefit appeal. See 42 C.F.R. §438.406(b)(2)(i); 42 C.F.R. §438.228(a).

2.19.1.6 Clinical Expertise of Decision-Maker. The CONTRACTOR shall require that decision-makers on grievances and decision-makers on any aspect of the appeal process (such as the Reconsideration decision) are individuals with appropriate clinical expertise, as determined by applicable law, in treating the enrollee's condition or disease if:

2.19.1.6.1 The decision hinges on whether a benefit request meets medical necessity,

2.19.1.6.2 The decision concerns whether to grant a request for expedited resolution of an appeal, or concerns a grievance about a previous denial of an expedited resolution request, or

2.19.1.6.3 The decision hinges on the decision-maker's assessment of clinical issues. See 42 C.F.R. §438.406(b)(2)(ii)(A) – (C); 42 C.F.R. §438.228(a).

2.19.1.7 Information to be considered. The CONTRACTOR's decision-makers shall take into account all comments, documents, records, and other information submitted during the grievance, prior authorization, or appeal process without regard to whether such information was submitted or considered in the initial adverse benefit determination. See 42 C.F.R. §438.406(b)(2)(iii); 42 C.F.R. §438.228(a).

A.2.19.2 **Notice of Adverse Benefit Determination (NABD) Requirements**

2.19.2.1 NABD Content. The CONTRACTOR'S NABD shall explain, in plain language, the adverse benefit determination the CONTRACTOR has made or intends to make. See 42 C.F.R. §438.404(b)(1).

2.19.2.2 NABD Content. The CONTRACTOR'S NABD shall explain the reasons for the adverse benefit determination, and shall explain the enrollee's right to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. See 42 C.F.R. §438.404(b)(2).

2.19.2.3 NABD Content. The CONTRACTOR'S NABD must explain the enrollee's right to appeal the CONTRACTOR's adverse benefit determination by filing a request for an appeal with TENNCARE. See 42 C.F.R. §438.404(b)(3); 42 C.F.R. 438.402(b)-(c).

2.19.2.4 NABD Content. The CONTRACTOR'S NABD shall explain the procedures necessary for requesting an appeal. See 42 C.F.R. §438.404(b)(4).

2.19.2.5 NABD Content: How to request expedited resolution. The CONTRACTOR'S NABD must explain the circumstances under which the appeal can be expedited and how to request expedited resolution. See 42 C.F.R. §438.404(b)(5).

2.19.2.6 NABD Content: Requests for Continuation of Benefits (COB). The CONTRACTOR'S NABD shall explain the enrollee's right to have benefits continue until the appeal is resolved and must explain the procedures necessary for exercising this right. Additionally, if permitted by TennCare policy, the NABD shall explain the circumstances under which the enrollee may be required to pay the costs of continued services. See 42 C.F.R. §438.404(b)(6).

2.19.2.7 NABD Templates. In order to ensure consistency and to lessen the risk of issuing a notice that fails to meet applicable requirements, the CONTRACTOR shall use TENNCARE-developed or TENNCARE-approved NABD templates. NABD templates shall be written in a format and language that, at a minimum, meets applicable notification standards set forth at 42 CFR §438.10 and the notice-content requirements prescribed by 42 CFR §438.404(b).

A.2.19.3 **Notice of Adverse Benefit Determination Timing**

2.19.3.1 When the CONTRACTOR's adverse benefit determination is a termination, suspension, or reduction of previously authorized covered service, the CONTRACTOR shall mail the NABD at least ten (10) days before the date of action. See 42 C.F.R. §438.404(c)(1); 42 C.F.R. §431.211.

2.19.3.2 The CONTRACTOR may mail the NABD as few as five (5) days prior to the date of action if TENNCARE has facts indicating that action should be taken because of probable fraud by the enrollee, and the facts have been verified, if possible, through secondary sources. See 42 C.F.R. §438.404(c)(1); 42 C.F.R. §431.214.

2.19.3.3 The CONTRACTOR shall mail the NABD by the date of the action when any of the following occur:

2.19.3.3.1 The enrollee has died,

2.19.3.3.2 The enrollee submits a signed written statement requesting service termination,

2.19.3.3.3 The enrollee submits a signed written statement including information that requires service termination or reduction and indicates an understanding that service termination or reduction will result,

2.19.3.3.4 The enrollee has been admitted to an institution where he or she is ineligible under the plan for further services,

2.19.3.3.5 The enrollee's address is determined unknown based on returned mail with no forwarding address,

2.19.3.3.6 The enrollee is accepted for Medicaid services by another state,

2.19.3.3.7 A change in the level of medical care is prescribed by the enrollee's physician,

2.19.3.3.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act, or

2.19.3.3.9 The transfer or discharge from a facility shall occur in an expedited fashion. See 42 C.F.R. §438.404(c)(1); 42 C.F.R. §431.213; 42 C.F.R. §431.231(d); section 1919(e)(7) of the Act; 42 C.F..R 483.12(a)(5)(i); 42 C.F.R. §483.12(a)(5)(ii).

2.19.3.4 The CONTRACTOR shall give NABD on the date of determination when the action is a denial of payment. See 42 C.F.R. §438.404(c)(2).

2.19.3.5 The CONTRACTOR shall give NABD as expeditiously as the enrollee's condition requires within fourteen (14) calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services. See 42 C.F.R. §438.210(d)(1); 42 C.F.R. §438.404(c)(3).

2.19.3.6 The CONTRACTOR may extend the fourteen (14) calendar day NABD timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional calendar days if the enrollee or the provider requests extension. See 42 C.F.R. §438.404(c)(4); 42 C.F.R. §438.210(d)(1)(i).

2.19.3.7 The CONTRACTOR may extend the fourteen (14) calendar day NABD timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional calendar days if the CONTRACTOR justifies to TENNCARE a need for additional information and shows how the extension is in the enrollee's best interest. See 42 C.F.R. §438.210(d)(1)(ii); 42 C.F.R. §438.404(c)(4).

2.19.3.8 If the CONTRACTOR extends the fourteen (14) calendar day NABD timeframe for standard authorization decisions that deny or limit services, the CONTRACTOR shall give the extension and inform the enrollee of the right to file a grievance with CONTRACTOR if the enrollee disagrees with the decision. See 42 C.F.R. §438.210(d)(1)(ii); 42 C.F.R. §438.404(c)(4)(i).

2.19.3.9 If the CONTRACTOR extends the fourteen (14) calendar day NABD timeframe for standard authorization decisions that deny or limit services, the CONTRACTOR shall issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. See 42 C.F.R. §438.210(d)(1)(ii); 42 C.F.R. §438.404(c)(4)(ii).

2.19.3.10 If the CONTRACTOR determines that following the standard authorization timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the CONTRACTOR shall make an expedited service authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. See 42 C.F.R. §438.210(d)(2)(i); 42 C.F.R. §438.404(c)(6).

2.19.3.11 The CONTRACTOR may extend the seventy-two (72) hour expedited service authorization decision time period by up to fourteen (14) calendar days if the enrollee requests an extension, or if the CONTRACTOR justifies to TENNCARE the need for additional information and how the extension is in the enrollee's interest. See 42 C.F.R. §438.210(d)(2)(ii); 42 C.F.R. §438.404(c)(6).

A.2.19.4 **Who May File Appeals**

2.19.4.1 Enrollees shall be instructed to file appeal requests with TENNCARE. If an enrollee attempts to contest an adverse benefit determination by filing an appeal request with CONTRACTOR (instead of with TENNCARE as instructed), CONTRACTOR shall, in accordance with 42 C.F.R. §438.406, assist the enrollee to ensure the prospective appeal is filed with TENNCARE. TENNCARE will send enrollee an acknowledgement letter and inform enrollee that the request has been received. See 42 C.F.R. §438.402(c)(1); 42 C.F.R. §438.406; and §438.408.

2.19.4.2 Enrollee-authorized representatives, acting on behalf of the enrollee and with the enrollee's written consent, may file appeal requests and may represent the enrollee during the appeal. The enrollee's treating provider may serve as an authorized representative, but may not request provision of continuation of benefits. See 42 C.F.R. §438.402(c)(1)(i) – (ii); 42 C.F.R. §438.408. See also definition of "Enrollee-Authorized Representative" herein at §A.1.

A.2.19.5 **Timeframes for Filing Requests for Appeal**

2.19.5.1 Enrollee must file an appeal request within sixty (60) calendar days from the date on the CONTRACTOR-issued NABD. It is TENNCARE's responsibility to determine whether or not the appeal request is timely. See 42 CFR 438.402(c)(2)(ii).

A.2.19.6 **Process for Filing a Standard or Expedited Request for Appeal**

2.19.6.1 Enrollee may file a request for appeal either orally or in writing. See 42 C.F.R. §438.402(c)(3)(ii).

2.19.6.2 ORR for Expedited Resolution Determination. When an enrollee files a request for expedited resolution of an appeal, TENNCARE will issue an On Request Report (ORR) to CONTRACTOR. The ORR requires CONTRACTOR to determine whether the request warrants expedited or standard resolution. If CONTRACTOR determines that the request warrants expedited resolution, within seventy-two (72) hours of the time that the expedited resolution request was filed, CONTRACTOR shall simultaneously supply TENNCARE with both its (1) resolution timeframe decision, and its (2) reconsideration determination. If CONTRACTOR determines that the appeal request warrants standard resolution, CONTRACTOR shall supply its resolution timeframe decision to TENNCARE within two (2) business days, and shall supply TENNCARE its reconsideration determination within the timeframe provided in Section A.2.19.6.2.1.

2.19.6.2.1 ORR for Reconsideration. If the enrollee's appeal request warrants expedited resolution, as provided in 2.19.6.2, the CONTRACTOR shall simultaneously supply TENNCARE with both its resolution timeframe decision and its reconsideration determination. If the CONTRACTOR determines that the appeal request warrants standard resolution, CONTRACTOR shall complete its Reconsideration review and submit its Reconsideration decision to TENNCARE, along with the other information requested in the ORR, within fourteen (14) days of the time that the appeal request was filed. If the CONTRACTOR denies a request for expedited resolution, the matter shall receive standard resolution. See 42 C.F.R. §438.410(c); 42 C.F.R. §438.408(b)(2); 42 C.F.R. §438.408(c)(2).

2.19.6.2.2 Test for whether Appeal warrants Standard or Expedited Resolution. A benefit under dispute warrants expedited resolution if the CONTRACTOR determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. Although the enrollee or his treating provider may request expedited resolution, the CONTRACTOR alone has the authority to determine whether an enrollee appeal receives expedited or standard resolution. See 42 C.F.R. §438.410(a); Final Rule, 81 Fed. Reg. 27,498, 27,519 (May 6, 2016) (to be codified at 42 C.F.R. pt. 438).

2.19.6.2.3 Information to be supplied in response to ORR for Reconsideration. CONTRACTOR's Reconsideration response shall contain all of the information used by CONTRACTOR in arriving at the adverse benefit determination. This includes the enrollee medical records and any other information considered, relied upon, or created in arriving at a Prior Authorization or Reconsideration decision. (TENNCARE will provide this information to enrollee when TENNCARE issues its Notice of Hearing to enrollee. See §2.19.6.4 below.) For example, CONTRACTOR's Reconsideration response must include the following:

2.19.6.2.3.1 Complete case file;

2.19.6.2.3.2 Medical records and medical history pertaining to the benefit under dispute;

2.19.6.2.3.3 NABD issued to enrollee by CONTRACTOR;

2.19.6.2.3.4 Prior authorization decision issued to requesting provider by CONTRACTOR;

2.19.6.2.3.5 Medical review substantiating the prior authorization decision; and

2.19.6.2.3.6 CONTRACTOR's Reconsideration decision upholding or reversing original prior authorization determination, along with the attendant substantiating medical review. See 42 C.F.R. §438.406(b)(5).

2.19.6.3 Parties at the Appeal's State Fair Hearing. The parties to a State Fair Hearing are TENNCARE and the enrollee (including enrollee's authorized representative, or the legal representative of a deceased enrollee's estate). See 42 C.F.R. §438.406(b)(6).

2.19.6.4 TennCare Notice of Hearing. TENNCARE will provide enrollee a Notice of Hearing, which informs enrollee of the hearing procedure and which contains the enrollee case file and includes the information used by the CONTRACTOR in arriving at its adverse benefit determination. TENNCARE will issue the Notice of Hearing sufficiently in advance of the requisite resolution timeframe. See 42 C.F.R. §438.406(b)(4); 42 C.F.R. §438.408(b); 42 C.F.R. §438.408(c).

2.19.6.5 The CONTRACTOR shall ensure that punitive action is not taken against a provider who requests expedited resolution, or who supports an enrollee's request for appeal. See 42 C.F.R. §438.410(b).

A.2.19.7 **Timeframes for Resolving Standard and Expedited Appeal Requests**

2.19.7.1 Each appeal shall be resolved as expeditiously as the enrollee's health condition requires. Standard appeals shall be resolved within ninety (90) calendar days of receipt; Expedited appeals shall be resolved within three business days of TENNCARE's receipt of CONTRACTOR's Reconsideration response. CONTRACTOR's Reconsideration response must be received within 72 hours of enrollee's request for appeal. See 42 C.F.R. §438.408(a); 42 C.F.R. §438.408(b)(2)-(3); 42 C.F.R. §431.244(f)(2).

2.19.7.2 The CONTRACTOR may extend the resolution timeframe by up to fourteen (14) calendar days if either:

2.19.7.2.1 The enrollee requests the extension, or

2.19.7.2.2 Consistent with TennCare policy, the CONTRACTOR shows the need for additional information and shows that the delay is in the enrollee's interest. See 42 C.F.R. §438.408(c)(1); 42 C.F.R. §438.408(b)(2).

2.19.7.3 If the CONTRACTOR extends the resolution timeframe pursuant to A.2.19.7.2, CONTRACTOR shall, within two (2) calendar days, give enrollee written notice of the reason for the extension. (Reasonable effort should also be made to confer oral notice). This written notice shall inform enrollee of the right to file a grievance with CONTRACTOR if enrollee disagrees with the extension. See 42 C.F.R. §438.408(c)(2)(i)-(iii); 42 C.F.R. §438.408(b)(2).

A.2.19.8 **Notice of Appeal Resolution**

2.19.8.1 TENNCARE must provide enrollee with a written and dated notice of appeal resolution. The notice of appeal resolution must be in a format and language that meets 42 C.F.R. §438.10.

2.19.8.2 If the notice of resolution concerns an expedited appeal, in addition to the written notice supplied to enrollee by TENNCARE, the CONTRACTOR shall make reasonable effort to confer oral notice of the expedited appeal resolution, and shall document its efforts to do so. See 42 C.F.R. §438.408(d)(2)(ii).

A.2.19.9 **Continuation of Benefits**

2.19.9.1 The CONTRACTOR shall not accept a continuation of benefits request from a provider, since providers are prohibited from requesting continuation of benefits pursuant to 42 C.F.R. §438.402(c)(1)(ii) and §438.420(b)(5). The CONTRACTOR shall continue the enrollee's benefits while an appeal is in process if all of the following occur:

2.19.9.1.1 The enrollee files the request for an appeal within sixty (60) calendar days following the date on the NABD.

2.19.9.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized Medicaid service.

2.19.9.1.3 The enrollee’s services were ordered by an authorized provider.

2.19.9.1.4 The period covered by the original authorization has not expired.

2.19.9.1.5 Enrollee files the request for continuation of benefits within ten (10) calendar days of the date on the NABD, or if enrollee files the request before the intended effective date of the proposed adverse benefit determination. See; 42 C.F.R. §438.420(b)(1)-(5); 42 C.F.R. §438.402(c)(2)(ii).

2.19.9.2 If, at the enrollee's request, the CONTRACTOR continues or reinstates the enrollee's benefits while the appeal is pending, the benefits shall be continued until one of the following occurs:

2.19.9.2.1 The enrollee withdraws the appeal; or

2.19.9.2.2 An appeal decision adverse to the enrollee is issued. See 42 C.F.R. §438.420(c)(1)-(3); 42 C.F.R. §438.408(d)(2).

2.19.9.3 The CONTRACTOR shall authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires (but no later than seventy-two (72) hours from the date it receives notice reversing the determination). See 42 C.F.R. §438.424(a). The CONTRACTOR's initial adverse determination can be reversed in one of three ways during the appeal process: (1) By the CONTRACTOR itself (during Reconsideration), (2) By TENNCARE following its pre-hearing medical necessity or coverage review, or (3) by the hearing officer's Initial Order resolving the appeal. In each of the three situations, TENNCARE will issue a directive instructing CONTRACTOR of the action it shall take and of the attendant deadline.

2.19.9.4 The CONTRACTOR shall pay for disputed services received by the enrollee while the appeal was pending in the event that the CONTRACTOR's Reconsideration determination or the TENNCARE appeal resolution reverses the CONTRACTOR's initial decision to deny authorization of the benefit under appeal. See 42 C.F.R. §438.424(b).

2.19.9.5 The CONTRACTOR shall notify the requesting provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. See 42 C.F.R. §438.210(c); 42 C.F.R. §438.404.

A.2.19.10 **Grievances**

2.19.10.1 The CONTRACTOR shall allow an enrollee to file an oral or written grievance with a CONTRACTOR at any time. See 42 C.F.R.438.402(c)(2)(i); 42 C.F.R.438.402(c)(3)(i).

2.19.10.2 The CONTRACTOR shall resolve each grievance and provide notice of grievance resolution within ninety (90) calendar days from the day the CONTRACTOR receives the grievance. See 42 C.F.R. §438.408(a); 42 C.F.R. §438.408(b)(1).

2.19.10.3 The CONTRACTOR shall issue a written acknowledgment of receipt of the grievance within five (5) business days. This written acknowledgement need not be conferred if the CONTRACTOR issues the notice of grievance resolution within five (5) business days of receiving the grievance.

2.19.10.4 The CONTRACTOR shall issue a written, dated notice of grievance resolution in a format and language that meets 42 C.F.R. §438.10. See 42 C.F.R. §438.408(d)(1).

A.2.19.11 **Grievance and Appeal Recordkeeping Requirements**

2.19.11.1 The CONTRACTOR must maintain records of grievances and appeals and shall make such records readily available to TENNCARE or to CMS upon request. See 42 C.F.R. §438.416(a); 42 C.F.R. §438.416(c).

2.19.11.2 The CONTRACTOR's record of each grievance and appeal shall include:

2.19.11.2.1 A general description of the reason for the appeal or grievance.

2.19.11.2.2 The date received.

2.19.11.2.3 The date of each review or, if applicable, review meeting.

2.19.11.2.4 The date of resolution and how it was resolved.

2.19.11.2.5 The identity of the enrollee for whom the appeal or grievance was filed. See 42 C.F.R. §438.416(b)(1)-(6).

A.2.19.12 **Provision of Information About Enrollee Grievance and Appeal Rights**

2.19.12.1 The CONTRACTOR shall inform its assigned enrollees, contracted providers and subcontractors about the appeal process and shall inform them of the toll-free number for filing oral grievances and appeals. See 42 C.F.R. §438.414; 42 C.F.R. §438.10(g)(1)(v).

2.19.12.2 The CONTRACTOR shall include information about the enrollee's grievance and appeal rights in the following materials:

2.19.12.2.1 NABD and notice of appeal resolution;

2.19.12.2.2 Provider and subcontractor contracts with CONTRACTOR;

2.19.12.2.3 Member Handbook and Provider Manual;

2.19.12.2.4 Provider training materials;

2.19.12.2.5 CONTRACTOR website.

2.19.13 The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section A.2.15.2, to the review of enrollee appeals and to addressing identified deficiencies with the CONTRACTOR's grievance process or with CONTRACTOR's role in the TENNCARE appeal process.

2.19.14 The CONTRACTOR shall have a designated business unit responsible for processing grievances and appeals in accordance with applicable law and TENNCARE requirements. CONTRACTOR's appeals unit shall include sufficient numbers of appropriately trained and licensed physicians, clinicians, and support staff necessary to timely process appeals in accordance with potentially evolving regulatory and TENNCARE requirements.

2.19.15 At any point in the appeal process, TENNCARE must have the authority to remove an enrollee from the CONTRACTOR's MCO when it is determined that such removal is in the best interest of the enrollee and TENNCARE.

2.19.16 The CONTRACTOR understands that the grievance and appeal process requirements are always subject to change based on legal developments and on TENNCARE's interpretation of its obligations under new or existing law.

2.19.17 The CONTRACTOR shall provide general and targeted education to its contracted providers regarding the appeal process. This training shall cover the provider's rights and obligations concerning the appeal process including provider's obligation to timely supply medical records necessary for the appeal process and including requirements concerning submission of requests for expedited prior authorization decisions and requests for expedited appeal resolution.

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

2.19.19 The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).

2.19.20 Enrollee TennCare eligibility and eligibility-related grievances and appeals, including but not limited to, long-term care eligibility and enrollment, termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities shall be directed to TENNCARE.

A.2.20 FRAUD, WASTE, AND ABUSE

A.2.20.1 General

2.20.1.1 The Tennessee Bureau of Investigation, Medicaid Fraud Control Division (TBI MFCD) is the state agency responsible for the investigation of provider fraud, waste, and abuse (FWA) in the TennCare program.

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

2.20.1.3 The Division of TennCare, Managed Care Operations, Office of Program Integrity (OPI) is the State Medicaid Agency unit responsible for the prevention, detection and investigation of alleged provider fraud, waste, and abuse of the TennCare program. OPI is responsible for providing the Managed Care Program Integrity Guidelines for FWA. These guidelines shall be utilized by all MCCs to implement and maintain compliance with TENNCARE's FWA policies and procedures.

2.20.1.4 The CONTRACTOR, and any subcontractors delegated responsibility for coverage of services or payment of claims under this Contract, shall implement and maintain a compliance program, as described 42 CFR 438.608, that includes, at a minimum:

2.20.1.4.1 Written policies, procedures, and standards of conduct that demonstrate compliance with all applicable requirements and standards under the Contract, as well as all Federal and state requirements, related to program integrity;

2.20.1.4.2 A designated Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with program integrity requirements. The Compliance Officer shall report to the CEO and the Board of Directors;

2.20.1.4.3 A Regulatory Compliance Committee, consisting of members of the Board of Directors; which is responsible for oversight of the CONTRACTOR's compliance program;

2.20.1.4.4 A system for training and education for the Compliance Officer, directors, managers, and employees regarding the CONTRACTOR's compliance program and program integrity-related requirements;

2.20.1.4.5 Effective lines of communication between the CONTRACTOR's Compliance Officer and employees;

2.20.1.4.6 Enforcement of compliance program standards and program integrity-related requirements through well-publicized disciplinary guidelines;

2.20.1.4.7 A system of dedicated staff with established and implemented procedures for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of identified compliance problems to reduce the potential for recurrence, and ongoing compliance with program integrity-related requirements.

2.20.1.5 The CONTRACTOR, as well as its subcontractors shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request.

2.20.1.6 The CONTRACTOR's providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request. For providers, this requirement may be satisfied through TENNCARE's provider registration process.

2.20.1.7 The CONTRACTOR shall have procedures in place for prompt reporting of all overpayments identified or recovered due to potential administrative and non-administrative fraud, waste, and abuse to the State.

2.20.1.8 The CONTRACTOR shall notify the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the CONTRACTOR.

2.20.1.9 The CONTRACTOR shall have a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

2.20.1.10 The CONTRACTOR shall establish written policies and procedures for its employees, subcontractors, providers, and agents that provide detailed information about the False Claims Act and any other federal and state laws described in section 1902(a)(68) of the Act, including whistleblower protections, administrative remedies for false claims, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs. The CONTRACTOR shall include in any employee handbook a description of the laws and the rights of employees to be protected as whistleblowers.

2.20.1.11 FWA referrals shall promptly be referred to the State Medicaid Program Integrity Unit and to the State Medicaid Fraud Control Division.

2.20.1.12 The CONTRACTOR shall promptly suspend partial or total payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.2. Partial suspension of payments shall require that the Contractor have the ability to suspend not just by provider but by specific CPT or other procedure code to allow partial suspensions.

2.20.1.13 The CONTRACTOR shall have in place a mechanism for a network provider to report to the CONTRACTOR when it has received an overpayment, to return the overpayment to the CONTRACTOR within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the CONTRACTOR in writing of the reason for the overpayment.

2.20.1.14 The CONTRACTOR may recoup and retain overpayments made to providers within timeframes determined by the state.

2.20.1.14.1 The CONTRACTOR shall notify TennCare OPI of any non-administrative overpayments identified outside of the timeframes determined by the state, or for which recovery is prohibited under Section A.2.20.1. The CONTRACTOR shall take no actions to recoup the overpayments without written authorization from TennCare OPI.

2.20.1.14.2 The CONTRACTOR shall report to TennCare OPI all non-administrative overpayments, both identified and recovered, on a quarterly basis.

2.20.1.15 The CONTRACTOR is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:

2.20.1.15.1 The improperly paid funds have already been recovered by the State of Tennessee, either by TENNCARE directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or

2.20.1.15.2 When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Tennessee or are the subject of pending Federal or State litigation or investigation,

2.20.1.15.3 The prohibition described in this section shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims.

2.20.1.15.4 The CONTRACTOR shall determine if the prohibition to recoup or withhold improperly paid funds is applicable utilizing methods as directed by TennCare OPI.

2.20.1.15.5 In the event that CONTRACTOR recoups or otherwise obtains funds in cases where overpayment recovery is prohibited, under this section or as otherwise directed by TENNCARE, the CONTRACTOR shall notify the Director of TennCare OPI and take action in accordance with written instructions from the Director of TennCare OPI.

2.20.1.15.6 The CONTRACTOR shall report quarterly on FWA cost savings information in a format provided by TENNCARE.

2.20.1.16 The CONTRACTOR shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.

2.20.1.17 The CONTRACTOR, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. The CONTRACTOR, its subcontractors and all tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall screen their owners and employees against the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). In addition, the CONTRACTOR and its subcontractors shall screen their owners and employees against the Social Security Master Death File. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the CONTRACTOR dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

2.20.1.18 The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud, waste, and abuse activities.

2.20.1.18.1 If the CONTRACTOR fails to adhere to the prohibitions and requirements of this section, the CONTRACTOR may be subject to forfeiture of the funds to the State and the imposition of liquidated damages as described in Section E.29.2.

2.20.1.19 The CONTRACTOR shall comply with all federal and state requirements regarding fraud, waste, and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

2.20.1.20 The CONTRACTOR shall comply with all written direction provided by TennCare OPI regarding fraud, waste, and abuse investigations, overpayments, and any other program integrity related activities and reporting.

A.2.20.2 **Reporting and Investigating Suspected Fraud, Waste, and Abuse**

2.20.2.1 The CONTRACTOR shall cooperate with all appropriate state and federal agencies, including TBI MFCD and/or OIG, in investigating fraud, waste, and abuse. In addition, the CONTRACTOR shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Contract.

2.20.2.2 The CONTRACTOR shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21).

2.20.2.3 The CONTRACTOR shall notify TBI MFCD and TennCare Office of Program Integrity simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to TennCare providers' billing anomalies and/or to safety of TennCare enrollees (TBI.MFCU@tn.gov; ProgramIntegrity.TennCare@tn.gov). Along with a notification, the CONTRACTOR shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to TBI MFCD and the TennCare Office of Program Integrity when the concerns and/or allegations of any tips are authenticated.

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

2.20.2.4.1 All tips (any program integrity case received within the previous two (2) weeks) shall be reported to TennCare OPI and TBI MFCD;

2.20.2.4.2 Suspected fraud, waste, and abuse in the administration of the program shall be reported to TennCare OPI, TBI MFCD and/or OIG;

2.20.2.4.3 All confirmed or suspected provider fraud, waste, and abuse shall immediately be reported to TBI MFCD and TennCare OPI; and

2.20.2.4.4 All confirmed or suspected enrollee fraud, waste, and abuse shall be reported immediately to OIG.

2.20.2.5 The CONTRACTOR shall use the Fraud Reporting Forms, or such other form as may be deemed satisfactory by the agency to whom the report is to be made under the terms of this Contract.

2.20.2.6 Pursuant to TCA 71-5-2603(c) the CONTRACTOR shall be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud, waste, and abuse by recipients, enrollees, applicants, or providers to TENNCARE and OIG or TBI MFCD, as appropriate.

2.20.2.7 The CONTRACTOR shall promptly perform a preliminary investigation of all incidents related to suspected and/or confirmed provider fraud and abuse. The CONTRACTOR shall not take any of the following actions once the suspected fraud is substantiated and reported to the state without prior written approval from the State:

2.20.2.7.1 Contact the subject of the investigation about any matters related to suspected and/or confirmed fraud or abuse;

2.20.2.7.2 Enter into or attempt to negotiate any settlement or agreement regarding incidents of suspected and/or confirmed fraud or abuse; or

2.20.2.7.3 Accept any monetary or other thing of valuable consideration offered by the subject(s) of the investigation in connection with incidents of suspected and/or confirmed fraud or abuse.

2.20.2.8 The CONTRACTOR shall immediately contact the TennCare OPI for guidance if, during the course of an audit, it is determined the provider is already under review by the State.

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

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

2.20.2.10 The CONTRACTOR shall suspend payment to a provider upon notification from TennCare OPI of the determination of a credible allegation of fraud.

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

2.20.2.12 The CONTRACTOR, subcontractor and providers, whether contract or non-contract, shall, upon request and as required by this Contract or state and/or federal law, make available to the TBI MFCD/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the TBI MFCD/OIG shall, as required by this Contract or state and/or federal law, be allowed access to the place of business and to all TennCare records of any contractor, subcontractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCD/OIG.

2.20.2.13 The CONTRACTOR and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section, Section A.2.20 of this Contract.

2.20.2.14 The CONTRACTOR shall notify the Director of TennCare Office of Program Integrity when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

2.20.2.15 If the CONTRACTOR subjects a provider (who is not otherwise determined to be under investigation or litigation involving the State or Federal government) to pre-payment review or any review requiring the provider to submit documentation to support a claim prior to the CONTRACTOR considering it for payment, as a result of suspected fraud, waste, and/or abuse, the CONTRACTOR shall adhere to the following, within ninety (90) days of requiring such action:

2.20.2.15.1 Initiate a retrospective medical and coding review on the relevant claims; and

2.20.2.15.2 If fraud, waste or abuse is still suspected after conducting the retrospective review, submit to TennCare OPI a suspected fraud referral, including all referral components as required by TennCare OPI.

2.20.2.15.3 A retrospective review shall not be conducted for providers who are determined to be under investigation or litigation involving the State or Federal government or other instances as deemed appropriate by TENNCARE.

2.20.2.16 Except as described in Section A.2.11.10.2 of this Contract, nothing herein shall require the CONTRACTOR to ensure non-contract providers are compliant with TENNCARE contracts or state and/or federal law.

2.20.2.17 In accordance with the Affordable Care Act and TennCare policy and procedures, the CONTRACTOR shall promptly report overpayments made by TENNCARE to the CONTRACTOR as well as overpayments made by the CONTRACTOR to a provider and/or subcontractor (See Section A.2.12.9.36).

A.2.20.3 **Compliance Plan**

2.20.3.1 The CONTRACTOR shall have a written fraud, waste, and abuse compliance plan. A paper and electronic copy of the plan shall be provided to TennCare OPI within ninety (90) calendar days of Contract execution and an electronic copy shall be provided annually thereafter. TENNCARE shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) calendar days of receipt. The CONTRACTOR shall make any requested updates or modifications available for review as requested by TennCare OPI within thirty (30) calendar days of a request.

2.20.3.2 The CONTRACTOR's fraud, waste, and abuse compliance plan shall:

2.20.3.2.1 Require that the reporting of suspected and/or confirmed fraud, waste, and abuse be done as required by this Contract;

2.20.3.2.2 Include a risk assessment of the CONTRACTOR's various fraud, waste, and abuse/program integrity processes. A risk assessment shall also be submitted on an 'as needed' basis and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment and fines), is issued on a provider with concerns of fraud, waste, and abuse. The CONTRACTOR shall inform TENNCARE of such action and provide details of such financial action. The assessment shall also include a listing of the CONTRACTOR's top three vulnerable areas and shall outline action plans in mitigating such risks;

2.20.3.2.3 Outline activities proposed for the next reporting year regarding employee education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste to ensure that all of its officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud, waste, and abuse compliance plan;

2.20.3.2.4 Outline activities proposed for the next reporting year regarding provider education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste and on identifying and educating targeted providers with patterns of incorrect billing practices and/or overpayments;

2.20.3.2.5 Outline unique policy and procedures, and specific instruments designed to identify, investigate, and report fraud, waste, and abuse activities under the CHOICES' program.

2.20.3.2.6 Contain procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this Contract; and

2.20.3.2.7 Include a description of the specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, such as:

2.20.3.2.7.1 A list of automated pre-payment claims edits;

2.20.3.2.7.2 A list of automated post-payment claims edits;

2.20.3.2.7.3 A list of desk audits on post-processing review of claims;

2.20.3.2.7.4 A list of reports of provider profiling and credentialing used to aid program and payment integrity reviews;

2.20.3.2.7.5 A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

2.20.3.2.7.6 A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials; and

2.20.3.2.7.7 A list of references in provider and member material regarding fraud, waste, and abuse referrals.

2.20.3.2.8 Include a list of provisions for the confidential reporting of plan violations to the designated person;

2.20.3.2.9 Include a list of provisions for the investigation and follow-up of any suspected or confirmed fraud, waste, and abuse, even if already reported, and/or compliance plan reports;

2.20.3.2.10 Ensure that the identities of individuals reporting violations of the CONTRACTOR's MCO are protected and that there is no retaliation against such persons;

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

2.20.3.2.12 Require any confirmed or suspected provider fraud, waste, and abuse under state or federal law be reported to TBI MFCD as well as TennCare Office of Program Integrity and that enrollee fraud, waste, and abuse be reported to the OIG;

2.20.3.2.13 Ensure that no individual who reports MCO violations or suspected fraud, waste, and abuse is retaliated against; and

2.20.3.2.14 Include work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk (providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

2.20.3.3 The CONTRACTOR shall have provisions regarding compliance with the applicable requirements of the Model Compliance Plan for Medicaid MCOs or Medicare+Choice Organizations/Medicare Advantage plans issued by the DHHS OIG.

2.20.3.4 The CONTRACTOR shall provide a list of procedures regarding implementation of TennCare policy on disclosure and adverse action reporting.

2.20.3.5 The CONTRACTOR shall have provisions in its Compliance plan regarding the reporting of fraud, waste, and abuse activities as required in Section A.2.30.15, Reporting Requirements.

2.20.3.6 The CONTRACTOR shall have provisions in its Compliance Plan regarding conducting monthly comparison of their provider files, including atypical providers, and Personal Care Service providers against the Social Security Master Death File, the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to TENNCARE each month. The CONTRACTOR shall establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure information as provided by TENNCARE.

2.20.3.7 The CONTRACTOR shall have provisions in its Compliance Plan regarding performing a monthly check for exclusions of their owners, agents and managing employees. The CONTRACTOR shall establish an electronic database to capture identifiable information on its owners, agents and managing employees and perform monthly exclusion checking. The CONTRACTOR shall provide the State Agency with such database and a monthly report of the exclusion check.

2.20.3.8 The CONTRACTOR shall have provisions in its Compliance Plan regarding prompt terminations of inactive providers due to inactivity in the past twelve (12) months, unless TENNCARE provides prior approval for a provider type to remain contracted or as otherwise required by TENNCARE.

2.20.3.9 The CONTRACTOR shall have provisions in its Compliance Plan regarding instructions to Personal Care Service providers to maintain written policies and procedures of their business model. The policy and procedures shall include at a minimum; roles and responsibilities of key personnel, organizational chart, succession planning, ownership, background checks for all personnel, fraud, waste, and abuse reporting protocols, and a plan for fraud, waste, and abuse employee training as required by Deficit Reduction Act of 2005 Section 6032.

2.20.3.10 The CONTRACTOR shall have provisions in its Compliance Plan to perform a coordinated audit of a sampling of Personal Care Service providers to ensure PCS providers are only audited by one Managed Care Organization. The results of the audits will be submitted annually to TennCare with the Compliance Plan.

A.2.21 FINANCIAL MANAGEMENT

The CONTRACTOR shall be responsible for sound financial management of its MCO. The CONTRACTOR shall adhere to the minimum guidelines outlined below.

A.2.21.1 Payments by TENNCARE

The CONTRACTOR shall accept payments remitted by TENNCARE in accordance with Section C.3 as payment in full for all services required pursuant to this Contract.

A.2.21.2 Savings/Loss

2.21.2.1 The CONTRACTOR shall not be required to share with TENNCARE any financial gains realized under this Contract.

2.21.2.2 TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Contract.

A.2.21.3 **Interest**

Interest generated from the deposit of funds paid to the CONTRACTOR pursuant to this Contract shall be the property of the CONTRACTOR and available for use at the CONTRACTOR's discretion.

A.2.21.4 **Third Party Liability Resources**

2.21.4.1 The TennCare program shall be the payer of last resort for all covered services in accordance with federal regulations. The CONTRACTOR shall exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the liability of third parties to pay for services rendered to enrollees under this Contract and cost avoid and/or recover any such liability from the third party. The CONTRACTOR shall develop and implement policies and procedures to meet its obligations regarding third party liability when the third party (e.g., long-term care insurance) pays a cash benefit to the member, regardless of services used or does not allow the member to assign his/her benefits.

2.21.4.1.1 If third party liability (TPL) exists for part or all of the services provided directly by the CONTRACTOR to an enrollee, the CONTRACTOR shall make reasonable efforts to recover from TPL sources the value of services rendered.

2.21.4.1.2 If TPL exists for part or all of the services provided to an enrollee by a subcontractor or a provider, and the third party will make payment within a reasonable time, the CONTRACTOR may pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount of TPL.

2.21.4.1.3 If the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR may reject the claim and return it to the provider for a determination of the amount of any TPL, unless the claim is for services described in TennCare policy, including the State Medicaid Manual, Section 3904.4.

2.21.4.1.4 The claims specified in Section A.2.21.4.1.3 shall be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party.

2.21.4.2 The CONTRACTOR shall deny payment on a claim that has been denied by a third party payer when the reason for denial is the provider or enrollee's failure to follow prescribed procedures, including but not limited to, failure to obtain prior authorization, timely filing, etc.

2.21.4.3 The CONTRACTOR shall treat funds recovered from third parties as offsets to claims payments. The CONTRACTOR shall report all cost avoidance values to TENNCARE in accordance with federal guidelines and as described in Section A.2.21.4 of this Contract.

2.21.4.4 The CONTRACTOR shall post all third party payments to claim level detail by enrollee.

2.21.4.5 Third party resources shall include subrogation recoveries. The CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation

recoveries collected by the CONTRACTOR outside of the claims processing system shall be treated by the CONTRACTOR as offsets to medical expenses for the purposes of reporting.

2.21.4.6 The CONTRACTOR shall conduct diagnosis and trauma code editing to identify potential subrogation claims. This editing should, at minimum, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'

2.21.4.7 TennCare cost sharing and patient liability responsibilities permitted pursuant to Sections A.2.6.7 and A.2.21.5 of this Contract shall not be considered TPL.

2.21.4.8 The CONTRACTOR shall provide TPL data to any provider having a claim denied by the CONTRACTOR based upon TPL.

2.21.4.9 The CONTRACTOR shall provide to TENNCARE any third party resource information necessary in a format and media described by TENNCARE and shall cooperate in any manner necessary, as requested by TENNCARE, with TENNCARE and/or a cost recovery vendor at such time that TENNCARE acquires said services.

2.21.4.10 TENNCARE may require a TennCare contracted TPL vendor to review paid claims that are over ninety (90) calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the CONTRACTOR's reported encounter data.

2.21.4.11 If the CONTRACTOR operates or administers any non-Medicaid HMO, health plan or other lines of business, the CONTRACTOR shall assist TENNCARE with the identification of enrollees with access to other insurance.

2.21.4.12 The CONTRACTOR shall demonstrate, upon request, to TENNCARE that reasonable effort has been made to seek, collect and/or report third party recoveries. TENNCARE shall have the sole responsibility for determining whether reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

2.21.4.13 TENNCARE shall be solely responsible for estate recovery activities and shall retain any and all funds recovered thorough these activities.

A.2.21.5 **Patient Liability**

2.21.5.1 TENNCARE will notify the CONTRACTOR of any applicable patient liability amounts for members via the outbound 834 enrollment file.

2.21.5.2 The CONTRACTOR shall delegate collection of patient liability to the nursing facility or community-based residential alternative facility and shall pay the facility net of the applicable patient liability amount. For members in CHOICES Groups 2 or 3 or ECF CHOICES receiving non-residential CHOICES HCBS or ECF CHOICES HCBS, the CONTRACTOR shall collect applicable patient liability amounts.

2.21.5.3 When TENNCARE notifies the CONTRACTOR of patient liability amounts for CHOICES or ECF CHOICES members via the outbound 834 enrollment file at any time other than the beginning of the month, then the CONTRACTOR shall determine and apply the prorated portion of patient liability for that month.

A.2.21.6 **Solvency Requirements**

2.21.6.1 Minimum Net Worth

2.21.6.1.1 The CONTRACTOR shall comply with the Risk-Based Capital (RBC) requirements set forth in TCA 56-46-201 et seq. The CONTRACTOR shall demonstrate compliance with this provision to TDCI in the financial reports filed with TDCI by the CONTRACTOR.

2.21.6.2 Restricted Deposits

2.21.6.2.1 The CONTRACTOR shall establish and maintain restricted deposits in accordance with TCA 56-32-112(b).

2.21.6.3 If the CONTRACTOR fails to meet the applicable net worth and/or restricted deposit requirement, said failure shall constitute a hazardous financial condition and the CONTRACTOR shall be considered to be in breach of the terms of the Contract.

A.2.21.7 **Accounting Requirements**

2.21.7.1 The CONTRACTOR shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this Contract and any other costs and expenditures made under the Contract.

2.21.7.2 Specific accounting records and procedures are subject to TENNCARE and federal approval. Accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the Contract period and for ten (10) years thereafter unless otherwise specified elsewhere in this Contract.

A.2.21.8 **Insurance**

2.21.8.1 The CONTRACTOR shall obtain adequate worker's compensation and general liability insurance coverage prior to commencing any work in connection with this Contract. Additionally, TENNCARE may require, at its sole discretion, the CONTRACTOR to obtain adequate professional malpractice liability or other forms of insurance. Any insurance required by TENNCARE shall be in the form and substance acceptable to TENNCARE.

2.21.8.2 Except as otherwise provided in Section A.2.12 or in the model contract with the FEA, the CONTRACTOR shall require that any subcontractors or contract providers obtain all similar insurance required of it prior to commencing work.

2.21.8.3 The CONTRACTOR shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to TENNCARE.

2.21.8.4 TENNCARE shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the CONTRACTOR, subcontractor and/or provider obtaining such insurance. The same holds true of any premiums paid on any insurance policy pursuant to this Contract.

2.21.8.5 Failure to provide proof of adequate coverage within the specified time period may result in this Contract being terminated.

A.2.21.9 **Ownership and Financial Disclosure**

2.21.9.1 The CONTRACTOR shall disclose, to TENNCARE, the Comptroller General of the United States or CMS, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in the time and manner set forth in accordance with federal and state requirements, including 42 CFR 438.604(a)(6); 42 CFR 438.606; 42 CFR 455.104(b)(1)(i) - (iii); 42 CFR 455.104(b)(2) - (4); 42 CFR 438.230; 42 CFR 438.608(c)(2) and Public Chapter 379 of the Acts of 1999.

2.21.9.2 The CONTRACTOR and its subcontractors shall collect the disclosure of health care-related criminal conviction information as required by 42 CFR§ 455.106 and establish policies and procedures to ensure that applicable criminal convictions are reported timely to the State. The CONTRACTOR shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The results of said screenings shall be provided to TENNCARE on a monthly basis. The word "contractors" in this section shall refer to all individuals listed on the disclosure form including providers and non-providers such as board members, owners, agents, managing employees, etc.

2.21.9.3 The CONTRACTOR and its subcontractors shall agree to disclose business transaction information upon request and as otherwise specified in federal and state regulations.

2.21.9.4 Disclosures shall be made in accordance with the requirements in Section A.2.30.16.2.2. The following information shall be disclosed:

2.21.9.4.1 The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, CONTRACTOR or in any provider, subcontractor or fiscal agent in which the disclosing entity, CONTRACTOR has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;

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

2.21.9.4.3 The identity of any person who has an ownership or control interest in the CONTRACTOR, or is an agent or managing employee of the CONTRACTOR and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the federal Title XX services program since the inception of those programs;

2.21.9.4.4 Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest;

2.21.9.4.5 If the CONTRACTOR is not a federally qualified HMO, the CONTRACTOR shall disclose certain transactions with parties in interest to TENNCARE. Transactions shall be reported according to the following guidelines:

2.21.9.4.5.1 The CONTRACTOR shall disclose the following transactions:

2.21.9.4.5.1.1 Any sale, exchange or lease of any property between the HMO and a party in interest;

2.21.9.4.5.1.2 Any lending of money or other extension of credit between the HMO and a party in interest; and

2.21.9.4.5.1.3 Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

2.21.9.4.5.2 The information which shall be disclosed in the transactions includes:

2.21.9.4.5.2.1 The name of the party in interest for each transaction;

2.21.9.4.5.2.2 A description of each transaction and the quantity or units involved;

2.21.9.4.5.2.3 The accrued dollar value of each transaction during the fiscal year; and

2.21.9.4.5.2.4 Justification of the reasonableness of each transaction.

2.21.9.4.5.3 If the Contract is being renewed or extended, the CONTRACTOR shall disclose information on business transactions which occurred during the prior contract period. If the Contract is an initial Contract with TENNCARE, but the CONTRACTOR has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period shall be disclosed. The business transactions which shall be reported are not limited to transactions related to serving the Medicaid/TennCare enrollment. All of the CONTRACTOR's business transactions shall be reported.

2.21.9.4.5.4 A party in interest is:

2.21.9.4.5.4.1 Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

2.21.9.4.5.4.2 Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;

2.21.9.4.5.4.3 Any person directly or indirectly controlling, controlled by, or under common control with an HMO; or

2.21.9.4.5.4.4 Any spouse, child, or parent of an individual described in Sections A.2.21.9.4.5.4.1, A.2.21.9.4.5.4.2, or A.2.21.9.4.5.4.3

2.21.9.4.5.5 TENNCARE and/or the Secretary of Health and Human Services may request information to be in the form of a consolidated financial statement.

A.2.21.10 **Internal Audit Function**

The CONTRACTOR shall establish and maintain an internal audit function responsible for providing an independent review and evaluation of the CONTRACTOR's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The CONTRACTOR's internal audit function shall be responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. Further, the CONTRACTOR's internal audit department shall be responsible for performance of the claims payment accuracy tests as described in Section A.2.22.6 of this Contract.

A.2.21.11 **Audit of Business Transactions**

2.21.11.1 The CONTRACTOR shall cause an audit of its business transactions to be performed by a licensed certified public accountant, including but not limited to the financial transactions made under this Contract. Such audit shall be performed in accordance with the requirements in Section A.2.30.16.3.5 of this Contract.

2.21.11.2 No later than December 1 of each year, the CONTRACTOR shall submit a copy of the full executed agreement to audit accounts to TENNCARE. Such agreement shall include the following language:

2.21.11.2.1 The auditor agrees to retain working papers for no less than ten (10) years and that all audit working papers shall, upon request, be made available for review by the Comptroller of the Treasury, the Comptroller's representatives, agents, and legal counsel, or the TennCare Division of the Tennessee Department of Commerce and Insurance, during normal working hours while the audit is in progress and/or subsequent to the completion of the report. Nothing in this Section shall be construed to modify or change the obligations of the CONTRACTOR contained in Section A.2.23.2 (Data and Document Management Requirements), A.2.23.3 (System and Data Integration Requirements), or A.2.23.6 (Security and Access Management Requirements) of this Contract.

2.21.11.2.2 Any evidence of fraud, such as defalcation, misappropriation, misfeasance, malfeasance, embezzlement, fraud or other illegal acts shall be reported by the auditor, in writing immediately upon discovery, to the Comptroller of the Treasury, State of Tennessee, who shall under all circumstances have the authority, at the discretion of the Comptroller, to directly investigate such matters. If the circumstances disclosed by the audit call for a more detailed investigation by the auditor than necessary under ordinary circumstances, the auditor shall inform the organization's governing body in writing of the need for such additional investigation and the additional compensation required therefore. Upon approval by the Comptroller of the Treasury, an amendment to this contract may be made by the organization's governing body and the auditor for such additional investigation.

A.2.22 CLAIMS MANAGEMENT

A.2.22.1 General

To the extent that the CONTRACTOR compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the CONTRACTOR shall process, as described herein, the provider's claims for covered benefits provided to members consistent with applicable CONTRACTOR policies and procedures and the terms of this Contract including but not limited to timely filing, compliance with all applicable state and federal laws, rules and regulations, including the development, staff and provider education and training, and implementation of all state and federal standardization initiatives (e.g., 5010, ICD 10, etc.) within the designated guidelines and timeframes specified by TENNCARE and/or CMS. The CONTRACTOR's claims processing system shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act.

A.2.22.2 Claims Management System Capabilities

2.22.2.1 The CONTRACTOR shall maintain a claims management system that can uniquely identify the provider of the service (ensuring all billing information related to tax-reporting business entities and information related to individuals who provide services are properly reported on claims), date of receipt (the date the CONTRACTOR receives the claim as indicated by a date-stamp), real-time-accurate history of actions taken on each provider claim (i.e., paid, denied, suspended, appealed, etc.), date of payment (the date of the check or other form of payment) and all data elements as required by TENNCARE for encounter data submission (see Section A.2.23), and can track and report service use against benefit limits in accordance with a methodology set by TENNCARE. In addition, the CONTRACTOR's claims management system shall support the requirements set out in Section A.2.23.4.1 of this Contract.

2.22.2.2 The CONTRACTOR shall have in place, an electronic claims management (ECM) capability that can handle online submission of individual claims by long-term care providers as well as accept and process batches of claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.). The online claims submission capability for long-term care providers shall be accessible via the World Wide Web or through an alternate, functionally equivalent medium.

2.22.2.3 The ECM capability shall function in accordance with information exchange and data management requirements specified in Section A.2.23 of this Contract.

2.22.2.4 As part of the ECM function, the CONTRACTOR shall also provide on-line and phone-based capabilities to obtain claims processing status information.

2.22.2.5 The CONTRACTOR shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

2.22.2.6 For any entities to which the CONTRACTOR makes payment via electronic transfers, the CONTRACTOR shall have a signed EFT form that shall have 42 CFR 455.18 and 455.19 statements immediately preceding the "Signature" section.

2.22.2.7 The CONTRACTOR shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the CONTRACTOR or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees/charges.

A.2.22.3 **Paper Based Claims Formats**

2.22.3.1 The CONTRACTOR shall comply at all times with standardized paper billing forms/formats (and all future updates) as follows:

Claim Type	Claim Form
Professional	CMS 1500
Institutional	CMS 1450/UB04
Dental	ADA

2.22.3.2 The CONTRACTOR shall not revise or modify the standardized forms or format.

2.22.3.3 For the forms identified in Section A.2.22.3.1, the CONTRACTOR shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with TENNCARE. These shall include, but not be limited to, HIPAA-based standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, as well as TDCI rules for Uniform Claims Process for TennCare in accordance with TCA 71-5-191.

2.22.3.4 The CONTRACTOR agrees that at such time that TENNCARE in conjunction with appropriate work groups presents recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within ninety (90) calendar days from notice by TENNCARE.

A.2.22.4 **Prompt Payment**

2.22.4.1 The CONTRACTOR shall comply with prompt pay claims processing requirements in accordance with TCA 56-32-126.

2.22.4.2 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for services delivered to a TennCare enrollee are paid within thirty (30) calendar days of the receipt of such claims.

2.22.4.3 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all claims for covered services delivered to a TennCare enrollee. The terms "processed and paid" are synonymous with terms "process and pay" of TCA 56-32-126(b)(1)(A) and (B).

2.22.4.4 Notwithstanding Sections A.2.22.4.1 through A.2.22.4.3, the CONTRACTOR shall comply with the following processing requirements for nursing facility claims and for CHOICES HCBS and ECF CHOICES HCBS claims for services submitted electronically in a HIPAA-compliant format:

2.22.4.4.1 Ninety percent (90%) of clean claims for nursing facility services and CHOICES HCBS and ECF CHOICES HCBS shall be processed and paid within fourteen (14) calendar days of receipt.

2.22.4.4.2 Ninety-nine point five percent (99.5%) of clean claims for nursing facility services and CHOICES HCBS and ECF CHOICES HCBS shall be processed and paid within twenty-one (21) calendar days of receipt.

2.22.4.5 The CONTRACTOR shall comply with the requirements in Sections A.2.22.4.2 and A.2.22.4.3 above for processing claims not submitted electronically in a HIPAA format.

2.22.4.6 The CONTRACTOR shall provide claims information and supporting claims documentation as specified by TENNCARE or TDCI in order for TENNCARE and/or TDCI to verify the CONTRACTOR's compliance with prompt payment requirements.

2.22.4.7 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

2.22.4.8 To the extent that the provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the provider agreement/contract between the provider and the CONTRACTOR or subcontractor, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or (iii) if the CONTRACTOR is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting remittance advice information from TENNCARE.

2.22.4.9 The CONTRACTOR shall not deny provider claims on the basis of untimely filing in situations regarding coordination of benefits or subrogation, in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the CONTRACTOR's MCO with a retroactive eligibility date. In situations of third party benefits, the time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment.

2.22.4.10 As it relates to MCO Assignment Unknown (see Sections A.2.13.12 and A.2.13.13), the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the member was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.22.4.11 For purposes of timely filing (see Section A.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 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 A.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 (A.2.12.9)

2.22.4.11.6 The CONTRACTOR shall specify in its provider manual a period of time that is consistent with the requirements of Section A.2.22.4.

2.22.4.12 The CONTRACTOR shall not require, as a condition to reimbursement, a Medicare Explanation of Benefits for nursing facility claims, nor shall the CONTRACTOR delay such reimbursement on the basis that third party liability must be captured and paid. However, the CONTRACTOR shall seek any applicable third party liability that is applicable and recover those amounts.

A.2.22.5 **Claims Dispute Management**

2.22.5.1 The CONTRACTOR shall have an internal claims dispute procedure that will be reviewed and approved in writing by TENNCARE prior to its implementation.

2.22.5.2 The CONTRACTOR shall contract with independent reviewers to review disputed claims as provided by TCA 56-32-126.

2.22.5.3 The CONTRACTOR shall systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

2.22.5.4 When the CONTRACTOR decides to pay any claims or portion of the claims, as part of a resolution to a provider complaint, the CONTRACTOR must send payment in full to the provider within twenty (20) calendar days of receipt of the CONTRACTOR's decision. The CONTRACTOR's failure to comply with these requirements may result in a Corrective Action Plan or Liquidated Damages.

2.22.5.5 The CONTRACTOR shall monitor, on an at least a monthly basis, the number, dollar value and percentage of each long-term care provider's denied claims for long-term care services (NF and CHOICES HCBS and ECF CHOICES HCBS), including the cause of such claims denial; take immediate action to resolve issues that are the responsibility of the CONTRACTOR and are preventing the payment of such claims for the identified provider and all other providers who may be affected by the same issue(s); and shall initiate training and technical assistance as needed to any long-term care provider whose monthly volume of denied claims for long-term care services exceeds ten percent (10%) during the first year following implementation of CHOICES or ECF CHOICES and twenty percent (20%) thereafter. The CONTRACTOR shall submit to TENNCARE on a quarterly basis, a report, in the manner and format prescribed by TENNCARE, of all long-term care contractors for whom the number or dollar value of denied claims for long-term care services exceeded ten percent (10%) during the first year following implementation of CHOICES or ECF CHOICES or thereafter twenty percent (20%) of the total number or dollar value of claims for long-term care services submitted by the provider during any month.

2.22.5.6 The CONTRACTOR shall also monitor, on an at least a monthly basis, the number, dollar value and percentage of each long-term care provider's rejected claims for long-term care services (NF and CHOICES HCBS and ECF CHOICES HCBS), including the cause of such claims rejection. The CONTRACTOR shall take immediate action to resolve issues that are the responsibility of the CONTRACTOR and are preventing the submission of clean claims for the identified provider and for all other providers who may be affected by the same issue(s). This shall include, but is not limited to issues with service authorizations. The CONTRACTOR shall initiate training and technical assistance as needed to any long-term care provider whose rejected claims for long-term care services are a result of provider error.

A.2.22.6 **Claims Payment Accuracy – Minimum Audit Procedures**

2.22.6.1 On a monthly basis the CONTRACTOR shall submit regional claims payment accuracy percentage reports (see Section A.2.30.17.1).

2.22.6.2 The report shall be based on an audit conducted by the CONTRACTOR. The audit shall be conducted by an entity or staff independent of claims management. Requirements for the internal audit function are outlined in Section A.2.21.10 of this Contract.

2.22.6.3 The audit shall utilize a random sample of all "processed or paid" claims upon initial submission in each month (the terms "processed and paid" are synonymous with terms "process and pay" of TCA 56-32-126(b)(1)(A) and (B)). A minimum sample of one hundred and sixty (160) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required. Additionally, each monthly sample of one hundred and sixty (160) claims shall contain a minimum of thirty (30) claims associated with nursing facility services provided to CHOICES members, thirty (30) claims associated with CHOICES HCBS provided to CHOICES members, and thirty (30) claims associated with ECF CHOICES HCBS provided to ECF CHOICES members.

2.22.6.4 The minimum attributes to be tested for each claim selected shall include:

2.22.6.4.1 Claim data correctly entered into the claims processing system;

2.22.6.4.2 Claim is associated to the correct provider, or if submitted by the FEA, the correct consumer-directed worker;

2.22.6.4.3 Service obtained the proper authorization;

2.22.6.4.4 Member eligibility at processing date correctly applied;

2.22.6.4.5 Allowed payment amount agrees with contracted rate and the terms of the provider agreement;

2.22.6.4.6 Duplicate payment of the same claim has not occurred;

2.22.6.4.7 Denial reason applied appropriately;

2.22.6.4.8 Copayment application considered and applied;

2.22.6.4.9 Patient liability correctly identified and applied;

2.22.6.4.10 Effect of modifier codes correctly applied;

2.22.6.4.11 Other insurance, including long-term care insurance, properly considered and applied;

2.22.6.4.12 Application of benefit limits;

2.22.6.4.13 Whether the processing of the claim correctly considered whether services that exceeded a benefit limit for CHOICES HCBS or ECF CHOICES HCBS were provided as a cost effective alternative;

2.22.6.4.14 Application of the expenditure cap for a CHOICES member in Group 3 or ECF CHOICES; and

2.22.6.4.15 Proper coding including bundling/unbundling.

2.22.6.5 For audit and verification purposes, the population of claims should be maintained. Additionally, the results of testing at a minimum should be documented to include:

2.22.6.5.1 Results for each attribute tested for each claim selected;

2.22.6.5.2 Amount of overpayment or underpayment for claims processed or paid in error;

2.22.6.5.3 Explanation of the erroneous processing for each claim processed or paid in error;

2.22.6.5.4 Determination if the error is the result of keying errors or the result of errors in the configuration or table maintenance of the claims processing system; and

2.22.6.5.5 Claims processed or paid in error have been corrected.

2.22.6.6 If the CONTRACTOR subcontracts for the provision of any covered services (see Section A.2.26), and the subcontractor is responsible for processing claims (see Section A.2.26.13), then the CONTRACTOR shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report shall be based on an audit conducted in compliance with the requirements of this Section A.2.22.6.

2.22.6.7 The CONTRACTOR shall also conduct analysis of its results to determine whether the underlying cause(s) of any claims processed or paid in error has also impacted other claims for the affected provider or for other providers and shall take immediate action to implement resolution across affected providers.

A.2.22.7 **Monthly Focused Claims Testing**

2.22.7.1 In addition to the claims payment accuracy testing procedures described in Section A.2.22.6, the CONTRACTOR shall perform a monthly self test on the accuracy of claims processing based on claims judgmentally selected by TDCI. The maximum number of claims selected by TDCI each month will not exceed twenty-five (25), unless TDCI, at its discretion, determines a larger sample is warranted based on the results of the accuracy tests. The results reported by the CONTRACTOR are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by the CONTRACTOR or subcontractors.

2.22.7.2 The monthly focused claims testing procedures include:

2.22.7.2.1 The CONTRACTOR shall complete the attribute sheets provided by TDCI for each claim to be tested within thirty (30) calendar days of receipt from TDCI.

2.22.7.2.2 The CONTRACTOR shall submit a plan of correction as requested by TDCI.

2.22.7.3 The CONTRACTOR shall also conduct analysis of the TDCI focused claims testing results to determine whether the underlying cause(s) of any claims processed or paid in error has also impacted other claims for the affected provider or for other providers and shall take immediate action to implement resolution across affected providers.

A.2.22.8 **Claims Processing Methodology Requirements**

2.22.8.1 The CONTRACTOR shall perform front end system edits, including but not limited to:

2.22.8.1.1 Confirming eligibility on each enrollee as claims are submitted on the basis of the eligibility information provided by the State that applies to the period during which the charges were incurred;

2.22.8.1.2 Third party liability (TPL);

2.22.8.1.3 Medical necessity (e.g., appropriate age/sex for procedure);

2.22.8.1.4 Prior approval: the system shall determine whether a covered service required prior approval and, if so, whether the CONTRACTOR granted such approval;

2.22.8.1.5 Duplicate claims: the system shall in an automated manner flag a claim as being (1) exactly the same as a previously submitted claim or (2) a possible duplicate and either deny or pend the claim as needed;

2.22.8.1.6 Covered service: the system shall verify that a service is a covered service and is eligible for payment;

2.22.8.1.7 Provider validation: the system shall approve for payment only those claims received from providers eligible to render services for which the claim was submitted, including requirements related to public health nurses as described in Section A.2.13.7.2;

2.22.8.1.8 Benefit limits: the system shall ensure that benefit limit rules set by TENNCARE are factored into the determination of whether a claim should be adjudicated and paid and whether CHOICES or ECF CHOICES HCBS that exceed a benefit limit were approved as a cost effective alternative; and

2.22.8.1.9 HIPAA compliancy validation prior to entering the claims adjudication system.

2.22.8.2 The CONTRACTOR shall perform system edits for valid dates of service: the system shall assure that dates of service are valid dates, e.g., date of discharge is later than date of admission; admission or discharge dates are not in the future or outside of a member's TennCare eligibility span.

2.22.8.3 Identify improper payments made to invalid, missing, and/or mismatched NPIs, and/or TINs/EINs.

2.22.8.4 The CONTRACTOR shall ensure that the cost neutrality cap or expenditure cap applicable to a particular CHOICES HCBS or ECF CHOICES member is not exceeded.

2.22.8.5 The CONTRACTOR shall perform post-payment review on a sample of claims to ensure services provided were medically necessary and were provided in accordance with state and federal requirements. This shall include, as applicable, review of provider documentation.

2.22.8.6 The CONTRACTOR shall have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

A.2.22.9 **Explanation of Benefits (EOBs) and Related Functions**

2.22.9.1 The CONTRACTOR shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TENNCARE.

2.22.9.2 The CONTRACTOR shall omit any claims in the EOB file that are associated with sensitive services. The CONTRACTOR, with guidance from TENNCARE, shall develop "sensitive services" logic to be applied to the handling of said claims for EOB purposes.

2.22.9.3 At a minimum, EOBs shall be designed to address requirements found in 42 CFR 455.20 and 433.116 as well as requirements associated with a change in TennCare policy and shall include: claims for services with benefit limits, claims with enrollee cost sharing, denied claims with enrollee responsibility, and a sampling of paid claims (excluding ancillary and anesthesia services).

2.22.9.4 On a monthly basis, the CONTRACTOR shall sample a minimum of one hundred (100) claims and associated EOBs. The sample shall be based on a minimum of twenty-five (25) claims per check run. The EOBs shall be examined for correctness based on how the associated claim was processed and for adherence to the requirements outlined in Section A.2.22.8. The CONTRACTOR shall ensure that the examined EOBs constitute a representative sample of EOBs from all types of services and provider

types. To the extent that the CONTRACTOR and/or TENNCARE considers a particular type of service or provider to warrant closer scrutiny, the CONTRACTOR shall over sample as needed.

