CONTRACT SUMMARY SHEET

8-8-05

RFS #	Contract #
318.65-208	FA-06-16560-00
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
Doral Dental of Tennessee, LLC	☐ C- or ☒ V- 352177954 00

Service Description

TennCare Dental Benefits Manager

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
October 1, 2005	September 30, 2008	Vendor	93.778 Dept. of Health & Human Services/Title XIX

Mark, if Statement is TRUE

☒ Contractor is on STARS as required ☒ Contractor's Form W-9 is on file in Accounts as required

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
318.66	370	134	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2006	$1,122,180.00	$1,122,180.00			$2,244,360.00
2007	$2,244,360.00	$2,244,360.00			$4,488,720.00
2008	$2,244,360.00	$2,244,360.00			$4,488,720.00
2009	$561,090.00	$561,090.00			$1,122,180.00
TOTAL:	$6,171,990.00	$6,171,990.00			$12,343,980.00

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
TOTAL:		
End Date:		

State Agency Fiscal Contact & Telephone #

Scott Pierce 507-6415

State Agency Budget Officer Approval

Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

RECEIVED 2005 SEP 26 PM 12: 39 COMPTROLLER'S OFFICE OFFICE OF MANAGEMENT SERVICES

Contractor Ownership

☐ African American ☐ Disabled ☐ Hispanic ☐ Small Business ☒ NOT minority/disadvantaged
☐ Asian ☐ Female ☐ Native American ☐ OTHER minority/disadvantaged

Contractor Selection Method

☒ RFP ☐ Competitive Negotiation ☐ Alternative Competitive Method
☐ Non-Competitive Negotiation ☐ Government ☐ Other

Procurement Process Summary

TennCare released a Request for Proposal on July 15, 2005. Seven proposals were submitted in response to this RFP. This contractor received the highest rating of combined experience/technical/cost proposals.

OCT - 3 2005

DIRECTOR OF ACCOUNTS

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
DORAL DENTAL OF TENNESSEE, LLC

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the "State" or "TennCare" and Doral Dental of Tennessee, LLC, hereinafter referred to as the "Contractor," or "DBM" (Dental Benefits Manager), is for the provision of dental administrative and management services as further defined in the "SCOPE OF SERVICES."

The Contractor is a for profit corporation.

The Contractor's address is: 12121 N. Corporate Parkway

Mequon, WI 53092

The Contractor's place of incorporation or organization is Wisconsin.

The Contractor is a corporation which has qualified as an Administrator (aka "Third Party Administrator") in compliance with Tennessee Code Annotated Section 56-6-401 et seq. and is licensed to operate as an adjustor or settler of claims in connection with dental insurance benefits coverage in the State of Tennessee and is capable of providing or arranging for health care services provided to covered persons for whom it receives payment and is engaged in said business and is willing to do so upon and subject to the terms and conditions hereof.

A. SCOPE OF SERVICES

The Contractor agrees to administer the TennCare dental benefit as specified in this Agreement. The Contractor shall make maximum efforts to ensure minimum disruption in service to members and a smooth interface of any claims processing or system changes to transfer necessary information without material disruption during implementation of the Agreement.

A.1. OBLIGATIONS OF THE Contractor

A.1.1. Services. The Contractor will manage the program in a manner that ensures an adequate network of qualified dental providers for whom the Contractor is responsible. These providers will render high quality, medically necessary, cost effective dental care. Furthermore, the Contractor will exercise every available means through this contract, provider agreement, office reference manual or Contractor's policies and procedures to ensure that the program is managed in this manner.

A.1.2. Benefit Packages. The Contractor will be responsible for ensuring that the following is provided:

A.1.2.1. Under Age 21, Preventive, diagnostic and treatment services. Any limitations described in this Agreement, including Attachment I, shall be exceeded to the extent that it is necessary in accordance with EPSDT requirements. At any time, by amendment to this contract, TennCare may alter the covered benefits for the TennCare Standard members under 21.

A.1.2.2. Orthodontics. Orthodontic services are limited to eligible individuals under age 21. There must be authorization for treatment and the treatment must have begun at least six (6)

months prior to the enrollee's 21st birthday. Approved treatment begun at least six (6) months prior to the enrollee's 21st birthday may continue past age 21 as long as the individual remains eligible. Orthodontic services are limited to individuals diagnosed with (1) a severe handicapping malocclusion or another developmental anomaly or injury resulting in severe malalignment or severe handicapping malocclusion of teeth, ascertained by using the Salzmann Malocclusion Severity Index, or any other method that is approved by TennCare, or (2) following the repair of an enrollee's cleft palate. Orthodontic treatment will not be authorized for cosmetic purposes.

A.1.3. Enrollee Cost Share Responsibilities. The Contractor and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TennCare in accordance with TennCare rules and regulations or TennCare approved policies and procedures for TennCare enrollees, nor may the Contractor and all providers and subcontractors charge enrollees for missed appointments. Enrollees may not be held liable for payments in the event of the Contractor's insolvency. Enrollees may not be held liable for payments in the event the State does not pay the Contractor, or the Contractor does not pay the provider. Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e. no balance billing by providers.)

Cost sharing responsibilities shall apply to services other than the preventive services described in Section A.1.2.1 and specified in the table below. Co-payments shall be applied on a sliding scale according to the enrollee's income. The procedure code listing for preventive services is as follows:

Preventive Dental Services for Children Under 21 Years of Age

D1110	Prophylaxis (when billed for children over age 12 and under age 21)
D1120	Prophylaxis
D1201	Topical Application of Fluoride (Prophylaxis included) - child
D1203	Topical Application of Fluoride (Prophylaxis not included) - child
D1310	Nutritional Counseling for Control of Dental Disease
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease
D1330	Oral Hygiene Instructions
D1351	Sealant per Tooth

The current sliding scale schedule to be used in determining applicable cost sharing responsibilities for TennCare enrollees is described in the chart below.

Co-Pay	0 to 100% of Poverty	101-199% of Poverty	200% and Above Poverty
Dental visits	0	$15 per visit	$25 per visit

The Contractor shall track and report to TennCare the amount of enrollee cost-sharing liabilities on a quarterly basis in a form and format to be specified by TennCare.

The Contractor shall be expressly prohibited from waiving or using any alternative cost sharing schedules, unless required by TennCare. Further, the Contractor shall not discourage enrollees from paying applicable co-payment obligations.

If, and at such time that changes occur to the cost sharing rules, the contractor will be notified of new co-payment rates.

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

Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable cost sharing responsibilities for TennCare covered services except as permitted by TennCare rule 1200-13-13-.08 and as described below. Providers may seek payment from an enrollee in the following situations:

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

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

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

4. the enrollee requests services that are non-TennCare covered services provided at the option of the Contractor in accordance with the terms of this Contract.

A.1.4. Adherence to TennCare Rules and Regulations: The Contractor shall perform all services under this Agreement. Contractor shall comply with all applicable administrative rules and TennCare written policies and procedures, as may be amended from time to time. TennCare shall provide Contractor with copies of such rules and policies.

A.1.5. The CONRACTOR shall demonstrate to TennCare progressively significant increases in the percentage of children being screened toward the achievement of a screening percentage of 80%.

A.2 EVIDENCE OF ENROLLEE COVERAGE AND ENROLLEE MATERIAL

A.2.1. Enrollee Materials. The Contractor shall distribute various types of enrollee materials as required in this Agreement. Specific information regarding these materials, the Member Handbook, Quarterly Newsletter and other items are outlined in Attachment II. Permissible and prohibited communication activities, enrollee and written materials guidelines are defined in Attachment II.

A.2.2. Failure to Comply with Enrollee Material Requirements. All services listed in A.1.2 must be provided as described and the materials must adhere to the requirements as described and must not mislead, confuse, or defraud the recipients or the State Agency. Failure to comply with the communication limitations contained in this Agreement, including but not limited to the use of unapproved and/or disapproved communication material, may result in the imposition by TennCare of one or more sanctions as provided in Section E.4 and Attachment I of this agreement.