2.22.9.5 Based on the EOBs sent to TennCare enrollees, the CONTRACTOR shall track any complaints received from enrollees and resolve the complaints according to its established policies and procedures. The resolution may be enrollee education, provider education, or referral to TBI/OIG. The CONTRACTOR shall use the feedback received to modify or enhance the EOB sampling methodology.

A.2.22.10 **Remittance Advices and Related Functions**

2.22.10.1 In concert with its claims payment cycle the CONTRACTOR shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as capitated payments generated and paid by the CONTRACTOR.

2.22.10.2 The status report shall contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to TPL data.

2.22.10.3 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.

2.22.10.4 In accordance with 42 CFR 455.18 and 455.19, the following statement shall be included on each remittance advice sent to providers: ‘‘I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws.”

A.2.22.11 **Processing of Payment Errors**

The CONTRACTOR shall not employ off-system or gross adjustments when processing corrections to payment errors, unless it requests and receives prior written authorization from TENNCARE.

A.2.22.12 **Notification to Providers**

For purposes of network management, the CONTRACTOR shall, at a minimum, notify all contract providers to file claims associated with covered services directly with the CONTRACTOR, or its subcontractors, on behalf of TennCare enrollees.

A.2.22.13 **Payment Cycle**

At a minimum, the CONTRACTOR shall run one (1) provider payment cycle per week, on the same day each week, as determined by the CONTRACTOR and approved in writing by TENNCARE.

A.2.22.14 **Excluded Providers**

2.22.14.1 The CONTRACTOR shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or is otherwise not in good standing with TENNCARE.

2.22.14.2 The CONTRACTOR shall not pay any claim submitted by a provider that is on payment hold under the authority of TENNCARE.

A.2.23 INFORMATION SYSTEMS

A.2.23.1 General Provisions

2.23.1.1 Systems Functions

The CONTRACTOR shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet TENNCARE and federal reporting requirements and other Contract requirements and that are in compliance with this Contract and all applicable state and federal laws, rules and regulations including HIPAA.

2.23.1.2 Systems Capacity

The CONTRACTOR's Systems shall possess capacity sufficient to handle the workload projected for the start date of operations and shall be scalable and flexible so they can be adapted as needed, within negotiated time frames, in response to changes in Contract requirements, increases in enrollment estimates, etc.

2.23.1.3 Electronic Messaging

2.23.1.3.1 The CONTRACTOR shall provide a continuously available electronic mail communication link (e-mail system) with TENNCARE.

2.23.1.3.2 The e-mail system shall be capable of attaching and sending documents created using software products other than CONTRACTOR's Systems, including TENNCARE's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

2.23.1.3.3 As needed, the CONTRACTOR shall be able to communicate with TENNCARE using TENNCARE's e-mail system over a secure virtual private network (VPN).

2.23.1.3.4 As needed, based on the sensitivity of data contained in an electronic message, the CONTRACTOR shall support network-to-network encryption of said messages.

2.23.1.4 Participation in Information Systems Work Groups/Committees

The CONTRACTOR and TENNCARE shall establish an information systems work group/committee to coordinate activities and develop cohesive systems strategies among TENNCARE and the MCOs. The Work Group will meet on a designated schedule as agreed to by TENNCARE and the CONTRACTOR.

2.23.1.5 Connectivity to TENNCARE/State Network and Systems

The CONTRACTOR shall be responsible for establishing connectivity to TENNCARE's/the state's wide area data communications network, and the relevant information systems attached to this network, in accordance to all applicable TENNCARE and/or state policies, standards and guidelines.

2.23.1.6 Systems Refresh Plan

The CONTRACTOR shall provide to TENNCARE an annual Systems refresh plan (see Section A.2.30.18). The plan shall outline how Systems within the CONTRACTOR's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The systems refresh plan shall also indicate how the CONTRACTOR will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

A.2.23.2 **Data and Document Management Requirements**

2.23.2.1 HIPAA and HITECH

The parties warrant that they are familiar with the Federal regulations under HIPAA and HITECH and agree to comply with the provisions as amended and to the extent the following apply: "Individually Identifiable Health Information," "Protected Health Information," "Unsecured PHI," "Safeguarding Enrollee Information," and "Privacy Breach"

2.23.2.2 Adherence to Data and Document Management Standards

2.23.2.2.1 The CONTRACTOR's Systems shall conform to the data and document management standards by information type/subtype detailed in the HIPAA Implementation and TennCare Companion guides, inclusive of the standard transaction code sets specified in the guides.

2.23.2.2.2 The CONTRACTOR's Systems shall conform to HIPAA standards for data and document management that are currently under development within one-hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or TENNCARE.

2.23.2.3 Data Model and Accessibility

The CONTRACTOR's Systems shall be Structured Query Language (SQL) and/or Open Database Connectivity (ODBC) compliant; alternatively, the CONTRACTOR's Systems shall employ a relational data model in the architecture of its databases in addition to a relational database management system (RDBMS) to operate and maintain said databases.

2.23.2.4 Data and Document Relationships

2.23.2.4.1 When the CONTRACTOR houses indexed images of documents used by members and providers to transact with the CONTRACTOR the CONTRACTOR shall ensure that these documents maintain logical relationships to certain key data such as member identification and provider identification number.

2.23.2.4.2 The CONTRACTOR shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, e.g., interactions with a particular member about a reported problem.

2.23.2.4.3 Upon TENNCARE request, the CONTRACTOR shall be able to generate a listing of all members and providers that were sent a particular document, the date and time that the document was generated, and the date and time that it was sent to particular members or providers or groups thereof. The CONTRACTOR shall also be able to generate a sample of said document.

2.23.2.5 Information Retention

2.23.2.5.1 The CONTRACTOR shall provide and maintain a comprehensive information retention plan that is in compliance with state and federal requirements. The plan shall comply with the applicable requirements of the Tennessee Department of General Services, Records Management Division.

2.23.2.5.2 The CONTRACTOR shall maintain information on-line for a minimum of three (3) years, based on the last date of update activity, and update detailed and summary history data monthly for up to three (3) years to reflect adjustments.

2.23.2.5.3 The CONTRACTOR shall provide forty-eight (48) hour turnaround or better on requests for access to information that is between three (3) years and six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is between six (6) and ten (10) years old.

2.23.2.5.4 If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

2.23.2.6 Information Ownership

All information, whether data or documents, and reports that contain or make references to said information, involving or arising out of this Contract is owned by TENNCARE. The CONTRACTOR is expressly prohibited from sharing or publishing TENNCARE information and reports without the prior written consent of TENNCARE.

A.2.23.3 **System and Data Integration Requirements**

2.23.3.1 Adherence to Standards for Data Exchange

2.23.3.1.1 The CONTRACTOR's Systems shall be able to transmit, receive and process data in HIPAA-compliant or TENNCARE-specific formats and methods, including but not limited to secure File Transfer Protocol (FTP) over a secure connection such as a VPN, that are in use at the start of Systems readiness review activities. These formats are detailed in the HIPAA Implementation and TennCare Companion guides.

2.23.3.1.2 The CONTRACTOR's Systems shall conform to future federal and/or TENNCARE specific standards for data exchange within one-hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or TENNCARE. The CONTRACTOR shall partner with TENNCARE in the

management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the CONTRACTOR shall conform to these standards as stipulated in the plan to implement such standards.

2.23.3.2 HIPAA Compliance Checker

All HIPAA-conforming exchanges of data between TENNCARE and the CONTRACTOR shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.

2.23.3.3 TENNCARE/State Website/Portal Integration

Where deemed that the CONTRACTOR's Web presence will be incorporated to any degree to TENNCARE's or the state's web presence/portal, the CONTRACTOR shall conform to the applicable TENNCARE or state standards for website structure, coding and presentation.

2.23.3.4 Connectivity to and Compatibility/Interoperability with TENNCARE Systems and IS Infrastructure

2.23.3.4.1 The CONTRACTOR shall be responsible for establishing connectivity to TENNCARE's/the state's wide area data communications network, and the relevant information systems attached to this network, in accordance to all applicable TENNCARE and/or state policies, standards and guidelines.

2.23.3.4.2 All of the CONTRACTOR's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with TENNCARE and/or state systems and shall conform to applicable standards and specifications set by TENNCARE and/or the state agency that owns the system.

2.23.3.5 Data Exchange in Support of TENNCARE's Program Integrity and Compliance Functions

The CONTRACTOR's System(s) shall be capable of generating files in the prescribed formats for upload into TENNCARE Systems used specifically for program integrity and compliance purposes.

2.23.3.6 Address Standardization

The CONTRACTOR's System(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

A.2.23.4 **Encounter Data Provision Requirements (Encounter Submission and Processing)**

2.23.4.1 General Encounter Data Standards

2.23.4.1.1 The CONTRACTOR's claims management system shall contain the following capabilities for the purpose of encounter data submissions:

2.23.4.1.1.1 Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.

2.23.4.1.1.2 Submission of enrollee encounter data to TENNCARE at a frequency and level of detail to be specified by CMS and TENNCARE, based on program administration, oversight, and program integrity needs.

2.23.4.1.1.3 Submission of all enrollee encounter data that TENNCARE is required to report to CMS.

2.23.4.1.1.4 Specifications for submitting encounter data to TENNCARE in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate.

2.23.4.2 Adherence to HIPAA Standards

The CONTRACTOR's Systems are required to conform to HIPAA-standard transaction code sets as specified in the HIPAA Implementation and TennCare Companion guides.

2.23.4.3 Quality of Submission

2.23.4.3.1 The CONTRACTOR shall submit encounter data that meets established TENNCARE data quality standards. These standards are defined by TENNCARE to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. TENNCARE will revise and amend these standards as necessary to ensure continuous quality improvement. The CONTRACTOR shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with TENNCARE data quality standards as originally defined or subsequently amended. The CONTRACTOR shall comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim. In the event that the CONTRACTOR denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the CONTRACTOR shall submit all available claim data to TENNCARE without alteration or omission. Where the CONTRACTOR has entered into capitated reimbursement arrangements with providers, the CONTRACTOR shall require submission of all utilization or encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims (see Section A.2.12.9.34); the CONTRACTOR shall require this submission from providers as a condition of the capitation payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data. The CONTRACTOR shall be required to submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by TENNCARE, in order to support comprehensive financial reporting and utilization analysis. The CONTRACTOR shall submit encounter data according to standards and formats as defined by TENNCARE, complying with standard code sets and maintaining integrity with all reference data sources including provider and member data. All encounter data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the CONTRACTOR for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted shall be completed within one (1) business day. Due to the need for timely data and to maintain integrity of processing sequence, should the CONTRACTOR fail to respond in accordance with this Section,

the CONTRACTOR shall address any issues that prevent processing of an encounter batch in accordance with procedures specified in Section A.2.23.13.

2.23.4.3.2 TENNCARE will reject an entire file or an individual encounter failing certain edits, as deemed appropriate and necessary by TENNCARE to ensure accurate processing or encounter data quality and will return these transactions to the CONTRACTOR for research and resolution. TENNCARE will require expeditious action on the part of the CONTRACTOR to resolve errors or problems associated with said claims or the adjudication thereof, including any necessary changes or corrections to any systems, processes or data transmission formats. The CONTRACTOR shall, unless otherwise directed by TENNCARE, address entire file rejects within two (2) business days of TENNCARE's rejection and individual encounter rejects within forty-five (45) calendar days of TENNCARE's rejection. Such errors will be considered acceptably addressed when the CONTRACTOR has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute. TennCare may require resubmission of the transaction with reference to the original in order to document resolution. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan as required may result in damages and sanctions as described in Section A.2.23.13.

2.23.4.4 <u>Provision of Encounter Data</u>

2.23.4.4.1 Within two (2) business days of the end of a payment cycle the CONTRACTOR shall generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the CONTRACTOR has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.

2.23.4.4.2 Any encounter data from a subcontractor shall be included in the file from the CONTRACTOR. The CONTRACTOR shall not submit separate encounter files from subcontractors.

2.23.4.4.3 The files shall contain settled claims and claim adjustments, including but not limited to adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the CONTRACTOR has a capitation arrangement.

2.23.4.4.4 The level of detail associated with encounters from providers with whom the CONTRACTOR has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the CONTRACTOR received and settled a fee-for-service claim.

2.23.4.4.5 The CONTRACTOR shall adhere to federal and/or TENNCARE payment rules in the definition and treatment of certain data elements, e.g., units of service, that are standard fields in the encounter data submissions and will be treated similarly by TENNCARE across all MCOs.

2.23.4.4.6 The CONTRACTOR shall provide encounter data files electronically to TENNCARE in adherence to the procedure and format indicated in the HIPAA Implementation and TennCare Companion guides.

2.23.4.4.7 The CONTRACTOR shall institute processes to ensure the validity and completeness of the data it submits to TENNCARE. At its discretion, TENNCARE will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: member ID, date of service, provider ID (including NPI number and Medicaid I.D. Number), category and sub category (if applicable) of service, diagnosis codes, procedure codes and modifiers, revenue codes, adherence to hard benefit limits, date of claim processing, and date of claim payment. Control totals shall also be reviewed and verified. Additionally, the CONTRACTOR shall reconcile all encounter data submitted to the State to control totals and to the CONTRACTOR's Medical Loss Ratio reports and supply the reconciliation to TENNCARE with each of the Medical Loss Ratio report submissions as specified in Section A.2.30.16.2.1 (see Section A.2.30.18.3).

2.23.4.4.8 Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the CONTRACTOR's applicable reimbursement methodology for that service.

2.23.4.4.9 The CONTRACTOR shall be able to receive, maintain and utilize data extracts from TENNCARE and its contractors, e.g., pharmacy data from TENNCARE or its PBM.

2.23.4.4.10 The CONTRACTOR shall not implement imitations of TENNCARE's Custom SNIP 7 Encounter Edits Listing or likewise use the TennCare Edifecs Ramp Manager tool for the purpose of preventing submission of post adjudicated encounter production data to TENNCARE. It is permissible for the CONTRACTOR to implement imitations of TENNCARE's Custom SNIP 7 Encounter Edits Listing prior to claim adjudication.

A.2.23.5 **Eligibility and Enrollment Data Exchange Requirements**

2.23.5.1 The CONTRACTOR shall receive, process and update outbound 834 enrollment files sent daily by TENNCARE.

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. If the CONTRACTOR has reason to believe they may not meet this requirement based on unusual circumstances, the CONTRACTOR must notify TENNCARE and TENNCARE may make an exception without requiring a Corrective Action Plan.

2.23.5.3 The CONTRACTOR shall submit daily, inbound 834 enrollment files to TENNCARE.

2.23.5.4 The CONTRACTOR shall report address changes, other TPL resource and PCP assignments for their members in the daily 834 inbound files within twenty-four (24) hours or within the next 834 inbound file submission to TENNCARE. If the CONTRACTOR has reason to believe they may not meet this requirement based on unusual circumstances, the CONTRACTOR must notify TENNCARE and TENNCARE may make an exception without requiring a Corrective Action Plan.

2.23.5.5 The CONTRACTOR shall transmit daily to TENNCARE, in the formats and methods specified in the HIPAA Implementation and TennCare Companion guides or as otherwise specified by TENNCARE: member address changes, telephone number changes, third party liability and PCP.

2.23.5.6 The CONTRACTOR shall be capable of uniquely identifying a distinct TennCare member across multiple populations and Systems within its span of control.

2.23.5.7 The CONTRACTOR shall be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by TENNCARE, and resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

A.2.23.6 **CoverKids Copayments and Out of Pocket Calculation Interface Requirements**

2.23.6.1 The CONTRACTOR shall be capable of automatic calculation of copayment and out-of-pocket maximums and shall maintain a year to date calculation of all copayments (including medical and vision services, dental services and prescription drugs) required by CoverKids members. The amounts shall be accumulated by family units and the CONTRACTOR shall provide and explanation of benefits (EOB) to the family when the covered members of the family have incurred copayments equal to five percent (5%) of the allowable family income. This shall include a daily interface with other managed care contractors serving the CoverKids population (DBM and PBM). Each CONTRACTOR shall update and maintain a daily file, transmit and receive the updated information to and from the DBM, PBM and other MCO Contractors. Once a family has reached the five percent (5%) threshold, the CoverKids family members shall not be responsible for copays for the remainder of the calendar year and provider payments shall be adjusted accordingly.

A.2.23.7 **System and Information Security and Access Management Requirements**

2.23.7.1 The CONTRACTOR's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

2.23.7.1.1 Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;

2.23.7.1.2 Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by TENNCARE and the CONTRACTOR; and

2.23.7.1.3 Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

2.23.7.2 The CONTRACTOR shall make System information available to duly authorized representatives of TENNCARE and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

2.23.7.3 The CONTRACTOR's Systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the CONTRACTOR and TENNCARE.

2.23.7.4 Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

2.23.7.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

2.23.7.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;

2.23.7.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;

2.23.7.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs;

2.23.7.4.5 Facilitate auditing of individual records as well as batch audits; and

2.23.7.4.6 Be maintained online for no less than two (2) years; additional history shall be retained for no less than ten (10) years and shall be retrievable within 48 hours.

2.23.7.5 The CONTRACTOR's Systems shall have inherent functionality that prevents the alteration of finalized records.

2.23.7.6 The CONTRACTOR shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The CONTRACTOR shall provide TENNCARE with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Contract.

2.23.7.7 The CONTRACTOR shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

2.23.7.8 The CONTRACTOR shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

2.23.7.9 The CONTRACTOR shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CONTRACTOR's span of control. This includes but is not limited to: no provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access.

2.23.7.10 The CONTRACTOR shall ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved in writing by TENNCARE.

2.23.7.11 The CONTRACTOR shall comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. At a minimum, the CONTRACTOR shall conduct a security risk assessment and communicate the results in an information security plan provided prior to the start date of operations. The risk assessment shall also be made available to appropriate federal agencies.

A.2.23.8 **Systems Availability, Performance and Problem Management Requirements**

2.23.8.1 The CONTRACTOR shall ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to Confirmation of MCO Enrollment (CME), ECM, and self-service customer service functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled System unavailability agreed upon by TENNCARE and the CONTRACTOR. Unavailability caused by events outside of a CONTRACTOR's span of control is outside of the scope of this requirement.

2.23.8.2 The CONTRACTOR shall ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7 a.m. and 7 p.m., in the time zone applicable to each Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday.

2.23.8.3 The CONTRACTOR shall ensure that the systems and processes within its span of control associated with its data exchanges with TENNCARE are available and operational according to specifications and the data exchange schedule.

2.23.8.4 In the event of a declared major failure or disaster, the CONTRACTOR's core eligibility/enrollment and claims processing systems shall be back online within seventy-two (72) hours of the failure's or disaster's occurrence.

2.23.8.5 Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of critical systems functions and the availability of critical information as defined in this Section of the Contract, including any problems impacting scheduled exchanges of data between the CONTRACTOR and TENNCARE, the CONTRACTOR shall notify the applicable TennCare staff via phone, fax and/or electronic mail within sixty (60) minutes of such discovery. In its notification the CONTRACTOR shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes.

2.23.8.6 Where the problem results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, the CONTRACTOR shall notify the applicable TENNCARE staff within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocols.

2.23.8.7 The CONTRACTOR shall provide to appropriate TENNCARE staff information on System unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

2.23.8.8 The CONTRACTOR shall resolve unscheduled System unavailability of CME and ECM functions, caused by the failure of systems and telecommunications technologies within the CONTRACTOR's span of control, and shall implement the restoration of services, within sixty (60) minutes of the official declaration of System unavailability. Unscheduled System unavailability to all other CONTRACTOR System functions caused by systems and telecommunications technologies within the CONTRACTOR's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability.

2.23.8.9 Cumulative System unavailability caused by systems and/or IS infrastructure technologies within the CONTRACTOR's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period.

2.23.8.10 The CONTRACTOR shall not be responsible for the availability and performance of systems and IS infrastructure technologies outside of the CONTRACTOR's span of control.

2.23.8.11 Within five (5) business days of the occurrence of a problem with system availability, the CONTRACTOR shall provide TENNCARE with full written documentation that includes a corrective action plan describing how the CONTRACTOR will prevent the problem from occurring again.

2.23.8.12 <u>Business Continuity and Disaster Recovery (BC-DR) Plan</u>

2.23.8.12.1 Regardless of the architecture of its Systems, the CONTRACTOR shall develop and be continually ready to invoke a BC-DR plan that is reviewed and prior approved in writing by TENNCARE.

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

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

2.23.8.12.4 The CONTRACTOR shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to TENNCARE that it can restore System functions per the standards outlined elsewhere in this Section, Section A.2.23 of the Contract.

2.23.8.12.5 The CONTRACTOR shall submit a baseline BC-DR plan to TENNCARE and communicate proposed modifications as required in Section A.2.30.18.

A.2.23.9 **System User and Technical Support Requirements**

2.23.9.1 The CONTRACTOR shall provide Systems Help Desk (SHD) services to all TENNCARE staff and the other agencies that may have direct access to CONTRACTOR systems.

2.23.9.2 The CONTRACTOR's SHD shall be available via local and toll-free telephone service and via e-mail from 7 a.m. to 7 p.m., in the time zone applicable to each Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, with the exception of State of Tennessee holidays. Upon TENNCARE request, the CONTRACTOR shall staff the SHD on a state holiday, Saturday, or Sunday.

2.23.9.3 The CONTRACTOR's SHD staff shall answer user questions regarding CONTRACTOR System functions and capabilities; report recurring programmatic and operational problems to appropriate CONTRACTOR or TENNCARE staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate TENNCARE login account administrator.

2.23.9.4 The CONTRACTOR shall ensure individuals who place calls to the SHD between the hours of 7 p.m. and 7 a.m., in the time zone applicable to each Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), shall be able to leave a message. The CONTRACTOR's SHD shall respond to messages by noon the following business day.

2.23.9.5 The CONTRACTOR shall ensure recurring problems not specific to System unavailability identified by the SHD shall be documented and reported to CONTRACTOR management within one (1) business day of recognition so that deficiencies are promptly corrected.

2.23.9.6 The CONTRACTOR shall have an IS service management system that provides an automated method to record, track and report on all questions and/or problems reported to the SHD.

A.2.23.10 **System Testing and Change Management Requirements**

2.23.10.1 The CONTRACTOR shall notify the applicable TENNCARE staff person of the following changes to Systems within its span of control within at least ninety (90) calendar days of the projected date of the change.

2.23.10.1.1 Major changes, upgrades, modifications or updates to application or operating software associated with the following core production Systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, and encounter data management; and

2.23.10.1.2 Conversions of core transaction management Systems.

2.23.10.2 If so directed by TENNCARE, the CONTRACTOR shall discuss the proposed change in the Systems work group.

2.23.10.3 The CONTRACTOR shall respond to TENNCARE notification of System problems not resulting in System unavailability according to the following time frames:

2.23.10.3.1 Within five (5) calendar days of receiving notification from TENNCARE the CONTRACTOR shall respond in writing to notices of system problems.

2.23.10.3.2 Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.

2.23.10.3.3 The CONTRACTOR shall correct the deficiency by an effective date to be determined by TENNCARE.

2.23.10.3.4 The CONTRACTOR's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.

2.23.10.3.5 The CONTRACTOR shall put in place procedures and measures for safeguarding against unauthorized modifications to CONTRACTOR Systems.

2.23.10.4 Valid Window for Certain System Changes

Unless otherwise agreed to in advance by TENNCARE as part of the activities described in this Section A.2.23.9, the CONTRACTOR shall not schedule System unavailability to perform System maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.

2.23.10.5 Testing

2.23.10.5.1 The CONTRACTOR shall work with TENNCARE pertaining to any testing initiative as required by TENNCARE.

2.23.10.5.2 The CONTRACTOR shall provide sufficient system access to allow testing by TENNCARE of the CONTRACTOR's systems during readiness review (see Section A.2.1.2) and as required during the term of the Contract.

A.2.23.11 **Information Systems Documentation Requirements**

2.23.11.1 The CONTRACTOR shall ensure that written System process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

2.23.11.2 The CONTRACTOR shall develop, prepare, print, maintain, produce, and distribute to TENNCARE distinct System design and management manuals, user manuals and quick/reference guides, and any updates.

2.23.11.3 The CONTRACTOR's System user manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system data.

2.23.11.4 When a System change is subject to TENNCARE prior written approval, the CONTRACTOR shall submit revisions to the appropriate manuals for prior written approval before implementing said System changes.

2.23.11.5 All of the aforementioned manuals and reference guides shall be available in printed form and/or on-line. If so prescribed, the manuals shall be published in accordance to the appropriate TENNCARE and/or TENNCARE standard.

2.23.11.6 The CONTRACTOR shall update the electronic version of these manuals immediately; updates to the printed version of these manuals shall occur within ten (10) business days of the update taking effect.

A.2.23.12 **Reporting Requirements (Specific to Information Management and Systems Functions and Capabilities)**

2.23.12.1 The CONTRACTOR shall comply with all reporting requirements as described in Section A.2.30.18 of this Contract.

2.23.12.2 The CONTRACTOR shall provide systems-based capabilities for access by authorized TENNCARE personnel, on a secure and read-only basis, to data that can be used in ad hoc reports.

A.2.23.13 **Other Requirements**

2.23.13.1 Statewide Data Warehouse Requirements

The CONTRACTOR shall participate in a statewide effort to tie all hospitals, physicians, and other providers' information into a data warehouse that shall include, but not be limited to, claims information, formulary information, medically necessary service information, cost sharing information and a listing of providers by specialty for each MCO.

2.23.13.2 Community Health Record for TennCare Enrollees (Electronic Medical Record)

2.23.13.2.1 At such time that TENNCARE requires, the CONTRACTOR shall participate and cooperate with TennCare to implement, within a reasonable time frame, a secure, Web-accessible community health record for TennCare enrollees.

2.23.13.2.2 The design of the Web site for accessing the community health record and the record format and design shall comply with HIPAA, other federal and all state privacy and confidentiality regulations.

2.23.13.2.3 The CONTRACTOR shall provide a Web-based access vehicle for contract providers to the System described in Section A.2.23.12.2.1 and shall work with said providers to encourage adoption of this System.

A.2.23.14 **Corrective Actions, Liquidated Damages and Sanctions Related to Information Systems**

2.23.14.1 Within five (5) business days of receipt of notice from TENNCARE of the occurrence of a problem with the provision and/or intake of an encounter or outbound 834 enrollment file or submission of an inbound 834 file, the CONTRACTOR shall provide TENNCARE with full written documentation that includes acknowledgement of receipt of the notice, a corrective action plan describing how the CONTRACTOR has addressed or will address the immediate problem and how the CONTRACTOR shall prevent the problem from recurring. In the event that the CONTRACTOR fails to correct errors which prevent processing of encounter or enrollment data in a timely manner as required by TENNCARE, fails to submit a corrective action plan may assess liquidated damages as specified in Section E.29.2. Continued or repeated failure to submit clean encounter data may result in the application of additional damages or sanctions, including possible forfeiture of the withhold (see Section C.3.9), or be considered a breach of the Contract.

2.23.14.2 Individual records submitted by the CONTRACTOR may be rejected; these records, once errors therein have been corrected, shall be resubmitted by the CONTRACTOR as stipulated by TENNCARE. In the event that the CONTRACTOR is unable to research or address reported errors in a timely manner as required by TENNCARE, the CONTRACTOR shall submit to TENNCARE a corrective action plan describing how the CONTRACTOR will research and address the errors and how the CONTRACTOR shall prevent the problem from recurring within five (5) business days of receipt of notice from TENNCARE that individual records submitted by the CONTRACTOR have been rejected. In the event that the CONTRACTOR fails to address or resolve problems with individual records in a timely manner as required by TENNCARE, which shall include failure to submit a corrective action plan as requested or required, or failure to comply with an accepted corrective action plan, TENNCARE may assess liquidated damages as specified in Section E.29.2. Continued or repeated failure to address reported errors may result in additional damages or sanctions including possible forfeiture of the withhold (see Section C.3.9) or be considered a breach of the Contract.

2.23.14.3 In the event that the CONTRACTOR fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the CONTRACTOR shall submit to TENNCARE a corrective action plan that describes how the failure will be resolved. The corrective action plan shall be delivered within five (5) business days of the conclusion of the test.

A.2.24 ADMINISTRATIVE REQUIREMENTS

A.2.24.1 General Responsibilities

2.24.1.1 TENNCARE shall be responsible for management of this Contract. Management shall be conducted in good faith with the best interest of the State and the citizens it serves being the prime consideration. Management of TennCare shall be conducted in a manner consistent with simplicity of administration and the best interests of enrollees, as required by 42 USC 1396a(a)(19).

2.24.1.2 The CONTRACTOR shall be responsible for complying with the requirements of this Contract and shall act in good faith in the performance of the requirements of this Contract.

2.24.1.3 The CONTRACTOR shall develop policies and procedures that describe, in detail, how the CONTRACTOR will comply with the requirements of this Contract and, as applicable, are specific to each Grand Region covered by this Contract, and the CONTRACTOR shall administer this Contract in accordance with those policies and procedures unless otherwise directed or approved in writing by TENNCARE.

2.24.1.4 The CONTRACTOR shall submit policies and procedures and other deliverables specified by TENNCARE to TENNCARE for review and/or written approval in the format and within the time frames specified by TENNCARE. The CONTRACTOR shall make any changes requested by TENNCARE to policies and procedures or other deliverables and in the time frames specified by TENNCARE.

2.24.1.5 As provided in Section E.19 of this Contract, should the CONTRACTOR have a question on policy determinations, benefits, or operating guidelines required for proper performance of the CONTRACTOR's responsibilities, the CONTRACTOR shall request a determination from TENNCARE in writing.

A.2.24.2 **Annual Behavioral Health Engagement Plan**

The CONTRACTOR shall submit an Annual Behavioral Health Engagement Plan, in a format specified by TENNCARE, which describes the CONTRACTOR's plan for engaging TennCare members, family representatives and behavioral health providers for the purpose of receiving input and advice regarding all aspects of behavioral health services according to the following requirements:

2.24.2.1 The CONTRACTOR's engagement activities shall involve at least fifty-one percent (51%) consumer and family representatives, of which the majority shall include individuals and/or families of those who may meet the clinical criteria of a priority enrollee;

2.24.2.2 There shall be geographic diversity;

2.24.2.3 There shall be cultural and racial diversity;

2.24.2.4 There shall be representation by behavioral health providers, Certified Peer Recovery Specialists and/or Certified Family Support Specialists and consumers (or family members of consumers) of substance abuse services, and the CONTRACTOR's Behavioral Health Consumer Advocates;

2.24.2.5 At a minimum, input shall include policy development, planning for services, service evaluation, and member, family member and provider education;

2.24.2.6 Whenever the CONTRACTOR's engagement plan involves travel, the CONTRACTOR shall pay travel costs for consumers and family representatives;

2.24.2.7 The CONTRACTOR shall provide education and training to ensure consumers, family representatives and providers have sufficient information and understanding of the CONTRACTOR's engagement activities to ensure active participation and involvement.

2.24.2.8 Upon request, the CONTRACTOR shall provide a report on the engagement activities outlined in the CONTRACTOR's annual engagement plan in a format specified by TENNCARE.

A.2.24.3 **CHOICES Advisory Group**

2.24.3.1 To promote a collaborative effort to enhance the long-term care service delivery system in each Grand Region covered by this Contract while maintaining a member-centered focus, the CONTRACTOR shall establish a CHOICES advisory group that is accountable to the CONTRACTOR's governing body to provide input and advice regarding the CONTRACTOR's CHOICES program and policies.

2.24.3.2 The CONTRACTOR's CHOICES advisory group shall include CHOICES members, member's representatives, advocates, and providers. At least fifty-one percent (51%) of the group shall be CHOICES members and/or their representatives (e.g., family members or caregivers). The advisory group shall include representatives from nursing facility and CHOICES HCBS providers, including community-based residential alternative providers. The group shall reflect the geographic, cultural and racial diversity of each Grand Region covered by this Contract.

2.24.3.3 At a minimum, the CONTRACTOR's CHOICES advisory group shall have input into the CONTRACTOR's planning and delivery of long-term care services, CHOICES QM/QI activities, program monitoring and evaluation, and member, family and provider education.

2.24.3.4 The CONTRACTOR shall provide an orientation and ongoing training for advisory group members so they have sufficient information and understanding of the CHOICES program to fulfill their responsibilities.

2.24.3.5 The CONTRACTOR's CHOICES advisory group shall meet at least quarterly, and the CONTRACTOR shall keep a written record of meetings.

2.24.3.6 The CONTRACTOR shall pay travel costs for advisory group members who are CHOICES members or their representatives.

2.24.3.7 The CONTRACTOR shall provide TENNCARE, in a manner prescribed by TENNCARE, a monthly summary that includes meeting agendas and minutes from all Advisory meetings that occurred within that month, except in instances where urgent policy or operational issues are identified. In those instances, the CONTRACTOR is required to notify TENNCARE within twenty-four (24) business hours in writing of any policy or operational concerns. The CONTRACTOR shall also provide TENNCARE with an agenda for advisory meetings at least one (1) week prior to the meeting.

2.24.3.8 As advisory group membership changes, the CONTRACTOR shall submit current membership lists to TENNCARE.

2.24.3.9 The CONTRACTOR shall participate in any LTSS Stakeholder Group discussions convened by TENNCARE for the purpose of ensuring that participants' views regarding the CHOICES program are solicited and sufficiently addressed, and shall also assist TENNCARE in identifying member, family member, and provider representatives to participate in these discussions.

2.24.3.10 In addition, the CONTRACTOR shall work with its CHOICES advisory group to convene community forums for individuals and families and for CHOICES providers in each Grand Region on at least an annual basis in order to provide member, family and provider education, and to gather input and advice regarding the CONTRACTOR's CHOICES program, policies and operation.

A.2.24.4 **ECF CHOICES Advisory Group**

2.24.4.1 To promote a collaborative effort to enhance the long-term care service delivery system for individuals with I/DD while maintaining a person-centered focus, the CONTRACTOR shall establish a Statewide ECF CHOICES Advisory Group to provide input and advice to the CONTRACTOR's executive management and governing body and to TENNCARE regarding the CONTRACTOR's ECF CHOICES program, policies and operation.

2.24.4.2 The CONTRACTOR's initial ECF CHOICES advisory group shall invite participation from each of the following organizations:

2.24.4.2.1 The Arc Tennessee;

2.24.4.2.2 Tennessee Council on Developmental Disabilities;

2.24.4.2.3 Tennessee Disability Coalition;

2.24.4.2.4 Disability Rights TN;

2.24.4.2.5 Tennessee Network of Community Organizations; and

2.24.4.2.6 In addition, the CONTRACTOR's initial ECF CHOICES advisory group shall invite participation from employment and community-based residential alternative providers who will participate in the CONTRACTOR's network.

2.24.4.3 The CONTRACTOR's initial ECF CHOICES advisory group shall meet at least quarterly beginning January 1, 2016 to provide input and advice regarding the CONTRACTOR's implementation of the ECF CHOICES program.

2.24.4.4 Upon implementation of ECF CHOICES, the CONTRACTOR shall identify individuals with I/DD enrolled in each ECF CHOICES group and representatives of such individuals (family members or conservators) for participation in the ECF CHOICES advisory group. The CONTRACTOR shall attempt to include participation of members and representatives from each of the three (3) Grand Regions, and shall provide accommodations as needed to facilitate their engagement. The CONTRACTOR shall pay travel costs for advisory group members who are ECF CHOICES members or their representatives. No later than ninety (90) days following the implementation of ECF CHOICES, at least twenty-six percent (26%) of the CONTRACTOR's ECF CHOICES advisory group shall be ECF CHOICES members, and at least fifty-one percent (51%) of the CONTRACTOR's ECF CHOICES advisory group shall be ECF CHOICES members and/or their representatives (e.g., family members or conservators). The advisory group shall continue to include representatives from each of the groups identified in A.2.24.3.2 and A.2.24.3.3. The group shall reflect the geographic, cultural and racial diversity of members covered by this Contract.

2.24.4.5 Upon implementation of ECF CHOICES, the CONTRACTOR shall facilitate an ECF CHOICES member-only advisory group composed exclusively of individuals with I/DD who participate in the ECF CHOICES program. Members of the ECF CHOICES member-only advisory group may also participate in the ECF CHOICES advisory group in Section A.2.24.4.4, but are not required to do so. The CONTRACTOR shall not require ECF CHOICES members participating in the ECF CHOICES advisory group to participate in the ECF CHOICES member-only advisory group. This member-only group shall meet independently of the ECF CHOICES advisory group and shall be responsible for identifying member concerns in ECF CHOICES and making recommendations for program improvements. The CONTRACTOR shall pay travel costs for member-only advisory group members who are ECF CHOICES members or their representatives. The CONTRACTOR shall assist the member-only group in escalating their concerns to the ECF CHOICES advisory group, the CONTRACTOR's management, and to TennCare.

2.24.4.6 Upon implementation of ECF CHOICES, the CONTRACTOR's ECF CHOICES advisory group and ECF CHOICES member-only advisory group shall meet at least quarterly, and the CONTRACTOR shall keep a written record of meetings. The CONTRACTOR shall invite advisory group and member-only advisory group members to assist in identifying topics for discussion at each meeting. The CONTRACTOR shall include in each meeting the opportunity to provide program recommendations to the CONTRACTOR and to TENNCARE and shall notify

TENNCARE, in a manner prescribed by TENNCARE, within one week of any issues, concerns, or recommendations from the advisory group meetings that would affect the broader program, policy or operations.

2.24.4.7 At a minimum, the CONTRACTOR's ECF CHOICES advisory group shall have input into the CONTRACTOR's planning and delivery of long-term services and supports, ECF CHOICES QM/QI activities, program monitoring and evaluation, and member, family and provider education.

2.24.4.8 In addition, the CONTRACTOR shall work with its ECF CHOICES advisory group to convene community forums for individuals and families and for ECF CHOICES providers in each Grand Region on at least an annual basis in order to provide member, family and provider education, and to gather input and advice regarding the CONTRACTOR's ECF CHOICES program, policies and operation.

2.24.4.9 The CONTRACTOR shall provide an orientation and ongoing training for advisory group members so they have sufficient information and understanding of the ECF CHOICES program to fulfill their responsibilities.

2.24.4.10 The CONTRACTOR shall submit to TENNCARE a listing of the membership of its ECF CHOICES advisory group and ECF CHOICES member-only advisory group on at least a quarterly basis.

2.24.4.11 The CONTRACTOR shall submit a schedule of all advisory group and member-only advisory group meetings and community forums to TENNCARE and DIDD. The schedule and any subsequent changes to meeting times and locations shall be submitted at least ten (10) business days in advance of each meeting.

2.24.4.12 The CONTRACTOR shall participate in any LTSS Stakeholder Group discussions convened by TENNCARE for the purpose of ensuring that participants' views regarding the ECF CHOICES program are solicited and sufficiently addressed, and shall also assist TENNCARE in identifying member, family member, and provider representatives to participate in these discussions.

A.2.24.5 **Settings Compliance Committee for CHOICES and ECF CHOICES**

2.24.5.1 The CONTRACTOR shall develop and maintain settings compliance committee for CHOICES and ECF CHOICES.

2.24.5.2 The settings compliance committee shall include, at a minimum, the following members of the CONTRACTOR's staff:

2.24.5.2.1 Behavioral Health Director (see A.2.29.1.3.5);

2.24.5.2.2 Member Advocate for individuals with I/DD (see Section A.2.29.1.3.35) for matters pertaining to ECF CHOICES members and CHOICES consumer advocate (see Section A.2.29.1.3.36) for matters pertaining to CHOICES members;

2.24.5.2.3 Behavior Supports Director (see A.2.29.1.3.6); and

2.24.5.2.4 Other persons, including the member's Care Coordinator or Support Coordinator and professional staff and/or consultants as deemed appropriate by the CONTRACTOR.

2.24.5.3 The settings compliance committee shall be responsible for the following related to CHOICES and ECF CHOICES members:

2.24.5.3.1 Reviewing plans of care or PCSPs and behavior support plans (BSPs), as applicable, that include restrictive interventions. The committee shall all review any information from the provider's Human Rights Committee, as applicable, identify and address potential compliance concerns, make recommendations regarding less restrictive interventions or referrals for appropriate services, ensure informed consent for any restrictions;

2.24.5.3.2 Reviewing any proposed or emergency right restrictions and restraints not contained in a plan of care, PCSP or BSP and any information from the provider's Human Rights Committee, as applicable, for potential compliance concerns, making recommendations regarding less restrictive interventions or referrals for appropriate services, and ensuring informed consent for any restrictions;

2.24.5.3.3 Periodically reviewing data regarding the use of interventions specified in A.2.24.5.3.1 or A.2.24.5.3.2 to determine ongoing effectiveness and whether such restriction should be discontinued;

2.24.5.3.4 Reviewing and making recommendations (Behavioral Health Director to prescriber) to the prescribing professional regarding potential instances of inappropriate utilization of psychotropic medications which include, but are not limited to:

2.24.5.3.4.1 The prescribed use of four (4) or more psychotropic medications by a member;

2.24.5.3.4.2 The prescribed use of two (2) or more psychotropic medications in the same class for a member; or

2.24.5.3.4.3 The prescribed use of PRN psychotropic medications;

2.24.5.3.4.4 Reviewing and making recommendations regarding complaints received pertaining to restrictive interventions or settings compliance concerns; and

2.24.5.3.4.5 Ensuring that any proposed restriction, including restrictions in provider-owned or controlled residential settings, is the least restrictive viable alternative and is not excessive, and that all requirements specified in 42 § C.F.R. 441.301(c)(4)-(5) are met.

2.24.5.4 The settings compliance committee shall meet at least monthly, or more frequently as needed to ensure timely review as detailed in A.2.24.5.3.

2.24.5.5 In addition to case notes regarding particular recommendations or actions pertaining to a member, the CONTRACTOR shall keep a record of the activities of the settings compliance committee and shall submit a quarterly report of such activities as specified in A.2.30.12.10.

2.24.5.6 The CONTRACTOR may rely on other internal committee structures or processes to conduct the activities required under Section A.2.24.5.3, but only if such internal committee structures or process include, at a minimum, the staff required under Section A.2.24.5.2, all of the activities required under A.2.24.5.3 are completed and within the timeframes specified in A.2.24.5.4, and documentation and reporting required pursuant to A.2.24.5.5 is completed.

A.2.24.6 **Abuse and Neglect Plan**

2.24.6.1 The CONTRACTOR shall develop and implement an abuse and neglect plan that includes protocols for preventing, identifying, and reporting suspected abuse, neglect, and exploitation of CHOICES and ECF CHOICES members who are adults (see TCA 71-6-101 *et seq*.) and suspected brutality, abuse, or neglect of CHOICES and ECF CHOICES members who are children (see TCA 37-1-401 *et seq*. and TCA 37-1-601 *et seq*.); a plan for educating and training providers, subcontractors, Care Coordinators, Support Coordinators, and other CONTRACTOR staff regarding the protocols; and a plan for training on at least an annual basis members, representatives, and caregivers regarding identification and reporting of suspected abuse and/or neglect.

2.24.6.2 The CONTRACTOR's abuse and neglect protocols shall include, but not be limited to the following:

2.24.6.2.1 Protocols for assessing risk for abuse and/or neglect, including factors that may indicate the potential for abuse and/or neglect;

2.24.6.2.2 Protocols for reducing a member's risk of abuse and/or neglect (e.g., frequency of Care Coordinator home visits, referrals to non-covered support services);

2.24.6.2.3 Indicators for identifying suspected abuse and/or neglect;

2.24.6.2.4 Requirements for reporting suspected abuse and/or neglect, including reporting suspected abuse and/or neglect of a child pursuant to TCA 37-1-403, reporting suspected abuse and/or neglect of an adult to APS pursuant to TCA 71-6-103, and reporting suspected abuse and/or neglect to the CONTRACTOR pursuant to Section A.2.15.7.1.4;

2.24.6.2.5 Steps for protecting a member if abuse and/or neglect is suspected (e.g., removing a staff person suspected of committing the abuse and/or neglect, making referrals for members to support services); and

2.24.6.2.6 Requirements regarding coordination and cooperation with APS/CPS investigations and remediations.

2.24.6.3 The CONTRACTOR's abuse and neglect plan shall also define the role and responsibilities of the FEA and supports broker (see definition in Section 1) in assessing and reducing a member's risk of abuse and neglect, identifying and reporting abuse and neglect, protecting a member if abuse and/or neglect is suspected; training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding the protocols identified in Sections 2.24.6.2.1 through 2.24.6.2.6 above; and training members and caregivers regarding identification and reporting of suspected abuse and/or neglect. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section A.2.24.6 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.

A.2.24.7 **Performance Standards**

The CONTRACTOR agrees TENNCARE may assess liquidated damages for failure to meet the performance standards specified in Attachment VII.

A.2.24.8 **Medical Records Requirements**

2.24.8.1 The CONTRACTOR shall maintain, and shall require contract providers and subcontractors to maintain, medical records (as defined in Section A.1) in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions.

2.24.8.2 The CONTRACTOR shall have medical record keeping policies and practices which are consistent with 42 CFR Part 456 and current NCQA standards for medical record documentation. The CONTRACTOR shall distribute these policies to practice sites. At a minimum, the policies and procedures shall address:

2.24.8.2.1 Confidentiality of medical records;

2.24.8.2.2 Medical record documentation standards; and

2.24.8.2.3 The medical record keeping system and standards for the availability of medical records. At a minimum the following shall apply:

2.24.8.2.3.1 As applicable, medical records shall be maintained or available at the site where covered services are rendered;

2.24.8.2.3.2 Enrollees (for purposes of behavioral health records, enrollee includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 *et seq.*, and, subject to reasonable charges, (except as provided in Section A.2.24.8.2.3.3 below) be given copies thereof upon request and to request that they be amended or corrected;

2.24.8.2.3.3 Provisions for ensuring that, in the event a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care provider, the first provider does not charge the enrollee or the second provider for providing the medical records; and

2.24.8.2.3.4 Performance goals to assess the quality of medical record keeping.

2.24.8.2.4 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records in conformity with TCA 33-3-101 *et seq.* for persons with serious emotional disturbance or mental illness.

2.24.8.2.5 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent.

A.2.25 MONITORING

A.2.25.1 **General**

2.25.1.1 TENNCARE, in its daily activities, shall monitor the CONTRACTOR for compliance with the provisions of this Contract.

2.25.1.2 TENNCARE, CMS, or their representatives shall at least annually monitor the operation of the CONTRACTOR for compliance with the provisions of this Contract and applicable federal and state laws and regulations. Monitoring activities shall include, but not be limited to, inspection of the CONTRACTOR's facilities, auditing and/or review of all records developed under this Contract including periodic medical audits, appeals, enrollments, disenrollments, termination of providers, utilization and financial records, reviewing management systems and procedures developed under this Contract and review of any other areas or materials relevant to or pertaining to this Contract. TENNCARE will emphasize case record validation because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes.

2.25.1.3 TENNCARE shall prepare a report of its findings and recommendations and require the CONTRACTOR to develop corrective action plans as appropriate.

2.25.1.4 As it pertains to LTSS audits, in the final audit summary, TENNCARE will provide feedback identifying quality or documentation deficiencies identified during the audit. When the CONTRACTOR receives the audit summary form TENNCARE, the CONTRACTOR shall submit to TENNCARE a formalized plan that includes steps in which the CONTRACTOR will take to address the deficiency, in a format and timeframe prescribed by TENNCARE. Once TENNCARE approves the plan, the CONTRACTOR shall ensure that the recommended changes and necessary re-education occurs. The CONTRACTOR shall submit to TENNCARE documentation that approved changes were made and/or re-education occurred with appropriate staff within the approved plan timeline. If the same documentation or quality issues are identified in subsequent audits after implementation of the TENNCARE approved plan, TENNCARE will designate the file as non-compliant and may address the deficiency with a Corrective Action Plan and/or Liquidated Damages.

A.2.25.2 **Facility Inspection**

TENNCARE, CMS, OIG, the Comptroller General or their representatives may conduct on-site inspections of premises, physical facilities and equipment of all health facilities and service delivery sites to be utilized by the CONTRACTOR in fulfilling the obligations under this Contract. Inspections may be made at any time during the Contract period and without prior notice.

A.2.25.3 **Inspection of Work Performed**

TENNCARE, CMS, or their representatives shall, at all reasonable times, have the right to enter into the CONTRACTOR's premises, or such other places where duties of this Contract are being performed, to inspect, monitor, or otherwise evaluate including periodic audits of the work being performed. The CONTRACTOR and all other subcontractors or providers shall supply reasonable access to all facilities and assistance for TENNCARE's representatives. The CONTRACTOR shall require that contracts with all subcontractors require the subcontractor to make available, for the purposes of an audit, evaluation, or inspection by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its TennCare members. All inspections and evaluations shall be performed in such a manner as to minimize disruption of normal business.

A.2.25.4 **Approval Process**

2.25.4.1 As specified by TENNCARE, TENNCARE must approve various deliverables/items before they can be implemented by the CONTRACTOR.

2.25.4.2 At any time that approval of TENNCARE is required in this Contract, such approval shall not be considered granted unless TENNCARE issues its approval in writing.

2.25.4.3 TENNCARE shall specify the deliverables (see Attachment VIII) to be submitted to TENNCARE, whether they require prior approval or not, deliverable instructions, submission and approval time frames, and technical assistance as required.

2.25.4.4 Should TENNCARE not respond to a submission of a deliverable in the amount of time agreed to by TENNCARE, the CONTRACTOR shall not be penalized with either liquidated damages or a withhold as a result of implementing the item awaiting approval. However, failure by TENNCARE to assess liquidated damages or withholds shall not preclude TENNCARE from requiring the CONTRACTOR to rescind or modify the item if it is determined by TENNCARE to be in the best interest of the TennCare program.

A.2.25.5 **Availability of Records**

2.25.5.1 The CONTRACTOR shall ensure within its own organization and pursuant to any agreement the CONTRACTOR may have with any other providers of service, including, but not limited to providers, subcontractors or any person or entity receiving monies directly or indirectly by or through TennCare, that TENNCARE representatives and authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to TENNCARE, the Office of the Inspector General (OIG), the Tennessee Bureau of Investigations, Medicaid Fraud Control Division (TBI MFCD), the Department of Health and Human Services, Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to services provided to TennCare enrollees.

2.25.5.2 The CONTRACTOR and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through TennCare shall make all records (including but not limited to, financial and medical records) available at the CONTRACTOR's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCD, DOJ and the DHHS OIG, TENNCARE or any duly authorized state or federal agency. Access will be either through on-site review of records or through the mail at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. The CONTRACTOR shall send all records to be sent by mail to TENNCARE within twenty (20) business days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE, authorized federal, state, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCD, DOJ and the DHHS OIG, or any duly authorized state or federal agency. Records related to appeals shall be forwarded within the time frames specified in the appeal process portion of this Contract. Such requests made by TENNCARE shall not be unreasonable.

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

2.25.5.4 The CONTRACTOR, any CONTRACTOR's management company and any CONTRACTOR's claims processing subcontractor shall cooperate with the State, or any of the State's contractors and agents, including, but not limited to TENNCARE, OIG, TBI MFCD, DOJ and the DHHS OIG, and the Office of the Comptroller of the Treasury, and any duly authorized governmental agency, during the course of any claims processing, financial or operational examinations or during any administrative, civil or criminal investigation, hearing or prosecution. This cooperation shall include, but shall not be limited to the following:

2.25.5.4.1 Providing full cooperation and direct and unrestricted access to facilities, information, and staff, including facilities, information and staff of any management company or subcontractor, to the State or any of the State's contractors and agents, which includes, but is not limited to TENNCARE, OIG, TBI MFCD, DOJ and the DHHS OIG, and the Office of the Comptroller of the Treasury and any duly authorized governmental agency, including federal agencies; and

2.25.5.4.2 Maintaining full cooperation and open authority for claims processing systems access and mailroom visits by TDCI or designated representatives or any authorized entity of the state or federal government, and to cooperate fully with detail claims testing for claims processing system compliance.

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

A.2.25.6 **Audit Requirements**

2.25.6.1 The CONTRACTOR and its providers, subcontractors and other entities receiving monies originating by or through TennCare shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Contract as well as medical information relating to the individual enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section A.2.20 of this Contract. Records other than medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for any authorized federal, state, including, but not limited to TENNCARE, OIG, TBI MFCD, DOJ and the DHHS OIG, and Office of the Comptroller of the Treasury personnel during the Contract period and ten (10) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or

audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the Contract period, these records shall be available at the CONTRACTOR's chosen location in Tennessee subject to the written approval of TENNCARE. If the records need to be sent to TENNCARE, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR, subcontractor or provider records must be requested and approved by TENNCARE in writing. Nothing in this Section shall be construed to modify or change the obligations of the CONTRACTOR contained in Section A.2.23.2 (Data and Document Management Requirements), A.2.23.3 (System and Data Integration Requirements), or A.2.23.6 (Security and Access Management Requirements) of this Contract.

2.25.6.2 The CONTRACTOR shall comply with Centers for Medicare & Medicaid Services (CMS) mandated Payment Error Rate Measurement (PERM) audits which occur every three (3) years on a fiscal year basis from July 1st through June 30th. All deadlines must be met as communicated from both CMS and TENNCARE.

2.25.6.2.1 The CONTRACTOR shall provide assistance with the state to obtain all requested and/or missing medical records from contracted providers, selected among the random audit sample, within the requested timeframe given by the CMS Review Contractor to prevent an audit finding.

2.25.6.2.2 The CONTRACTOR shall provide written procedures annually on June 1st to TENNCARE for review and approval detailing the internal and external procedures and activities that must occur in preparation to generate the PERM claims, provider, and recipient universe files, data dictionary, file layout, and transmission coversheets quarterly within each PERM cycle.

2.25.6.2.3 The CONTRACTOR shall implement a Quality Control component which must be documented in the CONTRACTOR's written procedures, to review all requested file layouts, data dictionaries, transmission coversheets, PERM claims, provider, and recipient universe files prior to submission to the state.

A.2.25.7 **Independent Review of the CONTRACTOR**

2.25.7.1 The CONTRACTOR shall cooperate fully with TENNCARE's External Quality Review Organization (EQRO) which will conduct a periodic and/or an annual independent review of the CONTRACTOR.

2.25.7.2 The CONTRACTOR shall cooperate fully with any evaluation of the TennCare program conducted by CMS.

A.2.25.8 **Accessibility for Monitoring**

For purposes of monitoring under this Contract, the CONTRACTOR shall make available to TENNCARE or its representative and other authorized state and federal personnel, all records, books, documents, and other evidence pertaining to this Contract, as well as appropriate administrative and/or management personnel who administer the MCO. The monitoring shall occur periodically during the Contract period and may include announced or unannounced visits, or both.

A.2.25.9 **Monitoring Quality of Care for CHOICES and ECF CHOICES**

In addition to any other monitoring activities conducted by TENNCARE, the CONTRACTOR shall cooperate fully with any monitoring activities conducted by TENNCARE regarding the CHOICES and ECF CHOICES program. These activities will include but not be limited to the following:

2.25.9.1 Quarterly and annual monitoring to ensure that CHOICES and ECF CHOICES members receive appropriate Population Health and the adequacy and appropriateness of these interventions based on stratification and setting. (See Section A.2.30.5).

2.25.9.2 Quality of care activities will be monitored through information obtained in a quarterly CHOICES Care Coordination Report and ECF CHOICES Support Coordination Report (see Sections A.2.30.6.7 and A.2.30.6.8) and through activities performed by the Quality Oversight Division of TennCare, ongoing monitoring by the TennCare Division of Long Term Services and Supports, and for specified services in CHOICES and ECF CHOICES, annual quality assurance surveys performed by DIDD. These activities may include monitoring and technical assistance through site visits to the CONTRACTOR, chart audits, phone calls, etc. TENNCARE may validate the CHOICES Care Coordination report and ECF CHOICES Support Coordination Report and may conduct a more in-depth review and/or request additional information for instances where the CONTRACTOR does not adhere to required timeframes. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance and to ensure the CONTRACTOR's oversight of contracted provider performance.

2.25.9.3 Quarterly monitoring to determine the CONTRACTOR's adherence to the requirements in this Contract regarding processes for identifying, assessing, and transitioning CHOICES and ECF CHOICES members who may have the ability and/or desire to transition from a nursing facility to the community. TENNCARE will review the CHOICES and ECF CHOICES Nursing Facility to Community Transition reports submitted by the CONTRACTOR (see Section A.2.30.6.3) to determine the CONTRACTOR's performance on specified measures. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.9.4 Monthly monitoring regarding missed and late visits. TENNCARE will review the CHOICES and ECF CHOICES HCBS Late and Missed Visits reports submitted by the CONTRACTOR (see Section A.2.30.6.5) to determine the CONTRACTOR's performance on specified measures. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.9.5 Ongoing monitoring of the quality of Care/Support Coordination, including comprehensive assessment and person-centered planning processes, provided to LTSS members enrolled in the CHOICES or ECF CHOICES programs to ensure that Care/Support Coordination processes are performed in a comprehensive, holistic, person-centered manner in accordance with best practices and evidence-based guidelines, and shall also include record reviews and announced/unannounced direct observation with Care/Support Coordinators. The CONTRACTOR shall, upon TENNCARE request, develop and provide to TENNCARE, and shall implement upon

approval by TENNCARE an action plan for remedying any deficiencies identified in PCSP development and/or monitoring of member outcomes

2.25.9.6 Quarterly monitoring of the CONTRACTOR's provider network file (see Section A.2.30.8) to ensure that CHOICES and ECF CHOICES provider network requirements are met (see Section A.2.11.7).

2.25.9.7 Annual monitoring of the CONTRACTOR's long-term care provider network development plan to ensure that the CONTRACTOR is making sufficient progress towards meeting its network development and expansion goals (see Section A.2.11.7.5). TENNCARE will review the plan provided by the CONTRACTOR and will evaluate the adequacy of the CONTRACTOR's long-term care network and the CONTRACTOR's efforts to improve the network where deficiencies exist.

2.25.9.8 Quarterly monitoring of critical incidents and Reportable Events. TENNCARE will review the CHOICES and ECF CHOICES HCBS Critical Incident and Reportable Event reports submitted by the CONTRACTOR (see Sections A.2.30.12.7 and A.2.30.12.8) to identify potential performance improvement activities. TENNCARE may conduct a more in-depth review and/or request additional information.

2.25.9.9 Quarterly monitoring of the CONTRACTOR's member complaints process to determine compliance with timeframes prescribed in Section A.2.19.2 of this Contract and appropriateness of resolutions. TENNCARE will review the CHOICES and ECF CHOICES Member Complaints Report submitted by the CONTRACTOR (see Section A.2.30.14), to determine the CONTRACTOR's performance on specified measures. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.9.10 The CONTRACTOR shall, on an ongoing basis, monitor the quality of services provided by contracted facilities to individuals for whom the CONTRACTOR has authorized ERC reimbursement. Such monitoring shall include, but is not limited to: monthly review of ERC quality data submitted by facilities to TENNCARE and, beginning July 1, 2015, onsite review by a respiratory care practitioner with sufficient experience to adequately monitor the quality of care provided by the facility to each of the CONTRACTOR's members. When deficiencies are found upon assessment or through other means, the CONTRACTOR must immediately report those deficiencies to TENNCARE. If the deficiencies raise concerns about potential licensure rule violations, the CONTRACTOR must also report them to the Tennessee Department of Health within twenty four (24) hours of discovery to determine whether the NF has complied with licensure standards. Additionally, the CONTRACTOR must determine whether or not they will continue to contract with the NF for ERC reimbursement.

2.25.9.11 As part of its responsibility to assist with compliance measures regarding the HCBS Settings Rule, the CONTRACTOR shall comply with all State contractor requirements in the Statewide Transition Plan, as amended, including tracking and monitoring provider transition plans and transitioning members to compliant providers when members' current providers have confirmed they are unable and/or unwilling to come into compliance. Any reports TENNCARE requests from the CONTRACTOR pursuant to this section are subject to the reporting requirements in Section A.2.30.1.4.

2.25.9.12 Review of all reports from the CONTRACTOR (see Section A.2.30) and any related follow up activities.

2.25.9.13 Other quality assurance and quality improvement activities as set forth in TennCare's approved Quality Strategy.

A.2.25.10 **Corrective Action Requirements**

2.25.10.1 If TENNCARE determines that the CONTRACTOR is not in compliance with one or more requirements of this Contract, TENNCARE will issue a notice of deficiency identifying the deficiency(ies), follow-up recommendations/requirements (e.g., a request for a corrective action plan), and time frames for follow-up.

2.25.10.2 Upon receipt of a notice of deficiency(ies) from TENNCARE, the CONTRACTOR shall comply with all recommendations/requirements made in writing by TENNCARE within the time frames specified by TENNCARE.

2.25.10.3 The CONTRACTOR shall be responsible for ensuring corrective action when a subcontractor or provider is not in compliance with the Contract.

A.2.26 SUBCONTRACTS

A.2.26.1 **Subcontract Relationships and Delegation**

If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below and as specified in Contract Section D.5:

2.26.1.1 The CONTRACTOR shall evaluate the prospective subcontractor's ability to perform the activities to be delegated;

2.26.1.2 The CONTRACTOR shall require that the agreement be in writing and specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;

2.26.1.3 Effective with any new subcontracts or upon the next amendment to existing subcontracts, the CONTRACTOR shall include a requirement that the subcontract may be terminated by the CONTRACTOR for convenience and without cause upon a specified number of days written notice;

2.26.1.4 The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations;

2.26.1.5 The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary; and

2.26.1.6 If the subcontract is for purposes of providing or securing the provision of covered services to enrollees, the CONTRACTOR shall ensure that all requirements described in Section A.2.12 of this Contract are included in the subcontract and/or a separate provider agreement executed by the appropriate parties.

A.2.26.2 **Legal Responsibility**

The CONTRACTOR shall be responsible for the administration and management of all aspects of this Contract including all subcontracts/subcontractors. The CONTRACTOR shall ensure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor for purposes of this Contract without prior written approval of the CONTRACTOR. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Contract are carried out in compliance with the Contract.

A.2.26.3 **Prior Approval**

All subcontracts, as defined in Section A.1 of this Contract, and revisions thereto shall be approved in advance in writing by TENNCARE. The CONTRACTOR shall revise subcontracts as directed by TENNCARE. Approval of subcontracts shall not be considered granted unless TENNCARE issues its approval in writing. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to TENNCARE within thirty (30) calendar days of execution. This written prior approval requirement does not relieve the CONTRACTOR of any responsibilities to submit all proposed material modifications of the CONTRACTOR's MCO operations to TDCI for prior review and approval as required by Title 56, Chapter 32, Part 1.

A.2.26.4 **Subcontracts for Behavioral Health Services**

If the CONTRACTOR subcontracts for the provision or management of behavioral health services, the subcontract shall be specific to the TennCare program, and the CONTRACTOR shall comply with the requirements in Section A.2.6.1.2 regarding integration of physical health and behavioral health services.

A.2.26.5 **Subcontracts for Assessments and Plans of Care**

If the CONTRACTOR subcontracts with an entity specifically to conduct care coordination functions, including level of care or comprehensive assessments or reassessments and/or developing or authorizing plans of care (see Section A.2.9.6), such subcontractor shall not provide any direct long-term care services. This does not preclude nursing facilities or hospitals contracted with the CONTRACTOR to deliver services from completing and submitting pre-admission evaluations.

A.2.26.6 **Subcontract with Fiscal Employer Agent (FEA)**

2.26.6.1 As required in Section A.2.9.7.3, the CONTRACTOR shall contract with TENNCARE's designated FEA to provide assistance to members choosing consumer direction of eligible CHOICES HCBS or eligible ECF CHOICES HCBS and to facilitate submission of claims for such services.

2.26.6.2 The CONTRACTOR may also contract with either TENNCARE's designated FEA or another entity prior approved by TENNCARE to manage payments to members or an authorized representative as specified in the approved PCSP for the Family Caregiver Stipend benefit or for other ECF CHOICES HCBS that require payment to the member or an authorized representative, including Family or Member Education and Training.

A.2.26.7 **Agreements with the Department of Intellectual and Developmental Disabilities (DIDD)**

2.26.7.1 The CONTRACTOR shall execute agreements with DIDD as needed to facilitate the implementation and ongoing operation of the ECF CHOICES program, including (but not limited to) any agreements necessary to facilitate exchange of data and information for purposes of network development and provider credentialing, member referral and intake, Reportable Event management, and quality assurance surveys.

A.2.26.8 **Standards**

The CONTRACTOR shall require and ensure that the subcontractor complies with all applicable requirements in this Contract. This includes, but is not limited to, Sections A.2.19, A.2.21.7, A.2.25.5, A.2.25.6, A.2.25.8, A.2.25.10, E.13, E.28, E.36, and D.7 of this Contract.

A.2.26.9 **Quality of Care**

If the subcontract is for the purpose of securing the provision of covered services, the subcontract shall specify that the subcontractor adhere to the quality requirements the CONTRACTOR is held to.

A.2.26.10 **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.

A.2.26.11 **Children in State Custody**

The CONTRACTOR shall include in its subcontracts a provision stating that subcontractors are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical or behavioral health services covered by TENNCARE.

A.2.26.12 **Assignability**

2.26.12.1 Transportation and claims processing subcontracts shall include language requiring that the subcontract agreement shall be assignable from the CONTRACTOR to the State, or its designee: i) at the State's discretion upon written notice to the CONTRACTOR and the affected subcontractor; or ii) upon CONTRACTOR's request and written approval by the State. Further, the subcontract agreement shall include language by which the subcontractor agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the CONTRACTOR.

2.26.12.2 Subcontractors shall not be permitted to assign TennCare funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (SAM) screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited.

A.2.26.13 **Claims Processing**

2.26.13.1 All claims for services furnished to a TennCare enrollee filed with a CONTRACTOR shall be processed by either the CONTRACTOR or by one (1) subcontractor retained by the organization for the purpose of processing claims. However, another entity can process claims related to behavioral health, vision, lab, durable medical equipment or transportation if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services. However, all claims processed by any subcontractor shall be maintained and submitted by the CONTRACTOR.

2.26.13.2 As required in Section A.2.30.20 of this Contract, where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II SOC1examination based on the Statement on Standards for Attestation Engagements (SSAE) No. 16.

A.2.26.14 **HIPAA Requirements**

The CONTRACTOR shall require all its subcontractors to adhere to HIPAA standard transaction requirements.

A.2.26.15 **Compensation for Utilization Management Activities**

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

A.2.26.16 **Notice of Subcontractor Termination**

2.26.16.1 When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCI.

2.26.16.2 TENNCARE reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

A.2.27 COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH)

A.2.27.1 TENNCARE and the CONTRACTOR shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA) and their accompanying regulations, and as amended.

A.2.27.2 The CONTRACTOR warrants to TENNCARE that it is familiar with the requirements of HIPAA and HITECH and their accompanying regulations, and shall comply with all applicable HIPAA and HITECH requirements in the course of this Contract including but not limited to the following:

2.27.2.1 Compliance with the Privacy Rule, Security Rule, and Notification Rule;

2.27.2.2 The creation of and adherence to sufficient Privacy and Security Safeguards and Policies;

2.27.2.3 Timely Reporting of Violations in the Access, Use and Disclosure of PHI; and

2.27.2.4 Timely Reporting of Privacy and/or Security Incidents.

2.27.2.5 Failure to comply may result in actual damages that the State incurs as a result of the breach and liquidated damages in accordance with Section E.29.2.

A.2.27.3 The CONTRACTOR warrants that it shall cooperate with TENNCARE, including cooperation and coordination with TENNCARE privacy officials and other compliance officers required by HIPAA and HITECH and their accompanying regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA and HITECH.

2.27.3.1 TENNCARE and the CONTRACTOR shall sign documents, including, but not limited to, business associate agreements, as required by HIPAA and HITECH, that are reasonably necessary to keep TENNCARE and the CONTRACTOR in compliance with HIPAA and HITECH.

A.2.27.4 As a party to this Contract, the CONTRACTOR hereby acknowledges its designation as a covered entity and/or business associate under the HIPAA regulations and agrees to comply with all applicable HIPAA and HITECH (hereinafter "HIPAA/HITECH") regulations.

A.2.27.5 In accordance with HIPAA/HITECH regulations, the CONTRACTOR shall, at a minimum:

2.27.5.1 Comply with requirements of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), including, but not limited to, the transactions and code sets, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data sharing agreements required under the regulations;

2.27.5.2 Transmit/receive from/to its providers, subcontractors, clearinghouses and TENNCARE all transactions and code sets required by the HIPAA/HITECH regulations in the appropriate standard formats, utilizing appropriate and adequate safeguards, as specified under the law and as directed by TENNCARE so long as TENNCARE direction does not conflict with the law;

2.27.5.3 Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA/HITECH standards, that it will be in breach of this Contract and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between TENNCARE and the CONTRACTOR and between the CONTRACTOR and its providers and/or subcontractors to a halt, if for any reason the CONTRACTOR cannot meet the requirements of this Section, TENNCARE may terminate this Contract in accordance with the Business Associate Agreement ancillary to this Contract;

2.27.5.4 Ensure that Protected Health Information (PHI) exchanged between the CONTRACTOR and TENNCARE is used only for the purposes of treatment, payment, or health care operations and health oversight and its related functions. All PHI not transmitted for these purposes or for purposes allowed under the federal HIPAA/HITECH regulations shall be de-identified to secure and protect the individual enrollee's PHI;

2.27.5.5 Report to TENNCARE's Privacy Office immediately upon becoming aware of any use or disclosure of PHI in violation of this Contract by the CONTRACTOR, its officers, directors, employees, subcontractors or agents or by a third party to which the CONTRACTOR disclosed PHI;

2.27.5.6 Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the CONTRACTOR pursuant to this Section;

2.27.5.7 Make available to TENNCARE enrollees the right to amend their PHI in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard;

2.27.5.8 Make an enrollee's PHI accessible to TENNCARE immediately upon request by TENNCARE;

2.27.5.9 Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA/HITECH regulations upon request;

2.27.5.10 Create and adopt policies and procedures to periodically audit adherence to all HIPAA/HITECH regulations, and for which CONTRACTOR acknowledges and promises to perform, including but not limited to, the following obligations and actions:

2.27.5.10.1 Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of TENNCARE agrees to use reasonable and appropriate safeguards to protect the PHI.

2.27.5.11 If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of an any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Contract, and in accordance with this Section of this Contract. The CONTRACTOR shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Contract. The CONTRACTOR shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Contract, the CONTRACTOR shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which cannot feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;

2.27.5.12 Implement all appropriate administrative, physical and technical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this

Contract and, including, but not limited to, privacy, security and confidentiality requirements in 45 CFR Parts 160 and 164;

2.27.5.13 Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;

2.27.5.14 Create and implement policies and procedures to address present and future HIPAA/HITECH regulatory requirements as needed, including, but not limited to: use and disclosure of data; de-identification of data; minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint, and breach notification;

2.27.5.15 Provide an appropriate level of training to its staff and employees regarding HIPAA/HITECH-related policies, procedures, enrollee rights and penalties prior to the HIPAA/HITECH implementation deadlines and at appropriate intervals thereafter;

2.27.5.16 Track training of CONTRACTOR staff and employees and maintain signed acknowledgements by staff and employees of the CONTRACTOR's HIPAA/HITECH policies;

2.27.5.17 Be allowed to use and receive information from TENNCARE where necessary for the management and administration of this Contract and to carry out business operations where permitted under the regulations;

2.27.5.18 Be permitted to use and disclose PHI for the CONTRACTOR's own legal responsibilities;

2.27.5.19 Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by CONTRACTOR employees and other persons performing work for the CONTRACTOR to have only minimum necessary access to PHI and personally identifiable data within their organization;

2.27.5.20 Continue to protect and secure PHI AND personally identifiable information relating to enrollees who are deceased for fifty (50) years following the date of an enrollee's death, effective September 23, 2013;

2.27.5.21 Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations;

2.27.5.22 Make available PHI in accordance with 45 CFR 164.524;

2.27.5.23 Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR 164.526; and

2.27.5.24 Obtain a third (3rd) party certification of their HIPAA standard transaction compliance ninety (90) calendar days before the start date of operations, if applicable, and upon request by TENNCARE.

A.2.27.6 The CONTRACTOR shall track all security incidents as defined by HIPAA/HITECH, and, as required by the HIPAA/HITECH Reports. The CONTRACTOR shall periodically report in summary fashion such security incidents.

A.2.27.7 TENNCARE and the CONTRACTOR are "information holders" as defined in TCA 47-18-2107. In the event of a breach of the security of CONTRACTOR's information system, as

defined by TCA 47-18-2107, the CONTRACTOR shall indemnify and hold TENNCARE harmless for expenses and/or damages related to the breach. Such obligations shall include, but not be limited to, mailing notifications to affected enrollees. Substitute notice to written notice, as defined by TCA 47-18-2107(e)(2) and (3), shall only be permitted with TENNCARE's express written approval. The CONTRACTOR shall notify TENNCARE's Privacy Office immediately upon becoming aware of any security incident that would constitute a "breach of the security of the system" as defined in TCA 47-18-2107.

A.2.27.8 NOTIFICATION OF BREACH & NOTIFICATION OF PROVISIONAL BREACH. The CONTRACTOR shall notify TENNCARE's Privacy Office immediately upon becoming aware of any incident, either confirmed or provisional, that represents or may represent unauthorized access, use or disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained or held by the CONTRACTOR, including any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the CONTRACTOR's system. This includes, but is not limited to, loss or suspected loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and/or disks.

A.2.27.9 Medicaid and CHIP – Verification of Income and Eligibility. The CONTRACTOR must provide safeguards that restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan:

2.27.9.1 Purposes directly related to the administration of Medicaid and CHIP include:

2.27.9.1.1 Establishing eligibility;

2.27.9.1.2 Determining the amount of medical assistance;

2.27.9.1.3 Providing services for beneficiaries; and

2.27.9.1.4 Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to Medicaid or CHIP administration.

2.27.9.2 The CONTRACTOR must have adequate safeguards to assure that:

2.27.9.2.1 Information is made available only to the extent necessary to assist in the valid administrative purposes of those receiving the information, and information received under 26 USC § 6103(l) is exchanged only with parties authorized to receive that information under that section of the Code; and

2.27.9.2.2 The information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.

2.27.9.3 The CONTRACTOR must have criteria that govern the types of information about applicants and beneficiaries that are safeguarded. This information must include at least:

2.27.9.3.1 Names and addresses;

2.27.9.3.2 Medical services provided;

2.27.9.3.3 Social and economic conditions or circumstances;

2.27.9.3.4 CONTRACTOR evaluation of personal information;

2.27.9.3.5 Medical data, including diagnosis and past history of disease or disability;

2.27.9.3.6 Any information received for verifying income eligibility and amount of medical assistance payments, including income information received from SSA or the Internal Revenue Service;

2.27.9.3.7 Any information received for verifying income eligibility and amount of medical assistance payments;

2.27.9.3.8 Income information received from SSA or the Internal Revenue Service must be safeguarded according to Medicaid and CHIP requirements;

2.27.9.3.9 Any information received in connection with the identification of legally liable third party resources; and

2.27.9.3.10 Social Security Numbers.

2.27.9.4 The CONTRACTOR must have criteria approved by the State specifying:

2.27.9.4.1 The conditions for release and use of information about applicants and beneficiaries;

2.27.9.4.2 Access to information concerning applicants or beneficiaries must be restricted to persons or CONTRACTOR representatives who are subject to standards of confidentiality that are comparable to those of the State;

2.27.9.4.3 The CONTRACTOR shall not publish names of applicants or beneficiaries;

2.27.9.4.4 The CONTRACTOR shall obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment to an authorized individual or entity;

2.27.9.4.5 If, because of an emergency situation, time does not permit obtaining consent before release, the CONTRACTOR shall notify the State, the family or individual immediately after supplying the information;

2.27.9.4.6 The CONTRACTOR's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials;

2.27.9.4.6.1 The CONTRACTOR shall notify the State of any requests for information on applicants or beneficiaries by other governmental bodies, the courts or law enforcement officials ten (10) days prior to releasing the requested information.

2.27.9.4.7 If a court issues a subpoena for a case record or for any CONTRACTOR representative to testify concerning an applicant or beneficiary, the CONTRACTOR must notify the State at least ten (10) days prior to the required production date so the State may work with the CONTRACTOR regarding CONTRACTOR's informing the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information, effective until Jan. 1, 2014; and

2.27.9.4.8 The CONTRACTOR shall not request or release information to other parties to verify income, eligibility and the amount of assistance under Medicaid or CHIP, prior to express approval from the State.

A.2.27.10 Social Security Administration (SSA) Required Provisions for Data Security. The CONTRACTOR shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. § 3541, et seq.), and related National Institute of Standards and Technology guidelines. In addition, the CONTRACTOR shall have in place administrative, physical, and technical safeguards for data.

2.27.10.1 The CONTRACTOR shall not duplicate in a separate file or disseminate, without prior written permission from TENNCARE, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the TennCare program. Should the CONTRACTOR propose a redisclosure of said data, the CONTRACTOR must specify in writing to TENNCARE the data the CONTRACTOR proposes to redisclose, to whom, and the reasons that justify the redisclosure. TENNCARE will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.

2.27.10.2 The CONTRACTOR agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.

2.27.10.3 The CONTRACTOR shall provide a current list of the employees of such CONTRACTOR with access to SSA data and provide such lists to TENNCARE upon request.

2.27.10.4 The CONTRACTOR shall restrict access to the data obtained from TENNCARE to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Contract. The CONTRACTOR shall not further duplicate, disseminate, or disclose such data without obtaining TENNCARE's prior written approval.

2.27.10.5 The CONTRACTOR shall ensure that its employees:

2.27.10.5.1 Properly safeguard PHI/PII furnished by TENNCARE under this Contract from loss, theft or inadvertent disclosure;

2.27.10.5.2 Understand that they are responsible for safeguarding this information at all times, regardless of whether or not the CONTRACTOR employee is at his or her regular duty station;

2.27.10.5.3 Ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;

2.27.10.5.4 Send emails containing PHI/PII only if encrypted or if to and from addresses that are secure; and

2.27.10.5.5 Limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

2.27.10.6 CONTRACTOR employees who access, use, or disclose TENNCARE or TennCare SSA supplied data in a manner or purpose not authorized by this Contract may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

2.27.10.7 Loss or Suspected Loss of Data – If an employee of the CONTRACTOR becomes aware of suspected or actual loss of PHI/PII, the appropriate designee of the CONTRACTOR must immediately contact TENNCARE upon becoming aware to report the actual or suspected loss. The CONTRACTOR will use the Loss Worksheet located at http://tn.gov/assets/entities/tenncare/attachments/phi_piiworksheet.pdf to quickly gather and organize information about the incident. The CONTRACTOR must provide TENNCARE with timely updates as any additional information about the loss of PHI/PII becomes available.

2.27.10.7.1 If the CONTRACTOR experiences a loss or breach of said data, TENNCARE will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the CONTRACTOR shall bear any costs associated with the notice or any mitigation.

2.27.10.8 TENNCARE may immediately and unilaterally suspend the data flow under this Contract, or terminate this Contract, if TENNCARE, in its sole discretion, determines that the CONTRACTOR has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Contract.

2.27.10.9 In order to meet certain requirements set forth in the State's Computer Matching and Privacy Protection Act Agreement (CMPPA) with the SSA, the Parties acknowledge that this Section shall be included in all agreements executed by or on behalf of the State. The Parties further agree that FISMA and NIST do not apply in the context of data use and disclosure under this Contract as the Parties shall neither use nor operate a federal information system on behalf of a federal executive agency. Further, NIST is applicable to federal information systems; therefore, although encouraged to do so, the State, its CONTRACTORs, agents and providers are not required to abide by the NIST guidelines.

2.27.10.10 This Section further carries out Section 1106(a) of the Act (42 U.S.C. § 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy Act of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. § 3541, et seq.), and related National Institute of Standards and Technology ("NIST") guidelines, which provide the requirements that the SSA stipulates that the CONTRACTOR must follow with regard to use, treatment, and safeguarding data in the event data is exchanged with a federal information system.

2.27.10.11 Definitions

2.27.10.11.1 "SSA-supplied data" – information, such as an individual's social security number, supplied by the Social Security Administration to TENNCARE to determine entitlement or eligibility for federally-funded programs (CMPPA between SSA and F&A; IEA between SSA and TENNCARE).

2.27.10.11.2 "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 C.F.R. § 160.103; OMB Circular M-06-19) – "Protected health information" or "PHI" means individually identifiable health information that is: (i) Transmitted

by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

2.27.10.11.3 "Personally Identifiable information" or "PII" refers to any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc., alone, or when combined with other personal or identifying information which is lined or linable to a specific individual, such as date and place of birth, mother's maiden name, etc.

2.27.10.11.4 "Individually Identifiable Health Information" – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

A.2.27.11 Sensitive Data Related to Alcohol and Drug Abuse Enrollee Records for Substance Abuse Treatment.

2.27.11.1 This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

2.27.11.2 A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 42 C.F.R. § 2.32 (SAMHSA)

A.2.27.12 Federal Tax Information (FTI).

2.27.12.1 Any FTI made available shall be used only for the purpose of carrying out the provisions of this Contract.

2.27.12.2 Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this Contract. Inspection by or disclosure to anyone other than an officer of employer of the Grantee is strictly prohibited.

A.2.27.13 Failure to comply with federal regulations regarding HIPAA/HITECH, SSA, Medicaid, CHIP, SAMHSA, and FTI data may result in criminal and civil fines and penalties.

A.2.28 NON-DISCRIMINATION COMPLIANCE REQUIREMENTS

A.2.28.1 The CONTRACTOR shall comply with Section D.7 of this Contract regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.

A.2.28.2 In order to demonstrate compliance with the applicable federal and state civil rights laws, guidance, and policies, including, but not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and 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 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209), the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section A.2.29.1.

2.28.2.1 The Contractor's Nondiscrimination Compliance Coordinator ("NCC") shall develop a CONTRACTOR nondiscrimination compliance training plan within thirty (30) days of the implementation of this Contract, to be approved by the Division of TennCare. This person shall be responsible for the provision of instruction regarding the plan to all CONTRACTOR staff within sixty (60) days of the implementation of this Contract. This person shall be responsible for the provision of instruction regarding the plan to providers and direct service subcontractors within ninety (90) days of the implementation of this Contract. The CONTRACTOR shall be able to show documented proof of such instruction.

2.28.2.1.1 On an annual basis, the NCC shall be responsible for making nondiscrimination training available to all CONTRACTOR staff and to its providers and subcontractors that are considered to be recipients of federal financial assistance under this Contract. The CONTRACTOR shall be able to show documented proof that the training was made available to the CONTRACTOR's staff and to its providers and subcontractors that are considered to be recipients of federal financial assistance under this Contract.

A.2.28.3 The CONTRACTOR's non-discrimination compliance plan shall include written policies and procedures that demonstrate non-discrimination in the provision of services to members. The policy shall also demonstrate non-discrimination in the provision of language assistance services for members with Limited English Proficiency and those requiring communication assistance in alternative formats (see Section A.2.18.2). These policies and procedures shall be prior approved in writing by TENNCARE.

A.2.28.4 The CONTRACTOR shall, at a minimum, emphasize non-discrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.

A.2.28.5 The CONTRACTOR shall keep such records as may be necessary in order to submit timely, complete and accurate compliance reports that may be requested by the U.S. Department of Health and Human Services ("HHS"), HCFA, and the Tennessee Human Rights Commission ("THRC") or their designees. If requested, the information shall be provided in a format and timeframe specified by HHS, HCFA, or THRC. The requested information may be necessary to enable HHS, HCFA, or THRC to ascertain whether the CONTRACTOR is complying with the applicable civil rights laws. For example, the CONTRACTOR should have available data showing the manner in which services are or will be provided by the program in question, and related data necessary for determining whether any persons are or will be denied such services on the basis of prohibited discrimination. Further examples of data that could be requested can be found at 45 C.F.R. § 80.6 and 28 C.F.R. § 42.406.

2.28.5.1 The CONTRACTOR shall permit access as set forth in the applicable civil rights laws, such as, 45 C.F.R. § 80.6 to HHS, HCFA, and THRC or their designees during normal business hours to such of its books, records, accounts, and other sources of information, and its facilities as may be pertinent to ascertain whether the CONTRACTOR is complying with the applicable civil rights laws.

2.28.5.2 The CONTRACTOR shall make available to beneficiaries and participants in HCFA's programs and other interested persons information regarding the provisions of the applicable civil rights laws as set forth in the implementing regulations, including 45 C.F.R. § 80.6 and 45 C.F.R. § 84.8. For example, a notification shall state, where appropriate, that the CONTRACTOR does not discriminate in admission or access to, or treatment or employment in, its programs or activities. The notification shall also include an identification of the responsible employee designated for its nondiscrimination compliance. This notice shall be considered a vital document and shall be available at a minimum in the English and Spanish languages.

A.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 A.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 A.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. If TENNCARE requests that the CONTRACTOR'S nondiscrimination compliance officer assist TENNCARE with conducting the initial investigation, the CONTRACTOR'S nondiscrimination compliance officer within five (5) business days from the date of the request shall start the initial investigation. 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 A.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 A.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.

A.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://tn.gov/tenncare/topic/non-discrimination-compliance. The discrimination complaint form shall be provided to TennCare enrollees upon request and in the member handbook. This complaint form shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages. 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.

A.2.28.8 The CONTRACTOR shall report on non-discrimination activities as described in Section A.2.30.22.

A.2.28.9 Should the CONTRACTOR not cover a TennCare covered service because of moral/ethical or religious reasons, the CONTRACTOR shall provide a list of these services to TENNCARE. This list shall be used by TENNCARE to provide information to TennCare members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.

2.28.9.1 Should the CONTRACTOR contract with providers and/or subcontractors to deliver services to TennCare members pursuant to the CONTRACTOR'S obligations under this Contract and the providers or subcontractors cannot provide a TennCare covered

service because of moral/ethical or religious reasons, the CONTRACTOR shall provide a list of these services to TENNCARE. This list shall be used by the CONTRACTOR and TENNCARE to provide information to TennCare members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.

A.2.28.10 Electronic and Information Technology Accessibility Requirements. To the extent that the CONTRACTOR is using electronic and information technology to fulfill its obligations under this Contract, the CONTRACTOR agrees to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508") and the Americans with Disabilities Act (or any subsequent standard adopted by an oversight administrative body, including the Federal Accessibility Board). To comply with the accessibility requirements for Web content and non-Web electronic documents and software, the CONTRACTOR shall use W3C's Web Content Accessibility Guidelines ("WCAG") level AA or higher (For the W3C's guidelines see: https://www.w3.org/WAI/standards-guidelines/wcag/new-in-21/) (More resources can be found at https://www.w3.org/WAI/ and https://www.access-board.gov/guidelines-and-standards/communications-and-it).

2.28.10.1 Should the CONTRACTOR have a designated staff member responsible for CONTRACTOR's electronic and information technology accessibility compliance, the name and contact information for this individual shall be provided to TENNCARE within ten (10) days of the implementation of this Contract and within ten (10) days of this position being reassigned to another staff member.

2.28.10.2 CONTRACTOR agrees to perform regularly scheduled (i.e., automatic) scans and manual testing for the most current WCAG level AA or higher compliance for all user content and applications in order to meet the standards for compliance. The CONTRACTOR must ensure that any system additions, updates, changes or modifications comply with the most current WCAG level AA or higher. Commercial Off-the-shelf ("COTS") products may be used to verify aspects of the most current WCAG level AA or higher compliance.

2.28.10.3 Additionally, the CONTRACTOR agrees to comply with Title VI of the Civil Rights Act of 1964. In order to achieve Title VI compliance the CONTRACTOR should add a system function that allows users to translate the content into a language other than English. This requirement may be satisfied by the provision of a link to Google translate or other machine translate tool.

2.28.10.4 Should the system or a component of the system fail to comply with the accessibility standards, the CONTRACTOR shall develop and submit to TENNCARE for approval a noncompliance report that identifies the areas of noncompliance, a plan to bring the system or component into compliance, an alternative/work around that provides users with the equivalent access to the content, and a timeframe for achieving that compliance. TENNCARE shall review the noncompliance report to determine whether or not it is acceptable and should be implemented. Once the noncompliance report is approved by TENNCARE the CONTRACTOR may implement the compliance plan. TENNCARE, in its sole discretion, shall determine when a satisfactory compliance plan resolution has been reached and shall notify the CONTRACTOR of the approved resolution. If CONTRACTOR is unable to obtain content that conforms to the most current WCAG level AA or higher, it shall demonstrate through its reporting to TENNCARE that obtaining or providing accessible content would fundamentally alter the nature of its goods and services or would result in an undue burden.

A.2.29 PERSONNEL REQUIREMENTS

A.2.29.1 **Staffing Requirements**

2.29.1.1 The CONTRACTOR shall have sufficient staffing capable of fulfilling the requirements of this Contract.

2.29.1.2 The CONTRACTOR shall submit to TENNCARE the names, resumes and contact information of the key staff identified below. The CONTRACTOR shall supply information regarding work experience for any employee upon request. The CONTRACTOR shall not employ any person in a key staff position that does not meet the requirements specified in the Contract for the position without prior written approval from TENNCARE. If a key staff position is specified in the Contract as "dedicated" to particular programs or functions, the CONTRACTOR shall not assign such key staff person to perform other responsibilities without prior written approval from TENNCARE. In the event of a change to any of the key staff identified in Section A.2.29.1.3, the CONTRACTOR shall notify TENNCARE within ten (10) business days of the change. TENNCARE may request the replacement of any CONTRACTOR staff that TENNCARE determines, at its sole discretion, is adversely affecting the CONTRACTOR's ability to meet the requirements of this Contract or is adversely affecting the CONTRACTOR's relationship with the State.

2.29.1.3 The minimum key staff requirements are listed below. If a full-time staff person is required, that means that one person shall perform that function (as opposed to multiple persons equaling a full-time equivalent). If a full-time staff person is not specified, the position does not require a full-time staff person.

2.29.1.3.1 A full-time administrator/project director dedicated to the TennCare program who has clear authority over the general administration and day-to-day business activities of this Contract;

2.29.1.3.2 A full-time staff person dedicated to the TennCare program who will assist the CONTRACTOR in the transition from the CONTRACTOR's implementation team to regular ongoing operations. This person shall be onsite in Tennessee from the start date of this Contract (see Section B.1) through at least one-hundred and twenty (120) days after the start date of operations;

2.29.1.3.3 A full-time Medical Director dedicated to the TennCare program who is a licensed physician in the State of Tennessee to oversee and be responsible for all clinical activities, including but not limited to the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures;

2.29.1.3.4 A full-time Medical Director dedicated exclusively to TennCare LTSS programs and services, including CHOICES and ECF CHOICES, and the populations served in LTSS programs, including frail elderly, adults with physical disabilities, and people of any age with intellectual or developmental disabilities. The LTSS Medical Director shall be a licensed physician in the State of Tennessee and have at least five (5) years of experience in directing health care services for frail elderly or adults with physical disabilities, or people of any age with intellectual or developmental disabilities. The LTSS Medical Director shall oversee and be responsible for all primary and physical health services provided to individuals receiving LTSS, and to comparable populations enrolled in TennCare, and all clinical activities pertaining to the operation of LTSS programs and services, including preventive care and the management and coordination of chronic conditions and physical health needs, and the integration and coordination of primary and other physical health services for members receiving LTSS. The LTSS Medical Director shall also be responsible for working with the Behavioral Health Director (see A.2.29.1.3.5) and the Behavior Supports Director (see A.2.29.1.3.6) to ensure the integration of physical and behavioral health services and supports and LTSS, as applicable, for individuals in each of these populations and to oversee the CONTRACTOR's quality improvement initiatives regarding behavior supports and the appropriate use of psychotropic medications in each of these populations.

2.29.1.3.5 A full-time senior executive dedicated exclusively to the TennCare program who is a board certified psychiatrist in the State of Tennessee and has at least five (5) years combined experience in mental health and substance abuse services. Experience directing behavioral health programs and services for special populations, including individuals with intellectual or developmental disabilities, shall be preferred, but not required. This person shall serve as the Behavioral Health Medical Director and shall oversee and be responsible for all behavioral health activities, including behavioral health services provided to individuals receiving LTSS and the populations served in LTSS programs (e.g., frail elderly, adults with physical disabilities, and people of any age with intellectual or developmental disabilities). The Behavioral Health Medical Director shall be responsible for the implementation of Behavior Crisis Prevention, Intervention and Stabilization Services as described in Section A.2.7.2.8.4 of this Contract; all behavioral health activities pertaining to the operation of LTSS programs and services, including the management and coordination of behavioral health needs; and the integration and coordination of behavioral health services for members receiving LTSS and comparable populations. The Behavioral Health Medical Director shall be responsible for working with the LTSS Medical Director (see A.2.29.1.3.4) and the Behavior Supports Director (see A.2.29.1.3.6) to ensure the integration of physical and behavioral health services and supports and LTSS, as applicable, for individuals in each of these populations, and to oversee the CONTRACTOR's quality improvement initiatives regarding behavior supports and the appropriate use of psychotropic medications in each of these populations;

2.29.1.3.6 A full-time senior executive who works primarily with the TennCare program and is dedicated to Tennessee's line of business. The individual must have a Master's degree in a health care related profession and at least five (5) years of combined experience in mental health and substance abuse service. Experience directing behavioral health programs and services for special populations, including individuals with intellectual or developmental disabilities, is required. This person shall be responsible for all behavioral health program operations and requirements.

2.29.1.3.7 A full-time Behavior Supports Director dedicated exclusively to TennCare LTSS programs and services, including CHOICES and ECF CHOICES, and the populations

served in LTSS programs (e.g., frail elderly, adults with physical disabilities, and people of any age with intellectual or developmental disabilities). who is a licensed psychologist in the State of Tennessee with experience in Applied Behavior Analysis or possesses current Certification by the Behavior Analyst Certification Board as a Board Certified Behavior Analyst, and has at least five (5) years' experience directing behavior support services, including and at least two (2) years' experience serving individuals with I/DD. The Behavior Supports Director shall oversee and be responsible for behavior support services provided to individuals receiving LTSS, and comparable populations. The Behavior Supports Director shall be responsible for working with the Behavioral Health Director (see A.2.29.1.3.5) to oversee the ongoing management of Behavior Crisis Prevention, Intervention and Stabilization Services as described in Section A.2.7.2.8.4 of this Contract and shall complete START training to become START-certified, and provide ongoing leadership of Model of Support (MOS) training for the CONTRACTOR's staff and contracted MOS implementation providers. The Behavior Supports Director shall be responsible for working with the LTSS Medical Director (see A.2.29.1.3.4) and the Behavioral Health Director (see A.2.29.1.3.5) to ensure the integration of physical and behavioral health services and supports and LTSS, as applicable, for individuals in each of these populations, and to oversee the CONTRACTOR's quality improvement initiatives regarding behavior supports and the appropriate use of psychotropic medications in each of these populations.

2.29.1.3.7.1 The CONTRACTOR shall ensure that this position is filled at least one hundred and twenty (120) days prior to the scheduled implementation of ECF CHOICES.

2.29.1.3.8 A full-time senior executive dedicated to the TennCare CHOICES program who has at least five (5) years of experience administering managed long-term care programs. On a case-by-case basis, equivalent experience in administering long-term care programs and services, including HCBS, or in managed care may be substituted, subject to the prior approval of TENNCARE. This person shall oversee and be responsible for all CHOICES activities;

2.29.1.3.8.1 The CONTRACTOR shall ensure that this position is filled at least one hundred and twenty (120) days prior to the scheduled implementation in each Grand Region covered by this Contract;

2.29.1.3.8.2 If the CONTRACTOR has not filled this position one hundred and eighty (180) days prior to the scheduled implementation in each Grand Region covered by this Contract, the CONTRACTOR shall designate another senior executive dedicated to the TennCare program to temporarily oversee CHOICES implementation activities, as prior approved by TENNCARE, until this position is filled (which, as specified in Section A.2.29.1.3.8.1 above, shall be at least one hundred and twenty (120) days prior to the scheduled implementation). Should another senior executive be temporarily designated to oversee CHOICES implementation activities, upon filling the full-time position as specified in Section A.2.29.1.3.8.1 above, the CONTRACTOR shall ensure the effective transition of all CHOICES implementation activities, including a minimum transition period of ninety (90) days;

2.29.1.3.9 A full-time executive director dedicated to the ECF CHOICES program who has at least two (2) years of experience administering managed long-term care programs and at least three (3) years of experience administering LTSS for individuals with I/DD. On a case-by-case basis, equivalent experience in administering long-term care programs and services, including HCBS, or in managed care may be substituted,

subject to the prior approval of TENNCARE. This person shall oversee and be responsible for all ECF CHOICES program operations and requirements;

2.29.1.3.9.1 The CONTRACTOR shall ensure that this position is filled at least one hundred and twenty (120) days prior to the scheduled implementation of ECF CHOICES;

2.29.1.3.9.2 If the CONTRACTOR has not filled this position one hundred and eighty (180) days prior to the scheduled implementation of ECF CHOICES, the CONTRACTOR shall designate another senior executive dedicated to the TennCare program to temporarily oversee ECF CHOICES implementation activities, as prior approved by TENNCARE, until this position is filled (which, as specified in Section A.2.29.1.3.9.1 above, shall be at least one hundred and twenty (120) days prior to the scheduled implementation). Should another senior executive be temporarily designated to oversee ECF CHOICES implementation activities, upon filling the full-time position as specified in Section A.2.29.1.3.9.1 above, the CONTRACTOR shall ensure the effective transition of all ECF CHOICES implementation activities, including a minimum transition period of ninety (90) days;

2.29.1.3.10 A full-time chief financial officer dedicated to the TennCare program responsible for accounting and finance operations, including all audit activities;

2.29.1.3.11 A full-time staff information systems director/manager dedicated to the TennCare program responsible for all CONTRACTOR information systems supporting this Contract who is trained and experienced in information systems, data processing and data reporting as required to oversee all information systems functions supporting this Contract including, but not limited to, establishing and maintaining connectivity with TennCare information systems and providing necessary and timely reports to TENNCARE;

2.29.1.3.12 A staff person designated as the contact available after hours for the "on-call" TennCare Solutions staff to contact with service issues;

2.29.1.3.13 A staff person to serve as the CONTRACTOR's Non-discrimination Compliance Coordinator. This person shall be responsible for the CONTRACTOR's compliance with applicable federal and state civil rights laws, regulations, rules and policies, including but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, and the Age Discrimination Act of 1975. The CONTRACTOR shall report to TENNCARE in writing, to its Office of Civil Rights Compliance, within ten (10) calendar days of the commencement of any period of time that the CONTRACTOR does not have a designated staff person for non-discrimination compliance. The CONTRACTOR shall report to TENNCARE at such time that the function is redirected as required in Section A.2.29.1.2;

2.29.1.3.14 A full-time staff person dedicated to the TennCare program responsible for member services, who shall communicate with TENNCARE regarding member service activities;

2.29.1.3.15 A full-time staff person dedicated to the TennCare program responsible for provider services and provider relations, including all network development and management issues. This person shall be responsible for appropriate education regarding provider participation in the TennCare (including CHOICES and ECF CHOICES) program; communications between the CONTRACTOR and its contract providers; and ensuring that providers receive prompt resolution of problems or inquiries. This person shall also be responsible for communicating with TENNCARE regarding provider service and provider relations activities. The FEA shall be responsible for education of and communication with consumer-directed workers, resolution of problems or inquiries from workers, and communication with TENNCARE regarding workers;

2.29.1.3.16 The CONTRACTOR shall maintain a minimum of one (1) dedicated CHOICES lead trainer. The CHOICES lead trainer shall be a part of the CONTRACTOR's management team, and shall be responsible for providing dedicated LTSS staff with current information on best practices and program enhancements or modifications, and attending meetings as requested by TENNCARE;

2.29.1.3.17 The CONTRACTOR shall maintain a minimum of one (1) dedicated ECF CHOICES lead trainer or may choose to employ a single LTSS Training Director dedicated to the CHOICES and ECF CHOICES programs, with a dedicated training SME for CHOICES and a dedicated training SME for ECF, both of whom report to the LTSS Training Director. The CHOICES lead trainer (see A.2.29.1.3.16) and the ECF CHOICES lead trainer; or the LTSS Training Director, as applicable, shall be a part of the CONTRACTOR's management team, and shall be responsible for the development and implementation of all ECF CHOICES staff training requirements, providing ECF CHOICES Support Coordinators and other ECF CHOICES staff with current information on best practices and program enhancements or modifications, and attending meetings as requested by TENNCARE;

2.29.1.3.17.1 The CONTRACTOR shall ensure that this position is filled at least one hundred and twenty (120) days prior to the scheduled implementation of ECF CHOICES;

2.29.1.3.18 A full-time staff person dedicated to the TennCare CHOICES program responsible for educating and assisting long-term care providers and the FEA regarding appropriate claims submission processes and requirements, coding updates, electronic claims transactions and electronic funds transfer; for the development and maintenance of CONTRACTOR resources such as CHOICES provider manuals, website, fee schedules, etc.; for technical assistance regarding long-term care claims submission and resolution processes; and for prompt resolution of long-term care claims issues or inquiries as specified in Section A.2.22.5. This person shall develop strategies to assess the effectiveness of the CONTRACTOR's claims education and technical assistance activities, gather feedback regarding the extent to which CHOICES long-term care providers are informed about appropriate claims submission processes and practices, and identify trends and guide the development of strategies to improve the efficiency of long-term care claims submission and resolution processes, as well as provider satisfaction;

2.29.1.3.19 A full-time staff person dedicated to the ECF CHOICES program and part of the CHOICES management team who shall be responsible for educating and assisting long-term care providers and the FEA regarding appropriate claims submission processes and requirements, coding updates, electronic claims transactions and electronic funds transfer; for the development and maintenance of CONTRACTOR resources such as ECF CHOICES provider manuals, website, fee schedules, etc.; for technical assistance regarding long-term care claims submission and resolution

processes; and for prompt resolution of long-term care claims issues or inquiries as specified in Section A.2.22.5. This person shall develop strategies to assess the effectiveness of the CONTRACTOR's claims education and technical assistance activities, gather feedback regarding the extent to which ECF CHOICES long-term care providers are informed about appropriate claims submission processes and practices, and identify trends and guide the development of strategies to improve the efficiency of long-term care claims submission and resolution processes, as well as provider satisfaction;

2.29.1.3.19.1 The CONTRACTOR shall ensure that this position is filled at least one hundred and twenty (120) days prior to the scheduled implementation of ECF CHOICES;

2.29.1.3.20 Maintain a sufficient number of full-time staff dedicated to the TennCare program as qualified trainers and coaches for the Patient-Centered Medical Home (PCMH) and TennCare's Tennessee Health Link organizations as well as trainers for providers regarding Episodes of Care (EOC). The CONTRACTOR's trainers and coaches shall comply with the requirements described in Section A.2.18.6.

2.29.1.3.21 At least one (1) full-time investigator per operating region dedicated solely to TennCare program investigations and at least three (3) additional staff persons responsible for all fraud, waste, and abuse detection activities, including two (2) full-time certified coders, and at least one (1) registered nurse, for medical record reviews dedicated solely to TennCare program fraud, waste, and abuse retrospective investigations. The investigator(s) shall have full knowledge of provider investigations related to the TennCare program and will be the key staff handling day-to-day provider investigation related inquiries from TENNCARE. The Investigators are required to be actively pursuing or currently have one or more of the listed credentials/degrees;

2.29.1.3.21.1 Certified Fraud Examiner;

2.29.1.3.21.2 NHCAA certified Anti-Fraud Investigator;

2.29.1.3.21.3 Degree in Statistics, Criminal Justice, Finance, Healthcare Management or any other related field that supports health care fraud investigations;

2.29.1.3.21.4 Certified Healthcare Coder;

2.29.1.3.21.5 Other nationally recognized healthcare certification.

2.29.1.3.22 A staff person responsible for all UM activities, including but not limited to overseeing prior authorizations. This person shall be a physician licensed in the State of Tennessee and shall ensure that UM staff have appropriate clinical backgrounds in order to make utilization management decisions;

2.29.1.3.23 A full time staff person dedicated to and responsible for all QM/QI activities. This person shall be a physician or registered nurse licensed in the State of Tennessee and report to the local health plan;

2.29.1.3.24 A staff person responsible for all appeal system resolution issues;

2.29.1.3.25 A staff person responsible for all claims management activities;

2.29.1.3.26 A staff person assigned to provide legal and technical assistance for and coordination with the legal system for court ordered services;

2.29.1.3.27 A staff person to serve as the Litigation Hold Contact. This individual shall be responsible for responding to all litigation hold requests from TennCare;

2.29.1.3.28 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;

2.29.1.3.29 A full-time staff person dedicated to the TennCare CHOICES program who is a registered nurse and has at least three (3) years' experience providing care coordination to persons receiving long-term care services and an additional two (2) years work experience in managed and/or long-term services and supports. This person shall oversee and be responsible for all care coordination activities for the CHOICES program, provide clinical and programmatic leadership to Care Coordinators, coordinate with the CHOICES lead trainer regarding ongoing care coordination training needs and activities, and ensure that appropriate tracking and monitoring systems are in place to support fulfillment of all contracted care coordination requirements as defined in this Contract, or in TennCare policy or protocol.

2.29.1.3.30 A full-time staff person dedicated to the TENNCARE ECF CHOICES program who is a registered nurse or who has a Master of Social Work (MSW) and has at least three (3) years' experience providing person-centered support coordination to individuals with I/DD receiving LTSS and an additional two (2) years' work experience in managed and/or long-term services and supports. On a case-by-case basis, equivalent experience in administering long-term services and supports, including HCBS, or in managed care may be substituted, subject to the prior approval of TENNCARE. This person shall oversee and be responsible for all support coordination activities for the ECF CHOICES program, provide clinical and programmatic leadership to Support Coordinators, coordinate with the ECF CHOICES lead trainer regarding ongoing support coordination training needs and activities, and ensure that appropriate tracking and monitoring systems are in place to support fulfillment of all contracted support coordination requirements as defined in this Contract, or in TennCare policy or protocol.

2.29.1.3.30.1 The CONTRACTOR shall ensure that this position is filled at least one hundred and twenty (120) days prior to the scheduled implementation of ECF CHOICES;

2.29.1.3.31 A sufficient number of CHOICES Care Coordinators that meet the qualifications in Section A.2.9.6.12 to conduct all required activities as specified herein;

2.29.1.3.32 A sufficient number of ECF CHOICES Support Coordinators that meet the qualifications in Section A.2.9.6.12 to conduct all required activities as specified herein;

2.29.1.3.33 Employed or contracted allied health professionals (including OT, PT, and SLP) as needed to participate as members of the interdisciplinary team to provide support and advisement to the CHOICES care coordination lead (A.2.29.1.3.29), ECF CHOICES support coordination lead (A.2.29.1.3.30), CHOICES Care Coordinators (A.2.29.1.3.31) and ECF CHOICES Support Coordinators (A.2.29.1.3.32) regarding the clinical needs of CHOICES and ECF CHOICES members in person-centered planning processes;

2.29.1.3.34 A consumer advocate for members receiving, or in need of, behavioral health services. This person shall be responsible for internal representation of members' interests including but not limited to: ensuring input in policy development, planning, decision making, and oversight as well as coordination of recovery and resilience activities;

2.29.1.3.35 A specialized member advocate for individuals with intellectual or other types developmental disabilities in each Grand Region in which the CONTRACTOR serves TennCare members. This member advocate shall be responsible for the internal representation of these members' interests, including, but not limited to, input into planning and delivery of services for individuals with I/DD, including the implementation of the ECF CHOICES program in the Grand Region, program monitoring and evaluation, and member, family, and provider education. The member advocate shall also be a resource for members concerning the following processes:

2.29.1.3.35.1 How to file a complaint with the member's MCO;

2.29.1.3.35.2 Facilitating resolution of any issues;

2.29.1.3.35.3 Making referrals to an appropriate CONTRACTOR staff;

2.29.1.3.35.4 Making recommendations to the CONTRACTOR on any changes needed to improve the CONTRACTOR's processes based on feedback from members with intellectual and other types of developmental disabilities; and

2.29.1.3.35.5 Making recommendations to TENNCARE regarding system or service improvements based on such feedback.

2.29.1.3.36 A designated consumer advocate for CHOICES members in each Grand Region. This person shall be responsible for internal representation of CHOICES members' interests including but not limited to input into planning and delivery of long-term care services, CHOICES QM/QI activities, program monitoring and evaluation, and member, family, and provider education. The consumer advocate shall also be a resource for CHOICES members concerning the following processes:

2.29.1.3.36.1 How to file a complaint with the member's MCO;

2.29.1.3.36.2 Facilitating resolution of any issues;

2.29.1.3.36.3 How to change Care Coordinators;

2.29.1.3.36.4 Making referrals to an appropriate CONTRACTOR staff;

2.29.1.3.36.5 Making recommendations to the CONTRACTOR on any changes needed to improve the CONTRACTOR's processes based on feedback from CHOICES members;

2.29.1.3.36.6 Making recommendations to TENNCARE regarding improvements for the CHOICES program; and

2.29.1.3.36.7 Participating as an ex officio member of the CHOICES Advisory Group required in Section A.2.24.3.

2.29.1.3.37 A full-time staff person dedicated to and responsible for all TennCare Kids services and related issues, including but not limited to, all TennCare Kids activities and EPSDT screening events. This person shall report to the local health plan.

2.29.1.3.38 A staff person responsible for working with the Department of Children's Services;

2.29.1.3.39 A senior executive responsible for overseeing all subcontractor activities, if the subcontract is for the provision of covered benefits;

2.29.1.3.40 A full-time staff person dedicated to and responsible for oversight of the NEMT program, including related reporting, auditing and resolution of issues and/or complaints;

2.29.1.3.41 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/DBM coordination. This person shall be responsible for overseeing the work of the DBM Care Coordination Committee and the DBM Claims Coordination Committee as described in Section A.2.9.10;

2.29.1.3.42 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/PBM coordination;

2.29.1.3.43 A staff person designated for interfacing and coordinating with the TDMHSAS Planning and Policy Council.

2.29.1.3.44 A staff person dedicated to overseeing Employment Services and Supports for LTSS programs and services, including CHOICES and ECF CHOICES. This person shall have at least three (3) years' experience in developing employment services and supports for persons with disabilities in integrated settings, which shall include at least one (1) year experience directing such programs and services; or other significant and relevant employment services expertise as approved by TENNCARE in writing. The Employment Services Director shall be responsible for leading the implementation of employment services and supports for members in CHOICES and ECF CHOICES; working with the Departments of Education and Labor and the Division of Vocational Rehabilitation Services to access and coordinate resources, as appropriate; and providing ongoing leadership of employment services and supports for the CONTRACTOR's staff and contracted providers. A staff person in this position must successfully complete Association of Community Rehabilitation Educators (ACRE) Professional Level Employment Training either prior to or during employment.

2.29.1.3.44.1 The CONTRACTOR shall ensure that this position is filled at least one hundred and twenty (120) days prior to the scheduled implementation of ECF CHOICES.

2.29.1.3.45 A staff person dedicated to overseeing Housing Services and Supports for LTSS programs and services, including CHOICES and ECF CHOICES. This person shall have at least three (3) years' experience in assisting the elderly and persons with disabilities to secure accessible, affordable housing through Federal and local programs including HUD subsidized housing (811, 202, HOME, etc.) and voucher programs (Housing Choice Vouchers, Non-Elderly Disabled 2 vouchers), public housing authorities, and USDA's Rural Development Single Family and Multi-Family programs. The Housing Specialist shall be responsible for working with the aforementioned housing agencies to help develop and access affordable housing services for members receiving LTSS, educating and assisting Care/Support Coordinators regarding affordable housing services for CHOICES and ECF CHOICES

members, and liaison with the TennCare Housing Director on TennCare's broader housing strategy and initiatives.

2.29.1.3.45.1 The CONTRACTOR shall ensure that this position is filled at least one hundred and twenty (120) days prior to the scheduled implementation of ECF CHOICE.

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, waste, 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.

2.29.1.5 The CONTRACTOR shall have a sufficient number of DBM Care Coordinators and claims coordinators to conduct all required activities, including but not limited to collaboration with the DBM and coordination with various state agencies.

2.29.1.6 The CONTRACTOR shall appoint specific staff to an internal audit function as specified in Section A.2.21.10.

2.29.1.7 At least one hundred and eighty (180) days prior to the scheduled implementation of in each Grand Region covered by this Contract, the CONTRACTOR shall establish a team dedicated to the implementation of the CHOICES program. This team shall be responsible for directing and overseeing all aspects of the implementation of CHOICES. The team shall be led by the full-time senior executive referenced in Section A.2.29.1.3.8 above and shall include, at a minimum, a staff person with responsibility for developing and implementing the CONTRACTOR's care coordination program, a staff person responsible for long-term care provider network development and provider relations, a staff person responsible for CHOICES provider claims education and assistance, a staff person responsible for long-term care QM/QI, a staff person responsible for IS issues related to CHOICES, and other staff as necessary to ensure the successful implementation of the CHOICES program and the seamless transition of members currently receiving long-term care services. The team shall report directly to the CONTRACTOR's senior management and shall interface with all of the CONTRACTOR's departments/business units as necessary to ensure the CONTRACTOR's readiness to provide services to CHOICES members in compliance with the requirements of this Contract.

2.29.1.8 The CONTRACTOR is not required to report to TENNCARE the names of staff not identified as key staff in Section A.2.29.1.3, unless requested by TennCare. However, the CONTRACTOR shall provide its staffing plan to TENNCARE.

2.29.1.9 The CONTRACTOR's project director, transition staff person, Medical Director, psychiatrist, Behavioral Health senior executive, Behavior Supports Director, CHOICES senior executive, ECF CHOICES senior executive, financial staff, member services staff, provider services staff, provider relations staff, CHOICES provider claims education and assistance staff, ECF CHOICES provider claims education and assistance staff, UM staff, appeals staff, Population Health Complex Case Management staff, care coordination leadership and staff, support coordination leadership and staff, CHOICES and ECF CHOICES lead trainers, consumer advocates, employment services director, housing specialist, and TennCare Kids 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. Staff assigned to and working in a geographic area of the state, but living in a border state do not require prior approval from TENNCARE as long as their primary work under this Contract is performed in-state.

2.29.1.10 The CONTRACTOR shall conduct training of staff in all departments to ensure appropriate functioning in all areas. This training shall be provided to all new staff members and on an ongoing basis for current staff.

2.29.1.11 The CONTRACTOR shall be required to have appropriate staff member(s) attend certain on-site meetings held at TennCare offices or at other sites as requested and designated by TENNCARE.

A.2.29.2 **Licensure and Background Checks**

2.29.2.1 Except as specified in this Section A.2.29.2.1 regarding the FEA, the CONTRACTOR is responsible for ensuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render services under applicable state law. The FEA shall be responsible for ensuring that consumer-directed workers are qualified to provide eligible CHOICES HCBS in accordance with TENNCARE requirements.

2.29.2.2 Except as specified in this Section A.2.29.2.2 regarding the FEA, the CONTRACTOR is responsible for conducting background checks in accordance with state law and TennCare policy and ensuring that all employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR conducts criminal background checks and registry checks in accordance with state law and TennCare policy. At a minimum, registry checks shall include a check of the Tennessee Abuse Registry, National and Tennessee Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE). The FEA shall be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers. Criminal background checks and registry checks must be performed on any employee or volunteer who will have direct contact with a member in CHOICES or ECF CHOICES. All criminal background and registry checks required in this Section must be completed prior to any such person having direct contact with a CHOICES or ECF CHOICES member. Any employee or volunteer supporting CHOICES or ECF CHOICES members who will not have direct contact with these members must have required registry checks completed prior to beginning this support. Unless federal or state laws prohibit individuals with certain criminal records from holding particular positions or engaging in certain occupations, an individual whose background check reveals past criminal conduct shall be given an opportunity to undergo an individualized assessment in accordance with the applicable laws and legal guidance, including, but not limited to CRA Section A.2.9.7.6 and TennCare Rule 1200-13-01.05.

A.2.29.3 **Board of Directors**

The CONTRACTOR shall provide to TENNCARE, in writing, a list of all officers and members of the CONTRACTOR's Board of Directors. The CONTRACTOR shall notify TENNCARE, in writing, within ten (10) business days of any change thereto.

A.2.29.4 **Employment and Contracting Restrictions**

The CONTRACTOR shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the entity's equity who has been debarred or suspended by any federal agency. The CONTRACTOR may not have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State. To the best of its knowledge and belief, the CONTRACTOR certifies by its signature to this Contract that the CONTRACTOR and its principals:

2.29.4.1 The CONTRACTOR shall not knowingly have a director, officer, partner, or person with direct or indirect ownership of more than five percent (5%) of the entity's equity who has been debarred, suspended, or otherwise excluded by any federal agency, order, or regulation, or who is a sanctioned individual under Section 1128(b)(8) of the Act, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

2.29.4.2 The CONTRACTOR shall not have a network provider, subcontractor, an employment, consulting, or any other agreement with a person that has been debarred, suspended, or otherwise excluded by any federal agency, order, or regulation for the provision of items or services that are significant and material to the entity's contractual obligation with the State or who is a sanctioned individual under Section 1128(b)(8) of the Act, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

2.29.4.3 The CONTRACTOR is prohibited from employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

2.29.4.4 To the best of its knowledge and belief, the CONTRACTOR certifies by its signature to this Contract that the CONTRACTOR and its principals:

2.29.4.4.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or contractor;

2.29.4.4.2 Have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction, violation of

federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

2.29.4.4.3 Are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in Section A.2.29.4.2 of this Contract; and

2.29.4.4.4 Have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

2.29.4.5 If the State learns that the CONTRACTOR is controlled by or has a relationship with an individual or entity identified in A.2.29.4.1 who has been debarred, suspended, or otherwise excluded by any federal agency, order, or regulation, the State may continue the existing CONTRACTOR agreement, unless directed otherwise by the Secretary of Health and Human Services. The State may not renew or extend the existing agreement with the CONTRACTOR unless the Secretary provides a written statement to the State and Congress describing compelling reasons for the renewal or extension.

A.2.30 REPORTING REQUIREMENTS

A.2.30.1 General Requirements

2.30.1.1 The CONTRACTOR shall comply with all the reporting requirements established by TENNCARE. TENNCARE shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required. TENNCARE may, at its discretion, change the content, format or frequency of reports.

2.30.1.2 TENNCARE may, at its discretion, require the CONTRACTOR to submit additional reports both ad hoc and recurring. If TENNCARE requests any revisions to the reports already submitted, the CONTRACTOR shall make the changes and re-submit the reports, according to the time period and format required by TENNCARE.

2.30.1.3 The CONTRACTOR shall submit all reports to TENNCARE, unless indicated otherwise in this Contract, according to the schedule below:

DELIVERABLES		DUE DATE
Daily Reports		Within two (2) business days.
Weekly Reports		Wednesday of the following week.
Monthly Reports		20th of the following month.
Quarterly Reports		30th of the following month.
Semi-Annual Reports		January 31 and July 31.
Annual Reports		Ninety (90) calendar days after the end of the calendar year

DELIVERABLES		DUE DATE
On Request Reports		Within three (3) business days from the date of the request unless otherwise specified by TENNCARE.

2.30.1.4 The CONTRACTOR shall submit all reports electronically and in the manner and format prescribed by TENNCARE and shall ensure that all reports are complete and accurate. The CONTRACTOR shall be subject to liquidated damages as specified in Section E.29.2. for reports determined to be late, incorrect, incomplete or deficient, or not submitted in the manner and format prescribed by TENNCARE until all deficiencies have been corrected. Except as otherwise specified by TENNCARE, all reports shall be specific to each Grand Region covered by this Contract.

2.30.1.5 Except as otherwise provided in this Contract, the CONTRACTOR shall submit all reports to the Division of TennCare.

2.30.1.6 The CONTRACTOR shall transmit to and receive from TENNCARE all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by TENNCARE, so long as TENNCARE direction does not conflict with the law.

2.30.1.7 As part of its QM/QI program, the CONTRACTOR shall review all reports submitted to TENNCARE to identify instances and/or patterns of non-compliance, determine and analyze the reasons for non-compliance, identify and implement actions to correct instances of non-compliance and to address patterns of non-compliance, and identify and implement quality improvement activities to improve performance and ensure compliance going forward.

A.2.30.2 **Eligibility, Enrollment and Disenrollment Reports**

2.30.2.1 The CONTRACTOR shall comply with the requirements in Section A.2.23.5 regarding eligibility and enrollment data exchange.

2.30.2.2 The CONTRACTOR shall submit a *Monthly Enrollment/Capitation Payment Reconciliation Report* that serves as a record that the CONTRACTOR has reconciled member eligibility data with capitation payments and verified that the CONTRACTOR has an enrollment record for all members for whom the CONTRACTOR has received a capitation payment, and that all members for whom the CONTRACTOR received a CHOICES or ECF CHOICES capitation payment are identified as CHOICES or ECF CHOICES members in the appropriate CHOICES or ECF CHOICES Group on the enrollment record.

2.30.2.3 The CONTRACTOR shall submit a *Quarterly Member Enrollment/Capitation Payment Report* in the event it has members for whom a capitation payment has not been made or an incorrect payment has been made. This report shall be submitted on a quarterly basis, with a one-month lag time and is due to TENNCARE by the end of the second month following the reporting period. For example, for the quarter ending September 30, the report is due by the end of November and should include all data received through the end of October for the quarter ending September 30. These quarterly reports shall include all un-reconciled items until such time that TENNCARE notifies the CONTRACTOR otherwise.

2.30.2.4 TENNCARE may provide the CONTRACTOR with information on members for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this information, the CONTRACTOR shall provide TENNCARE any information known by the CONTRACTOR that is missing or inaccurate in the report provided by TENNCARE. The CONTRACTOR shall submit this information to TENNCARE within the time frames specified by TENNCARE.

A.2.30.3 **TennCare Kids Outreach Reports**

2.30.3.1 The CONTRACTOR shall submit a *TennCare Kids Annual Outreach Plan* on August 15 of each year and must be written in accordance with guidance provided in Section A.2.7.4.2.1.

2.30.3.2 The CONTRACTOR shall submit a *TennCare Kids Quarterly Outreach Update* thirty (30) days following the end of each quarter based on the Federal Fiscal Year.

2.30.3.3 The CONTRACTOR shall submit a *TennCare Kids Year-End Outreach Update* sixty (60) days following the end of the Federal Fiscal Year.

A.2.30.4 **Specialized Service Reports**

2.30.4.1 The CONTRACTOR shall submit a semi-annual Psychiatric Hospital/RTF Readmission Report that provides: the percentage of members readmitted to the facility within seven (7) calendar days of discharge (the number of members readmitted divided by the total number of discharges); and the percent of members readmitted within thirty (30) calendar days of discharge (the number of members readmitted divided by the total number of discharges). The information shall be reported separately for members age eighteen (18) and over and under eighteen (18). These reports shall be submitted to TENNCARE on April 30 and November 30 of each year.

2.30.4.2 The CONTRACTOR shall submit a semi-annual Post-Discharge Services Report that provides information on Post-Discharge services appointments. The minimum data elements required are identified in Attachment IX, Exhibit B. These reports shall be submitted to TENNCARE on April 30 and November 30 of each year.

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2.30.4.4 The CONTRACTOR shall submit a TennCare Kids Quarterly Outreach Activities Report which shall be in a format designated by TENNCARE and shall include a listing of related and non-related TennCare Kids events.

2.30.4.5 The CONTRACTOR shall submit a Monthly EPSDT Claims Report, which shall include the number of EPSDT screening claims processed by region for the service dates beginning with the current federal fiscal year (October 1) through the last day of the current month. This report shall be due by the 20th day after the end of the reporting month.

2.30.4.6 The CONTRACTOR shall submit Payment Reform Engagement, Education and Outreach Reports as follows:

2.30.4.6.1 The CONTRACTOR shall submit an annual Provider Engagement Plan detailing communication plans with the Tennessee Health Link (THL), Patient Centered Medical Home (PCMH) and Episodes of Care providers no later than December 1st of

each year for review and approval by TENNCARE. The CONTRACTOR shall submit two separate Provider Engagement Plans, one for PCMH/THL and one for Episodes of Care. The Provider Engagement Plan shall be effective as of January 1st of the next calendar year.

2.30.4.6.1.1 The Provider Engagement Plans shall be written in accordance with guidance prepared by TENNCARE. This outreach plan shall outline communication efforts with providers engaged in the Tennessee Health Link (THL), Patient Centered Medical Home (PCMH) and Episodes of Care initiatives. It shall include, but is not limited to: all proposed education regarding reading and interpreting provider reports; all proposed details regarding report delivery and accessibility; a plan for (at least) quarterly leadership meetings between MCO program leads and PCMH/THL practice leadership; detailed strategy outlining the providers or quarterbacks to prioritize when conducting outreach efforts (i.e. providers who did not open reports or owe a penalty), schedule of conferences and webinars, details of the PCMH/THL CAP and Remediation Process due to poor performance.

2.30.4.6.1.2 For THL providers, the CONTRACTOR may meet quarterly in-person or virtually or by phone upon the providers' request. For PCMH providers who are in their first year of participation, the CONTRACTOR shall meet with the provider quarterly in-person. For PCMH providers who have participated in the initiative for at least one year, the CONTRACTOR may alter the quarterly in person meeting schedule and/or meet by phone.

2.30.4.6.2 The CONTRACTOR shall submit a quarterly Provider Engagement Tracker Report in accordance with guidance prepared by TENNCARE. The CONTRACTOR shall submit the Provider Engagement Tracker no later than one (1) week after each quarter in the calendar year for the Tennessee Health Link (THL), Patient Centered Medical Homes (PCMH) and Episodes of Care initiatives. There should be separate quarterly Provider Engagement Tracker for THL, PCMH and Episodes of Care that shall record all in-person visits, calls, mailings, and all other communications for THL, PCMH and Episodes of Care. Therefore, each quarter, a total of three (3) separate Provider Engagement Tracker shall be sent to TENNCARE by the CONTRACTOR. The details regarding when such outreach shall occur are described in Sections A.2.30.4.6.2.1 to A.2.30.4.6.2.3.

2.30.4.6.2.1 The CONTRACTOR shall alert all providers or quarterbacks to the availability of their reports through emails and/or letters. The CONTRACTER shall supplement alerts to providers or quarterbacks with calls, in-person visit, WebEx, fax, provider Information Expos, State Medical Association Conferences, or online videos.

2.30.4.6.2.2 In the initial communication to providers or quarterbacks, the CONTRACTOR shall provide instructions on 1) how to access full reports, and 2) how to share or update electronic contact information. Ensuring that providers have given their most up-to-date contact information is essential for them to receive alerts about any changes to their reports or newly released reports.

2.30.4.6.2.3 The CONTRACTOR shall also use in-person education, newsletters, web banners, and scripted calls to share general information and updates about Episode of Care, Patient Centered Medical Home and Health Link reports.

2.30.4.6.3 The CONTRACTOR shall submit a copy of the CONTRACTOR's Annual Review of each PCMH and THL organization engaged in coaching as described in Section A.2.18.6. The Annual Review shall be provided to TENNCARE via the agreed upon

shared platform (i.e., SharePoint or OneDrive) by the date provided and agreed upon by the PCMH and THL programs.

2.30.4.7 The CONTRACTOR shall submit Episodes of Care Reports as follows:

2.30.4.7.1 The CONTRACTOR shall send quarterly Episodes of Care Performance Report Summaries (i.e., The Principal Accountable Provider Lists or PAP list) to TENNCARE. The PAP list shall be submitted to TENNCARE no later than the Thursday prior to the week the reports are released to providers. The CONTRACTOR shall release quarterly Episodes of Care Performance Reports to providers via the CONTRACTOR's portal no later than the third Thursday of the following months: February, May, August and November. This includes making all required updates to the reports requested by the state to ensure compliance with Sections A.2.13.1.9.7 and A.2.13.1.9.9.

2.30.4.8 The CONTRACTOR shall submit PCMH Reports as follows:

2.30.4.8.1 The CONTRACTOR shall submit an annual PCMH Membership/Anticipated PCMH Contract Report. The report shall include PCMH membership counts as of June 30 of each year for members attributed to groups that are anticipated to sign TennCare PCMH contracts effective January 1 of the following year. PCMH membership shall exclude non-aligned dual eligible members. This PCMH Membership/Anticipated PCMH Contract Report is due to TENNCARE no later than July 31 of each year.

2.30.4.8.2 The CONTRACTOR shall submit an annual *PCMH Membership/Contracted PCMH Report*. The report shall include PCMH membership counts as of January 1 of each year for all members with an attributed PCP that is associated with a TIN contracted in the TennCare PCMH program. PCMH membership shall exclude non-aligned dual eligible members. This PCMH Membership/Contracted PCMH Report is due to TENNCARE no later than January 31 of each year.