A.2.3. Prohibited Communication Activities: The following information and activities are prohibited:

A.2.3.1. Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers. Further, the Contractor shall adhere to requirements for the written materials to assure that material is accurate and does not mislead, confuse or defraud the recipients or the state agency and materials shall be subject to review by TennCare.

A.2.3.2. There shall be no soliciting of enrollees;

A.2.4. The Contractor shall be responsible for postage on all mailings sent out by the Contractor.

A.3 STAFFING REQUIREMENTS

A.3.1 Office Location. Contractor must maintain a physical office in Metropolitan-Davidson County, Tennessee, or counties contiguous to Metropolitan-Davidson County. Staff specified in Section A.3.2.b shall be physically located in that office unless otherwise agreed to by TennCare.

A.3.2 Staffing Plan

A.3.2.a The Contractor shall 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.

A.3.2.b The administrative staffing for the plan covered by this Agreement must be capable of fulfilling the requirements of this Agreement and is in addition to contracted dental providers rendering clinical services. A single individual may hold more than one (1) position unless otherwise specified. The minimum staff requirements are as follows:

1. A full-time administrator (project director) specifically identified with overall responsibility for the administration of this Agreement. This person shall be at the Contractor's officer level and must be approved by the State. Said designee shall be responsible for the coordination and operation of all aspects of the Agreement;

2. Sufficient full-time support staff to conduct daily business in an orderly manner, including such functions as administration, accounting and finance, prior authorizations, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews;

3. A full-time EPSDT Outreach Coordinator whose primary duties include development and implementation of the Contractor's strategy to increase EPSDT screening rates;

4. A dentist who is licensed by and physically located in the State of Tennessee to serve as dental director to oversee and be responsible for the proper provision of covered services to members;

5. A staff of qualified, medically trained personnel, whose primary duties are to assist in evaluating medical necessity;

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

7. The Contractor shall appoint a staff person as its Non-discrimination Compliance Coordinator to be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Reconciliation Act of 1981 (P.E. 97-35) on behalf of the Contractor. The Contractor does not have to require that compliance with the aforementioned federal and state regulations be the sole function of the designated staff member. However, the Contractor shall identify the designated compliance staff member to TennCare by name. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported in writing to TennCare within ten (10) calendar days of the change.

8. The Contractor shall appoint a staff person to be responsible for communicating with TennCare regarding member service issues.

9. The Contractor shall appoint a staff person to be responsible for communicating with TennCare regarding provider service issues. Further, the Contractor shall have a provider service line staffed adequately to respond to providers' questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in this Agreement. The provider service lines shall be adequately staffed and trained to accurately respond to questions regarding the TennCare program, including but not limited to EPSDT. The Contractor shall adequately staff the provider service line to assure that the average wait time for assistance does not exceed 10 minutes.

10. The Contractor shall appoint Care Coordinators and Claim Coordinators in order to coordinate and resolve issues related to MCO/DBM coordination issues as described in Section A.8 of this Agreement. Further, the Contractor shall appoint a Care Coordination Committee and a Claims Coordination Committee made up of the Care/Claim Coordinators and other staff as appropriate. A list with the

names and phone numbers of said representatives shall be provided by the DBM to the MCO and TennCare.

11. The Contractor shall provide a twenty-four (24) hour toll-free telephone line accessible to enrollees that provides information to enrollees about how to access needed services. In addition, the Contractor shall appoint and identify in writing to TennCare a responsible contact available after hours for the "on-call" TennCare Solutions staff and enrollees to contact with service issues.

12. The Contractor shall identify in writing the name and contact information for the Project Director, Dental Director, EPSDT Outreach Coordinator, and the Non-discrimination Compliance Coordinator. Key contact persons shall also be provided for Accounting and Finance, Prior Authorizations, Claims Processing, Information Systems, Member Services, Provider Services, Appeal System Resolution, within thirty (30) days of Agreement execution. Any changes in staff persons during the term of this Agreement must be made in writing within 10 business days. The identity of each of the persons listed above shall be disclosed on the Contractor's web site.

The Contractor's failure to comply with staffing requirements as described in this agreement shall result in the application of intermediate sanctions and liquidated damages as specified in Section E.4 and Attachment I of this Agreement.

A.3.4. Licensure. The Contractor is responsible for assuring that all persons, whether they be employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render service under applicable state law and/or regulations. Failure to adhere to this provision shall result in assessment of $250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulation and TennCare may terminate this Agreement for cause as described in Section D.4. of this Agreement.

A.4. ACCESS AND AVAILABILITY TO CARE

The Contractor must arrange for the provision of all services described as covered in this Agreement. The Contractor shall maintain under contract, a state-wide provider network, including General Dentists and Dental Specialists, adequate to make services, service locations, and service sites available and accessible in accordance with the Terms and Conditions for Access and Availability of the TennCare Waiver and as contained herein. Nothing in this Agreement shall be construed to preclude the Contractor from closing portions of the network to new providers when all conditions of access and availability are met (see Paragraph A.4.1. and A.18.5)

A.4.1 Access to Care. The Contractor shall maintain a network of dental providers with a sufficient number of providers who accept new TennCare enrollees within each geographical location in the state so that appointment waiting times do not exceed 3 weeks for regular appointments and 48 hours for urgent care. The Contractor must consider the following:

a. The anticipated Medicaid enrollment
b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the DBM
c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services
d. The numbers of network providers who are not accepting new Medicaid patients

e. The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

The Contractor must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. Services must be available 24 hours a day, 7 days a week, when medically necessary.

A.4.2. Transport Time. The Contractor shall maintain under contract a network of dental providers to provide the covered services specified in A.1.2. statewide. The Contractor shall make services, service locations and service sites available and accessible so that transport time to dental providers will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards, as defined by TennCare. Exceptions must be justified and documented to the State on the basis of community standards.

A.4.3 Office Wait Time. Office waiting time shall not exceed 45 minutes.

A.4.4. Provider Choice. Each enrollee shall be permitted to obtain covered services from any general or pediatric dentist in the Contractor's network accepting new patients.

A.4.5. Out of Network Providers. If the Contractor's network is unable to provide necessary, medical services covered under the contract to a particular enrollee, the Contractor must adequately and timely cover these services out of network for the enrollee, for as long as the Contractor is unable to provide them. Out of network providers must coordinate with the Contractor with respect to payment. The Contractor must ensure that cost to the enrollee is no greater than in would be if the services were furnished within the network.

A.4.6 The Contractor must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

A.5. PROVIDER NETWORK REQUIREMENTS

A.5.1 The Contractor is encouraged to contract for the provision of services with Federally Qualified Health Clinics (FQHCs), FQHC look-alikes, metropolitan or county Health Departments, University affiliated dental programs and may, at the discretion of TennCare, be required to secure such contracts. In addition, where FQHCs with the capacity to deliver dental services are not utilized, the Contractor must demonstrate that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected needs in a service area without contracting with FQHCs.

If the Contractor utilizes FQHCs for services, the Contractor is required to address cost issues related to the scope of services provided by FQHCs and shall reimburse FQHCs on a cost related basis.

A.5.2 The Contractor must submit documentation assuring adequate network capacity and services as specified by the State.

A.6 MEMBER SERVICES

A.6.1. Members Services Hotline. Contractor shall provide a toll-free telephone service for all regular business days Monday through Friday. Since Tennessee spans two time zones, this service shall be operated from 7:00 a.m. Central Standard Time to 5:00 p.m. Central Standard Time and corresponding hours during periods of Daylight Savings Time. The member service lines shall be adequately staffed and individual staff trained to accurately respond to questions regarding covered services, to assist enrollees locate a participating dental provider, and other issues, including but not limited to EPSDT.

A.6.2. Translation Services. In addition to the toll-free telephone number, Contractor shall provide language translation services, either directly or by contracting with a service such as AT&T's Language Line (See Attachment III specifying Non-discrimination Compliance requirements).

A.6.3. TDD/TDY. The Contractor shall make TDD/TDY services available to members.

A.6.4 Appointment Assistance. The Contractor will assist members in obtaining appointments for covered services, including facilitation of member contact with a Participating Dental Provider who will establish an appointment. The Contractor shall track the number of requests for assistance to obtain an appointment, including the service area in which the enrollee required assistance.