2.30.4.8.3 The CONTRACTOR shall submit an annual *PCMH Risk Band Values for Activity Payments (pmpms) Report* for the upcoming performance year. The PCMH list of risk band values for activity payments Report will include the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than September 30 of each year.

2.30.4.8.4 The CONTRACTOR shall submit an annual *PCMH Practice Type Designations Report* assigned to participating PMCHs based upon the proportion of adult and/or children attributed as of June 30 of the year before the performance period begins. The PCMH practice type designations Report will include the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than September 30 of each year.

2.30.4.8.5 The CONTRACTOR shall submit an Annual PCMH Data Report including the data elements described by TENNCARE. This report shall be submitted to TENNCARE no later than June 15 of each year.

2.30.4.8.6 The CONTRACTOR shall submit a *PCMH Quality Summary Report* three (3) times a year which shall include the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than March 15, September 15, and December 15 of each year.

2.30.4.8.7 The CONTRACTOR shall submit quarterly, *PCMH Provider Sample Reports* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than February 15th, May 15th, August 15, and November 15th of each year.

2.30.4.8.8 The CONTRACTOR shall submit quarterly, *PCMH Provider Reports* to participating PCMHs. The reports will include the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than February 28th, May 31th, August 31, and November 30th of each year.

2.30.4.8.9 The CONTRACTOR shall submit a quarterly *PCMH Outcome Payment Summary Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than February 28th, May 31th, August 31, and November 30th of each year.

2.30.4.8.10 The CONTRACTOR shall submit a monthly *PCMH Monthly Payment Report* including the data elements described by TENNCARE. These reports shall be submitted no later than the 30th of every month.

2.30.4.8.11 The CONTRACTOR shall submit an annual *PCMH Member List for Outcome Panel Report* to participating PCMHs. The Report will include the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than August 31st of each year.

2.30.4.9 The CONTRACTOR shall submit Tennessee Health Link (THL) Reports as follows:

2.30.4.9.1 The CONTRACTOR shall submit a quarterly *Tennessee Health Link (THL) Report* including the data elements described by TENNCARE. Specified data elements shall be reported for each individual provider as described in the template provided by TENNCARE.

2.30.4.9.2 The CONTRACTOR shall submit Semi-Annual, a *Tennessee Health Link (THL) Engagement Evaluation Summary Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year.

2.30.4.9.3 The CONTRACTOR shall submit an annual *Tennessee Health Link (THL) Member list for Outcome Panel Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on September 30th of each year.

2.30.4.9.4 The CONTRACTOR shall submit an Annual *Tennessee Health Link (THL) DataReport* including the data elements described by TENNCARE. This report shall be submitted to TENNCARE no later than June 15 of each year.

2.30.4.9.5 The CONTRACTOR shall submit a *Tennessee Health Link (THL) Quality Summary Report* three (3) times a year which shall include the data elements described by TENNCARE. These reports shall be submitted to TENNCARE no later than March 15, September 15, and December 15 of each year.

2.30.4.9.6 The CONTRACTOR shall submit a quarterly *Tennessee Health Link (THL) Provider Sample Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on February 15th, May 15th, August 15, and November 15th of each year.

2.30.4.9.7 The CONTRACTOR shall submit a quarterly Tennessee Health Link (THL) Provider Report including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on February 28th, May 31th, August 31, and November 30th of each year.

2.30.4.9.8 The CONTRACTOR shall submit a quarterly *Tennessee Health Link (THL) Summary Report* including the data elements described by TENNCARE. These reports shall be submitted to TENNCARE on February 28th, May 31th, August 31, and November 30th of each year.

2.30.4.9.9 The CONTRACTOR shall submit a monthly *Tennessee Health Link (THL) Claims Payment Report* including the data elements described by TENNCARE. These reports shall be submitted on the 15th of each month.

2.30.4.10 The CONTRACTOR shall submit to TENNCARE, PCMH and THL Attribution Files for the Care Coordination Tool in accordance with TENNCARE policy. The PCMH and THL attribution files shall be submitted on a weekly basis and due no later than Friday within the specified time frame indicated by TENNCARE. If a holiday falls on a Friday, the CONTRACTOR shall send the PCMH and THL attribution files no later than the next business day within the specified time frame indicated by the TENNCARE. If the CONTRACTOR anticipates not being able to send the files by the specified time frame for any week, the CONTRACTOR shall notify TENNCARE via email as soon as possible but no later than the specified time when the attribution files are due.

A.2.30.5 **Population Health Reports**

2.30.5.1 The CONTRACTOR shall submit a semi-annual *Population Health Update Report* which shall include all data elements described by TENNCARE. The report shall be submitted to TENNCARE on January 31st and July 31st of each year.

2.30.5.2 The CONTRACTOR shall submit an annual *Population Health Outcome Metric Report* in the format described in the annual report template provided by TENNCARE. The report shall be submitted to TENNCARE on September 1st of each year.

2.30.5.3 The CONTRACTOR shall submit an annual *Population Health Program Strategy* following the guidance provided by TENNCARE addressing Section A.2.8 of this Contract. The Program Strategy shall meet or exceed the NCQA standard PHM 1: PHM Strategy and 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 report shall be submitted to TENNCARE on May 1st of each year.

2.30.5.4 The CONTRACTOR shall submit an annual *Population Health Impact Report* including the data elements described by TENNCARE. The report shall detail the CONTRACTOR's completion of NCQA PHM 6: Population Health Management Impact, Element A: Measuring Effectiveness and Element B: Improvement and Action. The reporting shall consist of a comprehensive analysis of the impact of the CONTRACTOR's PHM Strategy, for the reporting year, as well as a section indicating how the organization used the results from the comprehensive analysis to identify opportunities for improvement and acted on an opportunity for improvement, for the reporting year. The report shall be submitted to TENNCARE on September 1st of each year.

2.30.5.5 The CONTRACTOR shall submit a quarterly *Population Health Success Stories Report* including the data elements described by TENNCARE.

2.30.5.6 The CONTRACTOR shall submit a quarterly *Women of Child Bearing Age + Opioids Report* including the data elements described by TENNCARE.

A.2.30.6 **Service Coordination Reports**

2.30.6.1 For the first six (6) months after implementation in each Grand Region covered by this Contract, or as long as determined necessary by TENNCARE, the CONTRACTOR shall submit a monthly Status of Transitioning CHOICES Members Report that provides information regarding transitioning CHOICES members (see Section A.2.9.3). The report shall include information on the CONTRACTOR's current and cumulative performance on various measures.

2.30.6.1.1 The performance measures shall include but not be limited to the following:

2.30.6.1.1.1 Of transitioning CHOICES Group 1 members who were newly enrolled in CHOICES as of the implementation date, the number and percent for whom the CONTRACTOR has/has not conducted a face-to-face visit (see Section A.2.9.3.7).

2.30.6.1.1.2 Of transitioning CHOICES Group 2 members who were newly enrolled in CHOICES as of the implementation date, the number and percent for whom the CONTRACTOR has/has not conducted face-to-face visit and a comprehensive assessment and developed and authorized a new PCSP.

2.30.6.2 The CONTRACTOR shall submit a semi-annual *CHOICES Nursing Facility Diversion Activities Report*, and an *ECF CHOICES Nursing Facility Diversion Activities Report*. The corresponding reports shall each provide descriptions of the CONTRACTOR's nursing facility diversion activities by each of the groups specified in Section A.2.9.6.7, including a detailed description of the CONTRACTOR's success in identifying members for diversion, in diverting members, and in maintaining members in the community, as well as lessons learned, including a description of factors affecting the CONTRACTOR's ability to divert members, identified issues, strategies to address identified issues, and opportunities for systemic improvements in the CONTRACTOR's nursing facility diversion process(es).

2.30.6.3 The CONTRACTOR shall submit a semi-annual CHOICES and ECF CHOICES Nursing Facility and ICF/IID to Community Transition Report. The report shall include transitions of the CONTRACTOR's members from or to services provided in the CHOICES or ECF CHOICES programs. The CONTRACTOR shall not be expected to report on transitions of members from an ICF/IID into a Section 1915(c)

waiver. MFP participants (see Section A.2.9.8) shall be identified separately for each data element described herein. The report shall include information, by month, on specified measures, which shall include but not be limited to the following:

2.30.6.3.1 Number of CHOICES and ECF CHOICES members transitioned from a nursing facility or ICF/IID;

2.30.6.3.2 Of members who transitioned from a nursing facility or an ICF/IID, the number and percent of members who transitioned to:

2.30.6.3.2.1 A community-based residential alternative facility;

2.30.6.3.2.2 A residential setting where the member will be living independently;

2.30.6.3.2.3 A residential setting where the member will be living with a relative or other caregiver;

2.30.6.3.3 Of members who transitioned from a nursing facility or an ICF/IID, the number and percent of members who:

2.30.6.3.3.1 Are still in the community;

2.30.6.3.3.2 Returned to a nursing facility within ninety (90) days after transition;

2.30.6.3.3.3 Returned to a nursing facility more than ninety (90) days after transition.

2.30.6.3.4 Number of CHOICES members identified as potential candidates for transition from a nursing facility.

2.30.6.3.5 Of members identified as potential candidates for transition, the number and percent of members who were identified:

2.30.6.3.5.1 By referral (by type of referral, including but not limited to referral by treating physician, nursing facility, ICF/IID community-based organization, family, self, and other);

2.30.6.3.5.2 Via the MDS;

2.30.6.3.5.3 Via care coordination;

2.30.6.3.5.4 By other source.

2.30.6.3.6 Of members identified as potential candidates for transition, the number and percent of members who participated in the Peer-to-Peer Mentoring program.

2.30.6.4 The CONTRACTOR shall submit a monthly Nursing Facility Short-Term Stay Report in a format specified by TENNCARE that includes but it not limited to, for each CHOICES Group 2 and Group 3 member or ECF CHOICES Group 4, 5, and 6 member utilizing the short-term NF stay benefit, the name of each CHOICES Group 2 and Group 3 member or ECF CHOICES Group 4, 5, and 6 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include

explanation regarding why the benefit limit has been exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community or transition to Group 1, as applicable, including the anticipated timeline.

2.30.6.5 The CONTRACTOR shall submit a monthly CHOICES and ECF CHOICES HCBS Late and Missed Visits Report for CHOICES members regarding the following CHOICES HCBS: personal care, attendant care, and home-delivered meals and for ECF CHOICES members regarding the following ECF CHOICES: personal assistance and supportive home care. The report shall contain information on specified measures, including, at minimum, the following:

2.30.6.5.1 Total number of members enrolled in Group 2, Group 3, and in Groups 2 and 3 combined;

2.30.6.5.2 Total number of members enrolled in Group 4, 5, 6, and 7 and in Groups 4, 5, 6, and 7 combined;

2.30.6.5.3 Total number of CHOICES members with scheduled visits for each service type (personal care, attendant care, and home-delivered meals), by provider type (agency provider) and ECF CHOICES members with scheduled visits for each service (personal assistance and supportive home care);

2.30.6.5.4 Total number of scheduled visits for each service type, by provider type.

2.30.6.5.5 Of the total number of scheduled visits for each service type, by provider type; the percent that were:

2.30.6.5.5.1 On-time;

2.30.6.5.5.2 Late;

2.30.6.5.5.3 Missed.

2.30.6.5.6 Of the total number of late visits for each service type, by provider type; the percent that were:

2.30.6.5.6.1 Member-initiated;

2.30.6.5.6.2 Provider-initiated;

2.30.6.5.6.3 Due to weather/natural disaster.

2.30.6.5.7 Of the total number of late visits for each service type, by provider type; the number that were:

2.30.6.5.7.1 Member-initiated, by reason code;

2.30.6.5.7.2 Provider-initiated, by reason code;

2.30.6.5.7.3 Due to weather/natural disaster.

2.30.6.5.8 Of the total number of missed visits for each service type, by provider type; the percent that were:

2.30.6.5.8.1 Member-initiated;

2.30.6.5.8.2 Provider-initiated;

2.30.6.5.8.3 Due to weather/natural disaster.

2.30.6.5.9 Of the total number of missed visits for each service type, by provider type; the number that were:

2.30.6.5.9.1 Member-initiated, by reason code;

2.30.6.5.9.2 Provider-initiated, by reason code;

2.30.6.5.9.3 Due to weather/natural disaster.

2.30.6.5.10 Of the total number of missed visits for each service type, by provider type; the number and percent that were:

2.30.6.5.10.1 Made-up by paid support – provider staff;

2.30.6.5.10.2 Made-up by paid support – worker;

2.30.6.5.10.3 3 Made-up by unpaid support;

2.30.6.5.10.4 Not made-up.

2.30.6.5.11 The CONTRACTOR shall submit a monthly CHOICES and ECF CHOICES Provider Compliance Report for CHOICES members regarding personal care, attendant care, and home-delivered meals, and for ECF CHOICES members regarding personal assistance and supportive home care. The report shall contain information on specified measures including but not limited to the following:

2.30.6.5.11.1 Provider name and region in which the services are provided;

2.30.6.5.11.2 Provider ID;

2.30.6.5.11.3 Total number of visits and percentage of visits that were checked in and out via the GPS tablet;

2.30.6.5.11.4 Total number of visits and percentage of visits that were checked in and out via the IVR system;

2.30.6.5.11.5 Total number of visits and percentage of visits that were checked in and out via the worker's personal device;

2.30.6.5.11.6 Total number of visits and percentage of visits that were checked in and out via manual confirmation process due to system or authorization issues;

2.30.6.5.11.7 Total number of visits and percentage of visits that were checked in and out via manual confirmation process due to worker or provider issues. For each of these visits, the report shall include specific and immediate actions taken by the CONTRACTOR to address EVV compliance, and the efficacy of these actions in improving the provider's performance during the reporting period; and

2.30.6.5.11.8 Actions taken by the CONTRACTOR with the Providers to address compliance.

2.30.6.6 The CONTRACTOR shall submit a quarterly *CHOICES and ECF CHOICES Consumer Direction of HCBS Report*. The report shall include current information, by month, on specified measures, which shall include but not be limited to the following:

2.30.6.6.1 Total number of members enrolled in Group 2, Group 3, and in Groups 2 and 3 combined;

2.30.6.6.2 Total number of members enrolled in Group 4, Group 5, Group 6, and Group 7 and in Groups, 4, 5, 6, and 7 combined;

2.30.6.6.3 The number and percent of members in Groups 2 and 3 (combined) enrolled in consumer direction of eligible CHOICES HCBS;

2.30.6.6.4 The number and percent of members in Groups 4, 5, 6, and 7 (combined) enrolled in consumer direction of eligible ECF CHOICES;

2.30.6.6.5 Number of members referred to the FEA (for enrollment in consumer direction) by CHOICES and ECF CHOICES;

2.30.6.6.6 Maximum and average time from FEA referral to receipt of consumer-directed services by CHOICES and ECF CHOICES and combined;

2.30.6.6.7 Number and percent of members referred to the FEA who began services in a given month (for each month in the reporting period);

2.30.6.6.8 Number and percent of members enrolled in consumer direction who withdrew from consumer direction (for each month in the reporting period) by CHOICES and ECF CHOICES;

2.30.6.6.9 Number and percent of members enrolled in consumer direction who have a representative to assist the member in consumer direction by CHOICES and ECF CHOICES;

2.30.6.6.10 The number and percent of member receiving consumer-directed services by type of consumer-directed service (attendant care, companion care, in-home respite, or personal care for CHOICES and personal assistance, supportive home care, respite, and community transportation for ECF CHOICES);

2.30.6.6.11 The total number and the name, SSN, and phone number, and the authorized representative name and phone number, if applicable, of each member referred to the FEA (for enrollment into consumer direction) that has indicated on his Consumer Direction Participation Form that he does not wish to receive HCBS from contract providers pending enrollment into consumer direction, including the member's date of enrollment in CHOICES Group 2 or ECF CHOICES Group 4, 5, 6, or 7, the date of referral to the FEA for consumer direction, and the total number of days that HCBS have not been received by each member.

2.30.6.7 The CONTRACTOR shall submit a quarterly CHOICES Care Coordination Report, in a format specified by TENNCARE that includes, but is not limited to, information on care coordination staffing, enrollment and care coordination contacts, ongoing assessment, care planning and service initiation, self-directed healthcare tasks, and the CONTRACTOR's care coordination monitoring activities (See Section 2.9.6.13.1).

2.30.6.8 The CONTRACTOR shall submit a quarterly ECF CHOICES Support Coordination Report, in a format specified by TENNCARE that includes, but is not limited to, information on support coordination staffing, enrollment and support coordination contacts, , ongoing assessment, supports planning and service initiation, including the number and percent of newly enrolled members for whom immediately needed and ongoing services were initiated timely (see Sections A.2.9.6.2.5.3.1, A.2.9.6.2.5.3.2, A.2.9.6.3.26.1, and A.2.9.6.3.26.2) and in each instance they were not, the reason(s) for and length of delay, and the CONTRACTOR's support coordination monitoring activities (see Section 2.9.6.13.1).

2.30.6.9 The CONTRACTOR shall submit a monthly CHOICES and ECF CHOICES Caseload and Staffing Ratio Report.

2.30.6.9.1 The report shall reflect the weighted Care Coordinator-to-CHOICES member staffing ratios and Care Coordinator caseloads on the last business day of the month prior to the report submission (e.g. the report submitted in April will reflect the weighted caseloads and staffing ratios as they appeared on March 31);

2.30.6.9.2 The report shall include at a minimum:

2.30.6.9.2.1 The weighted average Care Coordinator-to CHOICES member staffing ratio;

2.30.6.9.2.2 The weighted caseload of CHOICES member assignments to each individual Care Coordinator;

2.30.6.9.2.3 The tenure of Care Coordinators (i.e., the number of months each Care Coordinator has been employed as a Care Coordinator with the CONTRACTOR); and

2.30.6.9.2.4 The number of reassigned members (i.e., the number of members on the CC caseload who were existing CHOICES members with the CONTRACTOR and were reassigned to the Care Coordinator during the month).

2.30.6.9.3 The report shall reflect the weighted Support Coordinator-to-ECF CHOICES member staffing ratios, and Support Coordinator-to-CHOICES member staffing ratios, if a Support Coordinator supports both ECF CHOICES and CHOICES members, and Support Coordinator caseloads on the last business day of the month prior to the report submission (e.g. the report submitted in April will reflect the weighted caseloads and staffing ratios as they appeared on March 31).

2.30.6.9.4 The report shall include at a minimum;

2.30.6.9.4.1 The weighted average Support Coordinator-to-ECF CHOICES member staffing ratio, including the Support Coordinator-to-CHOICES members staffing ratio, if applicable; and

2.30.6.9.4.2 The weighted caseload of ECF CHOICES member assignments, and if CHOICES member assignments, if applicable, to each individual Support Coordinator.

2.30.6.10 THE CONTRACTOR shall submit a monthly Regional Mental Health Institution Report. The report shall include, at a minimum, the following:

2.30.6.10.1 The number of members with I/DD referred for admission to an RMHI;

2.30.6.10.2 The number of members with I/DD diverted from admission to an RMHI to another more appropriate placement;

2.30.6.10.3 The number of members with I/DD admitted to an RMHI;

2.30.6.10.4 The length of stay for each member with I/DD in an RMHI as well as the average length of stay of all members with I/DD in an RMHI; and

2.30.6.10.5 The status of each member with I/DD referred to or receiving services in an RMHI, including transition date and progress toward arranging timely transition.

2.30.6.11 The CONTRACTOR shall submit a listing of members identified as potential pharmacy lock-in candidates (see Section A.2.9.10.3.2) twice a year on June 1 and December 1, according to the following parameters:

2.30.6.11.1 Members with at least 3 controlled substances in a three-month period, and

2.30.6.11.2 at least 3 different pharmacies, and

2.30.6.11.3 at least 3 different emergency room prescribers.

2.30.6.12 The CONTRACTOR shall submit a quarterly Pharmacy Services Report on the prescribing of selected medications mutually agreed-upon by TENNCARE and the CONTRACTOR and includes a list of the providers who appear to be operating outside industry or peer norms as defined by TENNCARE or have been identified as non-compliant as it relates to adherence to accepted treatment guidelines for use of said medications and the steps the CONTRACTOR has taken to personally intervene with each one of the identified providers as well as the outcome of these personal contacts.

2.30.6.13 The CONTRACTOR shall submit a Pharmacy Services Report, On Request when TENNCARE requires assistance in identifying and working with providers for any reason. These reports shall provide information on the activities the CONTRACTOR undertook to comply with TENNCARE's request for assistance, outcomes (if applicable) and shall be submitted in the format and within the time frame prescribed by TENNCARE.

2.30.6.14 The CONTRACTOR shall submit a Housing Profile Assessment Report semi-annually in a format specified by TENNCARE. This report shall monitor the housing needs of CHOICES and ECF CHOICES enrollees waiting to transition or post-transition and includes, but is not limited to, transition wait times, transition barriers, monthly income amounts, housing options chosen, and counties chosen for transition. Additionally, this report shall contain a listing of members receiving a housing supplement including but not limited to, 202 funds, CDBG funds, funds for assistive technology as it relates to housing, funds for home modifications, HOME dollars, housing choice vouchers (such as tenant based, project based, mainstream, or homeownership vouchers), housing trust funds, low income housing tax credits, section 811, USDA rural housing funds, Veterans Affairs housing funds, or other. This report shall contain the names, addresses, and monthly incomes of all the CONTRACTOR's members participating in the (MFP) Non-Profit Affordable Housing Development Grant Initiative. This report shall also contain a list of all members living in homes that are Medicaid-funded and built by Neighborworks America, and shall include the following minimum data elements: (1) member name; (2) member address; (3) member's CHOICES or ECF CHOICES Group number; (4) whether member participates in MFP; (5) date member moved into the Neighborworks America residence; (6) date member moved out of the

Neighborworks America residence (left blank if still currently residing at that location); (7) member's monthly rent paid; and (8) member's monthly income.

2.30.6.14.1 The second semi-annual submission each year will also include a brief narrative of the CONTRACTOR'S work strategy to create stronger networks and develop easier access to affordable housing. (See Section A.2.11.7.7).

2.30.6.15 The CONTRACTOR shall submit to TENNCARE on a monthly basis, a Community Living Supports and Community Living Supports – Family Model Placement Report on all of the CONTRACTOR's members who have entered or exited the CLS or CLS-FM residences during that month. The report shall include the name of each CHOICES Group 2 and Group 3 member or ECF CHOICES Group 5 or 6 member receiving CLS and CLS-FM services, the CLS/CLS-FM provider name, the member's address, the date CLS/CLS-FM services initiated at the address, the date CLS/CLS-FM services terminated at the address, if applicable, and the reason for such termination.

2.30.6.16 The CONTRACTOR shall submit to TENNCARE on a quarterly basis, a CHOICES HCBS Point of Service Satisfaction Report. In the manner prescribed by TENNCARE, the report shall include point-of service satisfaction data captured by the EVV (see A.2.9.6.13.6.20) by provider name and region.

2.30.6.17 The CONTRACTOR shall submit to TENNCARE on a quarterly basis, an ECF CHOICES HCBS Point of Service Satisfaction Report. In the manner prescribed by TENNCARE, the report shall include point-of service satisfaction data captured by the EVV by provider name and region.

2.30.6.18 The CONTRACTOR shall submit to TENNCARE on a monthly basis an ECF CHOICES Employment Report. In the manner prescribed by TENNCARE, this report shall provide employment data including the following:

2.30.6.18.1 The number and percent of the CONTRACTOR's ECF CHOICES members who are actively working in integrated competitive employment and separately in self-employment, including a breakdown by the number of hours worked, as specified by TENNCARE;

2.30.6.18.2 Number and percent of ECF CHOICES members who are earning at or above the minimum wage;

2.30.6.18.3 Number and percent of ECF CHOICES members actively engaged in employment planning, development, or preparation;

2.30.6.18.4 A listing of all members who have completed the informed choice process as prescribed in TennCare protocol; and

2.30.6.18.5 Any other employment data as specified by TENNCARE.

2.30.6.19 The CONTRACTOR shall submit to TENNCARE on a quarterly basis and ECF CHOICES Reimbursement Services Report. In the manner prescribed by TENNCARE, this report shall provide information about the following services:

2.30.6.19.1 For the conservatorship counseling and assistance service, the CONTRACTOR shall provide a report of the specific outcomes of this service, including the total number of members who received the service during the reporting period, how

many people were able to maintain their full rights (with or without supported decision making), how many people maintained part of their decision-making rights through alternative types of delegated decision-making, and how many people relinquished decision-making rights through the appointment of a conservator.

2.30.6.19.2 For the family caregiver education and training service, and separately for the individual education and training service, the CONTRACTOR shall provide a report of the total number of members who received the service during the reporting period, and a detailed listing of the types of education and training services reimbursed, including the number of members receiving such reimbursement and total expenditures for each type of education or training.

2.30.6.19.3 For the community support development, organization, and navigation service, the CONTRACTOR shall provide a report of the total number of members who received the service during the reporting period, and a narrative description about how the benefit is being used, i.e., the types of activities being undertaken to support individuals and their families in supporting one another and in identifying, building, and using supports available from community service organizations, and the outcomes that have been achieved.

2.30.6.19.4 For the peer-to-peer support and navigation for person-centered planning, self-direction, integrated employment/self-employment and independent community living service, the CONTRACTOR shall provide a report of the total number of members who received the service during the reporting period, and a narrative description of how the benefit is being used, i.e., the types of support and navigation requested, and whether such assistance was helpful in supporting the member to achieve their goals regarding person-centered planning, self-direction, integrated employment/self-employment and independent community living.

2.30.6.19.5 For the Family Caregiver Stipend, the name of each member whose family caregiver receives a stipend, the amount of the stipend, and how the member's employment and community integration support needs are being met.

2.30.6.20 The CONTRACTOR shall submit a quarterly Meeting the Urgent (RED FLAG) Needs of Members during Transition Report that provides data requested by TENNCARE following the provisions outlined in the "QUALITY OVERSIGHT OPERATIONAL PROTOCOL - Meeting the Urgent Needs of Members during Transition", which shall include but not be limited to:

2.30.6.20.1 The date that the 834 plan enrollment file was received by the MCO that shows that the applicable "Red Flag" member has been transferred to the MCO's membership (where applicable);

2.30.6.20.2 The date that the 834 plan enrollment file was received by the MCO (following the member's transition) that shows that the applicable "Red Flag" member has been transferred from the MCO's membership (where applicable);

2.30.6.20.3 The date that the "Transition Report/Data Request File" was sent to the Sending MCO;

2.30.6.20.4 The date that the "Transition Report/Data Request File" was received from the Receiving MCO;

2.30.6.20.5 The date of the first successful outreach contact;

2.30.6.20.6 The type of outreach;

2.30.6.20.7 The outreach recipient;

2.30.6.20.8 The final disposition of member outreach; and

2.30.6.20.9 A list of MCO employees that received Red Flag Trigger training.

2.30.6.20.10 The CONTRACTOR may request one (1) extension of up to three (3) business days from TENNCARE for completion of its "Red Flag" outreach process. TENNCARE shall designate the format in which the request may be made. Extension requests will only be granted by TENNCARE upon extenuating circumstances beyond the CONTRACTOR's control, and such request for an extension shall be made as soon as practicable but not later than twenty-four (24) hours after the third (3rd) business day of initial attempted member outreach.

2.30.6.21 The CONTRACTOR shall submit to TENNCARE a Semi-Annual HH/PDN Coordination Report demonstrating the CONTRACTOR's completion of requirements described in Sections A.2.9.4.1 in accordance with a template described by TENNCARE.

2.30.6.22 The CONTRACTOR shall provide a Monthly HH/PDN Coordination Report to TENNCARE, as described in Section 2.9.4.1.4.4.4, for each member outlining continued engagement, assessments, transition planning discussions and activities and supporting documentation. The report shall also include clinical assessment documenting whether the patient is ventilator dependent or has a tracheostomy or other complex respiratory care needs that qualify for PDN and current skilled nursing needs.

2.30.6.23 The CONTRACTOR shall provide a *Weekly Member MCO Selection/Assignment Report* in accordance with Section A.2.9.4.1.4.5.

2.30.6.24 The CONTRACTOR shall submit to TENNCARE a Semi-Annual HH/PDN ALJ/CEA Report demonstrating the CONTRACTOR's compliance with requirements described in Section A.2.9.4.1.8.

2.30.6.25 The CONTRACTOR shall submit to TennCare, on a monthly basis, an *ECF CHOICES Group 7 Report* in a manner prescribed by TennCare. Reports are due the following month using the reporting template prescribed by TennCare. Reports will include, at minimum, data on Referrals (including members requesting and/or considered for referral, as well as members actually referred), Enrollment & Service Initiation, Service Utilization, Providers, Staffing, Support Coordination, crisis events, outcomes, transitions, transition follow-ups, and re-entry into Group 7. Group 7 reports shall include outcomes information including but not limited to the number of days behavioral respite services were utilized, number of appointments missed, number of days the member remained in a community setting, and whether the member participated in paid employment, including the number of hours the member worked and the number of school days missed, as applicable.

2.30.6.26 The CONTRACTOR shall submit to TennCare, on a monthly basis, an *ECF CHOICES Group 8 Report* in a manner prescribed by TennCare. Reports are due the following month using the reporting template prescribed by TennCare. Reports will

include, at minimum, data on Referrals (including members requesting and/or considered for referral, as well as members actually referred), Enrollment & Service Initiation, Service Utilization, Providers, Staffing, Support Coordination, crisis events, outcomes, transitions, transition follow-ups, and re-entry into Group 8. Group 8 reports shall include outcomes information including but not limited to the number of days behavioral respite services were utilized, number of appointments missed, number of days the member remained in a community setting, and whether the member participated in paid employment, including the number of hours the member worked and the number of school days missed, as applicable.

2.30.6.27 The CONTRACTOR shall provide an Electronic Visit Verification (EVV) Monitoring Report in a manner and frequency as specified by TENNCARE. The purpose of this Report shall be to facilitate TennCare oversight of the CONTRACTOR's ongoing monitoring of services logged through the EVV system, including but not limited to overlapping visits, as well as remediation to address findings and support system improvement, as required by Section A.2.9.6.13

A.2.30.7 **LEFT BLANK INTENTIONALLY**

A.2.30.8 **Provider Network Reports**

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 A.2.11). This includes but is not limited to, PCPs, physician specialists, hospitals, home health agencies, CMHAs, nursing facilities, CHOICES HCBS providers, ECF CHOICES HCBS providers, and emergency and nonemergency transportation providers. For CHOICES HCBS and ECF CHOICES HCBS providers, the Provider Enrollment File shall identify the type(s) of CHOICES HCBS and ECF CHOICES HCBS the provider is contracted to provide and the specific counties in which the provider is contracted to deliver CHOICES HCBS and ECF CHOICES HCBS, by service type. For Behavioral Crisis Prevention, Intervention, and Stabilization Services for Individuals with Intellectual or Developmental Disabilities (see Section A.2.7.2.8.4), the report shall specify the specific counties in which the provider is contracted to deliver such services. 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.

2.30.8.2 The CONTRACTOR shall submit an annual Provider Compliance with Access Requirements Report that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access standards as well as an emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. This report/plan shall also be available upon request. (See Section A.2.11.1.10)

2.30.8.3 The CONTRACTOR shall submit a quarterly PCP Assignment Report that provides the following information for non-dual members: Provider Name, Provider Medicaid I.D. Number, NPI Number, Number of Enrollees assigned by Enrollee Age Category.

The enrollee age categories shall be consistent with the following: Age Under 1, Age 1 – 13, Age 14 – 20, Age 21- 44, Age 45 – 64, Age 65 +. (See Section A.2.11.2)

2.30.8.4 The CONTRACTOR shall submit an annual Report of Essential Hospital Services by September 1 of each year. The CONTRACTOR shall use the format in Attachment IX, Exhibit D.

2.30.8.5 The CONTRACTOR shall submit an Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness that shall include the CONTRACTOR's plan for monitoring behavioral health providers to ensure that they comply with the timeliness of appointment standards that are outlined for behavioral health in Attachment III for routine specialty MD (behavioral health) care and Attachment V for Outpatient Non-MD behavioral health services. This plan will be submitted for approval to the Division of TennCare by December 31 of each year and shall identify methods for determining how they will monitor and evaluate providers for compliance, develop corrective action plans for compliance, maintain records of audits for timeliness and describe efforts to improve timeliness of appointments. The minimum data elements required are identified in Attachment IX, Exhibit C.

2.30.8.6 The CONTRACTOR shall submit a Quarterly Behavioral Health Appointment Timeliness Summary Report that includes a quarterly summary of activities based on the Annual Plan for Monitoring of Behavioral Health Appointment Timeliness (See Section A.2.30.8.5). The minimum data elements required are identified in Attachment IX, Exhibit C.

2.30.8.7 The CONTRACTOR shall submit an annual FQHC Report by January 1 of each year. The CONTRACTOR shall use the form provided in Attachment IX, Exhibit E.

2.30.8.8 The CONTRACTOR shall, using a template provided by TENNCARE, submit a Quarterly CHOICES HCBS and ECF CHOICES Provider Criminal Background Check and Registry Check Report to demonstrate that the CONTRACTOR's CHOICES and ECF CHOICES providers are conducting criminal background checks in accordance with Section A.2.29.2.2 as reviewed during credentialing and recredentialing visits conducted during a given quarter.

2.30.8.9 The CONTRACTOR shall submit a Quarterly *HCBS Settings Report* that aggregates the HCBS Settings data collected pursuant to Section A.2.9.6.6.2.5 and identifies trends relating to member concerns with particular providers or provider settings, including steps for remediation to address these concerns.

2.30.8.10 The CONTRACTOR shall submit an annual Behavioral Health Service Matrix Report to TENNCARE. This report shall include full and complete information regarding the CONTRACTOR's behavioral health provider services in a format prescribed by TENNCARE.

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A.2.30.10 **Provider Payment Reports**

2.30.10.1 The CONTRACTOR shall submit a quarterly Related Provider Payment Report that lists all related providers and subcontractors to whom the CONTRACTOR has made payments during the previous quarter and the payment amounts. (See Section A.2.13.20)

2.30.10.2 The CONTRACTOR shall submit Check Run Summaries on at least a monthly basis. The summaries should be submitted for the relevant adjudication cycle(s) during the reporting period.

2.30.10.3 The CONTRACTOR shall submit a Claims Data Extract that shall be due at least on a monthly basis along with the Check Run Summaries and shall be submitted for the relevant adjudication cycle(s) during the reporting period.

2.30.10.4 The CONTRACTOR shall provide a monthly Reconciliation Report for the total paid amounts between the funds released for payment to providers and the FEA (for consumer-directed workers), the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The Reconciliation Report shall be submitted the month after the claims data extract is submitted.

2.30.10.5 Upon notification by TENNCARE, the CONTRACTOR shall submit a weekly Administrative Services Only Invoice Report for all payments to clinics designated as Federally Qualified Health Clinics or Rural Health Clinics.

A.2.30.11 **Utilization Management Reports**

2.30.11.1 The CONTRACTOR shall submit quarterly Cost and Utilization Reports. These reports shall be in an Excel spreadsheet format and submitted with a ninety (90) day lag and shall be due to TENNCARE one hundred twenty (120) calendar days following the quarter for which the CONTRACTOR is reporting. These reports shall be submitted on both a cumulative year basis and on a rolling twelve (12) month basis.

2.30.11.2 The CONTRACTOR shall provide quarterly Cost and Utilization Summaries. These summaries shall report on services paid during the previous quarter. The summaries shall include all data elements listed in Attachment IX, Exhibit F.

2.30.11.3 The CONTRACTOR shall identify and report the number of members who incurred non-nursing facility claims in excess of twenty-five thousand dollars ($25,000) on a rolling quarterly basis (high-cost claimants). The CONTRACTOR shall report the member's age, sex, primary diagnosis, and amount paid by claim type for each member. The name and other identifying information of the member shall be blinded in order to maintain confidentiality.

2.30.11.4 The CONTRACTOR shall submit a monthly CHOICES and ECF CHOICES Utilization Report. MFP participants (see Section A.2.9.8) shall be identified separately for each data element described herein. The report shall be submitted on a monthly basis with a one (1) month lag period (e.g., March information sent in the May report) and shall include a summary overview that includes the number of CHOICES and ECF CHOICES members who have not received any long-term care services within thirty (30) to fifty-nine (59) days, within sixty (60) to eighty-nine (89) days, or in ninety (90) days or more. The report shall also include detailed member data for members who have not received services in the last thirty (30) days, including the member's name, social security number, CHOICES or ECF CHOICES group, and CHOICES or ECF CHOICES enrollment date; date of last long-term care service; length of time without long-term care services; whether and when long-term care services will resume; and the reason/explanation why the member has not received long-term care services.

2.30.11.5 The CONTRACTOR shall submit a copy of the notification regarding the Referral Provider Listing (see Section A.2.14.3.5), a data file of the provider information used to create the listing, and documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity of the notices to providers, the date sent, and to whom. The CONTRACTOR shall submit this information at the same time it is sent to the providers as required in Section A.2.14.3.5.

2.30.11.6 Effective July 1, 2017, the CONTRACTOR shall submit an annual *Behavioral Health Coverage Annual Report* to the TENNCARE on or before March 1 of each year that contains information for enrollees in the TennCare program in accordance with Tennessee Code Annotated, 71-5-154, regarding coverage of mental health and alcohol and drug dependence benefits. This report shall include full and complete information regarding enrollees in the TennCare program in a format prescribed by TENNCARE.

A.2.30.12 **Quality Management/Quality Improvement Reports**

2.30.12.1 The CONTRACTOR shall submit a preliminary Performance Improvement Projects Topics report that includes information specified in Section A.15.3.6. The CONTRACTOR shall list and clearly categorize and label each PIP for the upcoming year into the area that it addresses. The CONTRACTOR shall indicate the current measurement year (Baseline, Y1, Y2, Extension Y3, Extension Y4, or Extension Y5) for each PIP. The CONTRACTOR shall also include the rationale for selection of each new PIP topic. The CONTRACTOR shall submit the report annually on or before March 31.

2.30.12.1.1 The CONTRACTOR shall submit an annual Report on Performance Improvement Projects that includes the information specified in Section A.2.15.3. For Performance Improvement Project topics that are conducted in more than one region of the State, the CONTRACTOR shall submit one Performance Improvement Projects Summary Report that includes region-specific data and information, including improvement strategies. The CONTRACTOR shall submit the report annually on July 30.

2.30.12.2 The CONTRACTOR shall submit its NCQA Accreditation Report (the final bound copy from NCQA) immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA.

2.30.12.3 The CONTRACTOR shall submit its annual reevaluation of accreditation status based on HEDIS scores immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA.

2.30.12.4 The CONTRACTOR shall submit to TENNCARE by June 15 of each calendar year a detailed explanation for any Medicaid HEDIS measure marked as "Not Reported".

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

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

2.30.12.7 The CONTRACTOR shall submit a quarterly CHOICES HCBS Critical Incidents Report (see Section A.2.15.7). MFP participants (see Section A.2.9.8) shall be identified separately for each data element described herein. The report shall provide information, by month regarding specified measures, which shall include but not be limited to the following:

2.30.12.7.1 A list of all critical incidents reported during the applicable reporting period, including the member name, CHOICES Group, type of incident, date of incident, setting, and type of provider;

2.30.12.7.2 The number of members in Group 2, Group 3, and Groups 2 and 3 combined;

2.30.12.7.3 The number of critical incidents, overall and by:

2.30.12.7.3.1 Type of incident;

2.30.12.7.3.2 Setting;

2.30.12.7.3.3 Type of provider (provider agency or consumer directed worker).

2.30.12.7.4 The percent of incidents by type of incident;

2.30.12.7.5 The percent of members in Groups 2 and 3 with an incident; and

2.30.12.7.6 A narrative describing the CONTRACTOR's analysis of critical incidents for the reporting period, including trends and patterns; opportunities for improvement; and strategies implemented by the CONTRACTOR to reduce the occurrence of incidents and improve the quality of CHOICES HCBS.

2.30.12.8 The CONTRACTOR shall submit a quarterly ECF CHOICES HCBS Reportable Event Report (see Section A.2.15.7.6). MFP participants (see Section A.2.9.8) shall be identified separately for each data element described herein. The report shall provide information, by month regarding specified measures, which shall include but not be limited to the following:

2.30.12.8.1 A list of all reportable events reported during the applicable reporting period, including the member name, ECF CHOICES Group, type of reportable event, date of reportable event, setting, and type of provider;

2.30.12.8.2 The number of members in Group 4, Group 5, Group 6, Group 7, and Group 8 and in Groups 4, 5, 6, 7, and 8 combined;

2.30.12.8.3 The number of Reportable Events, overall and by:

2.30.12.8.3.1 Type of Reportable Event, including whether the Reportable Event was Tier 1 or Tier 2;

2.30.12.8.3.2 Setting; and

2.30.12.8.3.3 Type of provider (provider agency or consumer directed worker).

2.30.12.8.4 The percent of Reportable Events by type of Reportable Event, stratified by Tier 1 and Tier 2 Reportable Events; and

2.30.12.8.5 The percent of members in Groups 4, 5, 6, 7, and 8 with a Reportable Event.

2.30.12.8.6 Any sanction actions taken by the CONTRACTOR regarding Reportable Events; and

2.30.12.8.7 A summary of the CONTRACTOR's findings from trending Reportable Events, including actions taken by the CONTRACTOR to prevent future Reportable Events.

2.30.12.9 The CONTRACTOR shall submit a quarterly Behavioral Health Adverse Occurrences Report in accordance with Section A.2.15.7.2 that provides information, by month regarding specified measures, which shall include but not be limited to the following:

2.30.12.9.1 The number of adverse occurrences, overall and by:

2.30.12.9.1.1 Date of occurrence

2.30.12.9.1.2 Type of adverse occurrence;

2.30.12.9.1.3 Location;

2.30.12.9.1.4 Provider name; and

2.30.12.9.1.5 Action Taken by Facility/Provider.

2.30.12.10 The CONTRACTOR shall submit a quarterly Settings Compliance Committee Report (see Section A.2.24.5). The report shall provide information regarding the committee's activities, as follows:

2.30.12.10.1 The date of each meeting of the committee and the meeting participants;

2.30.12.10.2 The total number of CHOICES plans of care and ECF CHOICES PCSPs and BSPs reviewed during the quarter (see Section A.2.24.5.3.1), and a summary of the outcomes of such reviews, including actions pertaining to individual members or providers or to broader systemic improvements;

2.30.12.10.3 The total number of proposed or emergency rights restrictions or restraints reviewed during the quarter that are not part of a plan of care or PCSP or BSP (see Section A.24.5.3.2), and a summary of the outcomes of such reviews, including actions pertaining to individual members or providers or to broader systemic improvements;

2.30.12.10.4 The total number of periodic data reviews regarding interventions specified in A.24.5.3.1 or A.24.5.3.2 conducted during the quarter (see Section A.24.5.3.3), and a summary of the outcomes of such reviews, including actions pertaining to individual members or providers or to broader systemic improvements;

2.30.12.10.5 The total number of reviews of psychotropic medications conducted during the quarter (see Section A.24.5.3.4), and a summary of the outcomes of such reviews, including actions pertaining to individual members or providers or to broader systemic improvements; and

2.30.12.10.6 The total number of complaints regarding restrictive interventions or settings compliance concerns received and reviewed during the quarter (see Section A.24.5.3.5), and a summary of the outcomes of such reviews, including actions pertaining to individual members or providers or to broader systemic improvements.

2.30.12.11 The CONTRACTOR shall distribute quarterly *MAT Network Quality Metrics Reports* to all contracted MAT providers on a NPI-level as described by TENNCARE. Reports

shall be distributed in a format described by TENNCARE no later than ninety (90) calendar days following the end of each calendar year quarter.

2.30.12.12 The CONTRACTOR shall submit a quarterly *MAT Network Quality Metrics Summary* Report no later than one hundred twenty (120) calendar days following the end of each calendar year quarter unless otherwise described by TENNCARE. The Summary Report shall synthesize all key information from the MAT Network Quality Metric Reports as described by TennCare. Reports will assess MAT providers and collect aggregate data indicative of provider performance, outcomes, and activity.

2.30.12.13 The CONTRACTOR shall submit in a form and format prescribed by TENNCARE a monthly System of Support (SOS) Report regarding Behavioral Crisis Prevention, Intervention, and Stabilization Services as described in Section 2.7.2.8.4. The report shall combine data collected by the CONTRACTOR from the SOS provider, as appropriate, with data collected directly by the CONTRACTOR. The CONTRACTOR shall establish and conduct ongoing processes to validate the accuracy of all information submitted, whether collected from the provider or directly by the CONTRACTOR and shall take prompt action as needed to address any problems with accurate reporting.

A.2.30.13 **Customer Service Reports/Provider Service Reports**

2.30.13.1 <u>Member Services/Provider Services/ED Phone Line Reports</u>

2.30.13.1.1 The CONTRACTOR shall submit a quarterly Member Services, Provider Services, and Utilization Management Phone Line Report. The data in the report shall be recorded by month and shall include the detailed rate calculations. The CONTRACTOR shall submit the report in the format specified in Attachment IX, Exhibit G.

2.30.13.2 The CONTRACTOR shall report separately any member services or utilization management phone lines operated by subcontractors.

2.30.13.3 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that includes stratification by physical health providers, behavioral health providers, CHOICES (nursing facility and HCBS) providers, and ECF CHOICES HCBS providers. The CONTRACTOR shall submit the report utilizing the template provided annually by TENNCARE. The report shall summarize the provider survey methods and findings and must provide an analysis of opportunities for improvement (see Section A.2.18.7.4) This report shall be submitted by January 30 each year.

2.30.13.4 The CONTRACTOR shall submit a quarterly Provider Complaints and Appeals Report, in a format prescribed by TENNCARE, which provides information on the complaints and appeals received either in writing or by phone regarding claims payment.

2.30.13.4.1 For those matters that have not been resolved in the current reporting period, they must continue to be reported until resolved. If a complaint or appeal has not been resolved within sixty (60) days, the CONTRACTOR shall continue to report to TENNCARE why that matter has not been resolved and the expected date of resolution. Any matter identified as having not been resolved within sixty (60) calendar days will be individualized and subject to separate independent reporting by the CONTRACTOR to TENNCARE. Failure to resolve an issue within sixty (60) days may result in a corrective action plan or liquidated damages:

A.2.30.14 **Member Complaints**

2.30.14.1 Upon receipt of a reporting template from TENNCARE and in accordance with specified timeframes for implementing the new report, the CONTRACTOR shall begin submitting a quarterly CHOICES and ECF CHOICES Member Complaints Report (see Section A.2.19.2) that includes information, by month, regarding specified measures, which shall include but not be limited to the following:

2.30.14.1.1 The number of complaints received in the month, overall, by type, and by CHOICES or ECF CHOICES Group;

2.30.14.1.2 The number and percent of complaints for which the CONTRACTOR met/did not meet the specified timeframe for resolution (see Section A.2.19.2.5).

2.30.14.2 The report shall also include identification of any trends regarding complaints (e.g., the type or number of complaints) and any action steps to address these trends, including quality improvement activities.

A.2.30.15 **Fraud, Waste, and Abuse Reports**

2.30.15.1 All Fraud, Waste and Abuse deliverables shall follow the guidance outlined in the Managed Care Program Integrity Guidelines provided by TennCare OPI. These guidelines are incorporated by reference and shall be utilized.

2.30.15.2 The CONTRACTOR shall submit a quarterly *Fraud, Waste, and Abuse Activities Report*. This report shall summarize the results of its fraud, waste, and abuse compliance plan (see Section A.2.20) and other fraud, waste, and abuse prevention, detection, reporting, and investigation measures.

2.30.15.3 The CONTRACTOR shall submit an annual *Fraud, Waste, and Abuse Compliance Plan* (see Section A.2.20.3 of this Contract) and provide a crosswalk of the detailed compliance plan requirements and the CONTRACTOR's compliance plan. These policies shall be submitted by July 1st of each year.

2.30.15.4 On an annual basis the CONTRACTOR shall submit its policies for employees, contractors, and agents that comply with Section 1902(a)(68) of the Social Security Act. These policies shall be submitted by July 1 of each year.

2.30.15.5 The CONTRACTOR shall submit a quarterly *Disclosure Submission Rate report* which shall provide the percentage of providers for which the CONTRACTOR has obtained a complete and current disclosure form in accordance with 42 CFR 455, TennCare policies and procedures, and this Contract (see Section A.2.12.9.37). The rate shall be provided for all tax-reporting entities with billing activities during the prior quarter. The quarterly report shall include a companion listing which shall include all tax-reporting entities with reimbursement amounts received in the prior reporting quarter along with the disclosure status. For all subcontractors and providers with a signed contract and/or with billing activities, the CONTRACTOR shall maintain a minimum of ninety-five percent (95%) compliance on all entities excluding providers who bill under emergency provisions. Should the CONTRACTOR attain a disclosure rate below ninety-five percent (95%), the CONTRACTOR shall be subject to liquidated damages and shall submit a corrective action plan that shall address the root causes of the non–compliance.

2.30.15.6 The CONTRACTOR shall submit a monthly *Program Integrity Exception List Report* that identifies employees or contractors (as defined in Section A.2.21.9) that have been reported on the HHS-OIG List of Excluded Individuals/Entities, the System for Award Management, the Social Security Master Death File, and/or the listing of Monthly Disciplinary Actions issued by the Professional Health Board.

2.30.15.7 The CONTRACTOR shall submit a monthly *List of Involuntary Terminations Report* (including providers termed due to sanctions, invalid licenses, services and billing concerns, etc.) due to program integrity concerns to TENNCARE.

2.30.15.8 The CONTRACTOR shall submit an annual *Recoveries Report* detailing all administrative and non-administrative recovery activities conducted by the CONTRACTOR during the previous calendar year. The report shall be submitted no later than February 15 every year and in the format provided by TennCare OPI.

2.30.15.9 The CONTRACTOR shall submit a quarterly *Explanation of Benefits (EOBs) Report* detailing the EOBs sent to members during the previous quarter. This report shall summarize the number of EOBs sent by category, member complaints, and complaint resolution (including referral to TBI/OIG). (See Section A.2.22.9)

2.30.15.10 The CONTRACTOR shall submit a Bi-monthly *Tips Report* of all tips of potential or suspected fraud, waste or abuse received during the previous two-week period, including tips that have not yet been assigned, have been screened out, and/or have been closed with no action.

2.30.15.11 The CONTRACTOR shall submit a quarterly *Fraud, Waste, and Abuse Cost Savings Information Report*, which shall include information regarding where savings were identified and the methodology used to calculate the cost avoidance.

2.30.15.12 The CONTRACTOR shall immediately submit a referral to TennCare OPI and TBI MFCD simultaneously once the suspected fraud, waste, and abuse is determined credible upon completion of an investigation.

2.30.15.13 In addition to the appropriate agency as described in Section A.2.20.2, the CONTRACTOR shall report all confirmed or suspected fraud, waste, and abuse to TENNCARE immediately in accordance with Section A.2.20.2.

A.2.30.16 **Financial Management Reports**

2.30.16.1 <u>Third Party Liability (TPL) Resources Reports</u>

2.30.16.1.1 The CONTRACTOR shall submit a monthly, quarterly and annual *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well funds for which the CONTRACTOR does not pay a claim due to TPL coverage or Medicare coverage. This CONTRACTOR shall calculate cost savings in categories described by TENNCARE.

2.30.16.2 <u>Financial Reports to TENNCARE</u>

2.30.16.2.1 The CONTRACTOR shall submit a *Medical Loss Ratio Report* monthly with cumulative year to date calculation and shall comply with the following:

2.30.16.2.1.1 The CONTRACTOR shall report all medical expenses, including for ECF CHOICES, costs related to the provision of support coordination, and complete the

supporting claims lag tables. Expenses shall be reported in accordance with the following:

2.30.16.2.1.1.1 Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense shall be prorated between types of expenses.

2.30.16.2.1.1.2 Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on pro rata basis.

2.30.16.2.1.1.3 Expense allocation shall be based on a generally accepted accounting method that is expected to yield the most accurate results.

2.30.16.2.1.1.4 Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense.

2.30.16.2.1.1.5 Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to the other entities.

2.30.16.2.1.2 The CONTRACTOR may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

2.30.16.2.1.2.1 The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the state.

2.30.16.2.1.2.2 The CONTRACTOR may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

2.30.16.2.1.2.3 If an CONTRACTOR's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

2.30.16.2.1.3 The MLR calculation in a MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

2.30.16.2.1.4 The CONTRACTOR shall aggregate data for all Medicaid eligibility groups covered under the Contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

2.30.16.2.1.5 The CONTRACTOR shall submit a MLR report to TENNCARE that includes, for each MLR reporting year:

2.30.16.2.1.5.1 Total incurred claims.

2.30.16.2.1.5.2 Expenditures on quality improving activities.

2.30.16.2.1.5.3 Expenditures related to activities compliant with program integrity requirements.

2.30.16.2.1.5.4 Non-claims costs.

2.30.16.2.1.5.5 Premium revenue.

2.30.16.2.1.5.6 Taxes.

2.30.16.2.1.5.7 Licensing fees.

2.30.16.2.1.5.8 Regulatory fees.

2.30.16.2.1.5.9 Methodology(ies) for allocation of expenditures.

2.30.16.2.1.5.10 Any credibility adjustment applied.

2.30.16.2.1.5.11 The calculated MLR.

2.30.16.2.1.5.12 Any remittance owed to the state, if applicable.

2.30.16.2.1.5.13 A comparison of the information reported with the audited financial report.

2.30.16.2.1.5.14 A description of the aggregation method used to calculate total incurred claims.

2.30.16.2.1.5.15 The number of member months

2.30.16.2.1.6 The CONTRACTOR shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the CONTRACTOR within One Hundred Eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the CONTRACTOR, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

2.30.16.2.1.7 In any instance where TENNCARE makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the CONTRACTOR shall:

2.30.16.2.1.7.1 Re-calculate the MLR for all MLR reporting years affected by the change.

2.30.16.2.1.7.2 Submit a new MLR report meeting the applicable requirements.

2.30.16.2.1.8 This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy.

2.30.16.2.1.9 The CONTRACTOR shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

2.30.16.2.1.10 The CONTRACTOR shall also file this report with its NAIC filings due in March and August of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary.

2.30.16.2.1.10.1 This report shall reconcile to NAIC filings including the supplemental TennCare income statement.

2.30.16.2.1.11 The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as

reported on the CONTRACTOR's encounter file submission as specified in Sections A.2.30.18.3 and A.2.23.4.

2.30.16.2.2 The CONTRACTOR shall submit an annual *Ownership and Financial Disclosure Report* to TENNCARE. This report shall include full and complete information regarding ownership, financial transactions and persons as described in Section A.2.21.9 and shall be submitted March 1 of each calendar year and at other times as required by TENNCARE. At a minimum, the information reported on shall include the following:

2.30.16.2.2.1 The name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its subcontractors. The address for corporate entities shall include as applicable primary business address, every business location, and P.O. Box address.;

2.30.16.2.2.2 The date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the CONTRACTOR and its subcontractors;

2.30.16.2.2.3 Other tax identification number of any corporation with an ownership or control interest in the CONTRACTOR and any subcontractor in which the CONTRACTOR has a five percent (5%) or more interest;

2.30.16.2.2.4 Information on whether an individual or corporation with an ownership or control interest in the CONTRACTOR is related to another person with ownership or control interest in the CONTRACTOR as a spouse, parent, child, or sibling;

2.30.16.2.2.5 Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the CONTRACTOR has a five percent (5%) or more interest is related to another person with ownership or control interest in the CONTRACTOR as a spouse, parent, child, or sibling

2.30.16.2.2.6 The name of any other disclosing entity in which an owner of the CONTRACTOR has an ownership or control interest; and

2.30.16.2.2.7 The name, address, date of birth, and SSN of any managing employee of the CONTRACTOR.

2.30.16.2.3 The CONTRACTOR shall submit its annual audit plan on March 1 of each year (see Section A.2.21.10).

2.30.16.3 <u>TDCI Financial Reports</u>

2.30.16.3.1 By no later than December 31 of each year, the CONTRACTOR shall submit to TDCI an annual *Financial Plan and Projection of Operating Results Report*. This submission shall include the CONTRACTOR's budget projecting revenues earned and expenses incurred on a calendar year basis through the term of this Contract. This budget shall be prepared in accordance with the form prescribed by TDCI and shall include narratives explaining the assumptions and calculations utilized in the projections of operating results.

2.30.16.3.2 By no later than July 31 of each year, the CONTRACTOR shall submit to TDCI a mid-year *Comparison of Actual Revenues and Expenses to Budgeted Amounts Report*. If necessary, the CONTRACTOR shall revise the calendar year budget based on its actual

results of operations. Any revisions to the budget shall include narratives explaining the assumptions and calculations utilized in making the revisions.

2.30.16.3.3 The CONTRACTOR shall submit to TDCI an *Annual Financial Report* required to be filed by all licensed health maintenance organizations pursuant to TCA 56-32-108. This report shall be on the form prescribed by the National Association of Insurance Commissioners (NAIC) for health maintenance organizations and shall be submitted to TDCI on or before March 1 of each calendar year. It shall contain an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The CONTRACTOR in preparing this annual report shall comply with any and all rules and regulations of TDCI related to the preparation and filing of this report. This Annual Report shall also be accompanied by the Medical Loss Ratio report, where applicable, completed on a calendar year basis. The CONTRACTOR shall submit a reconciliation of the Medical Loss Ratio report to the annual NAIC filing using an accrual basis that includes an actuarial certification of the claims payable (reported and unreported).

2.30.16.3.4 The CONTRACTOR shall file with TDCI, a *Quarterly Financial Report.* These reports shall be on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations and shall be submitted to TDCI on or before May 15 (covering first quarter of current year), August 15 (covering second quarter of current year) and November 15 (covering third quarter of current year). Each quarterly report shall also contain an income statement detailing the CONTRACTOR's quarterly and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The second quarterly report (submitted on August 15) shall include the Medical Loss Ratio report completed on an accrual basis that includes an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with National Association of Insurance Commissioners guidelines. The CONTRACTOR shall also submit a reconciliation of the Medical Loss Ratio report to the second quarterly NAIC report.

2.30.16.3.5 The CONTRACTOR shall submit to TDCI annual *Audited Financial Statements.* Such audit shall be performed in accordance with NAIC Annual Statement Instructions regarding the annual audited financial statements. There are three (3) exceptions to the NAIC statement instructions:

2.30.16.3.5.1 The CONTRACTOR shall submit the audited financial statements covering the previous calendar year by May 1 of each calendar year.

2.30.16.3.5.2 Any requests for extension of the May 1 submission date must be granted by the Office of the Comptroller of the Treasury pursuant to the "Contract to Audit Accounts."

2.30.16.3.5.3 The report shall include an income statement addressing the TENNCARE operations of the CONTRACTOR.

A.2.30.17 **Claims Management Reports**

2.30.17.1 The CONTRACTOR shall submit a monthly *Claims Payment Accuracy Report*. The report shall include the results of the internal audit of the random sample of all "processed or paid" claims (described in Section A.2.22.6) and shall report on the number and percent of claims that are paid accurately. As provided in Section A.2.22.6.6, if the CONTRACTOR subcontracts for the provision of any covered services, and the subcontractor is responsible for processing claims, then the CONTRACTOR shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report for each subcontractor shall include the results of the internal audit conducted in compliance with Section A.2.22.6 and shall report on the number and percent of claims that are paid accurately.

2.30.17.2 The CONTRACTOR shall submit a monthly *Focused Claims Testing Report*. The report shall include the results of the self test on the accuracy of claims processing based on claims that have been judgmentally selected by TDCI (see Section A.2.22.7). The CONTRACTOR shall complete the attribute sheets provided by TDCI for each claim to be tested within thirty (30) calendar days of receipt from TDCI.

2.30.17.3 The CONTRACTOR shall submit a weekly *Claims Activity Report.* This report shall identify the number of claims received, number of claims denied (by reason), number of claims paid, number of adjustments (including repayments), and total amount paid by the categories of service specified by TENNCARE.

2.30.17.4 The CONTRACTOR shall submit a quarterly CHOICES and ECF CHOICES Cost Effective Alternatives Report that provides information on cost effective alternative services provided to CHOICES and ECF CHOICES members (see Section A.2.6.5.2). MFP participants (see Section A.2.9.8) shall be identified separately for each data element described herein. The report shall provide information regarding specified measures, including but not limited to the following:

2.30.17.4.1 The number of members in Group 2, Group 3, and Groups 2 and 3 combined;

2.30.17.4.2 The number of members in Group 4, Group 5, Group 6, Group 7, and Group 8, and in Groups 4, 5, 6, 7, and 8 combined;

2.30.17.4.3 The number and percent of members authorized to receive cost effective alternative (CEA) CHOICES HCBS in excess of a benefit limit, overall and by service;

2.30.17.4.4 The number and percent of members authorized to receive CEA ECF CHOICES in excess of a benefit limit, overall and by service;

2.30.17.4.5 For members transitioning from a nursing facility to the community, the number of members authorized to receive a transition allowance as a CEA, the total amount of transition allowances authorized, the average transition allowance authorized;

2.30.17.4.6 A summary of items purchased with a transition allowance, including the most frequent categories of expenditure;

2.30.17.4.7 The number and percent of members authorized to receive other non-covered CHOICES HCBS as a CEA;

2.30.17.4.8 The number and percent of members authorized to receive other non-covered ECF CHOICES as a CEA;

2.30.17.4.9 A summary of other non-covered CHOICES HCBS authorized as a CEA, identifying the most frequently authorized services; and

2.30.17.4.10 A summary of other non-covered ECF CHOICES authorized as a CEA, identifying the most frequently authorized services.

2.30.17.5 The CONTRACTOR shall submit to TENNCARE on a quarterly basis, a Denied Claims Report on all contracted long-term care providers for CHOICES and ECF CHOICES (NF and HCBS) for whom the number or dollar value of denied claims for long-term care services exceeded ten percent (10%) for the first year and twenty percent (20%) thereafter of the total number or dollar value of claims for long-term care services submitted by the provider during any month. The report shall include the name and provider number of the long-term care contractor, the total number and percent of denied claims for long-term care services for that month, the cause(s) of such denied claims as identified by the CONTRACTOR, the total volume and dollar value of denied claims for long-term care services by each identified cause for the provider, the type of intervention (e.g., training or technical assistance) determined to be needed and provided by the CONTRACTOR, and current status of such denied claims (e.g., resubmitted, pending action by the provider, determined to be duplicate claims, etc.), the results of the CONTRACTOR's review in terms of whether other providers have been affected by the same issue, and actions taken by the CONTRACTOR to communicate with such affected providers and to resolve the issue(s) more broadly.

2.30.17.6 The CONTRACTOR shall submit to TENNCARE on a quarterly basis, a Rejected Claims Report on all long-term care claims for CHOICES and ECF CHOICES that were rejected per provider (NF and HCBS) for each month during the quarter, the total number and dollar value of rejected claims for long-term care services for each month by provider, the percentage of all claims submitted by each provider for each month that were rejected; the cause of such rejected claims and the total volume and dollar value of rejected claims for long-term care services by each identified cause, the type of intervention (e.g., provider training/technical assistance or CONTRACTOR systems adjustment) determined to be needed and provided by the CONTRACTOR, and the current status of such rejected claims (e.g., resubmitted, pending action by the provider, pending action by the CONTRACTOR, etc.), the results of the CONTRACTOR's review in terms of whether other providers have been affected by the same issue, and actions taken by the CONTRACTOR to communicate with such affected providers and to resolve the issue(s) more broadly.

A.2.30.18 **Information Systems Reports**

2.30.18.1 The CONTRACTOR shall submit an annual *Systems Refresh Plan* on December 1 for the upcoming year that meets the requirements in Section A.2.23.1.6.

2.30.18.2 The CONTRACTOR shall submit *Encounter Data Files* in a standardized format as specified by TENNCARE (see Section A.2.23.4) and transmitted electronically to TENNCARE on a weekly basis.

2.30.18.3 The CONTRACTOR shall provide an electronic version of a reconciliation between the amount paid as captured on the CONTRACTOR's encounter file submissions and the amount paid as reported by the CONTRACTOR in the 'CMS 1450 Claims Triangle' and 'CMS 1500 Claims Triangle' that accompanies the monthly Medical Loss Ratio report (see Section A.2.30.16.2.1). In the event of any variances, the CONTRACTOR shall submit a written explanation accompanied by a 'CMS 1450 Claims Triangle' by category of service and a 'CMS 1500 Claims Triangle' by category of service, as applicable, to substantiate the explanation of the variance and identify the categories of services to which the variance is attributable. In the event that TENNCARE requires further detail of the variances listed, the CONTRACTOR shall provide any other data as requested by TENNCARE. This information shall be submitted with the MLR report.