A.6.5. Provider Listing. The Contractor shall provide all enrollees (or heads of households), with a provider listing within thirty (30) days of initial enrollment, and upon request, such list shall include current provider address(es), telephone numbers, office hours, languages spoken, specialty and whether or not the provider is accepting new patients. The Contractor shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. All provider directories shall be approved by TennCare prior to the Contractor's distribution.

A.6.6 I.D. Card. The Contractor shall not be required to provide identification cards to TennCare enrollees; however, the Contractor shall provide TennCare with a written process detailing how members and providers will access information, including but not limited to, pertinent phone numbers for member services, provider identification of eligible individuals and access to prior authorization procedures, etc.

A.7 UTILIZATION MANAGEMENT

A.7.1. Policies and Procedures. The Contractor shall provide an electronic and two written copies of its dental management policies and procedures to TennCare for approval.

A.7.2. Prior Approvals. Said policies and procedures must clearly identify any services for which the Contractor will require network providers to obtain authorization prior to the provision of the service as well as any additional submissions (such as radiographs) that may be required for approval of a service. TennCare shall have thirty (30) days to review and approve or request modifications to the policies and procedures. Should TennCare not respond in the required amount of time, the Contractor shall not be penalized as a result of implementing the policies and procedures. However, failure to respond timely shall not preclude the State from requiring the Contractor to respond or modify the policy or operating guideline prospectively. Dental management policies and procedures must be consistent with the following requirements:

a. Requests for prior approvals that are denied by the Contractor must be denied in writing within 14 days of receipt.

b. Prior approval shall not be required for referrals from the Public Health Screening Program, Primary Care Physicians, and for preventive services as defined in A.1.2 and A.1.3.

c. Utilization management activities may not be structured so as to provide incentives for the individual or Contractor to deny, limit, or discontinue medically necessary services to any enrollee.

A.7.3. Retrospective Utilization Review. The Contractor will conduct retrospective treatment utilization review. This review will evaluate the dental provider's treatment practice within a network of individual providers performing similar processes and identify those whose treatment utilization pattern deviates from their peer's norm. The process will incorporate basic provider profiling, test edits, and statistical process controls (SPC). SPC is a methodology of evaluating normal statistical variability or "noise" within any type of process. Normally the statistical limits are set at ± three standard deviations so that any determination outside of these upper and lower control limits is expected to be a significant deviation from the network group being measured. If the type of finding elicited in the retrospective treatment utilization review process necessitates chart audit of a dental provider, the Contractor is expected to perform a chart audit.

The Contractor is required by this Agreement to maintain a Peer Review Committee made up of licensed Tennessee dentists in good standing in the state (See paragraph A.18.3). This committee will review the case files generated by the utilization review process. After the Tennessee Peer Review Committee has completed its review and established its findings and recommendations, these are then forwarded back to the Contractor for formal action. The Contractor will forward to the TennCare Dental Director and Office of Inspector General's Program Integrity Unit, a monthly audit update including a summary of its investigation and actions taken.

The Contractor's utilization review process intervention includes various options that safeguard children, improve quality of care, assure fiscal viability of the program and comport with TennCare's mission. These options include issuance of corrective action plans, provider education, recoupment of provider payments or any combination of these actions. Additionally, in accordance with its Provider Service Agreement, the Contractor may also choose to exercise its prerogative to terminate a dental provider with or without cause with thirty days notice.

A.7.4 Urgent Care. Contractor shall ensure access to services for urgent dental and oral conditions or injuries on the basis of the professional judgment of the enrollee's treating dentist, other dental professional, primary care provider or a triage nurse who is trained in dental care and oral health care.

A.7.4.1. The Contractor may not deny payment for treatment obtained when a representative of the Contractor instructs the eligible enrollee (ages 0–20) to seek emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the service has a contract with the Contractor. Under the terms of this Agreement and the TennCare MCO Agreement, the MCO is responsible for the provision of treatment for emergency medical conditions and is also responsible for the facilities and physician charges for dental services provided in a hospital emergency room.

A.7.4.2. The Contractor may not deny payment for treatment obtained when an eligible enrollee (ages 0-20) had an emergency medical condition, where it is the Contractor's responsibility to pay, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114 (a) of the definition of emergency medical conditions. Under the terms of this Agreement and the

TennCare MCO Agreement, the MCO is responsible for the provision of treatment for emergency medical conditions and is also responsible for the facilities and physician charges for dental services provided in a hospital emergency room.

A.7.5 Continuity of Care. The Contractor shall accept claims and authorize reimbursement for Covered Services that were approved or were part of a course of treatment that started prior to the Effective Date of this Agreement.

A.7.6. Referral Requirements. A patient must be referred by a general dentist or pediatric dentist to a dental specialist (e.g., oral surgeon, endodontist, orthodontist) for the initial visit for services requiring specialized expertise. Subsequent visits to the same specialist in a course of treatment do not require separate referrals. The Contractor must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain one outside the network, at no cost to the enrollee. Additionally, The Contractor must have a mechanism in place to allow special needs enrollees and enrollees determined to require an ongoing course of treatment direct access to specialists as appropriate.

A.8 CARE COORDINATION

A.8.1 Transition Period. In the event a TennCare enrollee is receiving medically necessary covered dental services the day before the effective date of this Agreement, the Contractor shall authorize the continuation of said services without any form or prior approval and regardless of whether the services are being provided by a provider within or outside the Contractor's provider network.

In order to ensure uninterrupted service delivery, the Contractor shall accept authorization files from the previous DBM and/or TennCare as directed to identify enrollees for whom prior approvals were issued prior to the effective date of this Agreement. To the extent that the approvals are for covered services and are within the parameters of the TennCare approved policies and procedures for prior approvals as outlined in Section A.7.2 of this Agreement, Contractor will accept and honor those prior approvals for the first ninety days of this Agreement.

A.8.2 Transition Management. The Contractor shall coordinate with the previous DBM so that dental inquiries received after January 1, 2006 are redirected to the Contractor.

A.8.3 Coordination Between MCO and Contractor (DBM). The provision of Dental services are the responsibility of the Contractor, however, the provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service (with the exception of anesthesia services administered by a dental provider or in a dentist office) shall remain with the MCO. The Contractor shall remain responsible for anesthesia services that are appropriately provided by a dental provider or in a dentist's office. The Contractor shall agree to coordinate dental and medical services in accordance with the following provisions.

The Contractor shall be responsible for: (1) authorizing dental services for which they have the responsibility to pay; and (2) arranging services that are not covered under this Agreement to be provided, when appropriate, with providers that are contracted in the MCO's plan. The MCO shall be responsible for authorizing said services that require transportation, anesthesia (with the exception of anesthesia services administered by a dental provider or in a dentist office), and/or medical services related to the dental service; however, the MCO may waive authorization of said services based on authorization of the dental services by the Contractor. The Contractor and the MCO may develop policies and

procedures to further clarify responsibilities of the DBM and the MCO. TennCare will work to facilitate implementation of said policies and procedures.

A.8.3.1 Services and Responsibilities

Coordination of dental services, at a minimum, include:

- Means for referral which assures immediate access for emergency care and a provision of urgent and routine care according to TennCare guidelines;
- Means for the transfer of information (to include items before and after the visit);
- Maintenance of confidentiality;
- Cooperation with the MCO regarding training activities provided by the MCO.
- Results of any identification and assessment of any enrollee with special health care needs (as defined by the State) so that those activities need not be duplicated;
- Mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.
- If applicable, the development of treatment plans for enrollees with special health care needs that are developed by the enrollee's primary care provider with enrollee participation and in consultation with any specialists caring for the enrollee. These treatment plans must be approved by the Contractor in a timely manner, if approval is required, and be in accord with any applicable State quality assurance and utilization review standards.