2.30.18.4 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.

2.30.18.5 The CONTRACTOR shall provide any information and/or data requested in a format to be specified by TENNCARE as required to support the validation, testing or auditing of the completeness and accuracy of encounter data submitted by the CONTRACTOR.

2.30.18.6 The CONTRACTOR shall submit a monthly *Systems Availability and Performance Report* that provides information on availability and unavailability by major system as well as response times for the CONTRACTOR's Confirmation of MCO Enrollment and Electronic Claims Management functions, as measured within the CONTRACTOR's span of control.

2.30.18.7 The CONTRACTOR shall submit a baseline *Business Continuity and Disaster Recovery (BC-DR)* plan for review and written approval as specified by TENNCARE. Thereafter, the CONTRACTOR shall submit, at a minimum, an annual update to their BC-DR. The CONTRACTOR shall communicate proposed modifications to the BC-DR plan at least fifteen (15) calendar days prior to their proposed incorporation. Such updates and/or modifications shall be subject to review and written approval by TENNCARE.

A.2.30.19 **LEFT BLANK INTENTIONALLY**

A.2.30.20 **Subcontract Reports**

2.30.20.1 If the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II SOC1 examination based on the Statement on Standards for Attestation Engagements (SSAE) No. 16 for each non-

affiliated organization processing claims that represent more than twenty percent (20%) of TennCare medical expenses of the CONTRACTOR. This report shall be performed by an independent auditor ("service auditor") and shall be due annually on May 1 for the preceding year operations or portion thereof.

2.30.20.2 In a Type II report, the auditor will express an opinion on whether the organization's description of controls presents the relevant aspects of the organization's actual controls in operation for the period specified in the report, typically one year. Also the report will determine whether the controls were suitably designed to achieve specified control objectives with sufficient effectiveness to provide reasonable, but not absolute assurance that the control objectives were achieved during the period specified.

2.30.20.2.1 The service auditor will express an opinion on (1) whether the service organization's description of its controls presents fairly, in all material respects, the relevant aspects of the service organization's controls that had been placed in operation as of a specific date, and (2) whether the controls were suitably designed to achieve specified control objectives, and (3) whether the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period specified.

A.2.30.21 **HIPAA/HITECH Reports**

The CONTRACTOR shall submit a *Privacy/Security Incident Report*. This report shall be provided at least annually, but the CONTRACTOR shall provide the report more frequently if requested by TENNCARE. The report shall include, at a minimum, the date of the incident, the date of notification to TENNCARE's privacy officer, the nature and scope of the incident, the CONTRACTOR's response to the incident, and the mitigating measures taken by the CONTRACTOR to prevent similar incidents in the future. Upon TENNCARE's request, the CONTRACTOR shall provide additional details within a reasonable amount of time. "Port scans" or other unsuccessful queries to the CONTRACTOR's information system shall not be considered a privacy/security incident for purposes of this report.

A.2.30.22 **Non-Discrimination Compliance Reports**

2.30.22.1 In June of every year this Contract is in effect, HCFA shall provide the CONTRACTOR with a Nondiscrimination Compliance Questionnaire. The CONTRACTOR shall answer the questions contained in the Compliance Questionnaire and submit the completed Questionnaire to HCFA within sixty (60) calendar days of receipt of the Compliance Questionnaire from HCFA with any requested documentation, which shall include, the CONTRACTOR's Assurance of Nondiscrimination. The signature date of the CONTRACTOR's Nondiscrimination Compliance Questionnaire shall be the same as the signature date of the CONTRACTOR's Assurance of Nondiscrimination. The Nondiscrimination Compliance Questionnaire deliverables shall be in a format specified by HCFA.

2.30.22.1.1 As part of the requested documentation for the Nondiscrimination Compliance Questionnaire, the CONTRACTOR shall submit copies of its nondiscrimination policies and procedures that demonstrate nondiscrimination in the provision of its services, programs, or activities provided under this Contract. These policies shall include topics, such as, working to reduce and end health disparities, the provision of language and communication assistance services for LEP individuals and individuals that require effective communication assistance in alternative formats (auxiliary aids or services), and providing assistance to individuals with disabilities. Any

nondiscrimination policies and procedures that are specific to HCFA program members shall be prior approved in writing by HCFA.

2.30.22.2 As a part of the requested documentation for the Nondiscrimination Compliance Questionnaire the CONTRACTOR shall include reports that capture data for all language and communication assistance services used and provided by the CONTRACTOR under this Contract. One report shall contain the names of the CONTRACTOR's language and communication assistance service providers, the languages that interpretation and translation services are available in, the auxiliary aids or services that were provided and that are available, the hours the language and communication assistance services are available, and the numbers individuals call to access language and communication assistance services. A separate report that captures a listing of language and communication assistance services that were requested by members (i.e. Arabic; Braille) and the methods used to provide the language and alternative communication service to the members (i.e. interpretation; translation). In addition, the report shall contain a listing of the number of LEP members that are enrolled in the MCO broken down by county and the languages that are spoken by these members. Upon request the CONTRACTOR shall provide a more detailed report that contains the requestor's name and identification number, the requested service, the date of the request, the date the service was provided, and the name of the service provider.

2.30.22.3 The CONTRACTOR shall submit a quarterly *Non-discrimination Compliance Report* which shall include the following:

2.30.22.3.1 A summary listing that captures the total number of the CONTRACTOR's new hires that have completed civil rights/nondiscrimination training and cultural competency training and the dates the trainings were completed for that quarter; and

2.30.22.3.1.1 A listing of the total number of the CONTRACTOR's employees that have completed annual civil rights training and cultural competency training and the dates completed for that quarter, if annual training was provided during that quarter.

2.30.22.3.2 An update of all written discrimination complaints filed by individuals, such as, employees, members, providers and subcontractors in which the discrimination allegation is related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR, which the CONTRACTOR is assisting TENNCARE with resolving. This update shall include, at a minimum: identity of the complainant, 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.

2.30.22.3.2.1 The CONTRACTOR shall also provide a listing of all discrimination claims that are reported to the CONTRACTOR that are claimed to be related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR or the CONTRACTOR'S subcontractors or providers including allegations of discrimination set forth in Section 2.12.21.1 and 2.15.7.6.3.2.7. This listing shall include, at a minimum: identity of the person making the report, the person's relationship to the CONTRACTOR, subcontractor, or provider, circumstances of the report (including name of member involved and the name of the person claimed

to have committed the discriminatory act), type of covered service related to the report, date of the report, the resolution, and date of resolution. When such reports are made, the CONTRACTOR shall offer to provide discrimination complaint forms to the individual making the report.

2.30.22.3.3 The language and communication assistance report shall capture a summary listing of the language and alternative communication services that were requested by the members (i.e. Arabic; Braille) and the method used to provide the language and alternative communication service to the members (i.e. interpretation; translation). In addition, the report shall contain a listing of the number of LEP members that are enrolled in the MCO broken down by county and the languages that are spoken by these members. Upon request the CONTRACTOR shall provide a more detailed report that contains the member's identification number, the requested service, the date of the request, the date the service was provided and the name of the service provider.

2.30.22.4 On an annual basis, the CONTRACTOR shall assist TENNCARE with its health disparities survey efforts. These surveys shall be conducted on-line over a period of 10 weeks.

2.30.22.4.1 On its website, the CONTRACTOR shall host weblinks/web-addresses that will redirect members and other survey participants to TENNCARE's website where the health disparities surveys are located. In addition, the CONTRACTOR shall assist TENNCARE with its health disparities survey efforts by sending emails, texts, and other electronic and social media communications to members and other survey participants. TENNCARE shall provide the CONTRACTOR with the weblinks/web-addresses to these survey questions and templates of the survey communication materials.

2.30.22.4.2 The CONTRACTOR shall collaborate with TENNCARE and other entities designated by TENNCARE to develop and implement projects, such as the annual health disparities action plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability statuses.

2.30.22.5 In accordance with the requirements set forth in 42 U.S.C. § 300kk, to the extent practicable, the CONTRACTOR shall develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language, and disability status for applicants and members and from applicants' and members' parents or legal guardians if applicants or members are minors or legally incapacitated individuals. In collecting this data the CONTRACTOR shall use the Office of Management and Budget (OMB) standards, at a minimum, for race and ethnicity measures. Race and Ethnic Standards established for Federal Statistics and Administrative Reporting include the following categories as defined by the OMB:

2.30.22.5.1 Race – American Indian or Alaska Native, Asian, black or African American, native Hawaiian or other Pacific Islander, white;

2.30.22.5.2 Ethnicity – Hispanic or Latino, Not Hispanic or Latino.

A.2.30.23 **Terms and Conditions Reports**

2.30.23.1 Quarterly, by January 30, April 30, July 30, and October 30 each year the CONTRACTOR shall make written disclosure regarding conflict of interest that includes the elements in Section E.28.

2.30.23.2 Pursuant to Section D.8, on a semi-annual basis the CONTRACTOR shall submit the attestation in Attachment X.

A.2.30.24 **ECF CHOICES Initiation of Services Report**

2.30.24.1 The CONTRACTOR shall submit a monthly ECF CHOICES Initiation of Services Report in a form and format and including data elements as specified by TENNCARE.

A.2.30.25 **CoverKids5% Annual Member Cost Sharing Report**

2.30.25.1 The CONTRACTOR shall submit a quarterly CoverKids 5% Annual Member Cost Sharing Report that identifies CoverKids members who may reach their 5% annual cost sharing maximum limit.

SECTION B CONTRACT PERIOD:

B.1 This Contract shall be effective for the period beginning January 1, 2014, and ending on December 31, 2022. The Middle Tennessee region is scheduled to have implementation of services effective January 1, 2015. Implementation dates for West and East Tennessee will be determined by the State and shared with the contractors within one month of announcement of the winning proposers. In no case will these implementation dates be earlier than January 1, 2015 or later than January 1, 2016.

B.2 Term Extension. The State reserves the right to extend this Contract for an additional period or periods of time representing increments of no more than one year and a total contract term of no more than eight (8) years, provided that such an extension of the contract term is effected prior to the current, contract expiration date by means of a contract amendment. If a term extension necessitates additional funding beyond that which was included in the original Contract, an increase of the State's maximum liability will also be effected through contract amendment, and shall be based upon payment rates provided in the original Contract.

SECTION C PAYMENT TERMS AND CONDITIONS:

C.1 MAXIMUM LIABILITY

C.1.1 In no event shall the maximum liability of the State under this Contract exceed Three Billion Seven Hundred Seventy-Five Million Three Hundred Thirty-One Thousand Eight Hundred Dollars ($3,775,331,800.00). The payment methodology in section C.3 shall constitute the entire compensation due the CONTRACTOR for all service and CONTRACTOR obligations hereunder regardless of the difficulty, materials or equipment required. The payment method or rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the CONTRACTOR.

The CONTRACTOR is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the CONTRACTOR and does not guarantee payment of any such funds to the CONTRACTOR under this Contract unless the State requests work and the CONTRACTOR performs said work. In which case, the CONTRACTOR shall be paid in accordance with the payment rates detailed in section C.3. The State is under no obligation to request work from the CONTRACTOR in any specific dollar amounts or to request any work at all from the CONTRACTOR during any period of this Contract.

C.1.2 If the Contract maximum would be exceeded as a result of an increase in enrollment, a change in mix of enrollment among rate cells or any rate adjustment pursuant to Section C.3.4, the State shall adjust the Contract maximum liability to accommodate the aforementioned circumstances. This adjustment shall be based on consultation with the State's independent actuary.

C.1.3 This Contract does not obligate the State to pay a fixed minimum amount and does not create in the CONTRACTOR any rights, interests or claims of entitlement in any funds.

C.1.4 The CONTRACTOR is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract. The maximum liability represents available funds for payment to the CONTRACTOR and does not guarantee payment of these funds to the CONTRACTOR under this Contract.

C.2 COMPENSATION FIRM

C.2.1 The capitation rates and the Maximum Liability of the State under this Contract are firm for the duration of the Contract and are not subject to escalation for any reason unless amended, or changed by the Notice specified in Section C.3.4.2 of this Contract.

C.3 PAYMENT METHODOLOGY

C.3.1 GENERAL

C.3.1.1 The CONTRACTOR shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in section C.1.

C.3.1.2 TENNCARE shall make monthly payments to the CONTRACTOR for its satisfactory performance and provision of covered services under this Contract. Capitation rates shall be paid according to the methodology as described in this Contract.

C.3.1.3 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 C.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, and any incentive payments (if applicable) are payment in full for all services provided pursuant to this Contract. 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 Contract.

C.3.1.4 The CONTRACTOR shall ensure that no payment is made to a network provider other than the services covered under the Contract between the state and the CONTRACTOR, except when these payments are specifically required to be made by the state in Title XIX of the Social Security Act, in 42 CFR 438.60, or when the state agency makes direct payments to network providers for graduate medical education costs approved under the state plan.

C.3.1.5 The CONTRACTOR shall fully participate in and faithfully execute all directed payment programs established by TENNCARE. These directed payment programs will be defined by TENNCARE. TENNCARE will establish criteria for each directed payment program, including but not limited to the time frame for the directed payment; providers who will participate in the directed payment; and the mechanism for the calculation and delivery of the amount(s) to be paid to the selected providers. The CONTRACTOR will collect and provide to TENNCARE such information as is required to support all directed payment programs. Directed payment programs will be in accordance with CMS requirements, including 42 CFR 438.6(c).

C.3.2 **ANNUAL ACTUARIAL STUDY**

In accordance with TCA 71-5-188, the State will retain a qualified actuary to conduct an annual actuarial study of the TennCare program. The CONTRACTOR shall provide any information requested and cooperate in any manner necessary as requested by TENNCARE in order to assist the State's actuary with completion of the annual actuarial study.

C.3.3 **CAPITATION PAYMENT RATES**

C.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 or ECF CHOICES, category of aid, age/sex combination and the Grand Region served by the CONTRACTOR under this Contract. TENNCARE shall take Third Party Liability (TPL) into account in the development of capitation rates consistent with this Contract (Section A.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.

3.3.1.1 The capitation payment for MFP participants who must also be enrolled in CHOICES or ECF CHOICES will be the applicable CHOICES or ECF CHOICES capitation payment. There will be no add-on for MFP participants.

3.3.1.2 The capitation payment for ECF CHOICES members shall be the capitation payment for physical and behavioral health services as specified in C.3.3.2 below. The CONTRACTOR shall be reimbursed separately for other costs related to the provision of services for ECF CHOICES members as specified in Section C.3.7.1.9 below.

C.3.3.2 The major aid categories are as follows:

3.3.2.1 Medicaid;

3.3.2.2 Uninsured/Uninsurable;

3.3.2.3 Disabled - The disabled rate is only for those enrollees who are eligible for Medicaid as a result of a disability; and

3.3.2.4 Duals/Waiver Duals - For the purpose of capitation rates, Duals/Waiver Duals are TennCare Medicaid or TennCare Standard enrollees who have Medicare eligibility.

C.3.3.3 TENNCARE will determine the appropriate rate category to which each enrollee is assigned for payment purposes under this Contract.

C.3.3.4 TENNCARE's assignment of an enrollee to a rate category is for payment purposes under this Contract, only, and is not an "adverse action" or determination of the benefits to which an enrollee is entitled under the TennCare program, TennCare rules and regulations, TennCare policies and procedures, the TennCare waiver or relevant court orders or consent decrees.

C.3.4 **CAPITATION RATE ADJUSTMENT**

C.3.4.1 The CONTRACTOR and TENNCARE agree that the capitation rates described in Section C.3 of this Contract may be adjusted periodically.

C.3.4.2 The CONTRACTOR and TENNCARE further agree that adjustments to capitation rates shall occur only by written notice from TENNCARE to the CONTRACTOR and followed up with Contract amendment. The notice will be given at least thirty (30) calendar days before the new rates are paid. Should the CONTRACTOR refuse to continue this Contract under the new rates, the CONTRACTOR then may activate the Termination provisions contained in Section E.14.7 of this Contract. During the six (6) month Termination Notice period the CONTRACTOR will continue to be paid under the new rates. In the event the CONTRACTOR indicates that it is refusing to accept the new rates, but does not choose to institute Termination proceedings under Section E.14.7 of this Contract then the State may at its option:

3.4.2.1 Declare that a public exigency exists under Section E.12 of this Contract. If the State makes this declaration the CONTRACTOR will continue to be paid under the new rates,

3.4.2.2 Declare that the Contract is Terminated for Convenience in whole or in part (one or more Grand Regions) under the provisions of Section E.14.6 and D.3. of this Contract. If the State makes this declaration the CONTRACTOR will continue to be paid under the new rates for the period of time until the Termination date.

C.3.4.3 The base capitation rates shall be adjusted by the State for health plan risk in accordance with the following:

3.4.3.1 Health plan risk assessment scores will be initially calibrated after current TennCare enrollees are assigned to the MCOs for retroactive application to payment rates effective on the start date of operations. This initial calibration will be based upon the distribution of enrollment on the start date of operations and health status information will be derived from encounter data submitted to TENNCARE by MCOs serving the Grand Region through the most recent twelve (12) month period deemed appropriate by the State's actuary.

3.4.3.2 Health plan risk assessment scores will be calibrated annually based upon health status information derived from encounter data submitted to TENNCARE by MCOs serving the Grand Region through the most recent twelve (12) month period deemed appropriate by the State's actuary.

3.4.3.3 TENNCARE will calibrate health plan risk assessment scores on an ongoing basis for the purpose of monitoring shifts in enrollment. If warranted prior to the next scheduled annual calibration as demonstrated by a significant change in health plan risk assessment scores, TENNCARE may adjust the original base capitation rates as subsequently adjusted for all MCOs.

3.4.3.4 In addition to the annual calibration of risk adjustment factors, those factors will be updated when there is a significant change in program participation. This may occur when an MCO is removed from a Grand Region. If an MCO is removed from a Grand Region, that MCO's membership may be temporarily distributed to TennCare Select or distributed to the remaining MCOs or to new MCOs. New risk adjustment values for the remaining MCOs or new MCO(s) will be calculated that consider the population that will be enrolled in the MCO for the remainder of the contract year only. In this instance, MCOs would be given the option to provide TENNCARE, in writing, with a six (6) months notice of termination in accordance with Section E.14.7.2. This notice option is not available for rate adjustments as described in Sections C.3.4.3.1 through C.3.4.3.3.

3.4.3.5 An individual's health status will be determined in accordance with a methodology established or adopted by TENNCARE and described in protocols developed by TENNCARE.

3.4.3.6 For CHOICES members, only the non-long-term care component of the base capitation rate will be adjusted for health plan risk. The long-term care component of the base capitation rate will not be adjusted for health plan risk. The long-term care component of the base capitation rate will be adjusted in accordance with a methodology established or adopted by TENNCARE and described in protocols developed by TENNCARE.

C.3.4.4 In addition to other adjustments specified in Section C.3.4 of this Contract, the capitation rates shall be adjusted annually for inflation in accordance with the recommendation of the State's actuary.

C.3.4.5 If (i) changes are required pursuant to federal or state statute, federal regulations, the action of a federal agency, a state or federal court, or rules and regulations of a State of Tennessee agency other than the Division of TennCare and (ii) the changes are likely to impact the actuarial soundness of the capitation rate(s) described in Section C.3.2, as determined by TENNCARE, TENNCARE shall have its independent actuary review the required change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TENNCARE's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

C.3.4.6 In the event TENNCARE amends TennCare rules or regulations or initiates a policy change not addressed in Section C.3.4.5 above that is likely to impact the capitation rate(s) described in Section C.3.4, as determined by TENNCARE, TENNCARE shall have its independent actuary review the proposed change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TENNCARE's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

C.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.

C.3.4.8 In the event the amount of the six percent (6%) premium tax is increased or decreased during the term of this Contract, the payments shall be increased or decreased by an amount equal to the increase/decrease in premium payable by the CONTRACTOR.

C.3.4.9 Any rate adjustments shall be subject to the availability of state appropriations.

C.3.5 **CAPITATION PAYMENT SCHEDULE**

TENNCARE shall make payment by the fifth (5th) business day of each month to the CONTRACTOR for the CONTRACTOR's satisfactory performance of its duties and responsibilities as set forth in this Contract.

C.3.6 **CAPITATION PAYMENT CALCULATION**

C.3.6.1 When eligibility has been established by the State for enrollees, the amount owed to the CONTRACTOR shall be calculated as described herein.

C.3.6.2 Each month payment to the CONTRACTOR shall be equal to the number of enrollees enrolled in the CONTRACTOR's MCO five (5) business days prior to the date of the capitation payment multiplied by the appropriate capitation rate(s) for the enrollee.

C.3.6.3 The capitation rates stated in Attachment XII will be the amounts used to determine the amount of the monthly capitation payment.

C.3.6.4 The actual amount owed the CONTRACTOR for each member shall be determined by dividing the appropriate monthly capitation rate(s) by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the member was enrolled in the CONTRACTOR's MCO.

C.3.6.5 The amount paid to the CONTRACTOR shall equal the total of the amount owed for all enrollees determined pursuant to Section C.3.6.4 less the withhold amount (see Section C.3.9), capitation payment adjustments made pursuant to Section C.3.7 or C.3.12, and any other adjustments, which may include withholds for penalties, damages, liquidated damages, or adjustments based upon a change of enrollee status.

C.3.7 **CAPITATION PAYMENT ADJUSTMENTS**

C.3.7.1 The State has the discretion to retroactively adjust the capitation payment for any enrollee if TENNCARE determines an incorrect payment was made to the CONTRACTOR; provided, however:

3.7.1.1 For determining the capitation rate(s) only, each Grand Region being served by the enrollee's MCO under this Contract will be used to determine payment. The capitation payment shall not be retroactively adjusted to reflect a different Grand Region of residence so long as the enrollee's MCO assignment is effective.

3.7.1.2 For individuals enrolled with a retroactive effective date on the date of enrollment, the payment rate for retroactive periods shall be the capitation rate(s) for the applicable rate category and the Grand Region in which the enrollee's assigned MCO is operating under this Contract as specified in Attachment XII, except that:

3.7.1.2.1 The CONTRACTOR agrees to manually process claims and reimburse providers for services incurred prior to the start date of operations of this Contract; however, the CONTRACTOR will not be at risk for these services. The CONTRACTOR shall be paid two dollars ($2.00) per claim as reimbursement for processing claims for services incurred prior to the start date of operations. Actual expenditures for covered services and the allowed amount for claims processing are subject to TCA 56-32-124. The CONTRACTOR shall negotiate provider reimbursement subject to TENNCARE prior written approval and prepare checks for payment of providers for the provision of covered services incurred during an enrollee's period of eligibility prior to the start date of operations on an as needed basis. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and format at least forty-eight (48) hours in advance of distribution of any provider payment related to this requirement. TENNCARE shall remit payment to the CONTRACTOR in an amount equal to: the amount to be paid to providers; plus, two dollars ($2.00) per claim processed by the CONTRACTOR; plus, an amount sufficient to cover any payment due in accordance with TCA 56-32-124 within forty-eight (48) hours of receipt of notice. The CONTRACTOR shall then release payments to providers within twenty-four (24) hours of the receipt of funds from the State. The CONTRACTOR is responsible for any payments required pursuant to TCA 56-32-124.

3.7.1.2.2 The CONTRACTOR will not receive a capitation payment for periods of retroactive eligibility greater than nine (9) months prior to the member's date of enrollment with the CONTRACTOR. The CONTRACTOR agrees to process claims and reimburse providers for services incurred during a period of retroactive eligibility more than nine (9) months prior to the member's date of enrollment with the CONTRACTOR; however, the CONTRACTOR will not be at risk for these services. Actual expenditures for covered services are subject to TCA 56-32-124. The CONTRACTOR shall reimburse providers in accordance with this Contract and shall submit to TENNCARE on a monthly basis a claims invoice file for the provision of covered services incurred during an enrollee's period of retroactive eligibility greater than nine (9) months prior to the member's date of enrollment with the CONTRACTOR. TENNCARE shall remit payment to the CONTRACTOR in an amount equal to: the

amount to be paid to providers; plus, an amount sufficient to cover any payment due in accordance with TCA 56-32-124 within ten (10) business days of receipt of notice; however, TENNCARE reserves the right to further review such claims and to recover any overpayments subsequently identified. The CONTRACTOR shall release payments to providers within two (2) business days of the receipt of funds from the State. The CONTRACTOR is responsible for any payments required pursuant to TCA 56-32-124. Based on the provisions herein, TENNCARE shall not make any further retroactive adjustments, other than those described herein.

3.7.1.3 If a provider seeks reimbursement for a service provided during a retroactive period of eligibility, the CONTRACTOR shall assess cost sharing responsibilities in accordance with the cost sharing schedules in effect on the date of service for which reimbursement is sought (see Attachment II) and collect patient liability from CHOICES members as applicable (see Sections A.2.6.7 and A.2.21.5).

3.7.1.4 Should TENNCARE determine after the capitation payment is made that an enrollee's capitation rate category had changed or the enrollee was deceased, TENNCARE shall retroactively adjust the payment to the CONTRACTOR as follows:

3.7.1.4.1 If an enrollee is deceased, TENNCARE shall recoup any and all capitation payments made after the enrollee's date of death, including any pro-rated share of a capitation payment intended to cover dates of service after the enrollee's date of death.

3.7.1.4.2 If an enrollee's capitation rate category has changed, TENNCARE shall retroactively adjust the payment to the CONTRACTOR to accurately reflect the enrollee's capitation rate category for the period for which payment has been made, up to a maximum of nine (9) months. For changes in an enrollee's eligibility category covering a retroactive period greater than nine (9) months that affect an enrollee's capitation rate category, the capitation payment made to the CONTRACTOR for periods greater than nine (9) months shall not be adjusted, and the CONTRACTOR shall consider the capitation payment already received as payment in full. Based on the provisions herein, TENNCARE shall not make any further retroactive adjustments, other than those described herein.

3.7.1.4.3 TENNCARE and the CONTRACTOR agree that the nine (9) month limitation described in Section C.3.7.1.4 is applicable only to retroactive capitation rate payment adjustments described in those paragraphs and shall in no way be construed as limiting the effective date of eligibility or enrollment in the CONTRACTOR's MCO.

3.7.1.5 The CONTRACTOR shall not be entitled to a CHOICES or ECF CHOICES capitation payment for any calendar month during which a CHOICES or ECF CHOICES member does not receive nursing facility services in CHOICES or ongoing CHOICES HCBS or ECF CHOICES HCBS, except under extenuating circumstances which must be reported to TENNCARE on the CHOICES and ECF CHOICES Utilization Report. Acceptable extenuating circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. The determination that the CONTRACTOR is not entitled to a CHOICES or ECF CHOICES capitation payment shall be made by TENNCARE based on information provided in monthly CHOICES and ECF CHOICES Utilization Reports and/or upon review and analysis of the CONTRACTOR's encounter data. For any month in which the CONTRACTOR is not entitled to the CHOICES or ECF CHOICES capitation payment, the capitation payment will be retroactively adjusted to reflect the appropriate non-CHOICES or non-ECF CHOICES capitation rate applicable for that month.

3.7.1.6 The effective date of the CHOICES or ECF CHOICES capitation payment may be retroactively adjusted by TENNCARE in any instance in which the CONTRACTOR fails to initiate nursing facility services in CHOICES or ongoing CHOICES HCBS or ECF CHOICES HCBS within the timeframes prescribed in Section A.2.9.6, in which case, the effective date of the CHOICES or ECF CHOICES capitation payment will be the date of initiation of nursing facility or ongoing HCBS.

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 in CHOICES or ongoing CHOICES HCBS or ECF CHOICES HCBS during each month that a CHOICES or ECF 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 A.2.23.4 of this Contract.

3.7.1.8 Payment adjustments resulting in a reduction or increase of the capitation rate shall be accomplished through the monthly capitation reconciliation process, or pursuant to other processes as established by TENNCARE.

3.7.1.9. *Payments related to the operation of the ECF CHOICES Program*

In addition to the capitation payment for physical and behavioral health services for members enrolled in ECF CHOICES as specified in C.3.3.1.2 above, the CONTRACTOR shall be reimbursed for:

3.7.1.9.1 Actual and reasonable costs related to the provision of support coordination, subject to a maximum specified by TENNCARE;

3.7.1.9.2 Actual and reasonable administrative costs related specifically to requirements for the operation of ECF CHOICES as defined in this agreement, including primarily the management and delivery of covered services to members, payments to providers for such services, and ongoing quality assurance and quality improvement activities, subject to a maximum specified by TENNCARE. Requirements set forth in this agreement that also apply to the operation of the CHOICES program or that affect populations served in CHOICES or ECF CHOICES but who are not enrolled in such programs shall be allocated to ECF CHOICES proportionate to the CONTRACTOR's population enrolled in ECF CHOICES, the CONTRACTOR's population enrolled in CHOICES, and the CONTRACTOR's members who are in the populations served in CHOICES or ECF CHOICES but who are not enrolled in such programs; and

3.7.1.9.3 The actual cost of ECF CHOICES HCBS and cost-effective alternative services provided under the ECF CHOICES program as a cost-effective alternative to NF services or to other ECF CHOICES services, in order to develop sufficient experience for purposes of establishing an actuarially sound capitation rate for ECF CHOICES HCBS.

3.7.1.9.4 Payments related to the operation of ECF CHOICES as specified in this section shall be paid based on a monthly invoice submitted by the CONTRACTOR. The invoice shall be submitted to TENNCARE in the form and format specified by TENNCARE.

3.7.1.10 In accordance with 42 CFR 438.6(e), states may make a monthly capitation payment to an MCO for an enrollee aged 21-64 receiving inpatient treatment in an IMD, as defined in 42 CFR 435.1010 for no more than fifteen (15) days during the period of the monthly capitation payment. Treatment received in an IMD outside of this requirement shall be invoiced by the CONTRACTOR in a manner described by TENNCARE.

C.3.8 **SERVICE DATES**

Except where required by this Contract or by applicable federal or state law, the CONTRACTOR shall not make payment for the cost of any services provided prior to the effective date of eligibility in the CONTRACTOR's MCO. The CONTRACTOR shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the CONTRACTOR's MCO.

C.3.9 **WITHHOLD OF THE CAPITATION RATE**

C.3.9.1 A withhold of the aggregate capitation payment shall be applied to ensure CONTRACTOR compliance with the requirements of this Contract and to provide an agreed incentive for assuring CONTRACTOR compliance with the requirements of this Contract. The withhold as described herein shall be applied by Grand Region and may be retained by Grand Region or statewide based upon specific deficiencies as determined by TENNCARE.

C.3.9.2 The amount due for the first monthly payment, and for each month thereafter, calculated pursuant to Section C.3.6 shall be reduced by the appropriate cash flow withhold percentage amount and set aside for distribution to the CONTRACTOR in the next regular monthly payment, unless retained as provided below.

3.9.2.1 Except as further provided below, the applicable capitation payment withhold amount will be equivalent to ten percent (10%) of the monthly capitation payment for the first six months following the start date of operations, and for any consecutive six (6) month period following the CONTRACTOR's cure of a deficiency as determined by TENNCARE;

3.9.2.2 If, during any consecutive six (6) month period following the start date of operations, TENNCARE determines that the CONTRACTOR has no deficiencies and has not issued a notice of deficiency, the monthly withhold amount will be reduced to five percent (5%) of the monthly capitation payment.

3.9.2.3 If, during any consecutive six (6) month period following a reduction of the monthly withhold amount to five percent (5%) of the monthly capitation payment, TENNCARE determines that the CONTRACTOR has no deficiencies and has not issued a notice of deficiency, the monthly withhold amount will be reduced to two and one half percent (2.5%) of the monthly capitation payment.

3.9.2.4 If the CONTRACTOR is notified by TENNCARE of a minor deficiency and the CONTRACTOR cures the minor deficiency to the satisfaction of TENNCARE within a reasonable time prior to the next regularly scheduled capitation payment cycle, TENNCARE may disregard the minor deficiency for purposes of determining the withhold.

3.9.2.5 If TENNCARE has determined the CONTRACTOR is not in compliance with a requirement of this Contract in any given month, TENNCARE may issue a written

notice of deficiency and TENNCARE may retain the amount withheld for the month prior to TENNCARE identifying the compliance deficiencies.

3.9.2.6 The withhold amounts for subsequent months thereafter in which the CONTRACTOR has not cured the deficiencies may at TENNCARE's discretion be applied in accordance with Section C.3.9.2.1 as described above. If the CONTRACTOR has attained a five percent (5%) withhold or a two and one half percent (2.5%) withhold and TENNCARE subsequently determines the CONTRACTOR is not in compliance with a requirement of this Contract, TENNCARE may provide written notice of such determination and TENNCARE may, at the discretion of TENNCARE, re-institute the retention of the ten percent (10%) withhold as described in Section C.3.9.2.1 at the next capitation payment cycle. Monthly retention of the withhold amount may continue for each subsequent month so long as the identified deficiencies have not been corrected.

3.9.2.6.1 These funds may not be distributed to the CONTRACTOR unless it is determined by TENNCARE the CONTRACTOR has come into compliance with the Contract requirement(s) within six (6) months of TENNCARE identifying these deficiencies. For example, if a specified deficiency(s) is corrected within four (4) months and there are no other identified deficiencies which the CONTRACTOR has been given written notice of by TENNCARE, the withhold for the four (4) consecutive months will be paid to the CONTRACTOR upon TENNCARE determination that the deficiency(s) was corrected. However, any amounts withheld by TENNCARE for six (6) consecutive months (i.e., six (6) consecutive capitation payment cycles) for the same or similar compliance deficiency(s) may be permanently retained by TENNCARE on the first day after the sixth consecutive month period and may not be paid to the CONTRACTOR. For purposes of permanent retention of the withhold amount, six (6) consecutive months shall be calculated from the date the withhold amount was initially retained and shall not be based on the date of the notice of deficiency or the date of notification of the withhold retention. If the same or similar specified deficiency(s) continues beyond six (6) consecutive months, TENNCARE may declare the MCO ineligible for future distribution of the ten percent (10%) incentive withhold and may continue to permanently retain any amounts withheld by TENNCARE for six (6) consecutive months. Such ineligibility will continue for each month TENNCARE determines the same or similar specified deficiency(s) continues to exist. Once a CONTRACTOR corrects the deficiency(s), TENNCARE may reinstate the MCO's eligibility for distribution of the ten percent (10%) compliance incentive payment of future withholds. If TENNCARE determines that distribution of the ten percent (10%) withhold is appropriate, distribution of the ten percent (10%) shall be made at the time of the next scheduled monthly check write which includes all other payments due the CONTRACTOR.

C.3.9.3 No interest shall be due to the CONTRACTOR on any sums withheld or retained under this Section. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract.

C.3.9.4 If TENNCARE has not identified CONTRACTOR deficiencies, TENNCARE will pay to the CONTRACTOR the withhold of the CONTRACTOR's payments withheld in the month subsequent to the withhold.

C.3.10 PAY-FOR-PERFORMANCE QUALITY INCENTIVE PAYMENTS

C.3.10.1 General

3.10.1.1 TENNCARE will make incentive payments to the CONTRACTOR in accordance with this Section C.3.10.

3.10.1.2 Pursuant to 42 CFR 438.6, incentive arrangements shall comply with the following:

3.10.1.2.1 The total of all payments made to the CONTRACTOR for a measurement year shall not exceed one hundred and five percent (105%) of capitation payments made to the CONTRACTOR. In addition, the total of all payments made to the CONTRACTOR for a year shall not exceed twenty five cents ($0.25) per member per month (PMPM) per region (East, Middle, West);

3.10.1.2.2 Are not renewed automatically;

3.10.1.2.3 Are made available to both public and private contractors under the same terms of performance;

3.10.1.2.4 Do not condition MCO participation in the incentive arrangement on the MCO entering into or adhering to intergovernmental transfer agreements.

3.10.1.3 In the first year that each measure is available, the CONTRACTOR regional average HEDIS score (as calculated by TENNCARE using audited MCO HEDIS results) for each of the measures specified by TENNCARE for the last full calendar year prior to the year that the CONTRACTOR began operating under this Contract will serve as the baseline. For example, in CY2020 (known as the HEDIS 2021 score), the full CY2019 data (known as the HEDIS 2020 score) will be used to generate the baseline. If complete TennCare HEDIS data for these measures is not available for the region for the year prior to the year that the CONTRACTOR began operating under this Contract, then the last year for which complete data is available will serve as the baseline.

3.10.1.4. Wave 1 measures will begin with measurement year 2019 and will remain in the program through measurement year 2020. At that time, TENNCARE will review for replacement and/or continuation. Wave 1 measures are the following HEDIS measures:

3.10.1.4.1 Timeliness of Prenatal Care;

3.10.1.4.2 Postpartum Care;

3.10.1.4.3 Adolescent well-care visits;

3.10.1.4.4 Diabetes-Retinal exam and BP <140/90;

3.10.1.4.5 Antidepressant Medication Management – continuation;

3.10.1.5 Wave 2 measures will begin with measurement year 2019 and remain in the program through measurement year 2021. At that time, TENNCARE will review for replacement and/or continuation. Wave 2 measures are the following HEDIS measures:

3.10.1.5.1 Breast Cancer Screening;

3.10.1.5.2 Immunization for Children – Combination 10;

3.10.1.5.3 Immunization for Adolescents – Combination 2;

3.10.1.5.4 Asthma Medication Ratio;

3.10.1.5.5 Follow-up after Hospitalization for Mental Illness – Within 7 Days;

3.10.1.5.6 Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.

3.10.1.6 If NCQA makes changes in any of the measures selected by TENNCARE, such that valid comparison to prior years will not be possible, TENNCARE, at its sole discretion, may elect to either eliminate the measure from pay-for-performance incentive eligibility or replace it with another measure.

C.3.10.2 **HEDIS Measures**

3.10.2.1 Beginning the first year of operations, on September 1 of each year, the CONTRACTOR shall be eligible for a maximum $.04 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures in accordance with Section C.3.10.2.2 below (calculated from the preceding calendar year's data). Each audited HEDIS measure payment is determined by both a National Benchmark payment and Significant Improvement payment. National Benchmark payments are defined using Quality Compass national benchmarks and Significant Improvement payments are defined using NCQA's minimum effect size change methodology (see Section C.3.10.3 below).

3.10.2.2 Incentive payments will be available for selected audited HEDIS measures as determined by TENNCARE following review and analysis of HEDIS plan-specific rates.

3.10.2.2.1 After the first full year of audited HEDIS measures, and each year thereafter, TENNCARE will notify the CONTRACTOR of the audited HEDIS measures that have been selected for eligibility for the specified calendar year's Pay-For-Performance Quality Incentive Measures in each region for which the CONTRACTOR serves.

3.10.2.2.2 The annual notification will advise the CONTRACTOR of the calendar year being measured and the specifics that TENNCARE will use to determine eligibility for the Pay-For-Performance Quality Incentive Payments.

C.3.10.3 **Quality Incentive Payment Methodology**

3.10.3.1 National Benchmark Payment: For each audited HEDIS measure, reporting year measure performance will be compared to the National Quality Compass benchmarks of the same reporting year. Quality Compass 'National All LOBs Average' rates will be used for this calculation. For measures that do not have a baseline value of ninety three percent (93%) or higher, no national benchmark payment will be applied to the total measure payment if measure performance decreases significantly between baseline and reporting years. A significant decrease will be defined as a negative point change as determined by the NCQA minimum effect size change methodology in Section A.3.10.3.2. CONTRACTOR comparative performance to these benchmarks will determine the PMPM incentive payment as follows:

National Benchmark	PMPM (per measure)
≥75th Percentile	+$0.02
≥50th Percentile & <75th Percentile	+$0.01
≥25th Percentile & <50th Percentile	$0.00
<25th Percentile	-$0.01

3.10.3.2 Significant Improvement Payment: For each audited HEDIS measure, a significant positive point change between the baseline rate and the reporting year rate will result in a per metric payment of $0.02 PMPM. A significant negative point change between the baseline rate and the reporting year rate will result in a per metric risk of -$0.02 PMPM. No risk will be assessed to measures with a baseline value of ninety three percent (93%) or higher. Significant positive and negative point changes will be determined by the NCQA minimum effect size change methodology as follows:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point change
60-74	At least a 5 percentage point change
75-84	At least a 4 percentage point change
85-92	At least a 3 percentage point change
93-96	At least a 2 percentage point change
97-99	At least a 1 percentage point change

C.3.11 **MFP INCENTIVE PAYMENTS**

C.3.11.1 Financial incentives will be paid to the CONTRACTOR based on activities performed as part of the MFP Rebalancing Demonstration and in accordance with the following:

3.11.1.1 Upon successful transition to the community of each MFP demonstration participant up to and including the MCO's established benchmark for the calendar year (or for a partial year at implementation, as applicable) – a one-time payment of $1,000.

3.11.1.1.1 If a member has been enrolled in more than one MCO during the ninety (90)-day minimum stay in a Qualified Institution established under ADA, the incentive payment shall be awarded to the MCO in which the person is enrolled at transition to the community and enrollment into MFP.

3.11.1.2 Upon successful transition to the community of each MFP demonstration participant that exceeds the MCO's established benchmark for the calendar year (or for a partial year at implementation, as applicable) – a one-time payment of $2,000.

3.11.1.2.1 If a member has been enrolled in more than one MCO during the ninety (90)-day minimum stay in a Qualified Institution established under ADA, the incentive payment shall be awarded to the MCO in which the person is enrolled at transition to the community and enrollment into MFP.

3.11.1.3 Upon each MFP demonstration participant's completion of community living for the full 365-day demonstration participation period without readmission to a nursing facility (excluding short-term SNF stays solely for purposes of receiving post-hospital

short-term rehabilitative services covered by Medicare) and only until December 31, 2018, a one-time payment of $5,000.

3.11.1.3.1 If a member has been enrolled in more than one MCO during the 365-day participation period in MFP, a pro-rated portion of the incentive payment shall be awarded to each MCO based on the number of days the member was enrolled in each plan. Only days included in the 365-day participation period shall be counted and not any days during which MFP participation was suspended during an inpatient facility stay.

3.11.1.4 Upon achievement of only one (1) of the remaining MFP program benchmarks 2-5 for each calendar year of the demonstration (or for a partial year at implementation, as applicable), a one-time payment of $10,000 per MCO (this payment shall be pro-rated for any partial year).

3.11.1.5 Upon achievement of only two (2) remaining MFP program benchmarks 2-5 for each calendar year of the demonstration (or for a partial year at implementation, as applicable), a one-time payment of $25,000 per MCO (this payment shall be pro-rated for any partial year).

3.11.1.6 Upon achievement of only three (3) remaining MFP program benchmarks 2-5 for each calendar year of the demonstration (or for a partial year at implementation, as applicable), a one-time payment of $50,000 per MCO (this payment shall be pro-rated for any partial year).

3.11.1.7 Upon achievement of all four (4) of the remaining MFP program benchmarks 2-5 for each calendar year of the demonstration (or for a partial year at implementation, as applicable), a one-time payment of $100,000 per MCO (this payment shall be pro-rated for any partial year).

C.3.11.2 The CONTRACTOR shall be eligible to receive only one incentive payment pertaining to benchmarks #s 2-5 which shall depend on the total number of benchmarks which the CONTRACTOR meets or exceeds. These incentive payments are not cumulative.

C.3.11.3 MFP incentive payments pertaining to benchmark #1 shall be payable semi-annually within sixty (60) days following the end of each semi-annual reporting period for activities performed during the semi-annual period.

C.3.11.4 The MFP incentive payments pertaining to benchmark #s 3-5 (which shall depend on the total number of these benchmarks which the CONTRACTOR meets or exceeds) shall be payable within sixty (60) days following the end of each calendar year for activities performed during the year.

C.3.12 **EFFECT OF DISENROLLMENT ON CAPITATION PAYMENTS**

C.3.12.1 Payment of capitation payments shall cease effective the date of the member's disenrollment from the CONTRACTOR's MCO, and the CONTRACTOR shall have no further responsibility for the care of the enrollee. Except for situations involving enrollment obtained by fraudulent applications or death, disenrollment from TennCare shall not be made retroactively.

C.3.12.2 **Fraudulent Enrollment**

3.12.2.1 In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the CONTRACTOR, at its discretion, may refund to TENNCARE all capitation payments made on behalf of persons who obtained enrollment in TennCare through such means and the CONTRACTOR may pursue full restitution for all payments made on behalf of the individual while the person was inappropriately enrolled in the CONTRACTOR's MCO.

3.12.2.2 In the event of enrollment obtained by fraud, misrepresentation or deception by the CONTRACTOR's staff, officers, employees, providers, volunteers, subcontractors, or anyone acting for or on behalf of the CONTRACTOR, TENNCARE may retroactively recover capitation amounts plus interest, as allowed by TCA 47-14-103, and any other monies paid to the CONTRACTOR for the enrollment of that individual. The refund of capitation payments plus interest will not preclude the State from exercising its right to criminal prosecution, civil penalties, trebled damages and/or other remedial measures.

C.3.13 **HMO PAYMENT TAX**

The CONTRACTOR shall be responsible for payment of applicable taxes for all payments received under this Contract pursuant to TCA 56-32-124. In the event the amount due pursuant to TCA 56-32-124 is increased during the term of this Contract, the payments to the CONTRACTOR shall be increased by an amount equal to the increase in the amount due by the CONTRACTOR.

C.3.14 **HEALTH INSURER FEE**

C.3.14.1 The CONTRACTOR and TENNCARE acknowledge that the CONTRACTOR is subject to a Health Insurer Fee (HIF) imposed by the federal government under the Patient Protection and Affordable Care Act (PPACA) of 2010. The CONTRACTOR is responsible for payment of a percentage of the Health Insurer Fee for all health insurance providers. The CONTRACTOR'S obligation is determined by the ratio of the CONTRACTOR'S net written premiums for the preceding year compared to the total net written premiums of all covered entities subject to the Health Insurer Fee for the same year.

C.3.14.2 The amount of the Health Insurer Fee attributable to the CONTRACTOR and attributable to the CONTRACTOR'S premiums under this Contract could affect the actuarial soundness of the premiums received by the CONTRACTOR from TENNCARE for the period during which the Health Insurer Fee is assessed. To preserve the actuarially sound capitation rate payments, TENNCARE shall reimburse the CONTRACTOR for the amount of the Health Insurer Fee, including an actuarially sound adjustment for the estimated impact of the non-deductibility of the Health Insurer Fee for Federal and State tax purposes, specifically attributable to the CONTRACTOR'S TENNCARE membership.

C.3.14.3 The monthly capitation rates will be paid excluding the amount for the Health Insurer Fee. Once the CONTRACTOR'S Health Insurer Fee amount is known, TENNCARE will determine the amount this is as a percent of the capitation rates paid in the previous fiscal year using the aggregate member months for the fiscal year as of the July following the fiscal year and the capitation rates paid for the fiscal year. TENNCARE will then calculate the amount owed to the CONTRACTOR, including any adjustments for Federal and State taxes, in aggregate for the 12 month fiscal year and pay the capitation adjustment as a single payment. The amount attributable to the CONTRACTOR'S TENNCARE membership shall be determined based on the CONTRACTOR'S final Form 8963 filing, the final notification of the Health Insurer Fee amount owed by the CONTRACTOR received from the United States Internal Revenue Service, and supporting documentation from the CONTRACTOR as requested by TENNCARE.

C.3.14.4 TENNCARE shall complete its calculation of the amount owed to the CONTRACTOR within ninety (90) days of its receipt of the final notification and supporting documentation from the CONTRACTOR. Payment is contingent on the availability of State funds and CMS approval of the capitation rates including the Health Insurer Fee adjustment. Capitation rates excluding the Health Insurer Fee adjustment will be included in the contracts and, following payment of the amount owed to the CONTRACTOR, separate rates will be added that contain the capitation rate adjustment to reflect the Health Insurer Fee.

C.3.15 **PAYMENT FOR DISTRIBUTION TO TENNCARE'S PBM**

C.3.15.1 TENNCARE shall make a payment to the CONTRACTOR in an amount equal to the invoice that is billed to the CONTRACTOR by the TennCare PBM. The CONTRACTOR shall make payment to the TennCare PBM no later than the Friday following receipt of the payment from TENNCARE unless extended by TENNCARE due to unforeseen circumstances or bank holidays. This payment is not considered a part of the CONTRACTOR's capitation payment and shall not be subject to the withhold described in Section C.3.9 of this Contract.

C.4 **TRAVEL COMPENSATION**

C.4.1 The CONTRACTOR shall not be compensated or reimbursed for travel, meals, or lodging.

C.5 **RETURN OF FUNDS AND DEDUCTIONS**

C.5.1 In accordance with the Affordable Care Act and TennCare policy and procedures, the CONTRACTOR shall report overpayments and, when it is applicable, return overpayments to TENNCARE within sixty (60) days from the date the overpayment is identified by the CONTRACTOR. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified by the CONTRACTOR may result in a penalty pursuant to state or federal law.

C.5.2 The CONTRACTOR shall refund to TENNCARE any overpayments due or funds disallowed pursuant to this Contract within thirty (30) calendar days of the date of written notification from TENNCARE, unless otherwise authorized by TENNCARE in writing.

C.5.3 The State reserves the right to deduct from amounts which are or shall become due and payable to the CONTRACTOR under this or any agreement or contract between the CONTRACTOR and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the CONTRACTOR.

C.6 **PREREQUISITE DOCUMENTATION**

C.6.1 The CONTRACTOR shall not invoice the State under this Contract until the State has received the following documentation properly completed.

C.6.1.1 The CONTRACTOR shall complete, sign, and present to the State an "Authorization Agreement for Automatic Deposit (ACH Credits) Form" provided by the State. By doing so, the CONTRACTOR acknowledges and agrees that, once said form is received by the State, all payments to the CONTRACTOR, under this or any other contract the CONTRACTOR has with the State of Tennessee shall be made by Automated Clearing House (ACH).

C.6.1.2 The CONTRACTOR shall complete, sign, and present to the State a "Substitute W-9 Form" provided by the State. The taxpayer identification number detailed by said form must agree with the CONTRACTOR's Federal Employer Identification Number or Tennessee Edison Registration ID referenced in this Contract.

C.6.1.3 The CONTRACTOR shall not be paid under this Contract until the CONTRACTOR has completed the appropriate forms and submitted them to the State.

SECTION D STANDARD TERMS AND CONDITIONS:

D.1 REQUIRED APPROVALS

The State is not bound by this Contract 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).

D.2 MODIFICATION AND AMENDMENT

This Contract may be modified only by a written amendment signed by all parties hereto and approved by both the officials who approved the base contract and, depending upon the specifics of the contract as amended, any additional officials required by Tennessee laws and regulations (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).

D.3 TERMINATION FOR CONVENIENCE

The State may terminate this Contract without cause for any reason. Said termination shall not be deemed a breach of contract by the State. The State shall give the CONTRACTOR at least thirty (30) days written notice before the effective termination date. The CONTRACTOR shall be entitled to compensation for satisfactory, authorized service completed as of the termination date, but in no event shall the State be liable to the CONTRACTOR for compensation for any service which has not been rendered. Upon such termination, the CONTRACTOR shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

D.4 TERMINATION FOR CAUSE

If the CONTRACTOR fails to properly perform its obligations under this Contract in a timely or proper manner, or if the CONTRACTOR violates any terms of this Contract, the State shall have the right to immediately terminate the Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the CONTRACTOR shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the CONTRACTOR.

D.5 SUBCONTRACTING

The CONTRACTOR shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, each shall contain, at a minimum, sections of this Contract below pertaining to "Conflicts of Interest," "Nondiscrimination," and “Records” (as identified by the section headings). Notwithstanding any use of approved subcontractors, the CONTRACTOR shall be the prime contractor and shall be responsible for all work performed.

D.6 **CONFLICTS OF INTEREST**

The CONTRACTOR warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the CONTRACTOR in connection with any work contemplated or performed relative to this Contract.

The CONTRACTOR acknowledges, understands, and agrees that this Contract shall be null and void if the CONTRACTOR is, or within the past six months has been, an employee of the State of Tennessee or if the CONTRACTOR is an entity in which a controlling interest is held by an individual who is, or within the past six months has been, an employee of the State of Tennessee.

D.7 **NONDISCRIMINATION**

The CONTRACTOR hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the CONTRACTOR on the grounds of handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The CONTRACTOR shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.8 **PROHIBITION OF ILLEGAL IMMIGRANTS**

The requirements of *Tennessee Code Annotated*, Section 12-4-124, *et seq.*, addressing the use of illegal immigrants in the performance of any Contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

D.8.1 The CONTRACTOR hereby attests, certifies, warrants, and assures that the CONTRACTOR shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The CONTRACTOR shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment X, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the CONTRACTOR and made available to state officials upon request.

D.8.2 Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the CONTRACTOR shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the CONTRACTOR and made available to state officials upon request.

D.8.3 The CONTRACTOR shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

D.8.4 The CONTRACTOR understands and agrees that failure to comply with this section will be subject to the sanctions of Tennessee Code Annotated, Section 12-4-124, et seq. for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Contract.

D.8.5 For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.

D.9 **RECORDS**

The CONTRACTOR shall maintain documentation for all charges under this Contract. The books, records, and documents of the CONTRACTOR, insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.10 **PREVAILING WAGE RATES**

All contracts for construction, erection, or demolition or to install goods or materials that involve the expenditure of any funds derived from the State require compliance with the prevailing wage laws as provided in *Tennessee Code Annotated*, Section 12-4-401, *et seq.*.

D.11 **MONITORING**

The CONTRACTOR's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.12 **PROGRESS REPORTS**

The CONTRACTOR shall submit brief, periodic, progress reports to the State as requested.

D.13 **STRICT PERFORMANCE**

Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

D.14 **INDEPENDENT CONTRACTOR**

The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or

direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

The CONTRACTOR, being an independent contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the CONTRACTOR's employees, and to pay all applicable taxes incident to this Contract.

D.15 **STATE LIABILITY**

The State shall have no liability except as specifically provided in this Contract.

D.16 **FORCE MAJEURE**

The obligations of the parties to this Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, natural disasters, riots, wars, epidemics, or any other similar cause.

D.17 **STATE AND FEDERAL COMPLIANCE**

The CONTRACTOR shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.

D.18 **GOVERNING LAW**

This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The CONTRACTOR agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The CONTRACTOR acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.

D.19 **COMPLETENESS**

This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D.20 **SEVERABILITY**

If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.

D.21 **HEADINGS**

Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

SECTION E SPECIAL TERMS AND CONDITIONS:

E.1 CONFLICTING TERMS AND CONDITIONS

Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.

E.2 COMMUNICATIONS AND CONTACTS

All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, in person; by overnight courier service with an asset tracking system, or by EMAIL or facsimile transmission with recipient confirmation or other electronic means, including but not limited to providing notice through computer data bases, software, or other systems made available to the CONTRACTOR by the State. Any such communications, regardless of method of transmission, shall be addressed to the respective party at the appropriate mailing address, facsimile number, or EMAIL address as set forth below or to that of such other party or address, as may be hereafter specified by written notice.

The State:

Deputy Commissioner
Department of Finance and Administration
Division of Health Care Finance and Administration
Division of TennCare
310 Great Circle Road
Nashville TN 37243
(615) 507-6443 (Phone)
(615) 253-5607 (FAX)
Darin.j.gordon@tn.gov

The CONTRACTOR:

Contractor Contact Name & Title
Contractor Name
Address
Email Address
Telephone # Number
FAX # Number

All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

E.3 SUBJECT TO FUNDS AVAILABILITY

The Contract is subject to the appropriation and availability of State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate the Contract upon written notice to the CONTRACTOR. Said termination shall not be deemed a breach of Contract by the State. Upon receipt of the written notice, the CONTRACTOR shall cease all work associated with the Contract. Should such an event occur, the CONTRACTOR shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Upon such termination, the

CONTRACTOR shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.4 **TENNESSEE CONSOLIDATED RETIREMENT SYSTEM**

The CONTRACTOR acknowledges and understands that, subject to statutory exceptions contained in *Tennessee Code Annotated*, Section 8-36-801, *et. seq*., the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to *Tennessee Code Annotated*, Title 8, Chapter 35, Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the CONTRACTOR agrees that if it is later determined that the true nature of the working relationship between the CONTRACTOR and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the CONTRACTOR, if a retired member of TCRS, may be required to repay to TCRS the amount of retirement benefits the CONTRACTOR received from TCRS during the period of this Contract.

E.5 **TENNESSEE DEPARTMENT OF REVENUE REGISTRATION**

The CONTRACTOR shall be registered with the Department of Revenue for the collection of Tennessee sales and use tax. This registration requirement is a material requirement of this Contract.

E.6 **CONFIDENTIALITY OF INFORMATION**

E.6.1 The CONTRACTOR shall comply with all state and federal law regarding information security and confidentiality of information. In the event of a conflict among these requirements, the CONTRACTOR shall comply with the most restrictive requirement.

E.6.2 All material and information, regardless of form, medium or method of communication, provided to the CONTRACTOR by the State or acquired by the CONTRACTOR pursuant to this Contract shall be regarded as confidential information in accordance with the provisions of state and federal law and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the CONTRACTOR to safeguard the confidentiality of such material or information in conformance with state and federal law and ethical standards.

E.6.3 The CONTRACTOR shall ensure that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the CONTRACTOR's performance under this Contract, whether verbal, written, tape, or otherwise, shall be treated as confidential information to the extent confidential treatment is provided under state and federal laws. The CONTRACTOR shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract and in compliance with federal and state law.

E.6.4 All information as to personal facts and circumstances concerning members or potential members obtained by the CONTRACTOR shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of TENNCARE or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Contract and shall be in compliance with federal and state law.

E.7 **INCORPORATION OF ADDITIONAL DOCUMENTS**

Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the CONTRACTOR's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below.

E.7.1 This Contract document with any attachments or exhibits (excluding the items listed at subsections E.7.2 through E.7.5, below);

E.7.2 Any clarifications of or addenda to the CONTRACTOR's proposal seeking this Contract;

E.7.3 The State solicitation, as may be amended, requesting proposals in competition for this Contract;

E.7.4 Any technical specifications provided to proposers during the procurement process to award this Contract;

E.7.5 The CONTRACTOR's proposal seeking this Contract.

E.8 **LOBBYING**

The CONTRACTOR certifies, to the best of its knowledge and belief, that:

E.8.1 No federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

E.8.2 If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this contract, grant, loan, or cooperative agreement, the CONTRACTOR shall complete and submit Standard Form-LLL, ``Disclosure Form to Report Lobbying," in accordance with its instructions.

E.8.3 The CONTRACTOR shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

E.8.5 This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into and is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, *U.S. Code*.

E.8.6 The CONTRACTOR certifies by signing this Contract, to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352.

E.8.7 The CONTRACTOR shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

E.9 **DEBARMENT AND SUSPENSION**

E.9.1 The CONTRACTOR certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

E.9.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;

E.9.1.2 Have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

E.9.1.3 Are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in Section E.9.1.2 of this certification; and

E.9.1.4 Have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

E.9.2 The Contractor shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded or disqualified

E.10 **CONTRACTOR COMMITMENT TO DIVERSITY**

The CONTRACTOR shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the CONTRACTOR's proposal responding to RFP-31865-00368 (Attachment 6.2, Section B) and resulting in this Contract.

The CONTRACTOR shall assist the State in monitoring the CONTRACTOR's performance of this commitment by providing, as requested, a quarterly report of participation in the performance of this Contract by small business enterprises and businesses owned by minorities, women, and persons with a disability. Such reports shall be provided to the state of Tennessee Governor's Office of Diversity Business Enterprise in form and substance as required by said office.

E.11 **FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA)**

This Contract requires the CONTRACTOR to provide supplies and/or services that are funded in whole or in part by federal funds that are subject to FFATA. The CONTRACTOR is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the CONTRACTOR provides information to the State as required.

E.11.1 The CONTRACTOR shall comply with the following:

E.11.1.1 Reporting of Total Compensation of the CONTRACTOR's Executives

11.1.1.1 The CONTRACTOR shall report the names and total compensation of each of its five most highly compensated executives for the CONTRACTOR's preceding completed fiscal year, if in the CONTRACTOR's preceding fiscal year it received:

11.1.1.1.1 80 percent or more of the CONTRACTOR's annual gross revenues from Federal procurement contracts and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

11.1.1.1.2 $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and

11.1.1.1.3 The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm.).

11.1.1.2 Executive means officers, managing partners, or any other employees in management positions.

E.11.1.2 Total compensation means the cash and noncash dollar value earned by the executive during the CONTRACTOR's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):

11.1.2.1 Salary and bonus.

11.1.2.2 Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.

11.1.2.3 Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.

11.1.2.4 Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.

11.1.2.5 Above-market earnings on deferred compensation which is not tax qualified.

11.1.2.6 Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000.

E.11.2 The CONTRACTOR must report executive total compensation described above to the State by the end of the month during which this Contract is awarded.

E.11.3 If this Contract is amended to extend its term, the CONTRACTOR must submit an executive total compensation report to the State by the end of the month in which the amendment to this Contract becomes effective.

E.11.4 The CONTRACTOR will obtain a Data Universal Numbering System (DUNS) number and maintain its DUNS number for the term of this Contract. More information about obtaining a DUNS Number can be found at: http://fedgov.dnb.com/webform/

E.11.5 The CONTRACTOR's failure to comply with the above requirements is a material breach of this Contract for which the State may terminate this Contract for cause. The State will not be obligated to pay any outstanding invoice received from the CONTRACTOR unless and until the CONTRACTOR is in full compliance with the above requirements.

E.12 **EXIGENCY EXTENTION**

E.12.1 At the option of the State, the CONTRACTOR agrees to continue services under this Contract when TENNCARE determines that there is a public exigency that requires the services to continue. Continuation of services pursuant to this Section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) calendar days written notice shall be given by TENNCARE before this option is exercised.

E.12.2 A written notice of exigency extension shall constitute an amendment to the Contract, may include a revision of the maximum liability and other adjustments permitted under Section 3, and shall be approved by the F&A Commissioner and the Office of the Comptroller of the Treasury.

E.12.3 During any periods of public exigency, TENNCARE shall continue to make payments to the CONTRACTOR as specified in Section C of this Contract.

E.13 **APPLICABLE LAWS AND REGULATIONS**

The CONTRACTOR agrees to comply with all applicable federal and state laws, rules and regulations, policies (including TennCare Standard Operating Procedures (so long as said TennCare Standard Operating Procedure does not constitute a material change to the obligations of the CONTRACTOR pursuant to this Contract)), consent decrees, and court orders, including Constitutional provisions regarding due process and equal protection of the law, including but not limited to:

E.13.1 42 CFR Chapter IV, Subchapter C (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

E.13.2 42 CFR Part 438, Managed care, including but not limited to 438.3, compliance with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in §434.6(a)(12) and § 447.26 of this subchapter .

E.13.3 45 CFR Part 74, General Grants Administration Requirements.

E.13.4 Titles 4, 47, 56, and 71, Tennessee Code Annotated, including, but not limited to, the TennCare Drug Formulary Accountability Act, Public Chapter 276 and The Standardized Pharmacy Benefit Identification Card Act.

E.13.5 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 (42 USC 7401, *et seq*.).

E.13.6 Title VI of the Civil Rights Act of 1964 (42 USC 2000d) and regulations issued pursuant thereto, 45 CFR Part 80.

E.13.7 Title VII of the Civil Rights Act of 1964 (42 USC 2000e) in regard to employees or applicants for employment.

E.13.8 Section 504 of the Rehabilitation Act of 1973, 29 USC 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84.

E.13.9 The Age Discrimination Act of 1975, 42 USC 6101 *et seq*., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.

E.13.10 42 U.S.C. § 18116.

E.13.11 Americans with Disabilities Act, 42 USC 12101 *et seq*., and regulations issued pursuant thereto, 28 CFR Parts 35, 36.

E.13.12 The Church Amendments (42 U.S.C. 300a-7).

E.13.13 Section 245 of the Public Health Service (PHS) Act (42 U.S.C. 238n).

E.13.14 Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209).

E.13.15 Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare, SCHIP and/or Medicaid program.

E.13.16 Tennessee Consumer Protection Act, TCA 47-18-101 *et seq*.

E.13.17 The TennCare Section 1115 waiver and all Special Terms and Conditions which relate to the waiver.

E.13.18 Executive Orders, including Executive Order 1 effective January 26, 1995 and Executive Order 3 effective February 3, 2003.