A.8.3.2 Operating Principles

Coordinating the delivery of dental services to TennCare members is the primary responsibility of the Contractor. To ensure such coordination, the Contractor shall identify a staff member to serve as lead for coordination of services with each MCO and shall notify the respective MCOs, and the Bureau of TennCare of the name, title, telephone number and other means of communicating with that coordinator. The Contractor shall be responsible for communicating the MCO provider services and/or claim coordinator contact information to all of its providers. With respect to specific member services, resolution of problems shall be carried out between the MCO coordinator and the DBM coordinator. Should systemic issues arise, the MCO and the Contractor agree to meet and resolve these issues. In the event that such issues cannot be resolved, the MCO and the Contractor shall meet with TennCare to reach final resolution of matters involved. Final resolution of system issues shall occur within ninety (90) days from referral to TennCare.

A.8.3.2.1. Resolution of Requests for Authorization. The DBM agrees and recognizes that the MCO shall agree through its contractual arrangement with the State, that any dispute concerning which party should respond to a request for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a TennCare member. DBM and MCO agree that Care Coordinators will, in addition to their responsibilities for care coordination, deal with issues related to requests for authorization which require

coordination between DBM and MCO. The DBM and MCO shall provide the other party with a list of its Care Coordinators and telephone number(s) at which each Care Coordinator may be contacted. When either party receives a request for authorization from a provider for a member and the party believes care is the responsibility of the other party, the Care Coordinator for that party will contact the respective Care Coordinator of the other party by the next business day after receiving the request for prior authorization and communicate to the enrollee or enrollee's provider for routine requests which shall be made within 14 days or less of the provider's request for prior authorization and immediately after receiving the request for prior authorization for urgent requests. The DBM and MCO will establish a coordination committee to address all issues of care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Agreement. The parties will attempt in good faith to resolve any dispute and communicate the decision to the provider requesting authorization of a service. In the event the parties cannot agree within 15 days of the provider's request for prior authorization, the party who first received the request from the provider will be responsible for authorization and payment to their contracted provider within the time frames designated by the Bureau of TennCare Both parties are responsible for enforcing hold harmless protection for the member. The parties agree that any response to a request for authorization shall not exceed 14 days and shall comply with the *Grier* Revised Consent Decree (modified) (www.tnjustice.org).

A.8.3.2.2 Claim Resolution Authorization. The DBM agrees and recognizes that the MCO shall agree through its contractual arrangement with the State, to designate one or more Claim Coordinators to deal with issues related to claims and payment issues that require coordination between DBM and MCO (parties). The DBM and MCO shall provide the other party, and TennCare with a list of its Claim Coordinators and telephone number(s) at which each Claim Coordinator may be contacted.

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

The DBM and MCO will establish a Claim Coordination Committee made up of Claims Coordinators and other representatives, as needed, from each party. The number of members serving on the Claim Coordination Committee shall be determined by the mutual agreement of the parties from time to time during the term of this Agreement, or, if the parties fail to agree within ten (10) calendar days of the execution of this Agreement, the Claim Coordination Committee shall consist of two (2) representatives of each party. The Claim Coordination Committee shall review any disputes and negotiate responsibility among the parties. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party will reimburse and abide by the prior decisions of that party. Reimbursement will be made within ten (10) business days of the Claim Coordination Committee's decision.

If the Claim Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) business days of the initial

referral to the Claim Coordination Committee, said claim shall be referred to the Chief Executive Officers (CEO) or the CEO's designee, of both DBM and MCO for resolution immediately. A meeting shall be held among the Chief Executive Officers or their designee(s), of the parties within ten (10) calendar days after the meeting of the Claims Coordination Committee, unless the parties agree to meet sooner.

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

The process as described above shall be completed within 30 days of receiving the claim for payment. In the event the parties cannot agree within 30 days of receiving the claim for payment, both parties will be responsible for enforcing hold harmless protection for the member and the party who first received the request or claim from the provider will be responsible for authorization and payment to the provider within the following time frames designated by the Bureau of TennCare: claims must be processed in accordance with the requirements of the MCO's and DBM's respective Agreements with the State of Tennessee. Moreover, the party that first received the request or claim from the provider must also make written request of all requisite documentation for payment and must provide written reasons for any denial.

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

The state, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) days of the receipt of the required information. The decision may reflect a split payment responsibility that will designate specific proportions to be shared by the MCO and the DBM which shall be determined solely by the State, or its designee based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the state, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars ($1000) for each request for resolution. The amount of the Contractor's payment responsibility shall be contained in the state's Decision. These payments may be made with reservation of rights regarding any such judicial resolution. If a party fails to pay the state for the Contractor's payment responsibility as described in this section within (30) calendar days of the date of the state's Decision, the state may deduct amounts of the Contractor's payment responsibility from any current or future amount owed the party.

A.8.3.2.3 Denial, Delay, Reduction, Termination or Suspension. The parties agree that any claims payment dispute or request for authorization shall not cause a denial,

delay, reduction, termination or suspension of any appropriate services to an eligible TennCare member ages 0-20. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim must be approved or disapproved based on the definition of emergency medical services specified in this Agreement.

A.8.3.2.4. Emergencies: Prior authorization shall not be required for emergency services prior to stabilization. Services provided in accordance with the following requirements that are outside of the scope of this agreement shall be considered an MCO responsibility. Coordination activities between the Contractor and the MCOs are outlined in Section A.8 of this contract.

A.8.3.2.4 (a) Contractor may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, or applicable state entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

A.8.3.2.4 (b) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

A.8.3.2.4 (c.) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.

A.8.3.2.4 (d) Post stabilization services are covered and paid for in accordance with provisions set forth in 42 CFR 422.113 (c). The MCO is financially responsible for post-stabilization services obtained within or outside the managed care organization that are pre-approved by a plan provider or other MCO representative.

A.8.3.2.4 (e) The MCO is financially responsible for post-stabilization care services obtained within or outside the MCO organization that are not pre-approved by a plan provider or other MCO organization representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCO organization for pre-approval of further post-stabilization care services.

A.8.3.2.4. (f) The MCO is financially responsible for post-stabilization care services obtained within or outside the MCO organization that are not pre-approved by a plan provider or other MCO organization representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if:

- The MCO does not respond to a request for pre-approval with 1 hour
- The MCO cannot be contacted; or
- The MCO representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c) is met.

A.8.3.2.4 (g) The MCO must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MCO organization.

A.8.3.2.4. (h) the MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the enrollee care;
- A plan physician assumed responsibility for the enrollee's care through transfer;
- An MCO representative and the treating physician reach an agreement concerning the enrollee's care; or
- The enrollee is discharged.

A.8.3.2.5 Claims Processing Requirements. All claims must be processed in accordance with the requirements of the MCO's and DBM's respective Agreements with the State of Tennessee.

A.8.3.2.6 Appeal of Decision. Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, T.C.A. §4-5-201 et seq. Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section.

A.8.3.2.7 Duties and Obligations. The existence of any dispute under this Agreement shall in no way affect the duty of the parties to continue to perform their respective obligations, including their obligations established in their respective contracts with the state pending resolution of the dispute under this Section. In accordance with T.C.A. § 56-32-226(b), a provider may elect to resolve the claims payment dispute through independent review.

A.8.3.2.8 Confidentiality. The DBM agrees and recognizes that the MCO shall agree through its contractual arrangement with the state, to cooperate with the state to develop Confidentiality Guidelines that (1) meet state, federal, and other regulatory requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both DBM and MCO standards. These standards will apply to both DBM's and MCO's providers and staff. If either party believes that the standards require updating, or operational changes are needed to enforce the standards, the parties agree to meet and resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

The DBM and MCO shall assure all materials and information directly or indirectly identifying any current or former enrollee which is provided to or obtained by or through the MCO's or DBM's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, Section E.18 of this Agreement, Title 42, Part 2, Code of Federal Regulations, and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless

required by applicable law, shall not be disclosed except in accordance with those Titles or to the TennCare Bureau, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former enrollee or potential enrollee.

A.8.3.2.9 Access to Service. The DBM agrees and recognizes that the MCO shall agree through its contractual arrangement with the State, to establish methods of referral which assure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

A.8.4 Tracking System. The Contractor shall develop and maintain a tracking system with the capability to identify the current screening status, pending preventive services, and screening due dates, referrals for corrective treatment, whether corrective treatment was provided, and dates of service for corrective treatment for each enrollee.

A.8.5. Provider Listing for MCO PCP's. The Contractor shall prepare updated provider listings to be provided to the MCOs for the purpose of distribution to MCO primary care providers. This listing must be provided to MCOs on a quarterly basis in accordance with a form, format and schedule as determined by TennCare.

A.9 PROVIDER SERVICES

A.9.1 Training.

A.9.1.a The Contractor shall provide continuing training for participating Dental Providers throughout the State. The Contractor shall hold at least two training sessions per year for each Grand Region in the state. At a minimum, training shall address EPSDT and the applicable provisions of the *Grier* Consent Decree (modified). The Contractor shall submit all training material to TennCare for approval at least 60 days prior to the training session. TennCare shall have fifteen (15) days to review and request changes, if necessary. If changes are requested, the Contractor must resubmit the training material within ten (10) days of receipt of TennCare's comments.

A.9.1.b The Contractor shall monitor provider compliance with EPSDT requirements and standard dental practice. The Contractor shall work as necessary with Participating Dental Providers to develop corrective action plans to bring Participating Dental Providers, when necessary, into compliance with standard dental practice.

A.9.1.c The Contractor shall notify all network providers to file claims associated with their services directly with the Contractor, or its subcontractors. The Contractor shall provide written instructions to all network providers for submitting claims for payment. The Contractor shall provide individual assistance with policies and billing instructions to providers as requested.

A.9.1.d Documentation of all formal training activities and individualized corrective action assistance will be provided to TennCare on a quarterly basis.

A.9.2. Provider Manual. The Contractor shall produce and distribute a dental program criteria manual to assist Participating Dental Providers. The manual shall clearly define covered services, limitations, exclusions, and utilization management procedures, including, but not limited to: prior approval requirements and special documentation requirements for treatment of members. The manual shall include a detailed description of billing

requirements for Participating Dental Providers and shall contain a copy of Contractor's paper billing form and electronic billing format. The Contractor shall produce and distribute revisions to the manual to participating providers within fifteen days. The Provider Manual and any revisions thereto must be submitted to TennCare for review and approval prior to distribution.

A.9.3. Practice Guidelines: The Contractor shall adopt practice guidelines that meet the following
requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professional in a particular field;
- Consider the needs of the enrollees;
- Are adopted in consultation with contracting health care professionals;
- Are reviewed and updated periodically as appropriate; and
- Are disseminated to all affected providers and, upon request, to enrollees and potential enrollees.

A.10 NETWORK DEVELOPMENT AND MANAGEMENT

A.10.1. Providers Providing On-going Treatment. If an enrollee is in a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services to such enrollee and the Contractor is aware of such ongoing course of treatment, the Contractor shall immediately provide written notice within fifteen (15) calendar days from the date that the Contractor becomes aware of such unavailability to such enrollee. Each notice shall include all components identified in the notice template to be provided by TennCare. The timing requirement for the provision of this notice shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the Contractor or when a provider fails credentialing, and instead shall be made immediately upon the Contractor becoming aware of the circumstances.

A.10.2. Other Provider Termination: If a provider ceases participation in the DBM, the Contractor shall make a good faith effort to give a written notice of termination of a contracted provider within 15 days after receipt or issuance of termination notice to each enrollee who received his/her primary care from or was seen on a regular basis by the terminated provider.

A.10.3. Network Deficiency. Upon final notification from TennCare of a network deficiency, which shall be based on the requirements of this Agreement and terms and conditions of the TennCare waiver, the Contractor shall immediately provide written notice to enrollees living in the affected area of a provider shortage in the Contractor's network. The notice content shall be reviewed and approved by TennCare prior to distribution.

A.10.4 Notice of Subcontractor Termination. When a subcontract that relates to the provision of services to enrollees or claims processing is being terminated between the Contractor and a subcontractor, the Contractor shall give at least thirty (30) days prior written notice of the termination to TennCare and the TennCare Division, TDCI. Said notices shall include, at a minimum; a Contractor's intent to change to a new subcontractors for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed to access services. In addition to prior written notice, the Contractor shall also provide TennCare with a transition plan, when requested, which shall include, at a minimum,

information regarding how prior authorization requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees, etc.

A.10.5. Other Provider Terminations. The Contractor shall notify TennCare of any provider termination and submit a template copy of the enrollee notice sent as well as an electronic listing identifying each enrollee to whom a notice was sent. The Contractor shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TennCare. If the termination was initiated by the provider, said notice shall include a copy of the provider's notification to the Contractor.

A.11 PROVIDER AGREEMENTS

The Contractor shall assure the provision of all covered services specified in this Contract. The Contractor shall enter into agreements with providers and/or provider subcontracting entities or organizations who will provide services to the enrollees in exchange for payment from the State for services rendered. It is the intention of this Contract that the Contractor make every effort to enter into provider agreements with those entities whose practices exhibit a substantive balance between Medicaid and commercial patients.

A.11.1 Provider agreements will be between the provider and Contractor, not between the provider and TennCare.

A.11.2. The Contractor shall submit one copy of all template provider agreements and copies of the face and signature pages of all executed agreements to TennCare.

A.11.3 The Contractor shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who do not meet all the parameters of the credentialing process as outlined in A.18.5 and Attachment IV, Standard IX.

A.11.4 Further, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance.

A.11.5 All provider agreements executed by the Contractor, and all provider agreements executed by subcontracting entities or organizations, pursuant to this Section shall, at a minimum, meet the following requirements: (No other terms or conditions agreed to by the Contractor and provider shall negate or supersede the following requirements.)

A.11.5. a. Be in writing. All new provider agreements and existing provider agreements as they are renewed, must include a signature page that contains Contractor and provider names, which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties.

A.11.5. b. Specify the effective dates of the provider agreement;

A.11.5. c. Specify in the provider agreement that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;

A.11.5. d. Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without approval of the Contractor;

A.11.5. e. Identify the population covered by the provider agreement;

A.11.5. f. Specify that provider may not refuse to provide medically necessary or covered services to a TennCare patient under this Contract for non-medical reasons, including, but not limited to, failure to pay applicable cost sharing responsibilities. The Contractor shall specify that an enrollee who is subject to a copayment requirement, pay applicable TennCare cost share responsibilities prior to receiving non-emergency services. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

A.11.5. g. Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;

A.11.5. h. Specify the amount, duration and scope of services to be provided by the provider;

A.11.5. i. Provide that emergency services for eligible enrollees aged 0-20 be rendered without the requirement of prior authorization of any kind. Retrospective review/authorization will be required.

A.11.5. j. If the provider performs laboratory services, the provider must meet all applicable requirements of the Clinical Laboratory Improvement Act (CLIA) of 1988 at such time that CMS (formerly HCFA) mandates the enforcement of the provisions of CLIA;

A.11.5. k. Require that an adequate record system be maintained for recording services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement). Enrollees and their representatives shall be given access to the enrollees' dental records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When a patient-provider relationship with a TennCare provider ends and the enrollee requests that dental records be sent to a second TennCare provider who will be the enrollee's primary dentist, the first provider shall not charge the enrollee or the second provider for providing the dental records;

A.11.5. l. Require that any and all records be maintained for a period not less than five (5) years from the close of the agreement and retained further if the records are under review or audit until the review or audit is complete. Said records shall be made available and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of authorized representative of the Contractor or TennCare and authorized federal, state and Comptroller personnel;

A.11.5.m. Provide that TennCare and the U.S. Department of Health and Human Services shall have the right to evaluate through inspection, whether announced or unannounced, or other means any records pertinent to this Contract including quality, appropriateness and timeliness of services and such evaluation, and when performed, shall be performed with the cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records;

A.11.5.n. Provide for monitoring, whether announced or unannounced, of services rendered to enrollees sponsored by the Contractor;

A.11.5.o. Whether announced or unannounced, provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and appeal procedures established by the Contractor and/or TennCare;

A.11.5. p. Specify that the Contractor shall monitor the quality of services delivered under the agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TennCare;

A.11.5. q. Require that the provider comply with corrective action plans initiated by the Contractor or be subject to recoupment of funds, termination or other penalties determined by TennCare;

A.11.5. r. Provide for submission of all reports and clinical information required by the Contractor;

A.11.5.s. Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Section E-18 of this Agreement;

A.11.5. t. Provide the name and address of the official payee to whom payment shall be made;

A.11.5. u. Make full disclosure of the method and amount of compensation or other consideration to be received from the Contractor;

A.11.5. v. Provide for prompt submission of information needed to make payment;

A.11.5. w. Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in T.C.A. 56-32-226 and Section A.13.3 of this Agreement;

A.11.5.x. Specify the provider shall accept payment or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the enrollee's third party payor) plus the amount of any applicable 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 cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the patient being served;

A.11.5.y. Specify that at all times during the term of the agreement, the provider shall indemnify and hold TennCare harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TennCare and the Contractor. This indemnification may be accomplished by incorporating Section 4-20 of the TennCare/MCO Agreement available at http://www.tennessee.gov/TennCare/providers/TCBHOMCO.html in its entirety in the provider agreement or by use of other language developed by the Contractor and approved by TennCare.