E.13.19 The Clinical Laboratory Improvement Amendments (CLIA) of 1988.

E.13.20 Requests for approval of material modification as provided at TCA 56-32-101 *et seq*.

E.13.21 Investigatory Powers of TDCI pursuant to TCA 56-32-132.

E.13.22 42 USC 1396 *et seq*. (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

E.13.23 The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Section 1171(5)(E) of the Social Security Act as enacted by HIPAA.

E.13.24 Title IX of the Education Amendments of 1972 regarding education programs and activities.

E.13.25 Title 42 CFR 422.208 and 210, Physician Incentive Plans.

E.13.26 Equal Employment Opportunity (EEO) Provisions.

E.13.27 Copeland Anti-Kickback Act.

E.13.28 Davis-Bacon Act.

E.13.29 Contract Work Hours and Safety Standards.

E.13.30 Rights to Inventions Made Under a Contract or Agreement.

E.13.31 Byrd Anti-Lobbying Amendment.

E.13.32 Subcontracts in excess of one hundred thousand dollars ($100,000) shall require compliance with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15).

E.13.33 Mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (P. L. 94-165.)

E.13.34 TennCare Reform Legislation signed May 11, 2004.

E.13.35 Federal Pro-Children Act of 1994 and the Tennessee Children's Act for Clean Indoor Air of 1995.

E.13.36 Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2.

E.13.37 Title 33 (Mental Health Law) of the Tennessee Code Annotated.

E.13.38 Rules of the Tennessee Department of Mental Health and Substance Abuse Services, Rule 0940 *et seq*.

E.13.39 Section 1902(a)(68) of the Social Security Act regarding employee education about false claims recovery.

E.13.40 TennCare rules and regulations.

E.13.41 TCA 3-6-101 *et seq*., 3-6-201 *et seq*., 3-6-301 *et seq*., and 8-50-505.

E.13.42 TCA 71-6-101 *et seq.*

E.13.43 TCA 37-1-401 *et seq*. and 37-1-601 *et seq*.

E.13.44 TCA 68-11-1001 *et seq.*

E.13.45 TCA 71-5-1401 *et seq.*

E.13.46 TCA 71-5-1003 *et seq.*, 71-5-1005 *et seq.*

E.13.47 Patient Protection and Affordable Care Act (PPACA).

E.13.48 The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as amended by PPACA.

E.13.49 The minimum and maximum hospital aggregate reimbursement levels as defined in Public Chapter 276, "The Annual Coverage Assessment Act of 2015".

E.13.50 Section 1914 of Title XIX of the Social Security Act and 42 CFR §447.30.

E.13.51 T.C.A. §§ 4-5-202, 71-3-1103 through 1108, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan

E.14 TERMINATION

In the event of termination, it is agreed that neither party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred during the course of this Contract. For terminations pursuant to Sections E.14.1, E.14.2, E.14.3, E.14.4 or E.14.6. TENNCARE will assume responsibility for informing all affected enrollees of the reasons for their termination from the CONTRACTOR's MCO.

E.14.1 Termination Under Mutual Agreement

Under mutual agreement, TENNCARE and the CONTRACTOR may terminate this Contract for any reason if it is in the best interest of TENNCARE and the CONTRACTOR. Both parties will sign a notice of termination which shall include, inter alia, the date of termination, conditions of termination, and extent to which performance of work under this Contract is terminated.

E.14.2 Termination by TENNCARE for Cause

E.14.2.1 The CONTRACTOR shall be deemed to have breached this Contract if any of the following occurs:

14.2.1.1 The CONTRACTOR fails to perform in accordance with any term or provision of the Contract;

14.2.1.2 The CONTRACTOR only renders partial performance of any term or provision of the Contract; or

14.2.1.3 The CONTRACTOR engages in any act prohibited or restricted by the Contract.

E.14.2.2 For purposes of Section E.14.2, items E.14.2.1.1 through E.14.2.1.3 shall hereinafter be referred to as "Breach."

E.14.2.3 In the event of a Breach by the CONTRACTOR, TENNCARE shall have available any one or more of the following remedies in addition to or in lieu of any other remedies set out in this Contract or available in law or equity:

14.2.3.1 Recover actual damages, including incidental and consequential damages, and any other remedy available at law or equity;

14.2.3.2 Require that the CONTRACTOR prepare a plan to immediately correct cited deficiencies, unless some longer time is allowed by TENNCARE, and implement this correction plan;

14.2.3.3 Recover any and/or all liquidated damages provided in Section E.29.2; and

14.2.3.4 Declare a default and terminate this Contract.

E.14.2.4 In the event of a conflict between any other Contract provisions and Section E.14.2.3, Section E.14.2.3 shall control.

E.14.2.5 In the event of Breach by the CONTRACTOR, TENNCARE may provide the CONTRACTOR written notice of the Breach and twenty (20) calendar days to cure the Breach described in the notice. In the event that the CONTRACTOR fails to cure the Breach within the time period provided, then TENNCARE shall have available any and all remedies described herein and available at law.

E.14.2.6 In the event the CONTRACTOR disagrees with the determination of noncompliance or designated corrective action described in the notice, the CONTRACTOR shall nevertheless implement said corrective action, without prejudice to any rights the CONTRACTOR may have to later dispute the finding of noncompliance or designated corrective action.

E.14.3 **Termination for Unavailability of Funds**

In the event that federal and/or state funds to finance this Contract become unavailable, TENNCARE may terminate the Contract immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR shall be entitled to receive and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date. Availability of funds shall be determined solely by TENNCARE.

E.14.4 **Termination Due to Change in Ownership**

E.14.4.1 In the event that an entity that contracts with TENNCARE to provide the covered services of this Contract in the same Grand Region(s) as the CONTRACTOR has or acquires an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in the CONTRACTOR, TENNCARE may terminate this Contract immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR will be entitled to reimbursement under the Contract provisions regarding mutual termination in Section E.14.1.

E.14.4.2 In the event that the CONTRACTOR has or acquires an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) of an entity that contracts with TENNCARE to provide the covered services of this Contract in the same Grand Region(s) as the CONTRACTOR, TENNCARE may terminate this Contract immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR will be entitled to reimbursement under the Contract provisions regarding mutual termination in Section E.14.1.

E.14.4.3 If an entity that contracts with TENNCARE to provide the covered services of this Contract in the same Grand Region(s) as the CONTRACTOR proposes to acquire an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in the CONTRACTOR, or the CONTRACTOR proposes to acquire an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in an entity that contracts with TENNCARE to provide covered services of this Contract in the same Grand Region(s) as the CONTRACTOR, the CONTRACTOR shall notify TENNCARE and shall provide TENNCARE with regular updates regarding the proposed acquisition.

E.14.5 **Termination for CONTRACTOR Financial Inviability, Insolvency or Bankruptcy**

E.14.5.1 If TENNCARE reasonably determines that the CONTRACTOR's financial condition is not sufficient to allow the CONTRACTOR to provide the services as described herein in the manner required by TENNCARE, TENNCARE may terminate this Contract in whole or in part, immediately or in stages. Said termination shall not be deemed a Breach by either party. The CONTRACTOR's financial condition shall be presumed not sufficient to allow the CONTRACTOR to provide the services described herein in the manner required by TENNCARE if the CONTRACTOR cannot demonstrate to TENNCARE's satisfaction that the CONTRACTOR has risk reserves and a net worth to meet the applicable net worth requirement specified in Section A.2.21.6 of this Contract.

E.14.5.2 CONTRACTOR insolvency or the filing of a petition in bankruptcy by or against the CONTRACTOR shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor or provider or the insolvency of said subcontractor or provider, the CONTRACTOR shall immediately advise TENNCARE.

E.14.6 **Termination by TENNCARE for Convenience**

TENNCARE may terminate this Contract for convenience and without cause upon thirty (30) calendar days written notice. Said termination shall not be a Breach of the Contract by TENNCARE, and TENNCARE shall not be responsible to the CONTRACTOR or any other party for any costs, expenses, or damages occasioned by said termination, i.e., without penalty.

E.14.7 **Termination by CONTRACTOR**

E.14.7.1 The CONTRACTOR shall have the option to provide TENNCARE with a six (6) months notice of termination on or by July 1 of each calendar year after receipt of notice of the capitation payment rates to become effective in July. Said notice shall terminate the Contract on the following December 31st.

E.14.7.2 The CONTRACTOR shall have the option to provide TENNCARE with a six (6) months notice of termination when risk adjustment factors are updated in accordance with Section C.3.4.3.4 due to a significant change in program participation. In this instance, the CONTRACTOR shall provide TENNCARE with written notice of termination within fourteen (14) calendar days of notice of the updated risk adjustment factors and capitation payment rates. Said notice shall terminate the Contract six (6) months after the date of notice of risk adjustment factors and capitation payment rates plus fourteen (14) calendar days.

E.14.8 **Termination Procedures**

E.14.8.1 The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall specify the provision of this Contract giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective.

E.14.8.2 Upon receipt of notice of termination, and subject to the provisions of this Section, on the date and to the extent specified in the notice of termination, the CONTRACTOR shall:

14.8.2.1 Stop work under the Contract, but not before the termination date;

14.8.2.2 At the point of termination, assign to TENNCARE in the manner and extent directed by TENNCARE all the rights, title and interest of the CONTRACTOR for the

performance of the subcontracts to be determined at need in which case TENNCARE shall have the right, in its discretion, to settle or pay any of the claims arising out of the termination of such agreements and subcontracts;

14.8.2.3 Complete the performance of such part of the Contract that shall have not been terminated under the notice of termination;

14.8.2.4 Take such action as may be necessary, or as a contracting officer may direct, for the protection of property related to this Contract which is in possession of the CONTRACTOR and in which TENNCARE has or may acquire an interest;

14.8.2.5 In the event the Contract is terminated by TENNCARE, continue to serve or arrange for provision of services to the enrollees in the CONTRACTOR's MCO for up to forty-five (45) calendar days from the Contract termination date or until the members can be transferred to another MCO, whichever is longer. During this transition period, TENNCARE shall continue to make payment as specified in Section 3;

14.8.2.6 Promptly make available to TENNCARE, or another MCO acting on behalf of TENNCARE, any and all records, whether medical, behavioral, related to long-term care services or financial, related to the CONTRACTOR's activities undertaken pursuant to this Contract. Such records shall be in a usable form and shall be provided at no expense to TENNCARE;

14.8.2.7 Promptly make available all signed provider agreements/contracts, including historical agreements/contracts, to TENNCARE in PDF format. (The CONTRACTOR shall have the option to submit said agreements on an on-going basis during the term of this Contract rather than at the end of this Contract). Upon termination of this Contract and completion of the CONTRACTOR's continuing obligations, the State will reserve all rights to pursue improper payments and false claims with the CONTRACTOR and/or directly with the CONTRACTOR's subcontractors and providers;

14.8.2.8 Promptly supply all information necessary to TENNCARE or another MCO acting on behalf of TENNCARE for reimbursement of any outstanding claims at the time of termination;

14.8.2.9 Submit a termination plan to TENNCARE for review, which is subject to TENNCARE written approval. This plan shall, at a minimum, contain the provisions in Sections E.14.8.2.10 through E.14.8.2.15 below. The CONTRACTOR shall agree to make revisions to the plan as necessary in order to obtain approval by TENNCARE. Failure to submit a termination plan and obtain written approval of the termination plan by TENNCARE shall result in the withhold of ten percent (10%) of the CONTRACTOR's monthly capitation payment;

14.8.2.10 Agree to maintain claims processing functions as necessary for a minimum of nine (9) months (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims;

14.8.2.11 Agree to comply with all duties and/or obligations incurred prior to the actual termination date of the Contract, including but not limited to, the appeal process as described in Section A.2.19;

14.8.2.12 File all reports concerning the CONTRACTOR's operations during the term of the Contract in the manner described in this Contract;

14.8.2.13 Take whatever other actions are necessary in order to ensure the efficient and orderly transition of members from coverage under this Contract to coverage under any new arrangement developed by TENNCARE;

14.8.2.14 In order to ensure that the CONTRACTOR fulfills its continuing obligations both before and after termination, maintain the financial requirements (as described in this Contract as of the CONTRACTOR's date of termination notice), fidelity bonds and insurance set forth in this Contract until the State provides the CONTRACTOR written notice that all continuing obligations of this Contract have been fulfilled; and

14.8.2.15 Upon expiration or termination of this Contract, submit reports to TENNCARE every thirty (30) calendar days detailing the CONTRACTOR's progress in completing its continuing obligations under this Contract. The CONTRACTOR, upon completion of these continuing obligations, shall submit a final report to TENNCARE describing how the CONTRACTOR has completed its continuing obligations. TENNCARE shall within twenty (20) calendar days of receipt of this report advise in writing whether TENNCARE agrees that the CONTRACTOR has fulfilled its continuing obligations. If TENNCARE finds that the final report does not evidence that the CONTRACTOR has fulfilled its continuing obligations, then TENNCARE shall require the CONTRACTOR to submit a revised final report. TENNCARE shall in writing notify the CONTRACTOR once the CONTRACTOR has submitted a revised final report evidencing to the satisfaction of TENNCARE that the CONTRACTOR has fulfilled its continuing obligations.

E.15 ENTIRE CONTRACT

E.15.1 This Contract, including any amendments, attachments or notice of capitation rate adjustments, represents the entire Contract between the CONTRACTOR and TENNCARE with respect to the subject matter stated herein, and supersedes all other contracts between the parties with regard to the provision of services described herein. Any communications made before the parties entered into this Contract, whether verbal or in writing, shall not be considered as part of or explanatory of any part of this Contract.

E.15.2 In the event of a conflict of language between the Contract, any amendments, or adjustments to the capitation rates, the provisions of the amendments and capitation rate adjustment notices shall govern.

E.15.3 All applicable state and federal laws, rules and regulations, consent decrees, court orders and policies and procedures (hereinafter referred to as Applicable Requirements), including those described in Section E.13 of this Contract are incorporated by reference into this Contract. Any changes in those Applicable Requirements shall be automatically incorporated into this Contract by reference as soon as they become effective. However, as provided in Section C.3.4.5 of this Contract, changes that are likely to impact the actuarial soundness of the capitation rate(s) shall be reviewed by TENNCARE's actuary and the appropriate adjustment to the impacted capitation rate(s) will be made via amendment pursuant to Section D.2.

E.15.4 Nothing contained herein shall prejudice, restrict or otherwise limit the CONTRACTOR's right to initiate action challenging such Applicable Requirements in a court of competent jurisdiction, including seeking to stay or enjoin the applicability or incorporation of such requirements into this Contract.

E.16 APPLICABILITY OF THIS CONTRACT

All terms, conditions, and policies stated in this Contract apply to staff, agents, officers, subcontractors, providers, volunteers and anyone else acting for or on behalf of the CONTRACTOR.

E.17 **TECHNICAL ASSISTANCE**

Technical assistance shall be provided to the CONTRACTOR when deemed appropriate by TENNCARE.

E.18 **PROGRAM INFORMATION**

Upon request, TENNCARE shall provide the CONTRACTOR complete and current information with respect to pertinent statutes, regulations, rules, policies, procedures, and guidelines affecting the CONTRACTOR's operation pursuant to this Contract.

E.19 **QUESTIONS ON POLICY DETERMINATIONS**

On an ongoing basis, should the CONTRACTOR have a question on policy determinations, benefits or operating guidelines, the CONTRACTOR shall request a determination from TENNCARE in writing. The State shall have thirty (30) calendar days to make a determination and respond unless specified otherwise. Should TENNCARE not respond in the required amount of time, the CONTRACTOR shall not be penalized as a result of implementing items awaiting approval. However, failure to respond timely shall not preclude the State from requiring the CONTRACTOR to respond or modify the policy or operating guideline prospectively. The CONTRACTOR shall be afforded at least sixty (60) calendar days to implement the modification.

E.20 **INTERPRETATIONS**

Any dispute between the CONTRACTOR and TENNCARE concerning the clarification, interpretation and application of all federal and state laws, regulations, or policy or consent decrees or court orders governing or in any way affecting this Contract shall be determined by TENNCARE. When a clarification, interpretation and application is required, the CONTRACTOR shall submit a written request to TENNCARE. TENNCARE will contact the appropriate agencies in responding to the request by submitting the written request to the agency within thirty (30) calendar days after receiving that request from the CONTRACTOR. Any clarifications received pursuant to requests for clarification, interpretation and application shall be forwarded upon receipt to the CONTRACTOR. Nothing in this Section shall be construed as a waiver by the CONTRACTOR of any legal right it may have to contest the findings of either the state or federal governments or both as they relate to the clarification, interpretation and application of statute, regulation, or policy or consent decrees or court orders.

E.21 **CONTRACTOR APPEAL RIGHTS**

The CONTRACTOR shall have the right to contest TENNCARE decisions pursuant to the provisions of TCA 9-8-301 et seq. for the resolution of disputes under this Contract. Written notice describing the substance and basis of the contested action shall be submitted to TENNCARE within thirty (30) calendar days of the action taken by TENNCARE. The CONTRACTOR shall comply with all requirements contained within this Contract pending the final resolution of the contested action.

E.22 **DISPUTES**

Any claim by the CONTRACTOR against TENNCARE arising out of the breach of this Contract shall be handled in accordance with the provision of TCA 9-8-301, et seq. Provided, however, the CONTRACTOR agrees that the CONTRACTOR shall give notice to TENNCARE of its claim thirty (30) calendar days prior to filing the claim in accordance with TCA 9-8-301, et seq.

E.23 **NOTIFICATION OF LEGAL ACTION AGAINST THE CONTRACTOR**

The CONTRACTOR shall give TENNCARE and TDCI immediate notification in writing by certified mail (or other means such as overnight delivery reasonably designed to document delivery) within five (5) business days of the CONTRACTOR being served with any administrative or legal action or complaint filed regarding any claim in law or equity made against the CONTRACTOR or an affiliate of the CONTRACTOR (including but not limited to a parent company), that would materially impact either such affiliate's ability to operate its business or the CONTRACTOR's performance of duties hereunder. The CONTRACTOR shall also provide similar notice of any arbitration proceedings instituted between a provider and the CONTRACTOR. The CONTRACTOR shall ensure that all tasks related to the provider agreement are performed in accordance with the terms of this Contract. It is the intent of this provision that the CONTRACTOR notify TENNCARE of any and all actions described herein that may affect the CONTRACTOR'S financial viability and/or program operations or integrity.

E.24 **DATA THAT MUST BE CERTIFIED**

E.24.1 In accordance with 42 CFR 438.604 and 438.606, when State payments to the CONTRACTOR are based on data submitted by the CONTRACTOR, the CONTRACTOR shall certify the data. The data that shall be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals and related documents including the medical loss ratio (MLR) report. The data shall be certified by one of the following: the CONTRACTOR's Chief Executive Officer, the CONTRACTOR's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the CONTRACTOR's Chief Executive Officer or Chief Financial Officer. The certification shall attest, based on best knowledge, information, and belief, as follows:

E.24.1.1 To the accuracy, completeness and truthfulness of the data; and

E.24.1.2 To the accuracy, completeness and truthfulness of the documents specified by the State.

E.24.2 The CONTRACTOR shall submit the certification concurrently with the certified data.

E.25 **USE OF DATA**

TENNCARE shall have unlimited but not exclusive rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the CONTRACTOR resulting from this Contract. However, TENNCARE shall not disclose proprietary information that is afforded confidential status by state or federal law.

E.26 **WAIVER**

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract may be waived except by written agreement of the Contract signatories or in the event the signatory for a party is no longer empowered to sign such Agreement, the signatory's

replacement. Forbearance, forgiveness, or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings, the other party shall have the right to invoke any remedy available under law or equity notwithstanding any such forbearance, forgiveness or indulgence.

E.27 **CONTRACT VARIATION/SEVERABILITY**

If any provision of this Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both TENNCARE and the CONTRACTOR shall be relieved of all obligations arising under such provision. If the remainder of the Contract is capable of performance, it shall not be affected by such declaration of finding and shall be fully performed. In addition, if the laws or regulations governing this Contract should be amended or judicially interpreted as to render the fulfillment of the Contract impossible or economically unfeasible, both TENNCARE and the CONTRACTOR will be discharged from further obligations created under the terms of the Contract.

E.28 **CONFLICT OF INTEREST**

E.28.1 The CONTRACTOR warrants that no part of the total Agreement amount provided herein shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state or federal officer or employee of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the CONTRACTOR in connection with any work contemplated or performed relative to this Contract unless disclosed to the Commissioner, Tennessee Department of Finance and Administration. For purposes of Section E.28. and its subparts of this contract, "immediate family member" shall mean a spouse or minor child(ren) living in the household.

E.28.1.1 Quarterly, by January 30, April 30, July 30, and October 30 each year, or at other times or intervals as designated by the Deputy Commissioner of the Division of TennCare, disclosure shall be made by the CONTRACTOR to the Deputy Commissioner of the Division of TennCare, Department of Finance and Administration in writing. The disclosure shall include, but not be limited to, the following:

28.1.1.1 A list of any state or federal officer or employee of the State of Tennessee as well as any immediate family member of a state or federal officer or employee of the State of Tennessee who receives wages or compensation from the CONTRACTOR; and

28.1.1.2 A statement of the reason or purpose for the wages or compensation. The disclosures shall be made by the CONTRACTOR and reviewed by TENNCARE in accordance with Standard Operating Procedures and the disclosures shall be distributed to, amongst other persons, entities and organizations, the Commissioner, Tennessee Department of Finance and Administration, the Tennessee Ethics Commission, the TennCare Oversight Committee and the Fiscal Review Committee.

E.28.1.2 This Contract may be terminated by TENNCARE and/or the CONTRACTOR may be subject to sanctions, including liquidated damages, under this Contract if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any state or federal officials or employees of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee if the offering or giving of said gratuity is in contravention or violation of state or federal law. It is understood by and between

the parties that the failure to disclose information as required under Section E.28 of this Contract may result in termination of this Contract and the CONTRACTOR may be subject to sanctions, including liquidated damages in accordance with Section E.29 of this Contract. The CONTRACTOR certifies that no member of or delegate of Congress, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially from this Contract.

E.28.2 The CONTRACTOR shall include language in all subcontracts and provider agreements and any and all agreements that result from this Contract between CONTRACTOR and TENNCARE to ensure that it is maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization. Said language may make applicable the provisions of Section E.28. to all subcontracts, provider agreements and all agreements that result from the Contract between the CONTRACTOR and TENNCARE.

E.29 FAILURE TO MEET CONTRACT REQUIREMENTS

It is acknowledged by TENNCARE and the CONTRACTOR that in the event of CONTRACTOR's failure to meet the requirements provided in this Contract and all documents incorporated herein, TENNCARE will be harmed. The actual damages which TENNCARE will sustain in the event of and by reason of such failure are uncertain, are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the CONTRACTOR shall be subject to damages and/or sanctions as described below. It is further agreed that the CONTRACTOR shall pay TENNCARE liquidated damages as directed by TENNCARE; provided however, that if it is finally determined that the CONTRACTOR would have been able to meet the Contract requirements listed below but for TENNCARE's failure to perform as provided in this Contract, the CONTRACTOR shall not be liable for damages resulting directly therefrom.

E.29.1 Intermediate Sanctions

E.29.1.1 TENNCARE may impose any or all of the sanctions as described in this Section upon TENNCARE's reasonable determination that the CONTRACTOR failed to comply with any corrective action plan (CAP) as described under Section A.2.25.10 or Section A.2.23.13 of this Contract, or is otherwise deficient in the performance of its obligations under the Contract, which shall include, but may not be limited to the following:

29.1.1.1 Fails substantially to provide medically necessary covered services;

29.1.1.2 Imposes on members cost sharing responsibilities that are in excess of the cost sharing permitted by TENNCARE;

29.1.1.3 Acts to discriminate among enrollees on the basis of their health status or need for health care services;

29.1.1.4 Misrepresents or falsifies information that it furnishes to CMS or to the State;

29.1.1.5 Misrepresents or falsifies information that it furnishes to a member, potential member, or provider;

29.1.1.6 Fails to comply with the requirements for physician incentive plans, as required by 42 CFR 438.3 and set forth (for Medicare) in 42 CFR 422.208 and 422.210;

29.1.1.7 Has distributed directly, or indirectly through any agent or independent contractor, marketing or member materials that have not been approved by the State or that contain false or materially misleading information; and

29.1.1.8 Has violated any of the other applicable requirements of Sections 1903(m), 1905(t) or 1932 of the Social Security Act and any implementing regulations.

E.29.1.2 TENNCARE shall only impose those sanctions it determines to be appropriate for the deficiencies identified. However, TENNCARE may impose intermediate sanctions on the CONTRACTOR simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe and/or numerous. TENNCARE will provide the CONTRACTOR with timely written notice before imposing any intermediate sanction (other than required temporary management). Intermediate sanctions may include:

29.1.2.1 Liquidated damages as described in Section E.29.2.

29.1.2.2 Suspension of enrollment (by region or statewide) in the CONTRACTOR's MCO;

29.1.2.3 Disenrollment of members (by region or statewide);

29.1.2.4 Limitation of the CONTRACTOR's service area;

29.1.2.5 Civil monetary penalties as described in 42 CFR 438.704, including civil monetary penalty of up to $25,000 for each failure to provide services;

29.1.2.6 Appointment of temporary management for an MCO as provided in 42 CFR 438.706. If the State imposes temporary management because the CONTRACTOR has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act or 42 CFR 438, the State will notify affected enrollees of their right to terminate enrollment without cause;

29.1.2.7 Suspension of all new enrollment (by region or statewide), including default enrollment, after the effective date of the sanction;

29.1.2.8 Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; or

29.1.2.9 Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance.

E.29.2 **Liquidated Damages**

E.29.2.1 <u>Reports and Deliverables</u>

29.2.1.1 For each day that a report or deliverable is late, incorrect, incomplete, or deficient, the CONTRACTOR shall be liable to TENNCARE for liquidated damages in the amount of one hundred dollars ($100) per day per report or deliverable unless specified otherwise in this Section. Liquidated damages for late reports/deliverables shall begin on the first day the report/deliverable is late.

29.2.1.2 Liquidated damages for incorrect reports or deficient deliverables shall begin on the first day after the report/deliverable was due.

29.2.1.3 For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due as specified elsewhere in this Contract or by TENNCARE.

E.29.2.2 Program Issues

29.2.2.1 Liquidated damages for failure to perform specific responsibilities or requirements as described in this Contract are shown in the chart below. Damages are grouped into three categories: **Level A**, **Level B**, and **Level C** program issues. Liquidated damages may be assessed by region or on a statewide basis depending upon the CONTRACTOR's failure to perform, the issue and damage as determined by TENNCARE.

29.2.2.2 Failure to perform specific responsibilities or requirements categorized as Level A are those which pose a significant threat to patient care or to the continued viability of the TennCare program

29.2.2.3 Failure to perform specific responsibilities or requirements categorized as Level B are those which pose threats to the integrity of the TennCare program, but which do not necessarily imperil patient care.

29.2.2.4 Failure to perform specific responsibilities or requirements categorized as Level C are those which represent threats to the smooth and efficient operation of the TennCare program but which do not imperil patient care or the integrity of the TennCare program.

29.2.2.5 TENNCARE may also assess liquidated damages for failure to meet performance standards as provided in Section A.2.24.7, Attachment VII, and Attachment XI of this Contract.

29.2.2.6 TENNCARE reserves the right to assess a general liquidated damage of five hundred dollars ($500) per occurrence with any notice of deficiency.

29.2.2.6.1 In circumstances for which TENNCARE has applied this general liquidated damage to a notice of a deficiency that is related in any way to CHOICES care coordination or ECF CHOICES support coordination processes and requirements which shall be determined by TENNCARE, the amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract.

29.2.2.7 **Liquidated Damages Chart**

LEVEL	PROGRAM ISSUES		DAMAGE
A.1	Failure to comply with claims processing as described in Section A.2.22 of this Contract		$10,000 per month, for each month that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of Section A.2.22 of this Contract

LEVEL	PROGRAM ISSUES		DAMAGE
A.2	Failure to comply with licensure and background check requirements in Section A.2.29.2 and Attachment XI of this Contract		$5,000 per calendar day that staff/provider/ /driver/agent/subcontractor is not licensed or qualified as required by applicable state or local law plus the amount paid to the staff/provider/driver/agent/subcontractor during that period
A.3	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child at risk of entering DCS custody		The actual amount paid by DCS and/or TENNCARE for necessary services or $1,000, whichever is greater
A.4	Failure to comply with obligations and time frames in the delivery of TennCare Kids screens and related services		MCO Statewide EPSDT Rate as determined from CMS416 Report: Below 70%: $75,000 Between 71% - 75%: $50,000 Between 76% - 79%: $25,000 AND $25,000 per Region for Screening Rate below 80% as determined from CMS 416 MCO Report $50,000 per Region for Screening Rate below 75% as determined from CMS 416 MCO Report
A.5	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized by the TENNCARE Chief Medical Officer		The actual amount paid by DCS and/or TENNCARE for necessary services or $1,000, whichever is greater
A.6(a)	Failure to timely authorize and arrange provision of a benefit directed by TENNCARE. "Timely" means as quickly as the enrollee's condition requires, but no later than within seventy-two (72) hours of the date the directive was issued. See Sections A.2.19.9.3 and A.2.19.9.4		$500 per calendar day CONTRACTOR is in default, plus: either (1) amounts sufficient to offset any savings CONTRACTOR garnered by failing to authorize provision of the benefit, or (2) actual cost to have the benefit conferred by an alternate contractor

LEVEL	PROGRAM ISSUES		DAMAGE
A.6(b)	Failure to timely authorize and arrange provision of a benefit approved by the CONTRACTOR on Reconsideration during the SFH process. "Timely" means as quickly as the enrollee's condition requires, but no later than within seventy-two (72) hours of receiving the approval decision. See section A.2.19.9.4		$500 per calendar day CONTRACTOR is in default, plus: either (1) amounts sufficient to offset any savings CONTRACTOR garnered by failing to authorize provision of the benefit, or (2) actual cost to have the benefit conferred by an alternate contractor
A.6(c)	Failure to authorize reimbursement pursuant to a TENNCARE directive within seventy-two (72) hours of the date the directive was issued. See Sections A.2.19.9.3 and A.2.19.9.4		$500 per calendar for each day CONTRACTOR is in default
A.6(d)	Proof of Compliance: Upon enrollee's receipt of the benefit or reimbursement authorized and arranged pursuant to A.6. (a)-(c), CONTRACTOR must supply TENNCARE with proof that enrollee actually received the directed benefit or benefit reimbursement. Absent TENNCARE approval of a good cause exception, failure to, within five (5) business days, supply TENNCARE with proof that the benefit has been rendered (or reimbursement has been sent). See Sections A.2.19.9.3 and A.2.19.9.4		$500 per calendar day CONTRACTOR is in default, plus: either (1) amounts sufficient to offset any savings CONTRACTOR garnered by failing to authorize provision of the benefit, or (2) actual cost to have the benefit conferred by an alternate contractor
A.7	Failure to comply with this Contract and federal rules/law regarding Sterilizations/Abortions/ Hysterectomies as outlined in Section A.2.7.8 of this Contract		$500 per occurrence or the actual amount of the federal penalty created by the CONTRACTOR's failure to comply, whichever is greater
A.8	Failure to provide coverage for prenatal care without a delay in care and in accordance with Section A.2.7.5 of this Contract		$500 per day, per occurrence, for each calendar day that care is not provided in accordance with the terms of this Contract

LEVEL	PROGRAM ISSUES		DAMAGE
A.9	Failure to provide continuation or restoration of benefits in accordance with section A.2.19.9		$500 per calendar day CONTRACTOR is in default, plus: either (1) amounts sufficient to offset any savings CONTRACTOR garnered by failing to authorize provision continuation or restoration of benefits, or (2) actual cost to have the benefit conferred by an alternate contractor
A.10	Failure to confer a timely and content-compliant Notice of Adverse Benefit Determination in accordance with sections A.2.19.2		$500 per calendar day CONTRACTOR is in default
A.11	Missed Home Health Shifts. Absent documentation establishing good cause in accordance with applicable TENNCARE policy, failure to provide authorized home health services (including home health aide services, nursing services, therapy services and other related services furnished in the enrollee's home).		$500 per calendar day CONTRACTOR is in default, plus: either (1) amounts sufficient to offset any savings CONTRACTOR garnered by failing to ensure provision of the benefit, or (2) actual cost to have the benefit conferred by an alternate contractor
A.12	Failure to provide a timely and complete response to a TENNCARE request for the CONTRACTOR's internal Appeal file or for Appeal-related documentation, such as notices issued to enrollee, medical records, and prior authorization requests and decisions.		$500 per calendar day CONTRACTOR is in default
A.13	Identification of a systemic failure of CONTRACTOR's Appeal System, as evidenced by CONTRACTOR's failure to meet compliance requirements for any aspect of the Appeal system in over 20% of Appealed cases during a 60-day period		$500 per calendar day CONTRACTOR is in default until a TENNCARE-approved corrective action plan is fully implemented by the CONTRACTOR

LEVEL	PROGRAM ISSUES		DAMAGE
A.14(a)	Failure to (1) provide an approved service timely, i.e., in accordance with timelines specified in this Contract, or when not specified therein, with reasonable promptness; or (2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service		The cost of services not provided plus $500 per day, per occurrence, for each day (1) that approved care is not provided timely; or (2) notice of delay is not provided and/or the CONTRACTOR fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service
A.14(b)	Failure to review nursing and aide care notes and the results of face-to-face assessments, including care coordination or case management visits conducted by the CONTRACTOR, prior to the reduction of any covered home health or private duty nursing services prescribed by a treating physician for a chronic condition, or to provide such documentation which supports the CONTRACTOR's medical necessity determination to TENNCARE upon request.		The cost of home health or private duty nursing services not provided plus $500 per day, per occurrence, for each day that care was not provided (i.e., denied or reduced)
A.14(c)	Failure to conduct prior authorization processes for home health or private duty nursing in accordance with service definitions in TennCare Rule 1200-13-13-01, medical necessity requirements at 1200-13-16, and specific prior authorization requirements at 1200-13-13-04(6).		The cost of home health or private duty nursing services provided plus $500 per day, per occurrence, for each day that home health or private duty nursing services were approved and provided in a manner that does not comport with service definitions in TennCare Rule 1200-13-13-01, medical necessity requirements at 1200-13-16, and specific prior authorization requirements at 1200-13-13-04(6)
A.15	Failure to confer a timely response to a contracted provider's request for Prior Authorization in accordance with 42 C.F.R. §438.210(d)		$500 per calendar day CONTRACTOR is in default
A.16(a)	Enrollee Benefit Appeals. Failure to confer a timely and complete response to an *On Request Report* instructing CONTRACTOR to determine whether a request for SFH warrants expedited resolution.		$500 per calendar day CONTRACTOR is in default

LEVEL	PROGRAM ISSUES		DAMAGE
A.16(b)	Enrollee Benefit Appeals. Failure to confer a timely and complete response to an *On Request Report* instructing CONTRACTOR to conduct Reconsideration of the CONTRACTOR -proposed Adverse Benefit Determination. The Reconsideration response shall contain the written medical review, the CONTRACTOR's Reconsideration decision and all information on which the decision was based.		$500 per calendar day CONTRACTOR is in default
A.16(c)	Enrollee Benefit Appeals. Failure to provide a timely and complete response to a TENNCARE request for appeal-related documentation including but not limited to: • prior authorization requests and decisions, • notices of ABD issued to enrollee, • Evidence-based criteria and other CONTRACTOR guidelines forming the basis for CONTRACTOR's ABD, • enrollee medical records and medical history considered by the CONTRACTOR in its PA or Reconsideration determination, • enrollee medical records submitted in relation to the PA or SFH request, • Medical Necessity reviews conducted by CONTRACTOR in relation to the PA or Reconsideration request, and • Any other information related to the benefit under dispute.		$500 per calendar day CONTRACTOR is in default

LEVEL	PROGRAM ISSUES		DAMAGE
A.16(d)	Enrollee Benefit Appeals. Failure to submit an expedited appeal/SFH request to TENNCARE within one (1) business day.		$500 per calendar day CONTRACTOR is in default
A.16(e)	Enrollee Benefit Appeals. Failure to submit a standard appeal/SFH request to TENNCARE within five (5) business days.		$500 per calendar day CONTRACTOR is in default
A.16(f)	Failure to notify TENNCARE prior to issuing an adverse benefit determination reducing or terminating services of any member age twenty-one (21) or older receiving PDN and/or HH services in excess of adult benefit limits and/or coverage criteria.		$500 per enrollee per occurrence
A.17(a)	Failure to comply with the timeframes for developing and approving a PCSP for transitioning CHOICES Group 2 or ECF CHOICES members authorizing and initiating nursing facility services for transitioning CHOICES members in Group 1, or initiating immediately needed and ongoing long-term care services for CHOICES or ECF CHOICES members (see Sections A.2.9.2, A.2.9.3, and A.2.9.6		$5,000 per month that the CONTRACTOR's performance is 85-89% by service setting (nursing facility or HCBS) $10,000 per month that the CONTRACTOR's performance is 80-84% by service setting (nursing facility or HCBS) $15,000 per month that the CONTRACTOR's performance is 75-79% by service setting (nursing facility or HCBS) $20,000 per month that the CONTRACTOR's performance is 70-74% by service setting (nursing facility or HCBS) $25,000 per month that the CONTRACTOR's performance is 69% or less by service setting (nursing facility or HCBS) These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract TENNCARE may opt, at its discretion, to apply a $500 per occurrence assessment in lieu of the methodology described above in addition to the cost of services not provided. 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 requirements as specified in Section A.2.9.6.12.9 of this Contract

LEVEL	PROGRAM ISSUES		DAMAGE
A.17(b)	Failure to complete the intake process in Sections A.2.9.6.2 and A.2.9.6.3 timely, including failure to submit an approved exception request for intake processes lasting more than thirty (30) days due to extenuating circumstances beyond the CONTRACTOR's control		$500 per day beginning on the next calendar day after the thirtieth (30th) calendar day, unless an exception is approved by TENNCARE These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.18(a)	Failure to meet the performance standards established by TENNCARE regarding missed visits for CHOICES or ECF CHOICES members (referred to herein as "specified HCBS")		$5,000 per provider per month that 11-15% of the provider's authorized visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), plus the cost of services not provided (if missed) by specified HCBS, in addition to the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act $10,000 per provider per month that 16-20% of the provider's authorized visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), plus the cost of services not provided (if missed) by specified HCBS, in addition to the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act $15,000 per provider per month that 21-25% of the provider's authorized visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), plus the cost of services not provided (if missed) by specified HCBS, in addition to the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act $20,000 per provider per month that 26-30% of the provider's authorized visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), plus the cost of services not provided (if missed) by specified HCBS, in addition to the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act

LEVEL	PROGRAM ISSUES		DAMAGE
			$25,000 per provider per month that 31% or more of the provider's authorized visits are late, missed, or manually-confirmed for a reason attributable to the CONTRACTOR or provider (provider initiated), plus the cost of services not provided (if missed) by specified HCBS, in addition to the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act TENNCARE may opt, at its discretion, to apply a $500 per occurrence assessment in lieu of the methodology described above in addition to the cost of services not provided (if missed) and the pass-through cost of any reduction in FMAP for personal care services related to non-compliance with the 21st Century Cures Act
A.18(b)	Failure to conduct ongoing real-time monitoring of missed and late visits (see 2.9.6.10.2.1.9 and 2.9.6.13.1.13)		$5,000 per occurrence
A.18(c)	Failure to address service gaps, and ensure that back-up plans are implemented and effectively working (see 2.9.6.10.2.1.10 and 2.9.6.13.1.13)		$5,000 per occurrence
A.19	Failure to provide continuity of care consistent with the services in place prior to the member's enrollment in the CONTRACTOR's CHOICES or ECF CHOICES Program for a CHOICES or ECF CHOICES member transferring from another MCO or upon implementation in the Grand Region (see Sections A.2.9.2 and A.2.9.3)		$500 per day beginning on the next calendar day after default by the CONTRACTOR in addition to the cost of the services not provided These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.20(a)	Failure to complete a comprehensive assessment, develop a PCSP and authorize and initiate all immediately needed and ongoing long-term services and supports specified in the PCSP for a CHOICES or ECF CHOICES member within specified timelines (see Section A.2.9.6)		$500 per day for each service not initiated timely beginning on the next calendar day after default by the CONTRACTOR in addition to the cost of the services not provided. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract

LEVEL	PROGRAM ISSUES		DAMAGE
A.20(b)	Failure to follow and complete the Employment Informed Choice process for ECF CHOICES members (see Section A.2.9.6.2 and A.2.9.6.3)		$500 per member per day for each day that the Employment Informed Choice process is not completed as specified in this Contract and pursuant to TennCare protocol. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.20(c)	Failure to identify a covered medically necessary service on a Member's PCSP because the CONTRACTOR's network of qualified providers (including the providers' workforce) is insufficient to timely initiate such service. (see Section A.2.11.7.4.1)		$500 per day for each covered medically necessary service not identified on the member's PCSP beginning on the next calendar day after which the service should have been initiated if it had been identified on the PCSP in addition to the cost of the services not provided. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract.
A.20(d)	Delay or failure to refer an individual for enrollment into ECF CHOICES Groups 7 or 8 because the CONTRACTOR's network of qualified providers is insufficient to timely initiate services in the Group or because the CONTRACTOR does not have adequate network capacity for the member's transition and ongoing support once stabilization is achieved (See Section A.2.11.7.4.2)		$500 per day for which the IBFCTSS or IBCTSS not initiated timely because of the CONTRACTOR's delay or failure in referring the individual for enrollment into ECF CHOICES Groups 7 or 8 beginning on the next calendar day after which the service should have been initiated if the individual had been timely referred in addition to the cost of the services not provided. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.21(a)	Failure to develop a PCSP for a CHOICES or ECF CHOICES member that includes all of the required elements, meets PCSP quality standards specified by TennCare, and which has been reviewed with and signed and dated by the member or his/her representative, unless the member/representative refuses to sign which shall be documented in writing		$500 per deficient PCSP These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract

LEVEL	PROGRAM ISSUES		DAMAGE
A.21(b)	Failure to develop and implement on a consistent and ongoing basis a comprehensive program for monitoring the effectiveness of its care coordination and support coordination processes, including ongoing quality reviews of an acceptable volume of PCSPs for each care/support coordinator to ensure accuracy, completeness, quality and consistency with quality standards as specified by TENNCARE; immediately remediate all individual findings identified through its monitoring process; track and trend such findings and remediation to identify systemic issues of poor performance and/or non-compliance; implement strategies to improve care coordination and support coordination processes and resolve areas of non-compliance, and measure the success of such strategies in addressing identified issues.		$10,000 plus $500 for each deficient PCSP for which individual findings were not timely remediated
A.22	Failure to process a referral by or on behalf of the CONTRACTOR's member for enrollment in the CHOICES or ECF CHOICES program in accordance with specified requirements and timelines (see Section A.2.9.6)		$500 per day for each day the CONTRACTOR was delinquent in completing the referral These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.23	Failure to initiate disenrollment of any member who is not receiving TennCare-reimbursed long-term care services and is not expected to resume receiving long-term care services within the next thirty (30) days in accordance with Section A.2.6.1.5.6		$1000 per occurrence plus $1000 for each month for which the capitation payment amount must be adjusted These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract

LEVEL	PROGRAM ISSUES		DAMAGE
A.24	Failure to facilitate transfers between nursing facilities for CHOICES members or to facilitate transitions between CHOICES Groups or ECF CHOICES Groups accordance with Sections A.2.9.6.10.1.1.5 and A.2.9.6.10.2.1.20		$500 per occurrence These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.25	Failure by the CONTRACTOR to ensure that all TennCare data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of TennCare enrollee PHI (See also ancillary Business Associate Agreement between the parties)		$500 per enrollee per occurrence, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those TennCare enrollees whose PHI was placed at risk by CONTRACTOR's failure to comply with the terms of this Contract, the CONTRACTOR shall be liable for all costs associated with the provision of such monitoring and/or safeguard services.
A.26	Failure by the CONTRACTOR to execute the appropriate agreements to effectuate transfer and exchange of TennCare enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party (See ancillary Business Associate Agreement between the parties)		$500 per enrollee per occurrence

LEVEL	PROGRAM ISSUES		DAMAGE
A.27	Failure by the CONTRACTOR to seek express written approval from TENNCARE prior to the use or disclosure of TennCare enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States (See ancillary Business Associate Agreement between the parties)		$1,000 per enrollee per occurrence
A.28	Failure by the CONTRACTOR to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach (See also ancillary Business Associate Agreement between the parties)		$500 per enrollee per occurrence, not to exceed $10,000,000
A.29	Failure to process a transition referral, including completion of a face-to-face transition screening and assessment and development of a transition plan timely and in accordance with Section A.2.9.6.8 and TENNCARE policy and protocols		$500 per occurrence These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract

LEVEL	PROGRAM ISSUES		DAMAGE
A.30	Failure to initiate CHOICES HCBS or for children under age 21, EPSDT benefits or ECF CHOICES HCBS, if applicable, provided as an alternative to nursing facility care in accordance with the member's plan of care or PCSP and to ensure that such HCBS or EPSDT benefits are in place immediately upon transition from a nursing facility to the community for any person transitioning from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2, or ECF CHOICES), including persons enrolled in MFP (see Section A.2.9.6.8.16)		$500 per day for each day that HCBS are not in place following transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2) in addition to the cost of services not provided These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.31	Failure to complete in a timely manner minimum care coordination or support coordination contacts required for persons transitioned from a nursing facility to CHOICES Group 2, 4, 5, or 6, including post-discharge and following a significant change in circumstances (see Sections A.2.9.6 and A.2.9.8)		$500 per occurrence These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.32	Failure to coordinate with the TDMHSAS and DIDD for the purpose of avoiding inappropriate admission of individuals with I/DD to an RMHI and/or coordinating timely discharge of individuals with I/DD from an RMHI, which shall include all of the elements specified in A.2.9.15.1		$5,000 per member with I/DD for which the CONTRACTOR failed to timely complete all coordination activities as prescribed in A.2.9.15.1.

LEVEL	PROGRAM ISSUES		DAMAGE
A.33	Failure to ensure that a level of care (i.e., PAE) and supporting documentation, including the *Safety Determination Request Form*, if appropriate, 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 A.2.9.6.3.19)		$2,000 per occurrence These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.34	Failure to ensure that a member utilizing the short-term stay benefit is transitioned from Group 2 or Group 3, or ECF CHOICES Group 4, 5, or 6, as applicable, to Group 1 or disenrolled from ECF CHOICES at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members and ECF CHOICES Group 4, 5, or 6 members (see Sections A.2.6.1.5.3.1 and A.2.6.1.5.6)		$500 per day, per occurrence for each calendar day that a member exceeds the ninety (90) day benefit limit in accordance with this Contract. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.35	Failure to complete and submit to TENNCARE at least eight (8) business days prior to expiration of a member's current LOC eligibility segment, a new LOC assessment, including all required supporting documentation needed to appropriately determine the member's LOC eligibility going forward (see Section A.2.9.6.10.3.1.2)		$500 per day, per occurrence for each calendar day beyond eight (8) business days prior to expiration of the member's current LOC eligibility segment. These amounts shall be multiplied by two (2) when the CONTRACTROR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract

LEVEL	PROGRAM ISSUES		DAMAGE
A.36	Failure to complete and submit a safety determination request upon referral from TENNCARE or as part of ongoing care coordination or support coordination pursuant to Sections A.2.9.6.3.19.6 and A.2.9.6.11.2.1.13		$500 per day after five (5) business days from the notification of referral from TENNCARE if the CONTRACTOR has not submitted a completed safety determination request to TENNCARE pursuant to A.2.9.6.3.19.6. $2,000 per occurrence for safety determination requests not completed and submitted to TENNCARE during ongoing care coordination pursuant to A.2.9.6.11.2.1.13. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.37	Failure to complete the PAE process and/or ensure that a PAE is submitted to TENNCARE within twenty (20) business days of the enrollment visit, per Section A.2.9.6.14, on all referrals, except those individuals who are screened out who do not subsequently request to continue the intake process or individuals who choose to terminate the intake process, which must be documented in writing		$500 per day beginning twenty (20) business days after completion of the enrollment visit until date of PAE submission
A.38	Failure to conduct and submit level of care reassessments pursuant to the requirements in Sections A.2.9.6.10.3.1.1 and A.2.9.6.10.3.1.1.3.2		$500 per day, per occurrence for each applicable timeline violated in Sections A.29.6.9.3.1.1 and A.2.9.6.10.3.1.1.3.2. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
A.39	Failure to report deficiencies related to ERC threshold standards of care and licensure rule violations to the Tennessee Department of Health within twenty-four (24) hours of discovery		$500 per day beginning twenty-four (24) hours after the discovery of the deficiency if the deficiency is not reported within twenty-four (24) hours to the Tennessee Department of Health (See Section A.2.25.9.10)

LEVEL	PROGRAM ISSUES		DAMAGE
A.40	Failure to provide advance notification to TENNCARE prior to admitting a member enrolled in any ECF CHOICES Group or any member with I/DD who would qualify for enrollment in any ECF CHOICES Group to a nursing facility, including for short-term stay, or to provide acceptable documentation of thoroughly exploring and exhausting all attempts to provide services in a more integrated community setting, as required in Section A.2.9.6.3.27.11.		$500 per day for each day of the inpatient stay for which such required notification was not provided
A.41	Failure to timely report CHOICES critical incidents and ECF CHOICES Reportable Events or to timely notify APS or law enforcement when appropriate pursuant to Sections A.2.15.7 and A.2.15.7.6.		$2,000 per occurrence with the failure to timely report CHOICES critical incidents and ECF CHOICES Reportable Events being a distinct occurrence from the failure to timely report such incidents and events to APS or law enforcement when appropriate These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12. of this Contract
A.42	Failure to complete transition planning, implementation, and monitoring requirements set forth in Section A.2.9.6.9 for a CHOICES or ECF CHOICES member transitioning to a new CBRA setting		$5,000 per occurrence These amounts shall be multiplied by two (2) when the CONTRACTROR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
B.1	Failure to provide referral provider listings to PCPs as required by Section A.2.14.3.5 of this Contract		$500 per calendar day

LEVEL	PROGRAM ISSUES		DAMAGE
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.3	Failure to submit Audited HEDIS and CAHPS results annually by June 15 as described in Sections A.2.15.5 and A.2.15.6		$250 per day for every calendar day reports are late
B.4	Failure to submit NCQA Accreditation Report as described in Section A.2.15.5		$500 per day for every calendar day beyond the 10th calendar day Accreditation Status is not reported
B.5	Failure to comply with Conflict of Interest, Lobbying, and/or Gratuities requirements described in Section E.8, E.28, E.30, or A.2.12.9.53		110% of the total amount of compensation paid by the CONTRACTOR to inappropriate individuals
B.6	Failure to disclose Lobbying Activities and/or quarterly conflict of interest disclosure as required by Section E.8, E.28, or A.2.12.9.53		$1,000 per day that disclosure is late
B.7	Failure to obtain approval of member materials as required by Section A.2.17 of this Contract		$500 per day for each calendar day that TENNCARE determines the CONTRACTOR has provided member material that has not been approved by TENNCARE
B.8	Failure to comply with time frames for providing Member Handbooks, I.D. cards, Provider Directories, Quarterly Member Newsletters, and CHOICES and ECF CHOICES member education materials as required in Section A.2.17		$5,000 for each occurrence

LEVEL	PROGRAM ISSUES		DAMAGE
B.9	If the CONTRACTOR knew or should have known that a member has not received long-term care services for thirty (30) days or more, failure to report on that member in accordance with Section A.2.30.11.4 (see also Section A.2.6.1.5.6)		For each member, an amount equal to the CHOICES capitation rate prorated for the period of time in which the member did not receive long-term care services, in addition to the recoupment of such capitation overpayment
B.10	Failure to achieve and/or maintain financial requirements in accordance with TCA		$500 per calendar day for each day that financial requirements have not been met
B.11	Failure to submit the CONTRACTOR's annual NAIC filing as described in Section A.2.30.16.3		$500 per calendar day
B.12	Failure to submit the CONTRACTOR's quarterly NAIC filing as described in Section A.2.30.16.3		$500 per calendar day
B.13	Failure to submit audited financial statements as described in Section A.2.30.16.3		$500 per calendar day
B.14	Failure to comply with fraud, waste, and abuse provisions as described in Section A.2.20 of this Contract		$500 per calendar day for each day that the CONTRACTOR does not comply with fraud, waste, and abuse provisions
B.15	Failure to require and ensure compliance with Ownership and Disclosure requirements as required in Section A.2.12.9.37 of this Contract Failure to maintain complete and current disclosures/attestations for all providers excluding providers billing under emergency provisions		$5,000 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B. 92 to 95% Compliance - $5000 per each full percentage point below 95% Under 92% Compliance - $10,000 per each full percentage point below 95%
B.16	Failure to maintain a CONTRACTOR Grievance or CONTRACTOR Appeal System as required in Section A.2.19 of this Contract		$500 per calendar day CONTRACTOR is in default
B.17	Failure to maintain required insurance as required in Section A.2.21.8 of this Contract		$500 per calendar day

LEVEL	PROGRAM ISSUES		DAMAGE
B.18	Failure to provide a written discharge plan or provision of a defective discharge plan for discharge from a psychiatric inpatient facility or mental health residential treatment facility as required in Section A.2.9.9.3.2 of this Contract		$1,000 per occurrence per case
B.19	Imposing arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section A.2.6.3 and A.2.14.1 of this Contract		$500 per occurrence
B.20	Failure to meet any timeframe regarding care coordination or support coordination for CHOICES or ECF CHOICES members (see Sections A.2.9.2, A.2.9.3, A.2.9.6, A.2.9.6.2.3.4(4), A.2.9.6.5.1.1, A.2.9.6.10.2.1.2, A.2.9.6.10.3, and A.2.24.6.2.1) other than the timeframes referenced in Program Issues 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 requirements as specified in Section A.2.9.6.12.12 of this Contract. 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 requirements as specified in Section A.2.9.6.12.12 of this Contract.
B.21	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement/contract as required in Section A.2.11.10 of this Contract		$5,000 per application that has not been approved and loaded into the CONTRACTOR's system or denied within thirty (30) calendar days of receipt of a completed credentialing application and a signed provider agreement/contract if applicable And/Or $1,000 per application per day for each day beyond thirty (30) calendar days that a completed credentialing application has not been processed as described in Section A.2.11.10 of this Contract

LEVEL	PROGRAM ISSUES		DAMAGE
B.22	Failure to maintain provider agreements in accordance with Section A.2.12 and Attachment XI of this Contract		$5,000 per provider agreement found to be non-compliant with the requirements outlined in this Contract
B.23	Failure to comply with the requirements regarding an agreement to audit accounts (Section A.2.21.11)		$1,500 for each day after December 1 of each year that the fully executed agreement for audit accounts is not submitted or for each day after December 1 of each year that the fully executed agreement does not include the required language
B.24	Failure to meet individual Annual Quality Survey standards in subsequent years		$5000 per occurrence for repeating a deficiency(ies) in subsequent years
B.25	Failure to comply with audit requirements as described in this Contract, including but not limited to Section A.2.25.		$500 per calendar day for each calendar day that TENNCARE determines the CONTRACTOR to be non-compliant with audit requirements and/or requests
C.1	Failure to comply in any way with staffing requirements as described in Section A.2.29.1 of this Contract		TENNCARE may opt at its discretion to assess $1,000.00 per calendar day, for each separate failure to comply with the required staffing requirements, from the first day of noncompliance through the thirtieth (30th) day of noncompliance. Additionally, at its discretion, TENNCARE may multiply this amount by two (2) for each day after thirty (30) calendar days for each specific instance that the CONTRACTOR fails to comply with the staffing requirements of the Contract
C.2	Failure to report provider notice of termination of participation in the CONTRACTOR's MCO		$250 per day
C.3	Failure to have subject appropriate staff member(s) attend onsite meetings as requested and designated by TENNCARE		$1000 per appropriate staff person per meeting as requested by TENNCARE
C.4	Failure to comply in any way with encounter data submission requirements as described in Section A.2.23 of this Contract (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE)		$25,000 per occurrence

LEVEL	PROGRAM ISSUES		DAMAGE
C.5	Failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE		An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TENNCARE
C.6	Failure to submit an inbound 834 within twenty-four (24) hours in accordance with Section A.2.23.5.4 and A.2.23.13.1		$500 per day, for each calendar day the CONTRACTOR fails to submit an inbound 834 timely and/or accurately (This may be in addition to the damages associated with an applicable corrective action plan in accordance with Section A.2.23.13.1 and Level B.2 herein
C.7	Failure to comply with the requirements regarding documentation for CHOICES or ECF CHOICES members (see Section A.2.9.6)		$500 per PCSP for members in Group 2 or 3 or in ECF CHOICES that does not include all of the required elements $500 per member file that does not include all of the required elements $500 per face-to-face visit where the Care Coordinator or Support Coordinator fails to document the specified observations These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
C.8	Failure to comply with the requirements regarding documentation for CHOICES or ECF CHOICES members (see Section A.2.9.6)		$500 per PCSP for members in Group 2 or 3 that does not include all of the required elements $500 per PCSP for members in Group 4, 5, or 6 that does not include all of the required elements $500 per member file that does not include all of the required elements $500 per face-to-face visit where the Care Coordinator or Support Coordinator fails to document the specified observations These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section A.2.9.6.12.12 of this Contract
C.9	Failure to submit a Provider Enrollment File that meets TENNCARE's specifications (see Section A.2.30.8.1)		$250 per day after the due date that the Provider Enrollment File fails to meet TENNCARE's specifications
C.10	Failure to achieve benchmarks of 37% PCMH membership (see Section A.2.13.1.9.4)		$500 per calendar day, per individual benchmark, for each day the CONTRACTOR fails to achieve and/or maintain each benchmark

E.29.2.3 Payment of Liquidated Damages

29.2.3.1 It is further agreed by TENNCARE and the CONTRACTOR that any liquidated damages assessed by TENNCARE shall be due and payable to TENNCARE within thirty (30) calendar days after CONTRACTOR receipt of the notice of damages. If payment is not made by the due date, said liquidated damages may be withheld from future payments by TENNCARE without further notice, as provided in Section C.5 of this Contract. It is agreed by TENNCARE and the CONTRACTOR that the collection of liquidated damages by TENNCARE shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Contract; however, in the event an appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by TENNCARE will be immediately returned to the CONTRACTOR. Any cure periods referenced in this Contract shall not apply to the liquidated damages described in this Section. With respect to **Level B** and **Level C** program issues (failure to perform responsibilities or requirements), the due dates mentioned above may be delayed if the CONTRACTOR can show good cause as to why a delay should be granted. TENNCARE has sole discretion in determining whether good cause exists for delaying the due dates.

29.2.3.2 Liquidated damages as described in Section E.29.2. shall not be passed to a provider and/or subcontractor unless the damage was caused due to an action or inaction of the provider and/or subcontractor. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

29.2.3.3 All liquidated damages imposed pursuant to this Contract, whether paid or due, shall be paid by the CONTRACTOR out of administrative costs and profits.

E.29.2.4 Application of Liquidated Damages for CHOICES and ECF CHOICES

In applying liquidated damages related to care and support coordination timeframes, HCBS missed visits, and the CHOICES and ECF CHOICES Utilization Report TENNCARE may take into consideration whether, as determined by TENNCARE, the CONTRACTOR promptly remedied a deficiency and/or a deficiency was due to circumstances beyond the CONTRACTOR's control. Such consideration shall be based on information provided by the CONTRACTOR in the applicable report (see Section A.2.30) and/or additional information submitted by the CONTRACTOR as requested by TENNCARE.

E.29.2.5 Waiver of Liquidated Damages

TENNCARE may waive the application of liquidated damages and/or withholds upon the CONTRACTOR if the CONTRACTOR is placed in rehabilitation or under administrative supervision if TENNCARE determines that such waiver is in the best interests of the TennCare program and its enrollees.

E.29.3 **Claims Processing Failure**

If it is determined that there is a claims processing deficiency related to the CONTRACTOR's ability/inability to reimburse providers in a reasonably timely and accurate fashion as required by Section A.2.22, TENNCARE shall provide a notice of deficiency and request corrective action. The CONTRACTOR may also be subject to the application of liquidated damages and/or intermediate sanctions specified in Sections E.29.1 and E.29.2 and the retention of withholds as specified in Section C.3.9. If the CONTRACTOR is unable to successfully

implement corrective action and demonstrate adherence with timely claims processing requirements within the time approved by TENNCARE, the State may terminate this Contract in accordance with Sections E.14 and D.4 of this Contract.

E.29.4 **Failure to Manage Medical Costs**

If TENNCARE determines the CONTRACTOR is unable to successfully manage costs for covered services, TENNCARE may terminate this Contract with ninety (90) calendar days advance notice in accordance with Section E.14 and of this Contract.

E.29.5 **Sanctions by CMS**

Payments provided for under this Contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730.

E.29.6 **Temporary Management**

TENNCARE may impose temporary management if it finds that the CONTRACTOR has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

E.30 **OFFER OF GRATUITIES**

By signing this Contract, the CONTRACTOR certifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the United States General Accounting Office, United States Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially due to influence in obtaining this Contract. This Contract may be terminated by TENNCARE if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the CONTRACTOR or the CONTRACTOR's agent or employees.

E.31 **ATTORNEY'S FEES**

In the event that either party deems it necessary to take legal action to enforce any provision of this Contract, and TENNCARE prevails, the CONTRACTOR agrees to pay all expenses of such action, including attorney's fees and cost of all state litigation as may be set by the court or hearing officer. Legal actions are defined to include administrative proceedings.

E.32 **GOVERNING LAW AND VENUE**

E.32.1 This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The CONTRACTOR agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract.

E.32.2 For purposes of any legal action occurring as a result of or under this Contract between the CONTRACTOR and TENNCARE, the place of proper venue shall be Davidson County, Tennessee.

E.33 **ASSIGNMENT**

This Contract and the monies that may become due hereunder are not assignable by the CONTRACTOR except with the prior written approval of TENNCARE.

E.34 **INDEPENDENT CONTRACTOR - SUPPLEMENTAL**

It is expressly agreed that the CONTRACTOR and any subcontractors or providers, and agents, officers, and employees of the CONTRACTOR or any subcontractors or providers, in the performance of this Contract shall act in an independent capacity and not as agents, officers and employees of TENNCARE or the State of Tennessee. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the CONTRACTOR or any subcontractor or provider and TENNCARE and the State of Tennessee.

E.35 **FORCE MAJEURE - SUPPLEMENTAL**

The CONTRACTOR shall not be liable for performance of the duties and responsibilities of this Contract when its ability to perform is prevented by causes beyond its control. These acts must occur without the fault or negligence of the CONTRACTOR. Such acts include destruction of the facilities due to hurricanes, fires, war, riots, and other similar acts. However, in the event of damage to its facilities, the CONTRACTOR shall be responsible for ensuring swift correction of the problem so as to enable it to continue its responsibility for the delivery of covered services. The failure of the CONTRACTOR's fiscal intermediary to perform any requirements of this Contract shall not be considered a 'force majeure'.

E.36 **INDEMNIFICATION**

E.36.1 The CONTRACTOR shall indemnify and hold harmless the State as well as its officers, agents, and employees (hereinafter the "Indemnified Parties") from all claims, losses or suits incurred by or brought against the Indemnified Parties as a result of the failure of the CONTRACTOR to comply with the terms of this Contract. The State shall give the CONTRACTOR written notice of each such claim or suit and full right and opportunity to conduct CONTRACTOR's own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to the CONTRACTOR, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.

E.36.2 The CONTRACTOR shall indemnify and hold harmless the Indemnified Parties as well as their officers, agents, and employees from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from the CONTRACTOR's or Indemnified Parties performance under this Contract. In any such action, brought against the Indemnified Parties, the CONTRACTOR shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. The State shall give the CONTRACTOR written notice of each such claim or suit and full right and opportunity to conduct the CONTRACTOR's own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to the CONTRACTOR, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.

E.36.3 While the State will not provide a contractual indemnification to the CONTRACTOR, such shall not act as a waiver or limitation of any liability for which the State may otherwise be legally responsible to the CONTRACTOR. The CONTRACTOR retains all of its rights to seek legal remedies against the State for losses the CONTRACTOR may incur in connection with the furnishing of services under this Contract or for the failure of the State to meet its obligations under the Contract.