A.11.5.z. Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the Plan's enrollees and the

Contractor under the agreement. The provider shall provide such insurance coverage at all times during the agreement and upon execution of the provider agreement furnish the Contractor with written verification of the existence of such coverage;

A.11.5.aa. Specify both the Contractor and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the health plan;

A.11.5.bb. Provide that any changes in applicable federal and state laws, TennCare rules and regulations or court orders, and revisions of such laws or regulations shall be followed as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the Contractor and provider agree to negotiate further any amendment as may be necessary to correct any inequities;

A.11.5.cc. Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc);

A.11.5.dd. Specify that both parties recognize that in the event of termination of this Agreement between the Contractor and TennCare for any of the reasons described in Section E. 5 of this Agreement, the provider shall immediately make available, to TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the Contractor/provider agreement. The provision of such records shall be at no expense to TennCare;

A.11.5.ee. Include provisions for resolution of disputes either by arbitration or another process mutually agreed to by the parties. Specify the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve non-emergency claims denied in whole or in part by the Contractor as provided at T.C.A. 56-32-226(b).

A.11.5.ff. Specify that the provider shall be required to accept TennCare reimbursement amounts for services provided under the agreement between the provider and Contractor to TennCare enrollees and shall not be required to accept TennCare reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the Contractor.

Specify that the Contractor shall give providers prior written notice of a determination that a reduction in the provider fee schedule is necessary to remain within the maximum liability of this Contract and further, specify that the Contractor shall give providers thirty (30) days prior written notice of said reductions and the provider shall agree to the adjusted rates;

A.11.5.gg. Specify that the provider must adhere to Quality of Care Monitors established by TennCare and Contractor and reviewed by the EQRO on an annual basis. The Quality of Care Monitors shall be attached to the provider agreement or specify in the agreement that it will be provided separately.

A.11.5.hh. Specify that a provider shall have at least, but no more than one hundred and twenty (120) calendar days from the date of rendering a health care service to file an initial claim with the Contractor except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the Contractor receives notification from TennCare of the enrollee's eligibility;

A.11.5.ii. Specify that the provider will comply with the appeal process including but not limited to assisting an enrollee by providing appeal forms and contact information including the appropriate address for submitting appeals for state level review;

A.11.5.jj. Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules, subsequent amendments, or any and all Court Orders;

A.11.5.kk. 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;

A.11.5.ll. All provider agreements must include language which informs providers of the package of benefits that EPSDT offers and the periodicity schedule with which those benefits must be provided. All provider agreements must contain language that references the EPSDT benefit package and periodicity schedule, including the information as described in Section A.16 of this Contract, or includes language that states those requirements.

A.11.5.mm. All provider agreements must include a provision which states that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TennCare ; and

A.11.5.nn. 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.

A.11.5. oo The Contractor shall give TennCare and the Tennessee Department of Commerce and Insurance, TennCare Division, immediate notification in writing by Certified Mail of any administrative or legal action or complaint filed regarding any claim made against the Contractor by a provider or enrollee which is related to the Contractor's responsibilities under this Contract, including but not limited to notice of any arbitration proceedings instituted between a provider and the Contractor. The Contractor shall ensure that all tasks related to the provider agreement are performed in accordance with the terms of this Contract.

A.11.5. pp Specify that the provider warrants that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractors, or consultant to the provider in connection with any work contemplated or performed relative to the agreement unless otherwise

authorized by the Commissioner, Tennessee Department of Finance and Administration.

A.11.5.qq. Specify that the provider 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 agreement or in the employment practices of the provider on the grounds of disability, age, race, color, religion, sex, national origin, economic status, payment source, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.

A.11.5.rr. Contracts must comply with requirements set forth in the BBA 1997 in 422.208 and 422.210 as it applies to physician incentive plans.

A.11.5.ss. The Contractor shall have in place written policies and procedures for the selection and/or retention of providers and policies and procedures must not discriminate against particular provider that service high risk populations or specialize in conditions that require costly treatment.

A.11.5.tt. The Contractor shall not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. The Contractor's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination.

A.11.5.uu. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

A.11.5.vv. The Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.

i. for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
ii. for any information the enrollee needs in order to decide among all relevant treatment options;
iii. for the risks, benefits, and consequences of treatment or non-treatment; and
iv. for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

A.11.6. Section A.11 shall not be construed to:

A.11.6.a. Require the Contractor to contract with providers beyond the number necessary to meet the needs of the enrollees.

A.11.6.b. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollees

A.12 SUBCONTRACTORS

A.12.1. Legal Responsibility. The Contractor shall be responsible for the administration and management of all aspects of this Agreement and the health plan covered thereunder. If the Contractor elects to utilize a subcontractor, the Contractor shall assure that the subcontractors shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractors for purposes of this Agreement, without approval of the Contractor. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the Contractor to TennCare to assure that all activities under this Agreement are carried out. Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the Contractor provided the services directly (i.e. no balance billing by providers). Contractor must ensure that it evaluates each prospective subcontractor's ability to perform the activities to be delegated and must specify in a written agreement with the subcontractors the activities and report responsibilities delegated to the subcontractors. Contractor must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. The Contractor's written agreement with the subcontractors must address the methodology for identifying deficiencies and providing corrective action plans.

A.12.2 Prior approval. All subcontracts and revisions thereto shall be approved in advance by TennCare. All subcontracts shall be maintained in accordance with the applicable terms of this Agreement. Once a subcontract has been executed by all of the participating parties, a copy of the signature page of the pre- approved contract fully executed subcontract shall be sent to the State within 30 days of execution.

A.12.3. Quality of Care Monitors. If the subcontract is for the purpose of securing the provision of enrollee benefits, the subcontract must specify that the subcontractors must adhere to the Quality of Care Monitors included in the Agreement as Attachment IV. The Quality of Care Monitors shall be included as part of the subcontract between the Contractor and the subcontractors or provided separately at the time the subcontract is executed, provided however, if the Quality of Care Monitors is not included in the subcontract, it shall be referenced in the agreement as being provided separately upon execution of the subcontract.

A.12.4. Limited English Proficiency (LEP) Provisions. The Contractor shall provide instruction for all direct service sub-Contractors regarding the Contractor's written procedure for the provision of language interpretation and translation services for enrollees with Limited English Proficiency.

A.12.5. Assignability. Claims processing subcontracts must include language that requires that the subcontract agreement shall be assignable from the Contractor to the State, or its designee: i) at the State's discretion upon written notice to the Contractor and the affected subcontractors; or ii) upon Contractor's request and written approval by the State. Further, the subcontract agreement must include language by which the subcontractors 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.

A.12.6. Claims Processing. All claims for services furnished to a TennCare enrollee filed with the Contractor must be processed by either the Contractor or by one (1) subcontractors retained by the organization for the purpose of processing claims.

A.12.7. HIPAA Requirements. The Contractor shall require all its subcontractors adhere to the HIPAA regulation requirements.