E.37 **ACTIONS TAKEN BY THE TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE**

The parties acknowledge that the CONTRACTOR is licensed to operate as a health maintenance organization in the State of Tennessee, and is subject to regulation and supervision by TDCI. The parties acknowledge that no action by TDCI to regulate the activities of the CONTRACTOR as a health maintenance organization, including, but not limited to, examination, entry of a remedial order pursuant to TCA 56-9-101, *et seq*., and regulations promulgated thereunder, supervision, or institution of delinquency proceedings under state law, shall constitute a breach of this Contract by TENNCARE.

E.38 **PROHIBITION OF PAYMENTS FOR ITEMS OR SERVICES OUTSIDE THE UNITED STATES**

E.38.1 Section 6505 of the Affordable Care Act amends section 1902(a) of the Social Security Act (the Act), and requires that a State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States (U.S.). This section of the Affordable Care Act is effective January 1, 2011, unless the Secretary determines that implementation requires State legislation, other than legislation appropriating funds, in order for the plan to comply with this provision.

E.38.2 For purposes of implementing this provision, section 1101(a)(2) of the Act defines the term "United States" when used in a geographical sense, to mean the "States." Section 1101(a)(1) of the Act defines the term "State" to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, when used under Title XIX.

E.38.3 Further, this provision prohibits payments to telemedicine providers located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Additionally, payments to pharmacies located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa are not permitted.

E.38.4 The Centers for Medicare & Medicaid Services (CMS) will require that, in the case of providers that have provided medical assistance or covered items and/or services to Medicaid beneficiaries under the State plan or under a waiver program, and are requesting reimbursement from the State Medicaid program, such reimbursement must be provided to financial institutions or entities located within the U.S. If it is found that payments have been made to financial institutions or entities outside of the U.S., States must recover these payments and must forward any Federal match for such payments to CMS consistent with the guidelines specified in Federal regulations at 42 CFR Part 433.

E.38.5 Any audits of claims by CMS to assure compliance with this provision will begin no earlier than June 1, 2011 and will only review claims submitted on or after June 1, 2011 for compliance with this section.

E.39 **SOCIAL SECURITY ADMINISTRATION (SSA) REQUIRED PROVISIONS FOR DATA SECURITY**

The CONTRACTOR shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 *(5* U.S.C. §552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. § 3541, *et seq*.), and related National Institute of Standards and Technology guidelines. In addition, the CONTRACTOR shall have in place administrative, physical, and technical safeguards for data.

E.39.1 The CONTRACTOR shall not duplicate in a separate file or disseminate, without prior written permission from TENNCARE, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the TennCare program. Should the CONTRACTOR propose a redisclosure of said data, the CONTRACTOR must specify in writing to TENNCARE the data the CONTRACTOR proposes to redisclose, to whom, and the reasons that justify the redisclosure. TENNCARE will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.

E.39.2 The CONTRACTOR agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.

E.39.3 The CONTRACTOR shall maintain a current list of the employees of such CONTRACTOR with access to SSA data and provide such lists to TENNCARE upon request and at any time there are changes.

E.39.4 The CONTRACTOR shall restrict access to the data obtained from TENNCARE to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Contract. The CONTRACTOR shall not further duplicate, disseminate, or disclose such data without obtaining TENNCARE's prior written approval.

E.39.5 The CONTRACTOR shall ensure that its employees:

E.39.5.1 Properly safeguard SSA data furnished by TENNCARE under this Contract from loss, theft or inadvertent disclosure;

E.39.5.2 Receive regular, relevant and sufficient SSA data related training, including use, access and disclosure safeguards and information regarding penalties for misuse of information;

E.39.5.3 Understand and acknowledge that they are responsible for safeguarding this information at all times, regardless of whether or not the CONTRACTOR employee is at his or her regular duty station;

E.39.5.4 Ensure that laptops and other electronic devices/ media containing SSA data are encrypted and/or password protected;

E.39.5.5 Send emails containing SSA data only if the information is encrypted or if the transmittal is secure; and

E.39.5.6 Limit disclosure of the information and details relating to a SSA data loss only to those with a need to know.

CONTRACTOR employees who access, use, or disclose TennCare SSA-supplied data in a manner or purpose not authorized by this Contract may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

E.39.6 Loss or Suspected Loss of Data – If an employee of the Contractor becomes aware of suspected or actual loss of SSA data, the Contractor must notify TennCare immediately upon becoming aware to report the actual or suspected loss. The Contractor must provide TennCare with timely updates as any additional information about the loss of SSA data becomes available.

E.39.6.1 If the CONTRACTOR experiences a loss or breach of said data, TENNCARE will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the CONTRACTOR shall bear any costs associated with the notice or any mitigation.

E.39.7 TENNCARE may immediately and unilaterally suspend the data flow under this Contract, or terminate this Contract, if TENNCARE, in its sole discretion, determines that the CONTRACTOR has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Contract Section.

E.39.8 Legal Authority

E.39.8.1 Federal laws and regulations giving SSA the authority to disclose data to TENNCARE and TENNCARE's authority to collect, maintain, use and share data with CONTRACTOR is protected under federal law for specified purposes:

39.8.1.1 Sections 1137, 453, and 1106(b) of the Social Security Act (the Act) (42 U.S.C. §§ 1320b-7, 653, and 1306(b)) (income and eligibility verification data);

39.8.1.2 26 U.S.C. § 6103(l)(7) and (8) (tax return. data);

39.8.1.3 Section 202(x)(3)(B)(iv) of the Act (42 U.S.C. § 401(x)(3)(B)(iv))(prisoner data);

39.8.1.4 Section 205(r)(3) of the Act (42, U.S.C. § 405(r)(3)) and Intelligence Reform and Terrorism Prevention Act of 2004, Pub. L. 108-458, 7213(a)(2) (death data);

39.8.1.5 Sections 402, 412, 421, and 435 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104-193) (8 U.S.C. §§ 1612, 1622, 1631, and 1645) (August 22, 1996 (quarters of coverage data);

39.8.1.6 Children's Health Insurance Program Reauthorization Act of 2009, (Pub. L. 111-3) (February 4, 2009) (citizenship data); and

39.8.1.7 Routine use exception to the Privacy Act, 5 U.S.C. § 552a(b)(3)(data necessary to administer other programs compatible with SSA programs).

E.39.8.2 This Section further carries out Section 1106(a) of the Act (42 U.S.C. § 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. § 3541 et seq.), and related National Institute of Standards and Technology ("NIST") guidelines as outlined in the CMPPA and IEA governing this data, which provide the requirements that the CONTRACTOR must follow with regard to use, treatment, and safeguarding data.

E.39.9 Definitions

E.39.9.1 "SSA-supplied data" as used in this Section – Personally Identifiable and Protected Health Information, such as an individual's social security number, income, disability or benefit status or related information, supplied by the Social Security Administration to TennCare in order to determine entitlement or eligibility for federally-funded programs such as Medicaid and CHIP. This information is subject to provisions outlined in a Computer Matching and Privacy Protection Act Agreement (CMPPA) between SSA and the State of Tennessee, and Information Exchange Agreement (IEA) between SSA and TennCare.

E.39.9.2 "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 CFR §160.103; OMB Circular M-06-19 located at http://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2006/m06-19.pdf –

Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

E.39.9.3 "Individually Identifiable Health Information" – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

E.39.9.4 "Personally Identifiable Information" – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

E.40 **EFFECT OF THE FEDERAL WAIVER ON THIS CONTRACT**

The provisions of this Contract are subject to the receipt of and continuation of a federal waiver granted to the State of Tennessee by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. Should the waiver cease to be effective, the State shall have the right to immediately terminate this Contract. Said termination shall not be a breach of this Contract by TENNCARE and TENNCARE shall not be responsible to the CONTRACTOR or any other party for any costs, expenses, or damages occasioned by said termination.

E.41 **TENNCARE FINANCIAL RESPONSIBILITY**

Notwithstanding any provision which may be contained herein to the contrary, TENNCARE shall be responsible solely to the CONTRACTOR for the amount described herein and in no event shall TENNCARE be responsible, either directly or indirectly, to any subcontractor or any other party who may provide the services described herein.

E.42 **TRANSFER OF CONTRACTOR'S OBLIGATIONS**

E.42.1 The CONTRACTOR shall immediately notify the State in writing of a proposed merger, acquisition or sale of its business operation, or the part of its business operation that provides services under this Contract, or that this Contract will be sold to or assumed by another entity. The entity that is proposed to assume the CONTRACTOR's duties under this Contract, whether through merger, acquisition, sale or other transaction, will be hereinafter described as the New Entity.

E.42.2 The CONTRACTOR (or, if the CONTRACTOR no longer exists as a legal entity, the New Entity) will provide to the State within a reasonable time, information that the State may require about the merger, acquisition or sale, which may include:

E.42.2.1 The date and terms of the merger, acquisition or sale, including specifically, but not limited to, adequate documentation of the financial solvency and adequate capitalization of the proposed New Entity;

E.42.2.2 Evidence of financial solvency and adequate capitalization of the proposed New Entity which may consist of:

42.2.2.1 Debt;

42.2.2.2 Assets;

42.2.2.3 Liabilities;

42.2.2.4 Cash flow;

42.2.2.5 Percentage of the total revenues of the company that are represented by this Contract;

42.2.2.6 The most recent annual financial reports;

42.2.2.7 The most recent annual financial reports filed with government agencies, if applicable.

E.42.2.3 A complete description of the relationship of any New Entity to any parent company or subsidiary or division resulting from the merger, acquisition or sale of the original CONTRACTOR's business or the part of the original CONTRACTOR's business that provides services under this Contract or from assumption by, or sale to, another entity of the contract itself, including:

42.2.3.1 The names and positions of corporate or company officers, project managers, other CONTRACTOR management staff with responsibilities under the Contract, and numbers and the type of technical or other personnel who will be responsible for fulfilling the obligations of the Contract, and any subcontracts that will be used to provide any personal or other services under the Contract by the New Entity and,

42.2.3.1 An organizational chart clearly describing the organizational structure of the New Entity, parent company, subsidiary, division or other unit of the entity or parent company with which it has merged or by which it, or the Contract, has been acquired.

E.42.2.4 Such additional evidence of financial solvency, adequate capitalization and information regarding corporate organizational and personnel assigned to the Contract as the State determines is necessary to evaluate the status of the proposed or consummated merger, acquisition or sale.

E.42.3 The original CONTRACTOR shall immediately notify the State in writing in the event of a change in its legal name and/or Federal Employer Identification Number (FEIN). The CONTRACTOR shall comply with State requests for copies of any documents that have been filed with state corporate records officials or other officials in the state of its incorporation that verify the name change and a narrative description of the reasons for the name change. If a New Entity has succeeded to the interest of the original CONTRACTOR, it shall immediately provide the State written notification of its Federal Employer Identification Number (FEIN), its complete corporate name, State of incorporation, and other documentation required to effectuate the transfer.

E.42.4 Notwithstanding any other provisions of this Contract to the contrary, the State may immediately terminate this Contract in whole or in stages in the event that it determines that the New Entity:

E.42.4.1 Has been debarred from State or Federal contracting in the past five years;

E.42.4.2 Has had a contract terminated for cause by the State of Tennessee within the past five years.

E.42.5 The CONTRACTOR shall be entitled to compensation for satisfactory, authorized service completed as of the termination date, but in no event shall the State be liable to the CONTRACTOR or New Entity for compensation for any service which has not been rendered. Upon such termination, the CONTRACTOR or New Entity shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.42.6 The New Entity shall provide to the State within ten (10) business days of the State's request, a notarized statement signed by an individual authorized to bind the New Entity certifying that all liabilities and obligations incurred by the former CONTRACTOR are assumed by the New Entity.

E.42.7 If the New Entity owes money to the State of Tennessee, it acknowledges that Tennessee Code Annotated Section 9-4-604 requires repayment of these funds and will enter into a legally binding agreement for repayment.

E.43 **SECTIONS/NUMBERING**

The Contract is divided into major Sections A through E with numbering references for subparagraphs included therein. The numbering within major Sections A through E are for purposes of identifying specific paragraph references. Section numbering within each major Section A through E may not contain the major Section A through E letter immediately prior to the Section number beyond 3 levels of numbers for purposes of convenience in this document. However, references to said paragraphs throughout the Contract language shall include the major Section reference A through E preceding each Section number referenced.

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

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

CONTRACTOR LEGAL ENTITY NAME

CONTRACTOR SIGNATURE **DATE**

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE:

Howard (Butch) Eley, Commissioner **DATE**

ATTACHMENTS

ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS

ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS

The CONTRACTOR shall provide medically necessary Behavioral Health Intensive Community Based Treatment Services, Tennessee Health Link, and psychiatric rehabilitation services according to the requirements herein.

All behavioral health services shall be rendered in a manner that supports the recovery of persons experiencing mental illness and enhance the development of resiliency of children and families who are impacted by mental illness, serious emotional disturbance, and/or substance use disorders. Recovery is a consumer driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life with a disability.

SERVICE	**Behavioral Health Intensive Community Based Treatment Services**

DEFINITION

Behavioral Health Intensive Community Based Treatment (ICBT) Services provide frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of Behavioral Health Intensive Community Based Treatment Services to adults and youth with complex needs including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Behavioral Health Intensive Community Based Treatment Services shall be rendered through a team approach which shall include a therapist and Care Coordinator who work under the direct clinical supervision of a licensed behavioral health professional. The primary goal of these services is to reach an appropriate point of therapeutic stabilization so the individual can be transitioned to less in home based services and be engaged in appropriate behavioral health office based services.

Intensive Community Based Treatment Services should include, at a minimum, the following elements and services as clinically appropriate:

- System Of Care principles
- Direct clinical supervision
- Evidenced-based comprehensive assessments and evaluations
- An average of 1-2 visits per week for individual therapy, family therapy, or Care Coordination

Intensive Community Based Treatment Services shall be outcome-driven, including, but not limited to these treatment outcomes:

- Strengthened family engagement in treatment services
- Increased collaboration among formal and informal service providers to maximize therapeutic benefits
- Progress toward child & family goals
- Increased positive coping skills
- Increased family involvement in the community
- Developed skills to independently navigate the behavioral health system

Intensive Community Based Treatment Services include CTT, CCFT, and PACT treatment models as described below:

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, care coordinators, and other therapists as needed) who provide a range of intensive, care coordination, treatment, and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to adults and families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other behavioral health services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited, therapeutic services designed for children and youth to provide stabilization and deter from out-of-home placement. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community. The service components of PACT include:

1) Services targeted to a specific group of individuals with severe mental illness;
2) Treatment, support and rehabilitation services provided directly by the PACT team;
3) Sharing of responsibility between team members and individuals served by the team;
4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
5) Comprehensive and flexible range of treatment and services;
6) Interventions occurring in community settings rather than in hospitals or clinic settings;
7) Twenty-four (24) hour a day availability of services; and
8) Engagement of individuals in treatment and recovery.

SERVICE	**Tennessee Health Link**

DEFINITION

Tennessee Health Link is a team of professionals associated with a mental health clinic or other behavioral health provider who provides whole-person, patient-centered, coordinated care for an assigned panel of members with behavioral health conditions. Members who would benefit from Tennessee Health Link will be identified based on diagnosis, health care utilization patterns, or functional need. They will be identified through a combination of claims analysis and provider referral.

Health Link professionals will use care coordination and patient engagement techniques to help members manage their healthcare across the domains of behavioral and physical health, including:

- Comprehensive care management (e.g., creating care coordination and treatment plans)
- Care coordination (e.g., proactive outreach and follow up with primary care and behavioral health providers)
- Health promotion (e.g., educating the patient and his/her family on independent living skills)
- Transitional care (e.g., participating in the development of discharge plans)
- Patient and family support (e.g., supporting adherence to behavioral and physical health treatment)
- Referral to social supports (e.g., facilitating access to community supports including scheduling and follow through)

SERVICE	**Psychiatric Rehabilitation**

DEFINITION

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual's recovery journey.

The service components included under psychiatric rehabilitation are as follows:

Psychosocial Rehabilitation

Psychosocial Rehabilitation is a community-based program that promotes recovery, community integration, and improved quality of life for members who have been diagnosed with a behavioral health condition that significantly impairs their ability to lead meaningful lives. The goal of Psychosocial Rehabilitation is to support individuals as active and productive members of their communities through interventions developed with a behavioral health professional or certified peer recovery specialist, in a non-residential setting. These interventions are aimed at actively engaging the member in services, and forming individualized service plan goals that will result in measurable outcomes in the areas of educational, vocational, recreational and social support, as well as developing structure and skills training related to activities of daily living. Such interventions are collaborative, person-centered, individualized, and ultimately results in the member's wellness and recovery being sustainable within the community without requiring the support of Psychosocial Rehabilitation. Psychosocial Rehabilitation must meet medical necessity criteria and may be provided in conjunction with routine outpatient services.

Psychosocial Rehabilitation services vary in intensity, frequency, and duration in order to resolve the member's ability to manage functional difficulties**.**

Supported Employment

Supported employment consists of evidenced based practices (e.g., individual placement and support) to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals' preferences, strengths, and experiences. This service also includes support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer Recovery Services

Peer recovery services are designed and delivered by people who have lived experience with behavioral health issues. A Certified Peer Recovery Specialist (CPRS) is someone who has self-identified as being in recovery from mental illness, substance use disorder, or co-occurring disorders of both mental illness and substance use disorder. In addition, a Certified Peer Recovery Specialist has completed specialized training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to provide peer recovery services based on the principles of recovery and resiliency. Certified Peer Recovery Specialists can provide support to others with mental illness, substance use disorder, or co-occurring disorder and help them achieve their personal recovery goals by promoting self-determination, personal responsibility, and the empowerment inherent in self-directed recovery.

Under the direct clinical supervision of a licensed behavioral health professional, peer recovery services provided by a Certified Peer Recovery Specialist may include: assisting individuals in the development of a strengths-based, person-centered plan of care; serving as an advocate or mentor; developing community support; and providing information on how to successfully navigate the behavioral health care system. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are provided so individuals can educate and support each other in the acquisition of skills needed to manage their recovery and access resources within their communities. Services are often provided during the evening and weekend hours.

Family Support Services

Family support services are used to assist other caregivers of children or youth diagnosed with emotional, behavioral, or co-occurring disorders, and are provided by a Certified Family Support Specialist under the direct clinical supervision of a licensed behavioral health professional. A Certified Family Support Specialist is a person who has previously self-identified as the caregiver of a child or youth with an emotional, behavioral or co-occurring disorder and who has successfully navigated the child-serving systems to access treatment and resources necessary to build resiliency and foster success in the home, school, and community. This individual has successfully completed and passed training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to assist other caregivers in fostering resiliency in their child based on the principles of resiliency and recovery; and has received certification from the Tennessee Department of Mental Health and Substance Abuse Services as a Certified Family Support Specialist.

These services include assisting caregivers in managing their child's illness and fostering resiliency and hope in the recovery process. These direct caregiver-to-caregiver support services include, but are not limited to, developing formal and informal supports, assisting in the development of strengths-based family and individual goals, serving as an advocate, mentor, or facilitator for resolution of issues that a caregiver is unable to resolve on his or her own, or providing education on system navigation and skills necessary to maintain a child with emotional, behavioral or co-occurring disorders in their home environment.

Illness Management & Recovery

Illness management and recovery services refer to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery. Illness management and recovery is not limited to one curriculum but is open to all evidenced-based and/or best practice classes and programs such as WRAP (Wellness Recovery Action Plan).

Supported Housing

Supported housing services refer to transitional services rendered at facilities that provide behavioral health staff supports for individuals who require treatment services in a highly structured, safe, and secure setting. Supported housing services are for TennCare Priority Enrollees and are intended to prepare individuals to live independently in a community setting. At a minimum, supported housing services include coordinated and structured personal care services to address the individuals' behavioral and physical health needs in addition to fifteen (15) hours per week of psychosocial rehabilitation services to assist individuals in achieving recovery and resiliency based goals and developing the life skills necessary to live independently in a community setting. The required fifteen (15) hours per week of psychosocial rehabilitation is not inclusive of the psychosocial rehabilitation services received in day programs. Supported housing services do not include the payment of room and board.

SERVICE	**Crisis Services**

Definition

Behavioral health crisis services shall be rendered to individuals with a mental health or substance use/abuse issue when there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others who have closely observed the individual experiencing the crisis. Crisis services are available twenty-four (24) hours a day, seven (7) days a week. Crisis services include twenty-four (24) hour toll free telephone lines answered in real time by trained crisis specialists and face-to-face crisis services including, but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Certified Peer Recovery Specialists and/or Certified Family Support Specialists shall be utilized in conjunction with crisis specialists to assist adults and children in alleviating and stabilizing crises and promote the recovery process as appropriate. Behavioral health crisis service providers are not responsible for pre-authorizing emergency involuntary hospitalizations.

The Mental Health Crisis Response Services - Community Face-to-Face Response Protocols provide guidance for calls that are the responsibility of a crisis response service to determine if a Face-to-Face evaluation is warranted and those that are not the responsibility of the crisis response service. These Protocols were developed to ensure that consumers who are experiencing a behavioral health crisis and have no other resources receive prompt attention. All responses are first determined by clinical judgment.

Guidance for All Calls:

- For calls originating from an Emergency Dept., telehealth is the preferred service delivery method for the crisis response service
- After determining that there is no immediate harm, ask the person if he or she can come to the closest walk-in center
- If a Mandatory Pre-screening Agent (MPA) not employed by a crisis response service is available, there may be no need for a crisis evaluation by mobile crisis
- For all other calls, unless specified in the Protocols, if a person with mental illness is experiencing the likelihood of immediate harm then a response is indicated.

SERVICE	Opioid Use Disorder Treatment

Definition

Treatments for opioid use disorder are designed and delivered across the continuum of care including but not limited to hospital, residential treatment, Intensive Outpatient Program, Office-Based Opioid Treatment, Opioid Treatment Program, primary care and peer recovery services. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful. The duration of treatment should be based on the needs of the persons served. For opioid use disorder, one essential component within the continuum is Medication Assisted Treatment. Medication Assisted Treatment (MAT) for persons diagnosed with opioid-use disorder is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. The medications used to achieve treatment goals include buprenorphine, naltrexone, and methadone products approved by the Food and Drug Administration (FDA) for the use in the treatment of opioid-use disorder.

All providers treating members with opioid use disorder must either provide Medication Assisted Treatment (MAT) or have a policy for referral to a MAT provider for those members wishing to access MAT. Providers must also maintain compliance with the licensure rules and/or program standards set by TDMHSAS to render MAT Services.

ATTACHMENT II
COST SHARING SCHEDULE

ATTACHMENT II
COST SHARING SCHEDULE
Non-Pharmacy Copayment Schedule
(unless otherwise directed by TENNCARE)

Poverty Level	Copayment Amounts
0% - 99%	$0.00
100% - 199%	$10.00, Hospital Emergency Room (waived if admitted) $5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $5.00, Physician Specialists (including Psychiatrists) $5.00, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $15.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $20.00, Physician Specialists (including Psychiatrists) $100.00, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)

COVERKIDS COST SHARING SCHEDULE

MEDICAL BENEFITS	Copay When Household Income is Less than 200% FPL	Copay When Household Income is Between 200% FPL and 250% FPL
Chiropractic care	$5 per visit	$15 per visit
Emergency room	$10 copay per use for non-emergency	$50 copay per use for non-emergency
Hospital admissions and other inpatient services	$5 per admission (waived if readmitted within 48 hours for same episode)	$100 per admission (waived if readmitted within 48 hours for same episode)
Inpatient mental health and substance abuse treatment	$5 per admission (waived if readmitted within 48 hours for same episode)	$100 per admission (waived if readmitted within 48 hours for same episode)
Outpatient mental health and substance abuse treatment	$5 per session	$15 per session
Physical, speech, and occupational therapy	$5 per visit	$15 per visit
Physician office visit	$5 per visit (primary care); $5 per visit (specialist)	$15 per visit (primary care); $20 per visit (specialist)
Prescription drugs	$1 generic; $3 preferred brand; $5 non-preferred brand	$5 generic; $20 preferred brand; $40 non-preferred brand
Vision services	$5 for lenses; $5 for frames (when lenses and frames are ordered at the same time, only one copay is charged)	$15 for lenses; $15 for frames (when lenses and frames are ordered at the same time, only one copay is charged)

ATTACHMENT III
GENERAL ACCESS STANDARDS

ATTACHMENT III
GENERAL ACCESS STANDARDS

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum, this shall include:

- Primary Care Physician or Extender:

  (a) Transport access Suburban/Rural: ≤ 30 miles travel distance and ≤ 45 minutes travel time

  (b) Transport access Urban: ≤ 20 miles travel distance and ≤ 30 minutes travel time

  (c) Patient Load: 2,500 or less for physician; one-half of this for a physician extender.

  (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

  (e) Documentation/Tracking requirements:

  + Documentation - Plans must have a system in place to document appointment scheduling times.

  + Tracking - Plans must have a system in place to document the exchange of member information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.

- Specialty Care and Emergency Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.

- Hospitals

  (a) Transport access, ≤ 30 miles travel distance and ≤ 45 minutes travel time, except in rural areas where access distance may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

- Long-Term Care Services:

  Transport access to licensed Adult Day Care providers, ≤ 20 miles travel distance and ≤ 30 minutes travel time for TennCare enrollees in urban areas, ≤ 30 miles travel distance and ≤ 45 minutes travel time for TennCare enrollees in suburban areas ≤ 60 miles travel distance and ≤ 90 minutes travel time for TennCare enrollees in rural areas, except where community standards and documentation shall apply.

- General Optometry Services:

  (a) Transport access ≤ 30 miles travel distance and ≤ 45 minutes travel time, except in rural areas where community standards and documentation shall apply.

  (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

- All other services not specified here shall meet the usual and customary standards for the community as determined by TENNCARE.

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.

ATTACHMENT IV
SPECIALTY NETWORK STANDARDS

ATTACHMENT IV
SPECIALTY NETWORK STANDARDS

The CONTRACTOR shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. A provider is considered a "specialist" if he/she has a provider agreement with the CONTRACTOR to provide specialty services to members.

Access to Specialty Care

The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

(1) The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent), and Urology; and

(2) The following access standards are met:
- Transport access ≤ 60 miles travel distance and ≤ 90 minutes travel time for at least 75% of non-dual members and
- Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for ALL non-dual members

Availability of Specialty Care

The CONTRACTOR shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each Grand Region was compared to the size of the population in each Grand Region. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000

Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Psychiatry (adult)	25,000
Psychiatry (child & adolescent)	150,000
Urology	30,000

Access to Opioid Use Disorder (OUD) treatment providers

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

(1) The CONTRACTOR shall have provider agreements with DATA 2000 Waiver approved OUD treatment providers only for the provision of covered services with buprenorphine and

(2) The following access standards are met:

- Transport access ≤ 45 miles travel distance and ≤ 45 minutes travel time for at least 75% of non-dual members and
- Transport access ≤ 60 miles travel distance and ≤ 60 minutes travel time for ALL non-dual members

Availability of OUD Treatment Care

The CONTRACTOR shall provide adequate numbers of OUD treatment providers for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of OUD treatment providers with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
OUD Treatment provider contracted to treat with buprenorphine	10,000
OUD Treatment provider contracted to treat with Methadone	50,000

Capacity of OUD Treatment Providers

All Contracted MAT Providers are required to have a DATA 2000 Waiver to provide Buprenorphine Medication Assisted Treatment (MAT). The DATA 2000 Waiver, as outlined by Substance Abuse and Mental Health Services Administration (SAMSHA), restricts the number of members a provider can treat across all payer types. The number of members a provider can treat is now on referred to as "slots."

To ensure access to OUD treatment across the state, TennCare will calculate the number of slots and/or providers needed for each MCO's contracted MAT network by Tennessee Grand Region (West, Middle, East) on an annual basis. The calculation will be based on prevalence of opioid use disorder (OUD) by Grand Region and MCO enrollment. The Capacity Standards will be **in addition** to the geographic and time standards outlined previously.

The updated adequacy standards will be provided July 1st of every year.

(Provider Enrollment File service type coding options for OUD treatment providers are identified in Attachment V.)

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.

ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

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 shall 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	Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all CHILD and ADULT members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Not subject to geographic access standards ----------	Within 30 calendar days
Outpatient Non-MD Services	Transport access ≤ 30 miles travel distance and ≤ 45 minutes travel time for at least 75% of CHILD and ADULT members and ≤ 60 miles travel distance and ≤ 60 minutes travel time for all CHILD and ADULT 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	Transport access ≤ 90 miles travel distance and ≤ 90 minutes travel time for 75% of CHILD and ADULT members and ≤ 120 miles travel distance and ≤ 120 minutes travel time for all CHILD and ADULT members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all CHILD and ADULT 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)	Not subject to geographic access standards	Within 10 business days

Outpatient Treatment Services (Substance Abuse)	Transport access ≤ 30 miles travel distance and ≤ 30 minutes travel time for 75% of CHILD and ADULT members and ≤ 45 miles travel distance and ≤ 45 minutes travel time for all CHILD and ADULT members	Within 10 business days; for detoxification – within 24 hours
Intensive Community Based Treatment Services	Not subject to geographic access standards	Within 7 calendar days
Tennessee Health Link Services	Not subject to geographic access standards	Within 30 Calendar Days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, Peer Recovery services or Family Support service	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 2 hours 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
Intensive Community Based Treatment Services	Adult - 66, or 83 Child – C7, G2, G6, or K1
Tennessee Health Link Services	Adult-31 Child-D7
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Recovery Services	88
Family Support Services	49
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
Opioid Use Disorder - Treatment with buprenorphine only	P1
Opioid Use Disorder - Treatment with buprenorphine OR naltrexone	P2
Opioid Use Disorder - Treatment with naltrexone only	P3
Opioid Use Disorder – Treatment with methadone	P4
Opioid Use Disorder – (Reserved for future use)	P5

ATTACHMENT VI
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ATTACHMENT VII
PERFORMANCE STANDARDS

ATTACHMENT VII
PERFORMANCE STANDARDS

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
1	Timely Claims Processing	Report from TDCI	90% of clean electronic claims for nursing facility services and CHOICES HCBS and ECF CHOICES HCBS are processed and paid within fourteen (14) calendar days of receipt 99.5% of clean electronic claims for nursing facility and CHOICES HCBS and ECF CHOICES HCBS shall be processed and paid within twenty-one (21) calendar days of receipt 90% of all other claims (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of claim. 99.5% of all other claims are processed within sixty (60) calendar days.	Percentage of clean electronic claims paid within 14 calendar days of receipt of claim, for each month Percentage of clean electronic claims processed within 21 calendar days of receipt of claim, determined for month Percentage of claims paid within 30 calendar days of receipt of claim, for each month Percentage of claims processed within 60 calendar days of receipt of claim, for each month	Monthly	$10,000 for each month determined not to be in compliance LD assessed on a regional basis based on regional reporting

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
2	Claims Payment Accuracy	Self-reported results based on an internal audit conducted on a statistically valid random sample will be validated by TDCI	97% of claims paid accurately upon initial submission	Percentage of total claims paid accurately for each month and by provider type (NF, CHOICES HCBS, and ECF CHOICES HCBS, and other)	Monthly	$5,000 for each full percentage point accuracy is below 97% for each month for each provider type (NF, CHOICES HCBS, and ECF CHOICES HCBS, and other) LD assessed on a regional basis based on regional reporting
3	Telephone Response Time/Call Answer Timeliness -Member Services Line	Member Services and Provider Services Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month LD assessed on a statewide basis based on statewide reporting
4	Telephone Response Time/Call Answer Timeliness -Provider Services Line	Member Services and Provider Services Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month LD assessed on a statewide basis based on statewide reporting
5	Telephone Response Time/Call Answer Timeliness -Utilization Management Line	Member Services and UM Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month LD assessed on a statewide basis based on statewide reporting

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
6	Telephone Response Time/Call Answer Timeliness – Nurse Triage/Nurse Advice Line	Nurse Triage/Nurse Advice Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point below 85% per month LD assessed on a statewide basis based on statewide reporting
7	Telephone Call Abandonment Rate (unanswered calls) – Member Services Line	Member Services and Provider Services Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month LD assessed on a statewide basis based on statewide reporting
8	Telephone Call Abandonment Rate (unanswered calls) – Provider Services Line	Member Services and Provider Services Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month LD assessed on a statewide basis based on statewide reporting

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
9	Telephone Call Abandonment Rate (unanswered calls) – UM Line	Member Services and UM Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month LD assessed on a statewide basis based on statewide reporting

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
10	Telephone Call Abandonment Rate (unanswered calls) – Nurse Triage/Nurse Advice Line	Nurse Triage/Nurse Advice Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	$25,000 for each full percentage point above 5% per month LD assessed on a statewide basis based on statewide reporting
11	Provider Network Documentation	Provider Enrollment File and provider agreement signature pages	100% of providers on the Provider Enrollment File have a signed provider agreement with the CONTRACTOR		Upon TENNCARE request	$1,000 for each provider for which the CONTRACTOR cannot provide a signature page from the provider agreement between the provider and the CONTRACTOR LD assessed on a regional basis based on regional reporting

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
12	Specialist Provider Network	Provider Enrollment File	1. Physician Specialists: Executed specialty physician contracts in all areas required by this Contract for the following specialists: allergy; cardiology; dermatology; endocrinology; gastroenterology; general surgery; nephrology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; psychiatry (adults); psychiatry (child/adolescent); and urology 2. Essential Hospital Services: Executed contract with at least one (1) tertiary care center for each essential hospital service 3. Center of Excellence for People with AIDS: Executed contract with at least two (2) Center of Excellence for AIDS within the CONTRACTOR's approved Grand Region(s) 4. Center of Excellence for Behavioral Health: Executed contract with all COEs for Behavioral Health within the CONTRACTOR's approved Grand Region(s)	Executed contract is a signed provider agreement with a provider to participate in the CONTRACTOR's network as a contract provider	Monthly	$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis The liquidated damage may be waived for Physician Specialists if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of physicians practicing in the area. The liquidated damage may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE LD assessed on a regional basis based on regional reporting

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
13	CHOICES HCBS Provider Network	Provider Enrollment File	At least two (2) providers for each CHOICES HCBS, other than community-based residential alternatives, to cover each county in the Grand Region	Executed contract is a signed provider agreement with a provider to participate in the CONTRACTOR's network as a contract provider	Quarterly	$25,000 if ANY of the listed standards are not met, either individually or in combination on a quarterly basis The liquidated damage may be waived if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of CHOICES HCBS provider serving the county and the CONTRACTOR has used good faith efforts to develop CHOICES HCBS providers to serve the county. The liquidated damage may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE LD assessed on a regional basis based on regional reporting

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
14	Provider Participation Accuracy	Provider Enrollment File	At least 90% of listed providers confirm participation in the CONTRACTOR's network	A statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the CONTRACTOR's network	Quarterly	$25,000 per quarter if less than 90% of providers confirm participation. The liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or may be waived by TENNCARE if the CONTRACTOR submits sufficient documentation to demonstrate 90% of providers in the sample are participating LD assessed on a regional basis based on regional reporting

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
15	Provider Information Accuracy	Provider Enrollment File	Data for no more than 10% of listed providers is incorrect for each data element	Data for no more than 10% of a statistically valid sample of participating providers on the most recent monthly provider enrollment is incorrect for each element as determined by TENNCARE	Quarterly	$5,000 per quarter if data for more than 10% but fewer than 31% of providers is incorrect for each data element $25,000 per quarter if data for more than 30% of providers is incorrect for each data element The $25,000 liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or may be waived by TENNCARE if the CONTRACTOR submits sufficient documentation LD assessed on a regional basis based on regional reporting

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
16	Distance/Time from provider to member	Provider Enrollment File	In accordance with this Contract, including Attachments III through V	Time and travel distance as measured by provider network analytics software described by TENNCARE	Monthly	$25,000 if ANY of the listed standards are not met, either individually or in combination, on a monthly basis. The liquidated damage may be lowered to $5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE. TENNCARE may waive the liquidated damage regarding distance to adult day care if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of adult day care providers and the CONTRACTOR has used good faith efforts to develop adult day care providers. LD assessed on a regional basis based on regional reporting.

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
17	OUD Treatment Network	Provider Enrollmen File	October 5, 2018 – OUD access standards to be 50% met. November 5, 2018 - OUD access standards to be 75% met. December 5, 2018 - OUD access standards to be 90% met. January 5, 2019 – OUD access standards to be 100% met	Executed contract is a signed provider agreement with a provider to participate in the CONTRACTOR's OUD network as a contract provider	Monthly	$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis. The liquidated damage may be waived if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of MAT providers in the area. The liquidated damage may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE LD assessed on a regional basis based on regional reporting

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
18	Generic Prescription Drug Utilization	Encounter data	Sixty percent (60%)	Number of generic prescriptions divided by the total number of prescriptions	Quarterly	$5,000 for each full percentage point Generic Prescription Utilization ratio is below 60% LD assessed on a regional basis based on regional reporting
19	Length of time between psychiatric hospital/RTF discharge and first subsequent mental health service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B	Post-Discharge Services Report	Discharged members receive a service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B within seven (7) calendar days of discharge. The standard (benchmark) for compliance is sixty percent (60%)	(1) Number of members discharged by length of time between discharge and first service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B, determined for each month (2) Average length of time between hospital discharge and first service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B, determined for each month	Semi-Annually	$3,000 for each quarter determined to not be in compliance LD assessed on a regional basis based on regional reporting
20	Seven (7) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 10% of members discharged from an inpatient or residential facility are readmitted within seven (7) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within seven (7) calendar days of discharge; determined for each month in the quarter	Semi-Annually	$1,500 for each quarter determined to not be in compliance LD assessed on a regional basis based on regional reporting

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE (Assessed by Region or Statewide depending on Reporting Requirement)
21	Thirty (30) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 15% of members discharged from an inpatient or residential facility are readmitted within thirty (30) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within thirty (30) calendar days of discharge; determined for each month in the quarter	Semi-Annually	$1,500 for each quarter determined to not be in compliance LD assessed on a regional basis based on regional reporting

ATTACHMENT VIII
DELIVERABLE REQUIREMENTS

ATTACHMENT VIII
DELIVERABLE REQUIREMENTS

GENERAL

This is a preliminary list of deliverables. The CONTRACTOR and TENNCARE shall agree to the appropriate deliverables, deliverable format/submission requirements, submission and approval time frames, and technical assistance as required. Deliverables shall be submitted to the Division of TennCare 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 A.2.1.1

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

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

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

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

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

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

8. TennCare Kids policies and procedures that ensure compliance with the requirements of Section A.2.7.6

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

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

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

12. Implementation plan for making admission, discharge and transfer data from applicable hospitals and pharmacy data available and/or accessible to all primary care practices in accordance with Section A.2.9.1.2.8

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

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

15. Transition of care policies and procedures that ensure compliance with Section A.2.9.5

16. Care coordination and support coordination policies and procedures that ensure compliance with Section A.2.9.6

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

18. Policies and procedures for coordination of physical health, behavioral health, and long-term care services that ensure compliance with Section A.2.9.8

19. If CONTRACTOR subcontracts for the provision of behavioral health services, agreement with the subcontractor in accordance with Section A.2.9.8.2 to ensure compliance with Section A.2.9.8

20. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section A.2.9.9

21. Policies and procedures for coordination of pharmacy services that ensure compliance with Section A.2.9.10

22. Policies and procedures for coordination of dental services that ensure compliance with Section A.2.9.11

23. Identification of members serving on the claims coordination committee in accordance with Section A.2.9.11.5.3

24. Policies and procedures for coordination with Medicare that ensure compliance with Section A.2.9.12

25. Policies and procedures for inter-agency coordination that ensure compliance with Section A.2.9.15

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

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

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

29. 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 A.2.11.5.2

30. Credentialing manual and policies and procedures that ensure compliance with Section A.2.11.9

31. Policies and procedures that ensure compliance with notice requirements in Section A.2.11.10

32. Notice of provider and subcontractor termination and additional documentation as required by Section A.2.11.10.2

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

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

35. Intent to use a physician incentive plan (PIP) to TENNCARE and TDCI (see Section A.2.13.10)

36. Any provider agreement templates or subcontracts that involve a PIP for review as a material modification (to TDCI) as required by (see Section A.2.13.10)

37. Pricing policies for emergency services provided by non-contract providers that ensure compliance with Section A.2.13.11.1

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

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

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

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

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

43. Evidence that NCQA accreditation application submitted and fee paid (Section A.2.15.5.2)

44. HEDIS ROADMAP as required by Section A.2.15.5.2

45. Copy of signed NCQA survey contract as required by Section A.2.15.5.2

46. Notice of date for ISS submission and NCQA on-site review as required by Section A.2.15.5.2

47. Notice of final payment to NCQA as required by Section A.2.15.5.2

48. Notice of submission of ISS to NCQA as required by Section A.2.15.5.2

49. Copy of completed NCQA survey and final report as required by Section A.2.15.5.2

50. Notice of any revision to NCQA accreditation status

51. Policies and procedures regarding critical incident and Reportable Event management and reporting to ensure compliance with Sections A.2.15.7.1 and A.2.15.7.6

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

53. Report critical incidents or adverse occurrences to TENNCARE within twenty-four (24) hours or four (4) hours, as applicable, pursuant to Sections A.2.15.7.1, A.2.15.7.2, A.2.15.7.3, A.2.15.7.4, A.2.15.7.6.4.1

54. Provider Preventable Conditions Reporting (see Section A.2.15.8)

55. If applicable, information on the use of the name of the CONTRACTOR's TennCare MCO pursuant to Section A.2.16.2

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

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

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

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

60. Provider manual that is in compliance with requirements in Section A.2.18.5

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

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

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

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

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

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

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

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

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

70. A risk assessment annually and "as needed" (see Section A.2.20.3.2.2)

71. TPL policies and procedures that ensure compliance with Section A.2.21.4

72. Accounting policies and procedures that ensure compliance with Section A.2.21.7

73. Proof of insurance coverage (see Section A.2.21.8)

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

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

76. Internal claims dispute procedure (see Section A.2.22.5)

77. EOB policies and procedures to ensure compliance with Section A.2.22.9

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

79. Proposed approach for remote access in accordance with Section A.2.23.6.10

80. Information security plan as required by Section A.2.23.6.11

81. Notification of Systems problems in accordance with Section A.2.23.7

82. Systems Help Desk services in accordance with Section A.2.23.8

83. Notification of changes to Systems in accordance with Section A.2.23.9

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

85. Notification of changes to membership of CHOICES Advisory Group and ECF CHOICES Advisory Group and current membership lists in accordance with Sections A.2.24.3 and A.2.24.4

86. An abuse and neglect plan in accordance with Section A.2.24.6

87. Medical record keeping policies and procedures that ensure compliance with Section A.2.24.8

88. Annual written procedures regarding PERM in accordance with Section A.2.25.6.2.2

89. Subcontracts (see Section A.2.26)

90. HIPAA policies and procedures that ensure compliance with Section A.2.27

91. Notification of breach and provisional breach in accordance with Section A.2.27

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

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

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

95. Changes to key staff as required by Section A.2.29.1.2

96. Staffing plan as required by Section A.2.29.1.8

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

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

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

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

101. Eligibility and Enrollment Data (see Section A.2.30.2.1)

102. Monthly Enrollment/Capitation Payment Reconciliation Report (see Section A.2.30.2.2)

103. Quarterly Member Enrollment/Capitation Payment Report (see Section A.2.30.2.3)

104. Information on members (see Section A.2.30.2.4)

105. TennCare Kids Annual Outreach Plan (see Section A.2.30.3.1)

106. TennCare Kids Quarterly Update (see Section A.2.30.3.2)

107. TennCare Kids Year-End Update (See Section A.2.30.3.3)

108. Psychiatric Hospital/RTF Readmission Report (see Section A.2.30.4.1)

109. Post-Discharge Services Report (see Section A.2.30.4.2)

110. TennCare Kids Quarterly Outreach Activities Report (see Section A.2.30.4.4)

111. Monthly EPSDT Claims Report (see Section A.2.30.4.5)

112. Provider Engagement Plan (see Section A.2.30.4.6.1)

113. Provider Engagement Tracker Report (see Section A.2.30.4.6.2)

114. Annual Review of each PCMH and THL Organization (see Section A.2.30.4.6.3)

115. Episodes of Care Performance Reports (see Section A.2.30.4.7.1)

116. PCMH Membership/Anticipated PCMH Contract Report (see Section A.2.30.4.8.1)

117. PCMH Membership/Contracted PCMH Report (see Section A.2.30.4.8.2)

118. PCMH Risk Band Values for Activity Payments (pmpms) Report (see Section A.2.30.4.8.3)

119. PCMH Practice Type Designations Report (see Section A.2.30.4.8.4)

120. PCMH Data Report (see Section A.2.30.4.8.5)

121. PCMH Quality Summary Report (see Section A.2.30.4.8.6)

122. PCMH Provider Sample Reports (see Section A.2.30.4.8.7)

123. PCMH Provider Reports (see Section A.2.30.4.8.8)

124. PCMH Outcome Payment Summary Report (see Section A.2.30.4.8.9)

125. PCMH Monthly Payment Report (see Section A.2.30.4.8.10)

126. PCMH Member List for Outcome Panel Report (see Section A.2.30.4.8.11)

127. Tennessee Health Link (THL) Report (see Section A.2.30.4.9.1)

128. Tennessee Health Link (THL) Engagement Evaluation Summary Report (see Section A.2.30.4.9.2)

129. Tennessee Health Link (THL) Member list for Outcome Panel Report (see Section A.2.30.4.9.3)

130. Tennessee Health Link (THL) Data Report (see Section A.2.30.4.9.4)

131. Tennessee Health Link (THL) Quality Summary Report Tennessee Health Link (THL) Quality Summary Report (see Section A.2.30.4.9.5)

132. Tennessee Health Link (THL) Provider Sample Report (see Section A.2.30.4.9.6)

133. Tennessee Health Link (THL) Provider Report (see Section A.2.30.4.9.7)

134. Tennessee Health Link (THL) Summary Report (see Section A.2.30.4.9.8)

135. Tennessee Health Link (THL) Claims Payment Report (see Section A.2.30.4.9.9)

136. PCMH and THL Attribution Files (see Section A.2.30.4.10)

137. Population Health Update Report (see Section A.2.30.5.1)

138. Population Health Outcome Metric Report (see Section A.2.30.5.2)

139. Population Health Program Strategy (see Section A.2.30.5.3)

140. Population Health Impact Report (see Section A.2.30.5.4)

141. Population Health Success Stories Report (see Section A.2.30.5.5)

142. Women of Child Bearing Age + Opioids Report (see Section A.2.30.5.6)

143. Status of Transitioning CHOICES Members Report (see Section A.2.30.6.1)

144. CHOICES Nursing Facility Diversion Activities Report (see Section A.2.30.6.2)

145. CHOICES and ECF CHOICES Nursing Facility to Community Transition Report (see Section A.2.30.6.3)

146. Monthly Nursing Facility Short-Term Stay Report (see Section A.2.30.6.4)

147. CHOICES HCBS and ECF CHOICES HCBS Late and Missed Visits Report (see Section A.2.30.6.5)

148. CHOICES and ECF CHOICES Consumer Direction of eligible CHOICES HCBS and ECF CHOICES HCBS Report (see Section A.2.30.6.6)

149. CHOICES Care Coordination Report (see Section A.2.30.6.7)

150. ECF CHOICES Support Coordination Report (see Section A.2.30.6.8)

151. Monthly CHOICES and ECF CHOICES Caseload and Staffing Ratio Report (see Section A.2.30.6.9)

152. Regional Mental Health Institution Report (see Section A.2.30.6.10)

153. Members identified as potential pharmacy lock-in candidates (see Section A.2.30.6.11)

154. Pharmacy Services Report (see Section A.2.30.6.12)

155. Pharmacy Services Report, On Request (see Section A.2.30.6.13)

156. Housing Profile Assessment Report (see Section A.2.30.6.14)

157. Community Living Supports and Community Living Supports – Family Model Placement Report (see Section A.2.30.6.15)

158. CHOICES HCBS Point of Service Satisfaction Report (see Section A.2.30.6.16)

159. ECF CHOICES HCBS Point of Service Satisfaction Report (see Section A.2.30.6.17)

160. ECF CHOICES Employment Report (see Section A.2.30.6.18)

161. ECF CHOICES Reimbursement Services Report (see Section A.2.30.6.19)

162. Meeting the Urgent (RED FLAG) Needs of Members during Transition Report (see Section A.2.30.6.20)

163. Semi-Annual HH/PDN Coordination Report (see Section A.2.30.6.21)

164. Monthly HH/PDN Coordination Report (see Section A.2.30.6.22)

165. Weekly Member MCO Selection/Assignment Report (see Section A.2.30.6.23)

166. Semi-Annual HH/PDN ALJ/CEA Report (see Section A.2.30.6.24)

167. ECF CHOICES Group 7 Report (See Section A.2.30.6.25)

168. ECF CHOICES Group 8 Report (See Section A.2.30.6.26)

169. Care Coordination and Support Coordination Electronic Visit Verification (EVV) Monitoring Report (See Section A.2.30.6.27)

170. Provider Enrollment File (see Section A.2.30.8.1)

171. Provider Compliance with Access Requirements Report (see Section A.2.30.8.2)

172. PCP Assignment Report (see Section A.2.30.8.3)

173. Report of Essential Hospital Services (see Section A.2.30.8.4)

174. Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness (see Section A.2.30.8.5)

175. Quarterly Behavioral Health Appointment Timeliness Summary Report (see Section A.2.30.8.6)

176. Annual FQHC Report (see Section A.2.30.8.7)

177. Quarterly CHOICES HCBS and ECF CHOICES Provider Criminal Background Check and Registry Check Report (see Section A.2.30.8.8)

178. Quarterly HCBS Settings Report (see Section A.2.30.8.9)

179. Behavioral Health Service Matrix Report (see Section A.2.30.8.10)

180. Related Provider Payment Report (see Section A.2.30.10.1)

181. Check Run Summaries Report (see Section A.2.30.10.2)

182. Claims Data Extract Report (see Section A.2.30.10.3)

183. Reconciliation Payment Report (see Section A.2.30.10.4)

184. Administrative Services Only Invoice Report (See Section A.2.30.10.5)

185. Cost and Utilization Reports (see Section A.2.30.11.1)

186. Cost and Utilization Summaries (see Section A.2.30.11.2)

187. Identification of high-cost claimants (see Section A.2.30.11.3)

188. CHOICES and ECF CHOICES Utilization Report (see Section A.2.30.11.4)

189. Referral Provider Listing and supporting materials (see Section A.2.30.11.5)

190. Behavioral Health Coverage Annual Report (see Section A.2.30.11.6)

191. Proposed Performance Improvement Projects Topics (see Section A.2.30.12.1)

192. Report on Performance Improvement Projects (see Section A.2.30.12.1.1)

193. NCQA Accreditation Report (see Section A.2.30.12.2)

194. NCQA revaluation of accreditation status based on HEDIS scores (see Section A.2.30.12.3)

195. Medicaid HEDIS measures marked as “Not Reported” (see Section A.2.30.12.4)

196. Reports of Audited HEDIS Results (see Section A.2.30.12.5)

197. Reports of Audited CAHPS Results (see Section A.2.30.12.6)

198. CHOICES HCBS Critical Incidents Report (see Section A.2.30.12.7)

199. ECF CHOICES HCBS Reportable Event Report (see Section A.2.30.12.8)

200. Behavioral Health Adverse Occurrences Report (see Section A.2.30.12.9)

201. Settings Compliance Committee Report (see Section A.2.30.12.10)

202. MAT Network Quality Metrics Reports (see Section A.2.30.12.11)

203. MAT Network Quality Metrics Summary Report (see Section A.2.30.12.12)

204. System of Support (SOS) Report (see Section A.2.30.12.13)

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

206. Provider Satisfaction Survey Report (see Section A.2.30.13.3)

207. Quarterly Provider Complaints and Appeals Report (see Section A.2.30.13.4)

208. Member Complaints Report (see Section A.2.30.14)

209. Fraud, Waste, and Abuse Activities Report (see Section A.2.30.15.2)

210. *Fraud, Waste, and Abuse Compliance Plan* (see Section A.2.30.15.3)

211. Policies in with Section 1902(a)(68) of the Social Security Act (see Section A.2.30.15.4)

212. Disclosure Submission Rate Report (see Section A.2.30.15.5)

213. Program Integrity Exception List Report (see Section A.2.30.15.6)

214. List of Involuntary Terminations Report (see Section A.2.30.15.7)

215. Recoveries Report (see Section A.2.30.15.8)

216. Explanation of Benefits (EOBs) Report (see Section A.2.30.15.9)

217. Tips Report (see Section A.2.30.15.10)

218. Fraud, Waste, and Abuse Cost Savings Information Report (see Section A.2.30.15.11)

219. Referral to TennCare OPI and TBI MFCD simultaneously once the suspected fraud, waste and abuse is determined credible upon completion of an investigation (see Section A.2.30.15.12)

220. Report all confirmed or suspected fraud, waste, and abuse to TENNCARE (see Section A.2.30.15.13)

221. Recovery and Cost Avoidance Report (see Section A.2.30.16.1.1)

222. Medical Loss Ratio (MLR) Report (see Section A.2.30.16.2.1)

223. Ownership and Financial Disclosure Report (see Section A.2.30.16.2.2)

224. Annual audit plan (see Section A.2.30.16.2.3)

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

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

227. Annual Financial Report (to TDCI) (see Section A.2.30.16.4.3)

228. Quarterly Financial Report (to TDCI) (see Section A.2.30.16.3.4)

229. Audited Financial Statements (to TDCI) (see Section A.2.30.16.3.5)

230. Claims Payment Accuracy Report (see Section A.2.30.17.1)

231. Monthly Focused Claims Testing Report (see Section A.2.30.17.2)

232. Claims Activity Report (see Section A.2.30.17.3)

233. CHOICES and ECF CHOICES Cost Effective Alternatives Report (see Section A.2.30.17.4)

234. Quarterly Denied Claims Report (See Section A.2.30.17.5)

235. Rejected Claims Report per provider (NF and HCBS) (see Section A.2.30.17.6)

236. Systems Refresh Plan (see Section A.2.30.18.1)

237. Encounter Data Files (see Section A.2.30.18.2)

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

239. Encounter/MLR Reconciliation Report (see Section A.2.30.18.4)

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

241. Systems Availability and Performance Report (see Section A.2.30.18.6)

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

243. Subcontracted claims processing report (see Section A.2.30.20.1)

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

245. Non-discrimination policy (see Section A.2.30.22.1)

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

247. Non-Discrimination Compliance Report (see Section A.2.30.22.3)

248. Disclosure of conflict of interest (see Section A.2.30.23.1)

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

250. ECF CHOICES Initiation of Services Report (see Section A.2.30.24)

251. CoverKids 5% Annual Member Cost Sharing Report (see Section A.2.30.25)

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

253. Return of funds in accordance with Section C.5

254. Termination plan in accordance with Section E.14.8

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

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

ATTACHMENT IX
REPORTING REQUIREMENTS

ATTACHMENT IX, EXHIBIT A
PSYCHIATRIC HOSPITAL/RTF READMISSION REPORT

ATTACHMENT IX, EXHIBIT A
PSYCHIATRIC HOSPITAL/RTF READMISSION REPORT

The *Psychiatric Hospital/RTF Readmission Report* required in Section A.2.30.4.1 shall include, at a minimum, the following data elements:

1. Readmission rates by age group (under 18 and 18 and over) for
   a.) Seven (7) days
   b.) Thirty (30) days

ATTACHMENT IX, EXHIBIT B
POST-DISCHARGE SERVICES REPORT

ATTACHMENT IX, EXHIBIT B
POST-DISCHARGE SERVICES REPORT

The *Post-Discharge Services Report* required in Section A.2.30.4.2 shall include, at a minimum, the following data elements:

1. MCO ID number

2. Number and percentage of compliance for kept appointments that occur within seven (7) calendar days of the date of discharge from psychiatric inpatient or residential treatment facility. Appointments that meet compliance include the following:

   A. Intake

   B. Non Urgent Services:
      1) MD Services (Medication Management, Psychiatric Evaluation)
      2) Non MD Services (Psycho- Therapy)
      3) Substance Abuse (SA) (SA IOP, SA therapy)
      4) Psychosocial Rehabilitation (Psych Rehab, Supportive Employment, Supported Housing, Illness Management and Recovery, Peer Recovery Services and Family Support Services)
      5) Tennessee Health Link

   C. Urgent Services:
      1) MD Services
      2) Non MD Services

3) Substance Abuse (SA IOP) or Detoxification

ATTACHMENT IX, EXHIBIT C
ANNUAL PLAN AND QUARTERLY SUMMARY FOR THE MONITORING OF BEHAVIORAL HEALTH APPOINTMENT TIMELINESS

ATTACHMENT IX, EXHIBIT C
ANNUAL PLAN AND QUARTERLY SUMMARY FOR THE MONITORING OF BEHAVIORAL HEALTH APPOINTMENT TIMELINESS

I. Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness

The *Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness* required in Section A.2.30.8.5 will be submitted to the Division of TennCare by December 31 of each year This deliverable shall include, at a minimum, the following elements:

1. A plan for how the CONTRACTOR monitors and evaluates behavioral health providers for compliance with the timeliness of appointment standards that are outlined for behavioral health in Attachment III for routine MD (behavioral health) specialty care and Attachment V for Outpatient Non-MD behavioral health services.
2. The plan shall include a delineation of methodologies used for monitoring and evaluation:
   a. The plan shall include at minimum, at least one method that incorporates either a phone survey or on-site audit.
   b. The report shall include the frequency of surveys/audits, number of site visits, and types of providers monitored, by (MD and non-MD), and by age group (under 18 years of age and 18 years of age and over) as well as number of phone calls or number of appointments evaluated for timeliness, by type (MD/non-MD) and (under 18 years of age and 18 years of age and over) for each provider.
3. This report will also include the types of correspondence with providers regarding timeliness of appointments; number of performance reports issued to providers, number of Corrective Action Plans (CAPs) issued to providers and results of follow-up to the CAPs.
4. A summary of overall findings will include a summary of results across providers; how representative the sample of surveys/site visits are of the overall volume of services provided; analysis of data collection and identification and resolution of problems, including percentage of compliance with standards in Attachments III and V, as outlined in # 1 above.
5. Description of record keeping, including results of audits and surveys, and requests for corrective action plans submitted to providers.
6. A summary of other methods used to monitor the timeliness of behavioral health appointments.

II. Quarterly Summary for the Monitoring of Behavioral Health Appointment Timeliness

The Quarterly Summary for the Monitoring of Behavioral Health Appointment Timeliness as required in Section A.2.30.8.6. will be due within thirty (30) days after completion of the quarter. This deliverable shall include, at a minimum, a summary and update of the quarterly activities and results outlined in the Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness as required in Section A.2.30.8.5, including strategies, results and outcomes of efforts to improve timeliness of appointments.

ATTACHMENT IX, EXHIBIT D
REPORT OF ESSENTIAL HOSPITAL SERVICES

ATTACHMENT IX, EXHIBIT D
REPORT OF ESSENTIAL HOSPITAL SERVICES

Instructions for Completing *Report of Essential Hospital Services*

The chart for the *Report of Essential Hospital Services* required in Section A.2.30.8.4 is to be prepared based on the CONTRACTOR's provider network for essential hospital services in each Grand Region in which the CONTRACTOR has (or expects to have) TennCare members.

- Fill out one report for each Grand Region. In the top portion of the grid, indicate the MCO name, the Grand Region, the total number of MCO members in the Grand Region and the date that such total enrollment was established.
- Provide information on each contract and non-contract facility that serves (or will serve) members in the identified Grand Region. The MCO should use a separate row to report information on each such facility.

1. In the first column, "Name of Facility" indicate the complete name of the facility.

2. In the second column, "TennCare ID" indicate the TennCare ID assigned to the facility.

3. In the third column, "NPI" indicate the National Provider Identifier issued to the facility.

4. In the fourth column, "City/Town" indicate the city or town in which the designated facility is located.

5. In the fifth column, "County" indicate the name of the county in which this facility is located.

6. In the sixth through the twelfth columns indicate the status of the CONTRACTOR's relationship with the specific facility for each of these covered hospital services, e.g. Neonatal, Perinatal, Pediatric, Trauma, Burn, Center of Excellence for AIDS, and Centers of Excellence for Behavioral Health. For example:

   - If the CONTRACTOR has an executed provider agreement with the facility for neonatal services, insert an "E" in the column labeled "Neonatal".
   - If the CONTRACTOR does not have an executed provider agreement with this facility for "Neonatal", but has another type of arrangement with this facility, the CONTRACTOR should indicate the code that best describes its relationship (L=letter of intent; R=on referral basis; N=in contract negotiations; O=other arrangement). For any facility in which the CONTRACTOR does not have an executed provider agreement and is using as a non-contract provider, the CONTRACTOR should submit a brief description (one paragraph) of its relationship with the facility including an estimated timeline for executing a provider agreement, if any.
   - If the CONTRACTOR does not have any relationship for neonatal services with the facility on this row, the CONTRACTOR should leave the cell labeled "neonatal" blank.

ATTACHMENT IX, EXHIBIT D
ESSENTIAL HOSPITAL SERVICES REPORT

MCO Name:			**Grand Region:**	
Number of TennCare Members:			**as of (date):**	

Name of Facility	**TennCare ID**	**NPI**	**City/ Town**	**County**	**Neonatal**	**Perinatal**	**Pediatric**	**Trauma**	**Burn**	**AIDS Center of Excellence**	**Center of Excellence for Behavioral Health**	**Comments**

E = Executed Provider Agreement
L = Letter of Intent
R = On Referral Basis
N = In Contract Negotiations
O = Other Arrangement
If no relationship for a particular service leave cell blank

ATTACHMENT IX, EXHIBIT E
FQHC REPORT

ATTACHMENT IX, EXHIBIT E
FQHC REPORT

MCO Name: _____

As of January 1, _____

Please provide the information identified below for each FQHC with which the MCO has a provider agreement.

1. FQHC Name: _____
2. FQHC Address: _____
   _____

3. Total Amount Paid for the previous twelve (12) month period from July 1 through June 30: _____

ATTACHMENT IX, EXHIBIT F
COST AND UTILIZATION SUMMARIES

ATTACHMENT IX, EXHIBIT F
COST AND UTILIZATION SUMMARIES

The quarterly Cost and Utilization Summaries required in Section A.2.30.11.2 shall include information for each of the following populations:

• Medicaid (Child and Adult)
• Uninsured (Child and Adult)
• Medically Eligible Child
• Non-CHOICES/Non-ECF CHOICES Disabled
• Non-CHOICES /Non-ECF CHOICES Duals
• CHOICES Duals
• CHOICES Non-Duals
• ECF CHOICES Duals
• ECF CHOICES Non-Duals

Summaries for the following shall be provided:

1) Data elements for *Top 25 Providers (broken down by facilities, practitioners, ancillary providers, transportation providers) by Amount Paid*

    - Rank
    - Provider type
    - Provider Name
    - Street Address (Physical Location)
    - City
    - State
    - Zip Code
    - Amount Paid to Each Provider
    - Amount Paid as a Percentage of Total Provider Payments

2) Data elements for *Top 25 Inpatient Diagnoses by Number of Admissions*

    - Rank
    - DRG Code (Diagnosis Code)
    - Description
    - Amount Paid
    - Admits
    - Admits as a Percentage of Total Admits

3) Data elements for *Top 25 Inpatient Diagnoses by Amount Paid*

    - Rank
    - DRG Code (Diagnosis Code)
    - Description
    - Admits
    - Amount Paid
    - Amount Paid as a Percentage of Total Inpatient Dollars

4) Data elements for *Top 25 Outpatient Diagnoses by Number of Visits*

- Rank
- Diagnosis code
- Description
- Amount Paid
- Visits
- Visits as a percentage of Total Outpatient Visits

5) Data elements for *Top 25 Outpatient Diagnoses by Amount Paid*

- Rank
- Diagnosis Code
- Description
- Visits
- Amount Paid
- Amount Paid as a Percentage of Total Outpatient Payments

6) Data elements for *Top 10 Inpatient Surgical/Maternity Procedures (DRGs) by Number of Admissions*

- Rank
- DRG Code
- Description
- Amount Paid
- Number of Admissions
- Admissions as a Percentage of Total Admissions

7) Data elements for *Top 10 Inpatient Surgical/Maternity Procedures (DRGs) by Amount Paid*

- Rank
- DRG Code
- Description
- Number of Procedures
- Amount Paid
- Amount Paid as a Percentage of Total Inpatient Surgical/Maternity Payments

8) Data elements for *Top 10 Outpatient Surgical/Maternity Procedures by Number of Procedures*

- Rank
- Procedure Code
- Description
- Amount Paid
- Number of Procedures
- Procedures as a Percentage of Total Surgical/Maternity Procedures

9) Data elements for *Top 10 Outpatient Surgical/Maternity Procedures by Amount Paid*

- Rank
- Procedure Code
- Description
- Number of Procedures
- Amount Paid
- Amount Paid as a Percentage of Total Outpatient Surgical/Maternity Payments

ATTACHMENT IX, EXHIBIT G
MEMBER SERVICES, PROVIDER SERVICES, AND UTILIZATION MANAGEMENT
PHONE LINE REPORT

ATTACHMENT IX, EXHIBIT G
MEMBER SERVICES, PROVIDER SERVICES, AND UTILIZATION MANAGEMENT
PHONE LINE REPORT

Instructions for Completing the *Member Services and Provider Services Phone Line Report*

The following definitions shall be used:

Abandoned Call: A call in the phone line queue that is terminated by the caller before reaching a live voice.