A.12.8. Notice of Subcontractor Termination. When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated between the Contractor and a subcontractors, the Contractor shall give at least thirty (30) days prior written notice of the termination to TennCare and the TennCare Division, TDCI. Such notice shall include, at a minimum, a Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide TennCare with a transition plan, when requested, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees, etc. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated damages or intermediate sanctions as described in Attachment I and Section E.4. of this Agreement. TennCare reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

A.12.9. Notice of Approval. Approval of subcontracts shall not be considered granted unless TennCare issues its approval in writing.

A.12.10. Subcontract Relationship and Delegation: If the Contractor delegates responsibilities to a subcontractors, the Contractor shall assure that the subcontracting relationship and subcontracting document(s) comply with the requirements of the Balanced Budget Act of 1997, including but not limited to, compliance with the applicable provisions of 42CFR 438.230(b) and 42 CFR 434.6 as described below:

A.12.10.a. The Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

A.12.10.b. The Contractor shall require that the agreement be in writing and specifies the activities and report responsibilities delegated to the subcontractors, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

A.12.10.c. The Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review consistent with industry standards or State MCO laws and regulations.

A.12.10.d. The Contractor shall identify deficiencies or areas for improvement and the Contractor and the subcontractors shall take corrective action as necessary.

A.13 CLAIMS PROCESSING REQUIREMENTS

The Contractor shall have in place, an automated claims processing system capable of accepting and processing paper claims and claims submitted electronically. The Contractor shall process, as described herein, the provider's claims for covered benefits provided to enrollees consistent with applicable TennCare policies and procedures and the terms of this Agreement. Contractor shall also participate in TennCare efforts to improve and standardize billing and payment procedures.

A.13.1. Electronic Billing System. Contractor shall maintain an electronic data processing system for Claims payment and processing and shall implement an electronic billing system for interested Participating Dental Providers. All Participating Dental Providers should be strongly encouraged and provided the training necessary to submit their claims electronically. The Contractor or any entities acting on behalf of the Contractor shall not charge providers for filing claims electronically. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The Contractor shall comply at all times with standardized paper billing forms/format as follows:

Claim Type	Claim Form
Dental	*ADA*

The Contractor shall not revise or modify the standardized form or format itself. Further, the Contractor agrees to adopt national EMC standards and standardized instructions and definitions that are consistent with industry norms for the forms identified above when developed by TennCare in conjunction with appropriate workgroups.

A.13.2. HIPAA. The Contractor agrees to comply with the Health Insurance Portability and Accountability Act (HIPAA). Further, the Contractor agrees that at such time that TennCare, in conjunction with appropriate work groups presents recommendations concerning claims billing and processing that are consistent with industry norms, the Contractor shall comply with said recommendations within one hundred and eighty (180) days from notice by TennCare to do so.

A.13.3 Timeliness and Accuracy of Payment. The Contractor agrees to comply with prompt pay claims processing requirements in accordance with TCA 56-32-226. Contractor shall ensure that ninety percent (90%) of claims for payment of services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of receipt of such claims. The Contractor shall process, and if appropriate pay, within sixty (60) days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program. "Pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to Contractor. "Process" means the Contractor must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. If requested by the provider, the Contractor shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment. The status report shall contain appropriate explanatory remarks related to payment or denial of the claims.

The Contractor shall contract with independent reviewers for the purposes of said reviewers to review disputed claims as provided by T.C.A. 56-32-226.

Failure to comply with the aforementioned claims processing requirements shall result in the Contractor being required to implement a corrective action plan and shall result in the application of liquidated damages and/or immediate sanctions as described in Section E.4 and Attachment I of this Contract.

A.13.4 Except where required by the Contractor's Agreement with TennCare or by applicable federal or state law, rule or regulation, the Contractor shall not make payment for the cost of any dental care provided prior to the effective date of eligibility in the Contractor's plan. The Contractor shall make payment for the cost of any covered services obtained on or after 12.01 a.m. on the effective date of eligibility in the Contractor plan.

A.13.5 When eligibility has been established by TennCare and the enrollee has incurred dental expenses that are covered benefits within the plan, the Contractor shall make reimbursement for the dental services at the regular negotiated rate if the service was provided by a contract provider. If the service was provided by a non-contracted provider, whom the Contractor has agreed to pay only for a specific service, the Contractor shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure. The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor or appropriate denial made by the Contractor.

A.14 MANAGEMENT INFORMATION SYSTEMS REQUIREMENTS

A.14.1 Data mapping. The Contractor shall complete all data mapping necessary to submit information to TennCare and respond to information provided by TennCare. This will consist of a cross-reference map of required TCMIS data and Contractor system data elements and data structures. TennCare will make any necessary data formats available to the Contractor.

A.14.2. Daily enrollment updates. The Contractor must have a procedure to maintain and update enrollee profiles that is capable of processing daily updates.

A.14.3. Contractor MIS Interface Requirements. Successful operation of the program requires ongoing interfaces with TCMIS and the Contractor MIS. The TennCare interface standard for data transfers will be via FTP with 36 track compressed cartridges for backup contingency, initial file loads and TennCare selected communications.

In order to ensure the security and confidentiality of all transmitted files, the Contractor must have a system that establishes a dedicated communication line connecting TCMIS to the Contractor's processing site. The cost of this communication line is to be borne solely by the Contractor. This dedicated communication line must meet the following specifications of the TennCare Bureau, OIR and the State of Tennessee:

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

ii. Contact TennCare's Director of Information Services before placing all line orders.

iii. Contractor is responsible for providing compatible mode table definitions and NCP configurations for all non-standard system gens.

iv. Contractor is responsible for supplying both host and remote modems for all non-State initiated circuits.

v. Dial-up access into production regions is prohibited.

A.14.4 Readiness Review. Immediately upon identification of Contractor, TennCare will work with Contractor to ensure that their processing system satisfies the functional and informational requirements of Tennessee's TennCare dental program. The Contractor will assist TennCare in the analysis and testing of the information systems and claims processing requirements prior to the delivery or services. The Contractor must provide system access to allow TennCare to test the Contractor's system through the TennCare network. Any software or additional communications network required for access will be provided by the Contractor.

A.14.5 Provider Assistance. The Contractor must be available Monday thru Friday, 7:00 am – 5:00 pm Central Standard Time (CST)/ Central Daylight Savings Time to respond to provider inquiries related to prior approval and claims status.

A.14.6. Help Desk for Prior Approval Operations. The Contractor will maintain toll-free telephone access to support the prior approval process. This Help Desk must be available between the hours of 7:00 a.m. and 5:00 pm, Central Standard Time/ Central Daylight Savings Time, Monday through Friday to respond to questions about Prior Approval Requests.

A.14.7. Data Validation Edits and Audits. The Contractor's claims processing system must perform the following validation edits and audits:

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

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

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

iv. Covered Service - The system must verify that a service is a valid covered service and is eligible for payment under the TennCare dental benefit for that eligibility group.

v. Provider Validation - The system must approve for payment only those claims received from providers eligible to provide dental services.

vi. Recipient Validation - The system must approve for payment only those claims for recipients eligible to receive dental services at the time the service was rendered.

vii. Eligibility Validation – The system must confirm the enrollee for whom a service was provided was eligible on the date the service was incurred.

viii. Quantity of Service - The system must validate claims to assure that the quantity of services is consistent with TennCare rules and policy.

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

x. Managed Care Organizations - The system must reject claims that should rightly be processed and paid by an enrollee's MCO for any and all physical health treatments.

A.14.8. Prior Approval Request Tracking. Each prior approval request processed by the Contractor will be assigned a unique number and be maintained in a database designed by the Contractor that will contain all pertinent information about the request and be available to Help Desk staff. This information will include, but not be limited to: provider, recipient, begin and end dates, covered service, request disposition (i.e., approved or denied).

A.14.9. System Security. The Contractor will apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and to communicate the results in a Information Security Plan provided prior to the delivery of services. The risk analysis will also be made available to appropriate Federal agencies.