Average Time to Answer: The average time that callers waited in the phone line queue (when the call was placed during the hours the phone line is open for services) before speaking to a MCO representative. This shall be reported in minutes: seconds (e.g. one minute and twenty-five seconds should be reported as 1:25).

Call Abandonment Rate: The number of calls (where the member/provider called directly into the phone line or selected a member/provider services option and was put in the call queue) that are abandoned by the caller or the system before being answered by a live voice, divided by the number of calls received by the phone line (during hours when the line is staffed with personnel—hours open for services) during the measurement period.

Call Answer Timeliness: The number of calls (where the member called directly into the phone line or selected a member/provider services option and was put in the call queue) that are answered by a live voice within thirty (30) seconds, divided by the number of calls received by the phone line (during hours when the line is staffed with personnel—hours open for services) during the measurement period.

ATTACHMENT IX, EXHIBIT G
MEMBER SERVICES, PROVIDER SERVICES, AND UTILIZATION MANAGEMENT PHONE LINE REPORT

MCO Name: _____
Report Submission Date: _____
Reporting Quarter: _____

*Statewide Data Only		[Month 1]	[Month 2]	[Month 3]
Member Services Line	Total Number of Calls Received			
	Total Number of Abandoned Calls			
	% of Calls Abandoned			
	Average Time to Answer Calls			
	Number of Calls Answered within 30 Seconds			
	% of Calls Answered within 30 Seconds			
Provider Services Line	Total Number of Calls Received			
	Total Number of Abandoned Calls			
	% of Calls Abandoned			
	Average Time to Answer			
	Number of Calls Answered within 30 Seconds			
	% of Calls Answered within 30 Seconds			
Utilization Management Line	Total Number of Calls Received			
	Total Number of Abandoned Calls			
	% of Calls Abandoned			
	Average Time to Answer			
	Number of Calls Answered within 30 Seconds			
	% of Calls Answered within 30 Seconds			

Narrative: [Explain performance deficiencies when identified and list action steps being taken to address reported deficiencies]

_____

_____

_____

ATTACHMENT X
ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

ATTACHMENT X

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

PRINTED NAME AND TITLE OF SIGNATORY

DATE OF ATTESTATION

ATTACHMENT XI
NEMT REQUIREMENTS

ATTACHMENT XI
NEMT REQUIREMENTS

A.1 GENERAL

A.1.1 The CONTRACTOR, in its delivery of NEMT services, shall comply with all of the requirements in this Attachment XI. The requirements in this Attachment are in addition to, not instead of, requirements found elsewhere in the Contract.

A.1.2 The CONTRACTOR shall develop written policies and procedures that describe how the CONTRACTOR, in the delivery of NEMT services, shall comply with the requirements of the Contract, including this Attachment. Pursuant to Section A.2.25.4 of the Contract, TENNCARE will specify the policies and procedures that must be prior approved in writing by TENNCARE. As part of its policies and procedures the CONTRACTOR shall develop an operating procedures manual detailing procedures for meeting, at a minimum, requirements regarding the following:

A.1.2.1 Requesting NEMT services (see Section A.3 of this Attachment);

A.1.2.2 Approving NEMT services (see Section A.4 of this Attachment); and

A.1.2.3 Scheduling, assigning and dispatching trips (see Section A.5 of this Attachment).

A.1.3 The CONTRACTOR shall develop and submit to the Division 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.

A.2 NEMT READINESS REVIEW

The readiness review referenced in Section A.2.1.2 of the Contract shall include NEMT. As part of the readiness review the CONTRACTOR shall demonstrate its ability to meet the NEMT requirements of the Contract, including this Attachment.

A.3 REQUESTING NEMT SERVICES

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.

A.3.2 Requests for NEMT services should be made at least seventy-two (72) hours based on calendar days before the NEMT service is needed. However, this timeframe does not apply to urgent trips (see Section A.5.7 of this Attachment), scheduling changes initiated by the provider, and follow-up appointments when the timeframe does not allow advance scheduling. In addition, the CONTRACTOR shall accommodate requests for NEMT services that are made within the

following timeframes: three (3) hours before the NEMT service is needed when the pick-up address is in an urban area and four (4) hours before the NEMT service is needed when the pick-up address is in a non-urban area. The CONTRACTOR shall provide additional education to members who fail to request transportation seventy-two (72) hours before the NEMT service is needed (see Section A.10 of this Attachment).

A.3.3 The CONTRACTOR shall not have a time limit for scheduling transportation for future appointments. For example, if a member calls to schedule transportation to an appointment that is scheduled in two (2) months, the CONTRACTOR shall arrange for that transportation and shall not require the member to call back at a later time. Members identified as a No Show and have been placed on probation may be required to call back at a later time.

A.4 APPROVING NEMT SERVICES

A.4.1 General

A.4.1.1 Transportation for a minor child shall not be denied pursuant to any policy that poses a blanket restriction due to member's age or lack of accompanying adult. Any decision to deny transportation of a minor child due to a member's age or lack of an accompanying adult shall be made on a case-by-case basis and shall be based on the individual facts surrounding the request and State of Tennessee law. Tennessee recognizes the "mature minor exception" to permission for medical treatment. The age of consent for children with mental illness is sixteen (16) (see TCA 33-8-202).

A.4.1.2 As part of the approval process, the CONTRACTOR shall:

A.4.1.2.1 Collect relevant information from the caller and enter it into the CONTRACTOR's system (see Section A.5.10 of this Attachment);

A.4.1.2.2 Verify the member's eligibility for NEMT services;

A.4.1.2.3 Determine the appropriate mode of transportation for the member;

A.4.1.2.4 Determine the appropriate level of service for the member;

A.4.1.2.5 Approve or deny the request. Transportation shall not be denied for a member with minor children with whom daycare could not be arranged when a member established the need for them to be included in order to reserve space and child restraint upon scheduling of the trip; and

A.4.1.2.6 Enter the appropriate information into the CONTRACTOR's system (see Section A.5.10 of this Attachment).

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 A.2.6.1.3 of the Contract).

A.4.3 **Determining the Appropriate Mode of Transportation**

A.4.3.1 General

A.4.3.1.1 If the criteria in Section A.4.2 of this Attachment are met, the CONTRACTOR shall determine what mode of transportation is appropriate to meet the needs of the member. The modes of transportation that shall be covered by the CONTRACTOR include, but are not limited to: fixed route, multi-passenger van, wheelchair van, invalid vehicle, ambulance and member mileage reimbursement program.

A.4.3.1.2 In order to determine the appropriate mode of transportation, the CONTRACTOR shall:

A.4.3.1.2.1 Determine whether the member is ambulatory and the member's current level of mobility and functional independence;

A.4.3.1.2.2 Determine whether the member will be accompanied by an escort, and, if so, whether the member requires assistance and whether the escort meets the requirements for an escort (see TennCare rules and regulations);

A.4.3.1.2.3 Determine whether a member is under the age of eighteen (18) and will be accompanied by an adult; and

A.4.3.1.2.4 Assess any special conditions or needs of the member, including physical or behavioral health disabilities.

A.4.3.2 Fixed Route

A.4.3.2.1 The CONTRACTOR shall utilize fixed route transportation whenever available and appropriate to meet the needs of the member.

A.4.3.2.2 The CONTRACTOR shall be familiar with schedules of fixed route transportation in communities where it is available and where it becomes available during the term of the Contract.

A.4.3.2.3 The CONTRACTOR shall distribute and/or arrange for the distribution of fixed route tickets, tokens or passes to members for whom fixed route transportation is available and appropriate. The CONTRACTOR shall have controls in place to track the distribution of tickets/tokens/passes. The CONTRACTOR shall use best efforts that tickets/tokens/passes are used appropriately.

A.4.3.2.4 The CONTRACTOR shall consider the following when determining whether fixed route transportation is available and appropriate for a member:

A.4.3.2.4.1 The furthest distance a member shall be required to travel to or from a fixed route transportation stop is one-third (1/3) of a mile;

A.4.3.2.4.2 The member shall not be required to change buses/trolleys more than once each leg of the trip;

A.4.3.2.4.3 Using fixed route transportation shall not increase travel time more than sixty (60) minutes as compared to transportation directly from the pick-up location to the drop-off destination;

A.4.3.2.4.4 The fixed route transportation schedule shall allow the member to arrive at the destination no more than sixty (60) minutes prior to the scheduled appointment time and shall be flexible on the return so that the member does not have to wait at the pick-up location more than sixty (60) minutes after the estimated time the appointment will end;

A.4.3.2.4.5 Whether fixed route transportation is appropriate based on the member's physical or behavioral health disabilities; and

A.4.3.2.4.6 Whether using fixed route for the requested trip is appropriate considering the accessibility of the stops and the safety in accessing the stops.

A.4.3.2.5 Fixed route shall not be appropriate for a member whose physician states in writing that the member cannot use fixed route transportation.

A.4.3.3 <u>Ambulance</u>

The CONTRACTOR's policies and procedures regarding the appropriateness of using an ambulance to provide covered NEMT services shall be based on Medicare's medical necessity requirements (see, e.g., 42 CFR 410.40 and Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services).

A.4.3.4 <u>Member Mileage Reimbursement</u>

The CONTRACTOR shall follow policies and procedures as provided by TENNCARE when utilizing this method of transportation. Reporting requirements are specified in Section A.19 of this Attachment

A.4.4 **Determining Level of Service**

A.4.4.1 The CONTRACTOR shall assess the member's needs to determine whether the member requires curb-to-curb, door-to-door, or hand-to-hand service (as these terms are defined in Exhibit A of this Attachment).

A.4.4.2 The CONTRACTOR may require a medical certification statement from the member's provider in order to approve door-to-door or hand-to-hand service. Medical

certification shall be completed within the timeframes specified in Section A.5.1.4 of this Attachment.

A.4.4.3 The CONTRACTOR shall ensure that members receive the appropriate level of service.

A.4.4.4 Failure to comply with requirements regarding level of service may result in liquidated damages as provided in Section E.29.2 of the Contract, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.4.5 **Standing Orders**

A.4.5.1 Except as provided in this Section A.4.5, the approval of Standing Orders by the CONTRACTOR shall be consistent with the requirements in Sections A.4.1 through A.4.4.

A.4.5.2 In order to approve a Standing Order (as defined in Exhibit A of this Attachment), the CONTRACTOR shall, at a minimum, call the provider to verify the series of appointments. The CONTRACTOR may, at its discretion, require that the member's provider certify the series of appointments in writing.

A.4.5.3 The CONTRACTOR shall approve Standing Orders consistent with the series of appointments. For example, if the member has a series of appointments over six (6) months, the CONTRACTOR shall approve transportation for each trip, including all legs of the trip, for the six (6) months. However, the CONTRACTOR shall verify the member's eligibility prior to each pick-up. The CONTRACTOR may verify additional information before each pick-up as necessary.

A.4.6 **Validating Requests**

A.4.6.1 The CONTRACTOR shall conduct random pre-transportation validation checks prior to the member receiving the services in order to prevent fraud, waste, 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.5.1.5 of this Attachment.

A.5 SCHEDULING, ASSIGNING, AND DISPATCHING TRIPS

A.5.1 General

A.5.1.1 The CONTRACTOR shall ensure that covered NEMT services are available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year.

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).

A.5.1.3 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.

A.5.1.4 The CONTRACTOR shall approve and schedule or deny a request for transportation (including all legs of the trip) within twenty-four (24) hours of receiving the request. This timeframe shall be reduced as necessary to ensure the member arrives in time for his/her appointment. Failure to comply with this requirement may result in liquidated damages as provided in Section E.29.2. of the Contract, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.5.1.5 The CONTRACTOR shall ensure that trips are dispatched appropriately and meet the requirements of this Attachment. The dispatcher shall, at minimum, provide updated information to drivers, monitor drivers' locations, and resolve pick-up and delivery issues.

A.5.1.6 Failure to comply with requirements regarding scheduling, assigning and dispatching trips may result in liquidated damages as provided in Section E.29.2 of the contract, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.5.2 Multi-Passenger Transportation

A.5.2.1 The CONTRACTOR may group enrollees and trips (or legs of trips) to promote efficiency and cost effectiveness. The CONTRACTOR may contact providers if necessary to coordinate multi-passenger transportation.

A.5.2.2 For multi-passenger trips, the CONTRACTOR shall schedule each trip leg so that a member does not remain in the vehicle for more than one (1) hour longer than the average travel time for direct transportation of that member.

A.5.2.3 Members shall not be required to arrive at their scheduled appointment more than one (1) hour before their appointment time. Members shall not be dropped off for their appointment before the provider's office or facility has opened their doors.

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.

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.

A.5.5 **Notifying NEMT Providers**

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.

A.5.5.2 The CONTRACTOR shall have the ability to send trip manifests to a NEMT provider by a facsimile device or secure electronic transmission, at the option of the NEMT provider. The CONTRACTOR shall ensure that provision of the trip manifest is in compliance with HIPAA requirements (see Section A.2.27 of the Contract). The CONTRACTOR shall have dedicated telephone lines available at all times for faxing purposes.

A.5.5.3 The trip manifests supplied to NEMT providers shall include all necessary information for the driver to perform the trip, including but not limited to the information listed in Exhibit B of this Attachment.

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.

A.5.5.5 The CONTRACTOR shall communicate information regarding cancellations to the NEMT provider in an expeditious manner to avoid unnecessary trips.

A.5.6 **Accommodating Scheduling Changes**

A.5.6.1 The CONTRACTOR shall accommodate unforeseen schedule changes and shall timely assign the trip to another NEMT provider if necessary.

A.5.6.2 The CONTRACTOR shall ensure that neither NEMT providers nor drivers change the assigned pick-up time without permission from the CONTRACTOR.

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 Contract, 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 E.29.2. of the Contract, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.5.8 **Adverse** Weather Plan

The CONTRACTOR shall have policies and procedures for transporting members who need critical medical care, including but not limited to renal dialysis and chemotherapy, during adverse weather conditions. “Adverse weather conditions” includes, but is not limited to, extreme heat, extreme cold, flooding, tornado warnings and heavy snowfall. The policies and procedures shall include, at a minimum, staff training, methods of notification, and member education.

A.5.9 **Contingency and Back-Up Plans**

The CONTRACTOR shall have policies and procedures that describe contingency plans for unexpected peak transportation demands and back-up plans for instances when a vehicle is excessively late (more than twenty (20) minutes late) or is otherwise unavailable for service.

A.5.10 **Approval and Scheduling System Features**

A.5.10.1 Each transportation request processed by the CONTRACTOR shall be assigned a unique number, shall contain all pertinent information about the request, and shall be available to NEMT Call Center staff. This information shall include, but not be limited to the following:

A.5.10.1.1 Verification of member’s TennCare eligibility (e.g., member name, address, Medicaid ID number, and telephone number if available; eligibility start and end dates);

A.5.10.1.2 Determination that service is a TennCare covered service (e.g., level of service) (see Section A.4.2 of this Attachment);

A.5.10.1.3 Determination that the transportation is a covered NEMT service (see Section A.4.2 of this Attachment);

A.5.10.1.4 Determination of the appropriate mode of transportation (e.g., member’s requested mode of transportation, member’s special needs, availability and appropriateness of fixed route, the approved mode of transportation, justification for the approved mode of transportation);

A.5.10.1.5 Determination of the appropriate level of service (see Section A.4.4 of this Attachment);

A.5.10.1.6 Information regarding Standing Orders (if applicable) (see Section A.4.5 of this Attachment);

A.5.10.1.7 Information about whether the request was modified, approved or denied and how the member was notified;

A.5.10.1.8 Information about approved and scheduled transportation (e.g., elements required for the trip manifest; see Section A.5.5 of this Attachment);

A.5.10.1.9 Whether the request was validated;

A.5.10.1.10 Timeframes for the approval process (e.g., date and time of request, determination, scheduling, and notification of member); and

A.5.10.1.11 If applicable, reason for trip cancellation.

A.5.10.2 The CONTRACTOR's approval and scheduling systems shall be coded such that policies and procedures are applied consistently.

A.5.10.3 Based on approval of previous NEMT services, the CONTRACTOR shall display members' permanent and temporary special needs, appropriate mode of transportation, and any other information necessary to ensure that appropriate transportation is approved and provided. All of this information shall be easily accessible by all NEMT Call Center staff.

A.5.10.4 The CONTRACTOR's approval and scheduling systems shall also support the following:

A.5.10.4.1 A database of NEMT providers that includes information needed to determine trip assignments such as but not limited to: types of vehicles, number of vehicles by type, lift capacity of vehicles, and geographic coverage.

A.5.10.4.2 Automatic address validations, distance calculations and trip pricing, if applicable;

A.5.10.4.3 Ability to generate a trip manifest (see Section A.5.5 of this Attachment);

A.5.10.4.4 Standing Order and Single Trip (as defined in Exhibit A of this Attachment) reservation capability; and

A.5.10.4.5 Ability to determine if fixed route transportation is available and appropriate for the member.

A.5.10.5 The CONTRACTOR's approval and scheduling system shall enable report and data submission as specified in the Contract.

A.6 PICK-UP AND DELIVERY STANDARDS

A.6.1 The CONTRACTOR shall ensure that NEMT providers arrive on time for scheduled pick-ups. The NEMT provider may arrive before the scheduled pick-up time, but the member shall not be required to board the vehicle prior to the scheduled pick-up time.

A.6.2 The CONTRACTOR shall ensure that drivers make their presence known to the member and wait until at least five (5) minutes after the scheduled pick-up time. If the member is not present five (5) minutes after the scheduled pick-up time, the driver shall notify the dispatcher before departing from the pick-up location.

A.6.3 The CONTRACTOR shall ensure that drivers provide, at a minimum, the approved level of service (curb-to-curb, door-to-door, or hand-to-hand).

A.6.4 The CONTRACTOR shall ensure that members arrive at pre-arranged times for appointments and are picked up at pre-arranged times for the return leg of the trip. If there is no pre-arranged time for the return leg of the trip, the CONTRACTOR shall ensure that members are picked up within one (1) hour after notification Pick-up and drop-off times should be captured in such a way to allow reporting as requested by TENNCARE. Members shall not be required to arrive at their scheduled appointment more than one (1) hour before their appointment time. Members shall not be dropped off for their appointment before the provider's office or facility has opened their doors.

A.6.5 The CONTRACTOR shall ensure that the waiting time for members for pick-up does not exceed ten (10) minutes past the scheduled pick-up time. Scheduled pick-up times shall allow the appropriate amount of travel time to assure the members arrive giving them sufficient time to check-in for their appointment. Members shall be dropped off for their appointment no less than fifteen (15) minutes prior to their appointment time to prevent the drop off time from being considered a late drop off.

A.6.6 The CONTRACTOR shall ensure that if the driver will not arrive on time to the pick-up location, the driver shall notify the dispatcher, and the member is contacted.

A.6.7 The CONTRACTOR shall ensure that if the driver will not arrive on time to an appointment, the driver shall notify the dispatcher, and the provider is contacted.

A.6.8 The driver may refuse transportation when the member, his/her escort, or an accompanying adult (for a member under age eighteen (18)), according to a reasonable person's standards, is noticeably indisposed (disorderly conduct, indecent exposure, intoxicated), is armed (firearms), is in possession of illegal drugs, knives and/or other weapons, commits a criminal offense, or is in any other condition that may affect the safety of the driver or persons being transported. The CONTRACTOR shall ensure that if a driver refuses to transport a member the driver immediately notifies the dispatcher, and the dispatcher notifies the CONTRACTOR.

A.6.9 The CONTRACTOR shall ensure that in the event of an incident or accident (see Section A.17.2 of this Attachment), the driver notifies the dispatcher immediately to report the incident or accident and that, if necessary, alternative transportation is arranged. The CONTRACTOR shall ensure that it is promptly notified of any incident or accident.

A.6.10 Failure to comply with requirements regarding pick-up and delivery standards may result in liquidated damages as provided in Section E.29.2. of the Contract, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.7 VEHICLE STANDARDS

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.

A.7.2 The CONTRACTOR shall ensure that all vehicles comply with the vehicle requirements developed by the CONTRACTOR and prior approved in writing by TENNCARE, which at a minimum shall include compliance with applicable federal, state, and local requirements, the requirements in this Section, and the requirements in Exhibit C of this Attachment.

A.7.3 The CONTRACTOR shall ensure that any vehicle used to cross a state's border complies with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.

A.7.4 The CONTRACTOR shall ensure that each vehicle has a real-time link, telephone or two-way radio. Pagers are not acceptable as a substitute for this requirement.

A.7.5 The CONTRACTOR shall ensure that all vehicles transporting members with disabilities comply with applicable requirements of the Americans with Disabilities Act (ADA), including the accessibility specifications for transportation vehicles.

A.7.6 The CONTRACTOR shall ensure that, at minimum, all vehicles providing stretcher transport are owned and operated by an entity licensed by the Tennessee Department of Health (DOH) to provide invalid services, have an active valid permit issued by DOH as a ground invalid vehicle, and comply with DOH's requirements for ground invalid vehicles.

A.7.7 The CONTRACTOR shall ensure that, except as otherwise permitted by State of Tennessee law, all ambulances are owned and operated by an entity licensed by DOH to provide ambulance services, have an active valid ambulance permit from DOH, and comply with DOH's requirements for ambulances. The CONTRACTOR shall also ensure that vehicles comply with any applicable local requirements.

A.7.8 As required in Section A.17 of this Attachment, the CONTRACTOR shall inspect all vehicles (except fixed route, invalid vehicles, and ambulances) for compliance with applicable requirements and shall immediately remove any vehicle that is out of compliance.

A.7.9 Failure to comply with requirements regarding vehicle standards may result in liquidated damages as provided in Section E.29.2. of the Contract, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.8 TRAINING AND STANDARDS FOR DRIVERS

A.8.1 The CONTRACTOR shall ensure that all drivers receive appropriate training and meet applicable standards, as specified in this Section A.8. These requirements do not apply to drivers of fixed route transportation. Drivers of fixed route transportation shall comply with all rules, regulations, policies and procedures promulgated by the fixed route carrier, federal, state or local law.

A.8.2 Driver Training

A.8.2.1 The CONTRACTOR shall ensure that all drivers receive appropriate training prior to providing services under the Contract and annually thereafter. This shall include a

minimum of thirty-two (32) hours of training prior to providing services under the Contract 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.

A.8.2.2 Driver training shall include, at a minimum the following:

A.8.2.2.1 Customer service;

A.8.2.2.2 Passenger assistance;

A.8.2.2.3 Sensitivity training;

A.8.2.2.4 Behavioral health and substance abuse issues;

A.8.2.2.5 Title VI requirements (Civil Rights Act of 1964);

A.8.2.2.6 HIPAA privacy requirements;

A.8.2.2.7 ADA requirements (Americans with Disabilities Act of 1990);

A.8.2.2.8 Wheelchair securement/safety;

A.8.2.2.9 Seat belt usage and child restraints;

A.8.2.2.10 Handling and reporting accidents and incidents;

A.8.2.2.11 Emergency evacuation;

A.8.2.2.12 Daily vehicle inspection;

A.8.2.2.13 Defensive driving;

A.8.2.2.14 Risk management;

A.8.2.2.15 Communications;

A.8.2.2.16 Infection control;

A.8.2.2.17 Annual road tests; and

A.8.2.2.18 Reporting enrollee and provider fraud, waste, and abuse.

A.8.3 **Standards for Drivers**

A.8.3.1 The CONTRACTOR shall ensure that all drivers comply with driver requirements developed by the CONTRACTOR and prior approved in writing by TENNCARE, which at a minimum shall include compliance with applicable federal, state, and local requirements, the requirements of this Section, and the requirements in Exhibit D of this Attachment.

A.8.3.2 The CONTRACTOR shall ensure that all drivers are at least eighteen (18) years of age and have a Class D driver license with F (for hire endorsement) or commercial driver

license (Class A, B, or C) issued by the State of Tennessee or the equivalent licensure issued by the driver's state of residence.

A.8.3.3 The CONTRACTOR shall ensure that all drivers meet the State of Tennessee requirements regarding proof of financial responsibility and/or insurance.

A.8.3.4 The CONTRACTOR shall ensure that any driver that crosses a state's border complies with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.

A.8.3.5 The CONTRACTOR shall ensure that any personnel contracted by or employed by a NEMT provider to provide medical assistance to a member during a non-emergency ambulance trip is licensed by the State of Tennessee as an emergency medical technician (EMT) and complies with DOH requirements for EMTs.

A.8.3.6 The CONTRACTOR shall ensure that all drivers pass a physical examination prior to providing services under the Contract 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. All driver files (including but not limited to, HRAs, private vendor's, etc.) must contain an attestation signed by the driver including the effective dates of the physical examination.

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 and 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. The CONTRACTOR shall ensure that all drivers have been tested within the last five (5) years in the event they have not been randomly selected for testing. 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. Drivers should be randomly selected from the current utilized drivers for drug and alcohol testing with no less than twenty percent (20%) of drivers tested per calendar year. The drivers tested shall be reported to TENNCARE quarterly as described in the reporting section of this Attachment XI. Results of drug and alcohol testing shall be maintained in the driver's file as to allow for unscheduled file audits. All driver files (including but not limited to, HRAs, private vendor's, etc.) must contain an attestation signed by the driver containing the date of the drug and alcohol test if the actual test results cannot be provided.

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. 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, pled guilty 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.8.3.9 The CONTRACTOR shall ensure that drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies the CONTRACTOR if a driver is arrested for, charged with, or convicted of a criminal offense that would disqualify the driver under the Contract.

A.8.3.10 The CONTRACTOR shall ensure that no driver has been convicted of a criminal offense related to the driver's involvement with Medicare, Medicaid, or the federal Title XX services program (see Section 1128 of the Social Security Act and 42 CFR 455.106).

A.8.3.11 The CONTRACTOR shall verify that drivers are not listed on the Tennessee Sexual Offender Registry and the equivalent registry showing data from all fifty (50) states prior to providing services under this Contract 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.

A.8.3.12 The CONTRACTOR shall ensure that drivers maintain an acceptable Motor Vehicle Report containing data for any state the driver has previously lived prior to providing services under the Agreement and annually thereafter. Annual updates shall only contain information for the states the driver has resided in since the last update. The Motor Vehicle Report shall, at a minimum, show the following:

A.8.3.12.1 No conviction within the past ten (10) years for a major moving traffic violation such as driving while intoxicated or driving under the influence;

A.8.3.12.2 No conviction for reckless driving within the previous thirty-six (36) month period;

A.8.3.12.3 No conviction for leaving the scene of a personal injury or fatal accident within the previous thirty-six (36) months;

A.8.3.12.4 No conviction for a felony involving the use of an automobile within the previous thirty-six (36) months;

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;

A.8.3.12.6 Conviction for no more than one (1) at-fault accident resulting in personal injury or property damage within the previous thirty-six (36) months; and

A.8.3.12.7 Not have a combination of conviction for one (1) at-fault accident resulting in personal injury or property damage and conviction for one (1) unrelated minor moving traffic violation within the previous thirty-six (36) months.

A.8.3.13 The CONTRACTOR shall require that drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies the CONTRACTOR of any moving traffic violation or if a driver's license is suspended or revoked.

A.8.3.14 The CONTRACTOR shall ensure that all ambulance drivers and invalid vehicle drivers comply with applicable DOH and local requirements.

A.8.3.15 The CONTRACTOR shall require that drivers maintain daily transportation logs containing, at a minimum, the information listed in Exhibit E of this Attachment.

A.8.3.16 As required in Section A.17 of this Attachment, the CONTRACTOR shall monitor drivers and immediately remove any driver that is out of compliance with applicable requirements.

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.

A.8.4 Failure to comply with requirements regarding driver training and driver standards may result in liquidated damages as provided in Section E.29.2 of the Contract, Section A.20 of this Attachment, and/or Exhibit F of this Attachment

A.9 NEMT CALL CENTER

A.9.1 The CONTRACTOR shall maintain a NEMT Call Center to handle requests for NEMT services as well as questions, comments, and inquiries from members and their representatives, NEMT providers, and providers regarding NEMT services. The NEMT Call Center may use the same infrastructure as the CONTRACTOR's member services line, but the CONTRACTOR shall have a separate line or queue for NEMT calls, and NEMT Call Center staff shall be dedicated to NEMT calls.

A.9.2 The NEMT Call Center shall be appropriately staffed twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days a year to handle the call volume in compliance with the performance standards in Section A.9.6 of this Attachment. The CONTRACTOR shall ensure continuous availability of NEMT Call Center services.

A.9.3 Between the hours of 7:00 PM and 5:00 AM in the time zone applicable to each 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.

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.

A.9.5 The CONTRACTOR's NEMT Call Center system shall have the capability to identify and record the phone number of the caller if the caller's phone number is not blocked.

A.9.6 The CONTRACTOR shall have the capability of making outbound calls.

A.9.7 The CONTRACTOR shall maintain sufficient equipment and NEMT Call Center staff to handle anticipated call volume and ensure that calls are received and processed in accordance with the requirements of this Section A.9 and the following performance standards for each line or queue:

A.9.7.1 Answer rate – At least eighty-five percent (85%) of all calls are answered by a live voice within thirty (30) seconds;

A.9.7.2 Abandoned calls – No more than five percent (5%) of calls are abandoned; and

A.9.7.3 Hold time – Average hold time, including transfers to other CONTRACTOR staff, is no more than three (3) minutes.

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.

A.9.9 The CONTRACTOR shall have qualified bi-lingual (English and, at minimum, Spanish) NEMT Call Center staff to communicate with callers who, at a minimum, speak Spanish, The CONTRACTOR shall provide oral interpretation services via a telephone interpretation service free of charge to callers with Limited English Proficiency.

A.9.10 The CONTRACTOR's NEMT Call Center shall accommodate callers who are hearing and/or speech impaired.

A.9.11 The CONTRACTOR shall operate an automatic call distribution system for its NEMT Call Center.

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.

A.9.13 The welcome message for the NEMT Call Center shall be in English and shall include, at minimum, a Spanish language prompt.

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 (6th) grade reading level and must be prior approved in writing by TENNCARE.

A.9.15 The CONTRACTOR shall advise callers that calls to the NEMT Call Center are monitored and recorded for quality assurance purposes.

A.9.16 The CONTRACTOR shall record a statistically valid sample of incoming and outgoing calls to/from the NEMT Call Center for quality control, program integrity and training purposes.

A.9.17 The CONTRACTOR shall monitor and audit at least one percent (1%) of calls of each NEMT Call Center staff member on a monthly basis. The CONTRACTOR shall develop a tool for auditing calls, which shall include components to be audited and the scoring methodology. The CONTRACTOR shall use this monitoring to identify problems or issues, for quality control, and for training purposes. The CONTRACTOR shall document and retain results of this monitoring and subsequent training.

A.9.18 The CONTRACTOR's NEMT Call Center system shall be able to produce the reports specified in Section A.19 of this Attachment as well as on request and ad hoc reports that TENNCARE may request.

A.9.19 The CONTRACTOR shall analyze data collected from its NEMT Call Center system as necessary to perform quality improvement, fulfill the reporting and monitoring requirements of the Contract, and ensure adequate resources and staffing.

A.9.20 Failure to comply with requirements regarding the NEMT Call Center may result in liquidated damages as provided in Section E.29.2. of the Contract, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.10 NEMT MEMBER EDUCATION

A.10.1 The CONTRACTOR shall develop materials to inform and educate members about NEMT services.

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.

A.10.3 All written materials shall comply with Section A.2.17 of the Contract and must be prior approved in writing by TENNCARE.

A.10.4 Prior to the start date of operations, as specified by TENNCARE, the CONTRACTOR shall mail member education materials to its members by first class mail and at the CONTRACTOR's expense.

A.11 NON-COMPLIANT MEMBERS

A.11.1 The CONTRACTOR shall provide targeted education to members who do not comply with the CONTRACTOR's policies and procedures regarding NEMT services. All member materials shall comply with Section A.2.17 of the Contract and must be prior approved in writing by TENNCARE.

A.11.2 The CONTRACTOR shall not take any action to sanction members who do not comply with the CONTRACTOR's policies and procedures.

A.11.3 Members shall not be charged for no-shows (as defined in Exhibit A of this Attachment). The CONTRACTOR shall monitor NEMT member no-shows and enforce the No-Show Policy provided to them by TENNCARE. Probation periods for non-compliant members shall be enforced as described in the policy. Failure to administer this policy and adhere to the probation notice requirements schedule shall result in liquidated damages as described in Exhibit F of this Attachment.

A.12 NEMT PROVIDER NETWORK

A.12.1 The CONTRACTOR shall establish a network of qualified NEMT providers to provide covered NEMT services to meet the transportation needs of members. In developing its network of qualified NEMT providers the CONTRACTOR shall comply with Section A.2.11.1 of the Contract.

A.12.2 The CONTRACTOR shall have sufficient NEMT providers in its network (numbers and types of vehicles and drivers) so that the failure of any NEMT provider to perform will not impede the ability of the CONTRACTOR to provide NEMT services in accordance with the requirements of the Contract.

A.12.3 The CONTRACTOR shall ensure that its NEMT providers have a sufficient number of vehicles and drivers available to meet the timeliness requirements of the Contract (see Section A.5 of this Attachment).

A.12.4 The CONTRACTOR shall provide Human Resource Agencies (HRAs) the opportunity to become a NEMT provider if the HRA is qualified to provide the service and agrees to the terms of the CONTRACTOR's NEMT provider agreement, which shall be no more restrictive than for other NEMT providers and include alternative indemnification language as specified in Section A.13.4 of this Attachment.

A.12.5 Notwithstanding an adequate network of providers or anything in this Contract 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.

A.12.6 The CONTRACTOR shall ensure that its NEMT providers are qualified to perform their duties. Except as specified in A.12.5, this includes, but is not limited to, meeting applicable federal, state or local licensure, certification, or registration requirements. Failure to comply with requirements regarding licensure requirements may result in liquidated damages as provided in Section E.29.2. of the Contract.

A.12.7 The CONTRACTOR's NEMT provider network must be prior approved in writing by TENNCARE and shall be subject to ongoing review and approval by TENNCARE. Failure to comply with NEMT provider network requirements may result in liquidated damages as provided in Section E.29.2. of the Contract.

A.13 NEMT PROVIDER AGREEMENTS

A.13.1 All NEMT provider agreements shall comply with applicable requirements of the Contract, including but not limited to prior written approval of template agreements and revisions thereto by the Tennessee Department of Commerce and Insurance (TDCI).

A.13.2 Except for fixed route, NEMT providers used for contingency or back-up (see Section A.5.9 of this Attachment), or as otherwise agreed to by TENNCARE in writing, the CONTRACTOR shall not use transportation providers with which the CONTRACTOR has not executed a provider agreement.

A.13.3 In addition to the requirements in other sections of the Contract, all NEMT provider agreements shall meet the following minimum requirements:

A.13.3.1 Include provisions related to payment for cancellations (see Section A.5.5.5 of this Attachment), no-shows (as defined in Exhibit A to this Attachment), escorts, and adults accompanying members under age eighteen (18);

A.13.3.2 Specify the services to be provided by the NEMT provider, including, as applicable, mode(s) of transportation and dispatching.

A.13.3.3 Include expectations for door-to-door, hand-to-hand, and curb-to-curb service (see Section A.4.4 of this Attachment and definitions in Exhibit A of this Attachment);

A.13.3.4 Include or reference trip manifest requirements (see Section A.5.5 of this Attachment);

A.13.3.5 Include urgent trip requirements (see Section A.5.7 of this Attachment);

A.13.3.6 Include or reference back-up service requirements (see Section A.5.9 of this Attachment);

A.13.3.7 Include or reference pick-up and delivery standards (see Section A.6 of this Attachment);

A.13.3.8 Require the NEMT provider to notify the CONTRACTOR of specified events, including no-shows (see Section A.6.2 of this Attachment), accidents, moving traffic violations, and incidents (see Section A.6.9 of this Attachment);

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.

A.13.3.10 Include or reference vehicle standards (see Section A.7 of this Attachment);

A.13.3.11 Require the NEMT provider to notify the CONTRACTOR if a vehicle is out of service or otherwise unavailable;

A.13.3.12 Include or reference training requirements for the NEMT provider (see Section A.16.2 of this Attachment) and for drivers (see Section A.8.2 of this Attachment);

A.13.3.13 Include or reference driver standards (see Section A.8.3), including driver log requirements (see Section A.8.3.15 of this Attachment) and require the NEMT provider to provide copies of driver logs to the CONTRACTOR upon request; and

A.13.3.14 Require the NEMT provider to secure and maintain adequate insurance coverage prior to providing any NEMT services under the Contract, including, at minimum, the following:

A.13.3.14.1 Workers' Compensation/ Employers' Liability (including all states coverage) with a limit not less than the relevant statutory amount or one million dollars ($1,000,000) per occurrence for employers' liability whichever is greater;

A.13.3.14.2 Comprehensive Commercial General Liability (including personal injury and property damage, premises/operations, independent contractor, contractual liability and completed operations/products) with a bodily injury/property damage combined single limit not less than one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) in the aggregate; and

A.13.3.14.3 Automobile Coverage (including owned, leased, hired, and non-owned vehicles) with a bodily injury/property damage combined single limit not less than one million dollars ($1,000,000) per occurrence.

A.13.4 If the CONTRACTOR has a provider agreement with a HRA, the agreement shall meet the requirements specified in Sections A.13.1 and A.13.3 above and shall also include indemnification language negotiated with the HRA and prior approved in writing by TENNCARE as an alternative to the indemnification language referenced in the Contract.

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.

A.13.6 Failure to comply with provider agreement requirements may result in liquidated damages as provided in Section E.29.2. of the Contract.

A.14 PAYMENT FOR NEMT SERVICES

A.14.1 General

In addition to requirements in the Contract regarding payment for services, when paying for NEMT services the CONTRACTOR shall comply with the requirements in this Attachment. In addition to the requirements of this Contract and this Attachment, the CONTRACTOR shall have a policy to address fuel price adjustments.

A.14.2 Payment for Fixed Route

A.14.2.1 The CONTRACTOR shall make every effort to provide tickets/tokens/passes to a member in a manner that ensures receipt prior to the scheduled transportation.

A.14.2.2 If the CONTRACTOR cannot provide tickets/token/passes prior to the scheduled transportation, the CONTRACTOR shall offer the member the choice of having the CONTRACTOR arrange alternate transportation or reimbursing the member for the cost of the applicable fare for the fixed route transportation approved by the CONTRACTOR.

A.14.2.3 The CONTRACTOR may negotiate agreements with fixed route transportation entities. Such agreements must be prior approved in writing by TENNCARE.

A.14.3 Validation Checks

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, waste, and abuse requirements of the Contract. The CONTRACTOR may exclude services when conducting post-validation in which billing of those services as appropriate (e.g., Pre-natal visits) cannot not be validated in the required timeframe.

A.14.3.2 The CONTRACTOR shall perform post-transportation validation checks for fixed route transportation as specified in the CONTRACTOR's policies and procedures, which must be prior approved in writing by TENNCARE.

A.15 NEMT CLAIMS MANAGEMENT

A.15.1 The CONTRACTOR shall process NEMT provider claims consistent with the claims management requirements of the Contract.

A.15.2 The CONTRACTOR shall submit encounter data for NEMT services that meets the requirements in the Contract, including compliance with HIPAA's electronic transactions and code set requirements.

A.15.3 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for NEMT services delivered to a member are processed within thirty (30) calendar days of the receipt of such claims.

A.15.4 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all NEMT provider claims for covered NEMT services delivered to a member.

A.15.5 The CONTRACTOR shall pay ninety-seven percent (97%) of NEMT claims accurately upon initial submission.

A.15.6 The CONTRACTOR shall conduct an audit of NEMT claims that complies with the requirements in the Contract regarding a claims payment accuracy audit.

A.15.7 Failure to comply with requirements regarding NEMT claims management may result in liquidated damages as provided in Section E.29.2. of the Contract, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.16 NEMT PROVIDER MANUAL AND NEMT PROVIDER EDUCATION AND TRAINING

A.16.1 NEMT Provider Manual

A.16.1.1 The CONTRACTOR shall issue a NEMT provider manual to all NEMT providers. The CONTRACTOR may distribute the NEMT provider manual electronically (e.g., through its website) so long as NEMT providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the NEMT provider.

A.16.1.2 The NEMT provider manual must be prior approved in writing by TENNCARE and shall include, at a minimum, the following:

A.16.1.2.1 Description of the TennCare program;

A.16.1.2.2 Covered and non-covered NEMT services, including requirement that transportation must be to a TennCare covered service;

A.16.1.2.3 Prior approval requirements;

A.16.1.2.4 Vehicle requirements;

A.16.1.2.5 Driver requirements;

A.16.1.2.6 Protocol for encounter data elements reporting/records;

A.16.1.2.7 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;

A.16.1.2.8 Payment policies;

A.16.1.2.9 Information on members' appeal rights;

A.16.1.2.10 Member rights and responsibilities;

A.16.1.2.11 Policies and procedures of the provider complaint system; and

A.16.1.2.12 Important phone numbers of all departments/staff a NEMT provider may need to reach at the CONTRACTOR's MCO.

A.16.1.3 The CONTRACTOR shall disseminate bulletins to NEMT providers as needed to incorporate any needed changes to the provider manual.

A.16.2 NEMT Provider Education and Training

A.16.2.1 The CONTRACTOR shall develop and implement a plan to educate NEMT providers, including initial orientation sessions and continuing education. The initial orientation shall include at minimum the topics included in the NEMT provider manual.

A.16.2.2 The CONTRACTOR shall ensure that all NEMT provider staff, including but not limited to dispatchers, supervisors, and mechanics, receive appropriate training before providing services under the Contract and on an ongoing basis thereafter.

A.17 NEMT QUALITY ASSURANCE AND MONITORING

A.17.1 NEMT Quality Assurance Program

A.17.1.1 As part of the CONTRACTOR's QM/QI program required by the Contract, the CONTRACTOR shall develop and implement a quality assurance program for NEMT services. The description of the program (the NEMT Quality Assurance Plan) shall include policies and procedures outlining the objectives and scope of the program as well as activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of NEMT services.

A.17.1.2 The NEMT Quality Assurance Plan shall include at least the following:

A.17.1.2.1 The CONTRACTOR's procedures for monitoring and improving member satisfaction with NEMT services;

A.17.1.2.2 The CONTRACTOR's procedures for ensuring that all NEMT services paid for are properly approved and actually rendered, including but not limited to validation checks (see Sections A.4.6 and A.14.3) and an annual analysis matching physical health and behavioral health claims/encounters and NEMT claims/encounters;

A.17.1.2.3 The CONTRACTOR's procedures for monitoring and improving the quality of transportation provided pursuant to the Contract, including transportation provided by fixed route; and

A.17.1.2.4 The CONTRACTOR's monitoring plan for NEMT providers, as detailed in Section A.17.3 of this Attachment.

A.17.2 Accidents and Incidents

The CONTRACTOR shall document accidents and incidents that occur while services are being delivered under the Contract. An incident is defined as an occurrence, event, breakdown, or public disturbance that interrupts the trip, causing the driver to stop the vehicle, such as a passenger being unruly or ill.

A.17.3 NEMT Provider Monitoring Plan

A.17.3.1 The CONTRACTOR shall develop and implement a plan for monitoring NEMT providers' compliance with all applicable local, state and federal law. The plan shall

also monitor NEMT providers' compliance with the terms of their provider agreements and all NEMT provider-related requirements of the Contract, including but not limited to driver requirements, vehicle requirements, member complaint resolution requirements, and the delivery of courteous, safe, timely and efficient transportation services.

A.17.3.2 Monitoring activities shall include, but are not limited to:

A.17.3.2.1 On-street observations;

A.17.3.2.2 Random audits of NEMT providers;

A.17.3.2.3 Accident and incident reporting;

A.17.3.2.4 Statistical reporting of trips;

A.17.3.2.5 Analysis of complaints;

A.17.3.2.6 Driver licensure, driving record, experience and training;

A.17.3.2.7 Enrollee safety;

A.17.3.2.8 Enrollee assistance;

A.17.3.2.9 Completion of driver trip logs;

A.17.3.2.10 Driver communication with dispatcher; and

A.17.3.2.11 Routine scheduled vehicle inspections and maintenance.

A.17.4 **NEMT Provider Corrective Action**

A.17.4.1 The CONTRACTOR shall have policies and procedures for ensuring that an appropriate corrective action is taken when a NEMT provider furnishes inappropriate or substandard services, when a NEMT provider does not furnish services that should have been furnished, or when a NEMT provider is out of compliance with federal, state, or local law. The CONTRACTOR shall provide notification of the corrective action initiated between the CONTRACTOR and their NEMT provider as they occur.

A.17.4.2 The CONTRACTOR shall immediately remove from service any vehicle, driver, or EMT found to be out of compliance with the requirements of the Contract, including any federal, state or local law. The vehicle, driver, or EMT may be returned to service only after the CONTRACTOR verifies that the deficiencies have been corrected. Any deficiencies, and actions taken to remedy deficiencies, shall be documented and become a part of the vehicle's and/or the person's permanent records.

A.17.4.3 As required in Section A.19.5.72 of this Attachment, the CONTRACTOR shall report on monitoring activities, monitoring findings, corrective actions taken, and improvements made.

A.17.5 **NEMT Member Satisfaction Survey**

A.17.5.1 The CONTRACTOR shall conduct a member satisfaction survey regarding NEMT services for the first six (6) months after the start date of operations or as otherwise specified by TENNCARE and annually thereafter.

A.17.5.2 The purpose of the survey is to verify the availability, appropriateness and timeliness of the trips provided and the manner in which the CONTRACTOR's staff and the NEMT provider's staff interacted with members.

A.17.5.3 The survey topics shall include, but are not limited to:

A.17.5.3.1 NEMT Call Center interaction;

A.17.5.3.2 Confirmation of scheduled trip;

A.17.5.3.3 Driver and CONTRACTOR staff courtesy;

A.17.5.3.4 Driver assistance, when required;

A.17.5.3.5 Overall driver behavior;

A.17.5.3.6 Driver safety and operation of the vehicle;

A.17.5.3.7 Condition, comfort and convenience of the vehicle; and

A.17.5.3.8 Punctuality of service.

A.17.5.4 The format, sampling strategies and questions of the survey must be prior approved in writing by TENNCARE, and TENNCARE may specify questions that are to appear in the survey.

A.17.5.5 The CONTRACTOR shall assure that surveys are conducted for randomly selected members within twenty-four (24) hours (when conducted by phone) of receiving the service or within a week (when conducted via postal service) throughout the calendar year at a minimum not to exceed a quarterly basis. One percent (1%) of trips provided should be surveyed and responded to during each calendar quarter. Results are reported annually using a quarterly breakdown.

A.17.5.6 The CONTRACTOR shall submit reports regarding these surveys as required in Section A.19.5.8 of this Attachment.

A.17.6 **Vehicle Inspection**

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).

A.17.6.2 The CONTRACTOR shall develop and implement policies and procedures for vehicle inspections. These policies and procedures must be prior approved in writing by TENNCARE and shall include inspection forms, inspection stickers and a list of trained inspectors, including the names of all employees or subcontractors who are authorized to inspect vehicles for the CONTRACTOR. Inspection forms shall have a checklist that includes all the applicable vehicle standards of the Contract and of local, state and federal law. The CONTRACTOR shall test all communication equipment during all vehicle inspections.

A.17.6.3 Upon completion of a successful inspection, an inspection sticker shall be applied to the vehicle. The inspection sticker shall be placed on the outside of the passenger side rear window in the lower right corner. The sticker shall state the license plate number and vehicle identification number of the vehicle. Records of all inspections shall be maintained by the CONTRACTOR.

A.18 NEMT SUBCONTRACTS

If the CONTRACTOR delegates any of its responsibilities regarding NEMT services, it shall comply with the subcontracting requirements in the Contract, including prior written approval of the subcontract by TENNCARE.

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 scheduled pick-up time, actual pick-up time, members appointment time, time the member was dropped-off for the appointment, pre-arranged return pick-up time, time the member requested pick-up (if not pre-arranged), actual return pick-up time and time the member arrived at their final destination.

A.19.1.3 Drug and Alcohol Testing Report. The CONTRACTOR shall submit a quarterly report providing a listing of drivers who have been drug and alcohol tested during the reporting period. A minimum of five percent (5%) of drivers should be reported each quarter. The report shall include, at minimum, the name of the driver tested for drugs and alcohol, name of the provider that the driver is contracted with, social security number of the driver, date the driver was authorized to transport and the date the test was conducted. Drivers' drug and alcohol test should be current within the last five (5) years.

A.19.1.4 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.19.1.5 No-Show Report. The CONTRACTOR shall submit a monthly no – show report utilizing the template provided by TENNCARE.

A.19.1.6 Member Mileage Reimbursement Report. The CONTRACTOR shall submit a quarterly MMR report utilizing the template provided by TENNCARE.

A.19.1.7 Provider Send Back Report. The CONTRACTOR shall provide a monthly Provider Send Back report which includes the name of NEMT provider, name of TennCare Member, date the trip was scheduled with call center, the appointment date and the date the provider sent the unaccepted trip back utilizing the template provided by TENNCARE.

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 A.2.22.6 of the Contract 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.19.4.3 The CONTRACTOR shall submit a monthly NEMT claims status report. The report shall include the number of claims received, total paid claims, total denied claims and the total of pended claims by the NEMT brokerage for the previous months activity.

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 A.1 of the Contract 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 Contract, 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 Contract, 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 Contract.

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.

A.20 Performance Standards

The CONTRACTOR agrees that TENNCARE may assess liquidated damages against the CONTRACTOR for failure to meet the performance standards as specified in Exhibit F of this Attachment.

Exhibit A
NEMT DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

The terms used in this Attachment shall be given the meaning used in TennCare rules and regulations. However, the following terms, when used in this Attachment, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

Definitions

1. **Commercial Carrier Transport:** Transportation provided by a common carrier, including but not limited to buses (e.g., Greyhound), trains (e.g., Amtrak), airplanes, and ferries.

2. **Curb-to-Curb Service:** Transportation provided to passengers who need little if any assistance between the vehicle and the door of the pick-up point or destination. The driver shall provide assistance according to the enrollee's needs, including assistance as necessary to enter and exit the vehicle, but assistance shall not include the lifting of any enrollee. The driver shall remain at or near the vehicle and not enter any buildings.

3. **Door-to-Door Service:** Transportation provided to enrollees with disabilities who need assistance to safely move between the door of the vehicle and the door of the passenger's pick-up point or destination. The driver shall exit the vehicle and assist the enrollee from the door of the pick-up point, e.g., residence, accompany the passenger to the door of the vehicle, and assist the passenger in entering the vehicle. The driver shall assist the enrollee throughout the transport and to the door of the destination.

4. **Federal Motor Carrier Safety Administration (FMCSA):** A separate administration within the United States Department of Transportation established pursuant to the Motor Carrier Safety Improvement Act of 1999. Its primary mission is to reduce crashes, injuries, and fatalities involving large trucks and buses.

5. **Fixed Route**: Transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule, does not deviate from the route or the schedule, and picks up passengers at designated stops. Fixed route transportation includes, but is not limited to, non-commercial buses, commuter trains, and trolleys.

6. **Hand-to-Hand Service:** Transportation of an enrollee with disabilities from an individual at the pick-up point to a provider staff member, family member or other responsible party at the destination.

7. **Hospital Discharge:** Notification by a hospital that an enrollee is ready for discharge. A hospital discharge shall be considered an urgent trip.

8. **HRAs:** Human Resource Agencies. These agencies are the delivery system for human services, including transportation to rural residents, throughout the State of Tennessee. The nine HRAs are: Delta HRA, East Tennessee HRA, First Tennessee HRA, Mid-Cumberland HRA, Northwest HRA, South Central Development District, South West HRA, Upper Cumberland HRA, and South East HRA.

9. **No-Show:** A trip is considered a no-show when the driver arrived on time, made his/her presence known, and the member cancels at the door or is not present five (5) minutes after the scheduled pick-up time.

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

11. **Private Automobile:** An enrollee's personal vehicle or the personal vehicle of a family member or friend, to which the enrollee has access.

12. **Single Trip:** Transport to and/or from a single TennCare covered service. A trip generally has at least two (2) trip legs but there can be one (1) or more than two (2) (multiple) trip legs.

13. **Standing Order:** Transport to and/or from multiple recurring medical appointments for TennCare covered services for the same enrollee with the same provider for the same treatment or condition (can be one (1) or multiple trip legs).

14. **TennCare Covered Services:** The health care services available to TennCare enrollees, as defined in TennCare rules and regulations. This includes, but is not limited to, physical health, behavioral health, pharmacy, dental services, and institutional services. TennCare covered services includes TennCare Kids services. For purposes of NEMT, TennCare covered services does not include CHOICES or ECF CHOICES HCBS or 1915(c) HCBS waiver services.

15. **Tennessee Department of Intellectual and Developmental Disabilities (DIDD):** The state agency responsible for providing services and supports to Tennesseans with intellectual and developmental disabilities. DIDD is a division of the Tennessee Department of Finance and Administration.

16. **Trip Leg:** One-way transport from a pick-up point to a destination. A trip generally has at least two (2) trip legs.

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). At a minimum, these shall be considered urgent trips: Hospital and Crisis Stabilization Unit discharges and same-day appointments with outpatient behavioral health providers.

Exhibit B
TRIP MANIFESTS

The trip manifests supplied to NEMT providers shall include all necessary information for the driver to perform the trip for each enrollee, including but not limited to:

1. Number assigned by the CONTRACTOR for approved trip;
2. NEMT provider name;
3. The mode of transportation;
4. MCO name;
5. Enrollee's name;
6. Enrollee's age;
7. Enrollee's sex;
8. Trip date;
9. Number of legs for the trip (e.g., one-way, round trip, or multiple legs);
10. Origin of trip/place of pick-up (e.g., residence)
11. Time of pick-up for the time zone applicable to the pick-up location;
12. Address of the pick-up, including street address, city, county, state, and zip code;
13. Enrollee's phone number(s);
14. Number of riders;
15. Time of appointment for the time zone applicable to the appointment location;
16. Provider name;
17. Address of the provider, including street address, city, county, state, and zip code;
18. Provider's phone number(s);
19. Return trip times for the applicable time zone(s) and addresses, if applicable;
20. Any additional stops (e.g., pharmacy);
21. Any special needs of the enrollee;
22. Any special instructions to the driver, e.g., door-to-door or hand-to-hand service;
23. Whether enrollee has third party coverage, including Medicare; and
24. Notes.

The CONTRACTOR may express time in regular time (AM or PM) or in military time (using the 24-hour clock); however, the selected method for expressing time (regular or military) shall be used consistently by the CONTRACTOR and by all of the CONTRACTOR's subcontractors, NEMT providers and drivers.

Exhibit C
VEHICLE REQUIREMENTS

All vehicles, except for fixed route vehicles and ambulances, shall meet the following requirements:

1. The number of persons in the vehicle, including the driver, shall not exceed the vehicle manufacturer's approved seating capacity.
2. All vehicles shall have adequately functioning heating and air-conditioning systems.
3. All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position. All vehicles shall have an easily visible interior sign that states: "ALL PASSENGERS SHALL USE SEAT BELTS". Seat belts shall be stored off the floor when not in use.
4. Each vehicle shall use child safety seats in accordance with state law.
5. All vehicles shall have at least two (2) seat belt extensions.
6. For use in emergency situations, each vehicle shall be equipped with at least one (1) seat belt cutter that is kept within easy reach of the driver.
7. All vehicles shall have functioning interior light(s) within the passenger compartment.
8. All vehicles shall have an accurate, operating speedometer and odometer.
9. All vehicles shall have two (2) exterior rear view mirrors, one (1) on each side of the vehicle.
10. All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment.
11. The exterior of all vehicles shall be clean and free of broken mirrors or windows, excessive grime, major dents, or paint damage that detract from the overall appearance of the vehicles.
12. The interior of all vehicles shall be clean and free of torn upholstery, floor or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease or litter; or hazardous debris or unsecured items.
13. All vehicles shall be smooth riding, so as not to create passenger discomfort.
14. All vehicles shall have the NEMT provider's business name and telephone number decaled on at least both sides of the exterior of the vehicle. The business name and phone number shall appear in lettering that is a minimum of three inches in height and of a color that contrasts with its surrounding background.
15. To comply with confidentiality requirements, no words may be displayed on the vehicle that implies that TennCare enrollees are being transported. The name of the NEMT provider's business may not imply that TennCare enrollees are being transported.
16. The vehicle license number and the CONTRACTOR's toll-free phone number shall be prominently displayed on the interior of each vehicle. This information and the complaint procedures shall be clearly visible and available in written format (at a minimum, in English and Spanish) in each vehicle for distribution to enrollees upon request.
17. The vehicle shall have a current inspection sticker issued by the CONTRACTOR on the outside of the passenger side rear window in the lower right corner.
18. Smoking shall be prohibited in all vehicles at all times. All vehicles shall have an easily visible interior sign that states: "NO SMOKING".
19. All vehicles shall carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.

20. All vehicles shall be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves, and sterile eyewash.
21. Each vehicle shall contain a current map of the applicable geographic area with sufficient detail to locate enrollee and provider addresses.
22. Each vehicle shall be equipped with a regulation size Class B chemical type fire extinguisher. The fire extinguisher shall have a visible, current (up-to-date) inspection tag or sticker showing an inspection of the fire extinguisher by the appropriate authority within the past twelve (12) months. The extinguisher shall be mounted in a bracket located in the driver's compartment and be readily accessible to the driver and passenger(s).
23. Each vehicle shall be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer.
24. Each vehicle shall be equipped with emergency triangles.
25. Each vehicle that is required to stop at all railroad crossings shall have a railroad crossing decal that says that the vehicle stops at all railroad crossings.
26. Each vehicle shall have a real-time link, telephone or two-way radio. Pagers are not acceptable as a substitute.

Exhibit D
DRIVER REQUIREMENTS

The requirements listed below shall apply to all drivers of vehicles other than fixed route vehicles and ambulances.

1. All drivers shall be courteous, patient, and helpful to all passengers.
2. All drivers shall be neat and clean in appearance.
3. No driver shall use alcohol, narcotics, illegal drugs or prescription medications that impair the ability to perform while on duty. No driver shall abuse alcohol or prescription medications or use illegal drugs at any time.
4. All drivers shall wear and have visible an identification badge that is easily readable and identifies the driver and the NEMT provider.
5. No driver shall smoke or eat while in the vehicle, while assisting an enrollee, or in the presence of any enrollee.
6. Drivers shall not wear any type of headphones at any time while on duty, with the exception of hands-free headsets for mobile telephones. Mobile telephones may only be used for communication with the NEMT provider, the dispatcher, or the CONTRACTOR.
7. Drivers shall exit the vehicle to open and close vehicle doors when passengers enter or exit the vehicle.
8. The driver shall provide an appropriate level of assistance to an enrollee when requested or when necessitated by the enrollee's mobility status or personal condition. This includes curb-to-curb, door-to-door, and hand-to-hand service, as required.
9. The driver shall assist enrollees in the process of being seated including the fastening of seat belts, securing children in properly-installed child safety seats, and properly securing passengers in wheelchairs.
10. The driver shall confirm, prior to departure, that all seat belts are fastened properly, and that all passengers, including passengers in wheelchairs, are safely and properly secured.
11. Upon arrival at the destination, the driver shall park the vehicle so that the enrollee does not have to cross streets to reach the entrance of the destination.
12. Drivers shall visually confirm that the enrollee is inside the destination.
13. The driver shall not leave an enrollee unattended at any time.
14. If an enrollee or other passenger's behavior or any other condition impedes the safe operation of the vehicle, the driver shall park the vehicle in a safe location out of traffic, notify the NEMT provider/dispatcher, and request assistance.

Exhibit E
DRIVER LOGS

The CONTRACTOR shall require that the NEMT providers' drivers maintain daily transportation logs containing, at a minimum, the information listed below. Fixed route transportation is excluded from this requirement.

1. Date of service;
2. Driver's name;
3. Driver's signature;
4. Name of escort or accompanying adult (for enrollees under age eighteen (18) and relationship to enrollee (if applicable);
5. Vehicle Identification Number (VIN);
6. Enrollee's name;
7. The NEMT provider's name;
8. Number assigned by the CONTRACTOR for the approved trip;
9. Mode of transportation approved;
10. Actual start time (from the base station) for the time zone applicable to the starting location;
11. Scheduled pick-up time for the time zone applicable to the pick-up location;
12. Actual pick-up location and time for the time zone applicable to the pick-up location;
13. Actual departure time from pick-up location for the time zone applicable to the pick-up location;
14. Actual destination and time for the time zone applicable to the destination;
15. Actual number of wheelchairs, escorts, and accompanying adults (for enrollees under age eighteen (18));
16. Odometer readings at each point of pick-up and of drop-off; and
17. Notes, if applicable. At a minimum, the log shall show notes in the case of cancellations, incomplete requests, "no-shows", accident and incident.

For ambulance, the log shall also contain, at a minimum:

1. Patient assessment by ambulance personnel and a chronological narrative of care/service rendered by ambulance personnel;
2. Itemized list of specialized services and/or supplies; and
3. Type of vehicle used for transport (class or service category).

The CONTRACTOR may express time in regular time (AM or PM) or in military time (using the 24-hour clock); however, the selected method for expressing time (regular or military) shall be used consistently by the CONTRACTOR and by all of the CONTRACTOR's subcontractors, NEMT providers and drivers.

Exhibit F
PERFORMANCE STANDARDS AND LIQUIDATED DAMAGES

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 requirements (see Section A.5.1 of this Attachment)		Up to $1,000 per deficiency at TENNCARE's discretion
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
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 Contract $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

No.	PERFORMANCE STANDARD		LIQUIDATED DAMAGE
6	Comply with driver training requirements and driver standards (see Section A.8 of this Attachment) Comply with driver requirements as it relates to drug and alcohol testing		$2,500 per calendar day per driver for each calendar day that a driver is not in compliance with the driver standards The following sanctions are specifically for drug and alcohol standards for NEMT drivers. For the first deficiency: $5,000 for failure to meet the five (5%) requirement for drug and alcohol testing per quarter. For the second deficiency: $7,500 for failure to meet the five (5%) requirement for drug and alcohol testing per quarter. For the third and subsequent deficiencies: $10,000 for failure to meet the five (5%) requirement for drug and alcohol testing per quarter
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
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

No.	PERFORMANCE STANDARD		LIQUIDATED DAMAGE
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 reporting period
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
13	Failure by the CONTRACTOR to comply with the pre-validation requirements and the post-validation requirements (see Section A.4.6 and Section A.14.3 of this Attachment XI)		$5,000 for failure to meet the 2% benchmark for pre-validations of NEMT scheduled trips $1,000 for failure to meet the 2% benchmark for post-validations of NEMT trips; and $100 per calendar day until an acceptable report has been received by TENNCARE beginning on the date the CONTRACTOR is notified of the deficiency
14	Failure by the CONTRACTOR to provide an acceptable Member Satisfaction Survey as required summarizing the methods and findings identifying opportunities for improvement in NEMT Services (see Sections A.17.5 and A.19.5.8 of this Attachment)		$2500 for failure to provide an acceptable survey as required
15	Failure by the CONTRACTOR to enforce the Member No-Show Policy and adhere to the requirements of the policy provided to you by TENNCARE (see Section A.11.3 of this Attachment)		$100 per occurrence for failure to follow the notification requirements of the No-Show Policy $100 per occurrence for failure to follow the probationary requirements of the No-Show Policy $100 per occurrence for failure to administer the No Show policy to a Non-Compliant Member reported to you by the driver

ATTACHMENT XII

CAPITATION RATES