The following specific security measures should be included in the system design documentation and operating procedures:

i. Computer hardware controls that ensure acceptance of data from authorized networks only.
ii. At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes.
iii. Manual procedures that provide secure access to the system with minimal risk.
iv. Multilevel passwords, identification codes or other security procedures that must be used by State agency or Contractor personnel.
v. All Contractor MIS software changes are subject to TennCare approval prior to implementation.
vi. System operation functions must be segregated from systems development duties.

A.14.10 Disaster Preparedness and Recovery at the Automated Claims Processing Site. The Contractor must submit evidence that they have a Business Continuity/Disaster Recovery plan for their Central Processing Site. If requested, test results of the plan must be made available to TennCare. The plan must be able to meet the requirements of any applicable state and federal regulations, the TennCare Bureau and Tennessee's OIR.

The Contractor's Business Continuity/Disaster Recovery Plan must include sufficient information to show that they meet the following requirements:

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

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

iii. Smoking must be prohibited at the site.

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

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

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

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

A.14.11 Transition Upon Termination Requirements. At the expiration of this Contract, or if at any time the state should terminate this Contract, the Contractor will cooperate with any subsequent Contractor who might assume administration of the dental benefits program. TennCare will withhold final payment to the Contractor until transition to the new Contractor is complete. The state will give the Contractor thirty (30) days notice that a transfer will occur.

In the event that a subsequent Contractor is unable to assume operations on the planned date for transfer, the Contractor will continue to perform MIS operations on a month to month basis for up to six months beyond the planned transfer date.

A.15 COVERED BENEFITS

A.15.1 Covered Benefits: The Contractor shall provide or arrange for the provision of Covered Benefits to members in accordance with the terms of this Agreement, including but not limited to, Section A.1.2 of this Agreement.

A.15.2 Medical Necessity. The determination of medical necessity shall be made on a case by case basis. The Contractor shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The Contractor shall have the ability to place tentative limits on a service; however, such limits shall be exceeded when medically necessary based on a patient's individual characteristics. Any procedures used to determine medical necessity shall be consistent with the following definition.

Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:

i. Consistent with the symptoms or diagnosis and treatment of the enrollee's condition, disease, ailment or injury; and
ii. Appropriate with regard to standards of good dental practice; and
iii. Not solely for the convenience of an enrollee, dentist, institution or other provider; and
iv. The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and
v. When applied to enrollees under 21 years of age who are eligible for EPSDT, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
vi. is no more restrictive than the State Medicaid program and
vii. addresses the extent to which the Contractor is responsible for covering services related to the following:
   - The prevention, diagnosis and treatment of health impairments.
   - The ability to achieve age-appropriate growth and development
   - The ability to attain, maintain, or regain functional capacity

A.15.3. EPSDT. The Contractor shall provide Early, Periodic Screening, Diagnostic and follow-up Treatment services as medically necessary to children under the age of twenty-one, who are eligible for EPSDT, in accordance with federal regulations as described in 42 CFR part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21, whether or not such services are covered under the TennCare Program state plan and without regard to any service limits otherwise established in this Contract. This requirement shall be met by either direct provision of the service by the Contractor or by referral, when appropriate, in accordance with 42 CFR 441.61.

A.15.4 Standards of Care. Standards of care shall be taken from published recommendations of nationally recognized authorities such as; The American Dental Association, The American Academy of Pediatric Dentistry and the American Association of Oral and Maxillofacial Surgeons. The standard of care for the community will also be recognized. Participating Dental Providers shall not differentiate or discriminate in the treatment of any member on the basis of race, color, sex, religion, national origin, age, handicap, health, economic status or payment source.

A.15.5 Transportation. Transportation to covered services is a covered service for TennCare members and is the responsibility of the member's MCO. Should transportation to a dental service be necessary for a member, Contractor will coordinate with the MCO to ensure that the transportation is provided.

A.15.6 Coordination with Public Health. Contractor will work closely and cooperatively with the Health Department(s) to accomplish the goals of their School Based Screening Referral, Follow-up, Sealant and TennCare Oral Evaluation and Outreach Program for Children targeting approximately 230,000 children. Identification of children with urgent dental needs as well as identification of children with unmet needs will require Contractor to arrange care for these children according to the access standards identified in Section A.4. of this Agreement. Close coordination between the Oral Health Services Section of the Tennessee Department of Health and the Contractor will be necessary to facilitate referral arrangements and to ensure that encounter data files from the SBDPP are incorporated into encounter data files provided to TennCare.

A.16 EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

A.16.1. EPSDT Dental Services. Contractor shall require Dental Providers to follow practice guidelines for preventive health services identified by TennCare including early periodic screening, diagnosis and treatment services (EPSDT). EPSDT includes timely provision of exams, cleaning, fluoride treatment, sealants and referral for treatment of Child Members. Performance objectives have been established for providing EPSDT services. Contractor will be evaluated on those performance objectives using the annual CMS 416 report which measures the following: any dental service provided using ADA CDT5 codes D0100-D9999; preventive dental services provided using ADA CDT5 codes D1000-D1999 and dental treatment services provided using ADA CDT5 codes D2000-D9999.

A.16.2. Contractor's Outreach Activities. The Contractor shall conduct regularly scheduled outreach activities designed to educate enrollee's about the availability of EPSDT services and to increase the number of children receiving services. Within 45 days of execution of this Agreement, the Contractor shall submit a proposed outreach plan. The Contractor's plan shall identify the target population, service areas, specific outreach activities, schedule for completion and include copies of any material to be released to enrollees. The outreach plan shall be updated at least annually. The proposed plan and any related material shall require approval by TennCare. TennCare shall have thirty (30)

days to review material and provide notice of approval or notice to make changes. TennCare may require the Contractor to coordinate its efforts with outreach projects being conducted by TennCare or other state agencies. The Contractor shall submit an annual report to TennCare identifying results of its outreach activities.

Failure to comply with the requirements of this Section may result in the application of intermediate sanctions or liquidated damages as provided in Section E.4. and Attachment I of this Agreement.

A.17 APPEAL SYSTEM REQUIREMENTS

All enrollees shall have the right to file appeals regarding adverse actions taken by the Contractor. For purposes of this requirement, appeal shall mean an enrollee's right to contest verbally or in writing, any adverse action taken by the Contractor to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness, or availability of such benefits. The Contractor must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider must be in writing. The Contractor shall provide written materials, reviewed and approved by TennCare, informing enrollees of their appeal rights. The Contractor must notify enrollees in writing of any decision to deny a service authorization request, or to authorize an amount, duration, or scope less than requested. The Contractor shall have appeal procedures in accordance with TennCare rule 1200-13-12-.11 or any applicable TennCare rules, subsequent amendments, or subsequent Court Orders governing the appeals process

A.17.1. Appeals. The Contractor's appeal process shall include, at a minimum, the following:

A.17.1.a The Contractor shall have a contact person appointed. Said person will be knowledgeable of appeal procedures and direct all appeals whether the appeal is verbal or the enrollee chooses to file in writing. Should an enrollee choose to appeal in writing, the enrollee will be instructed to file via mail to the designated P. O. Box for appeals related to the Contractor;

A.17.1.b There shall be sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of Adverse Actions Affecting a TennCare Program Enrollee. Staff shall be knowledgeable about applicable state and federal law and all court orders governing appeal procedures, as they become effective. This shall include, but not be limited to, appointed staff members and phone numbers identified to TennCare where appropriate staff may be reached;

A.17.1.c Staff shall be educated concerning the importance of the procedure and the rights of the enrollee and the timeframes in which action must be taken by the Contractor regarding the handling and disposition of an appeal;

A.17.1.d. The appropriate individual or body within the Contractor organization having decision-making authority as part of the appeal procedure shall be identified;

A.17.1.e. The Contractor shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Furthermore, appeal forms shall be available at each service site and by contacting the Contractor. However, enrollees shall not be required to use an appeal form in order to file an appeal;

A.17.1.f. Upon request, the enrollee shall be provided a TennCare approved appeal form(s);

A.17.1.g. All appellants shall have the right to reasonable assistance by the Contractor during the appeal process and must be informed of the rules that govern representation;

A.17.1.h. TennCare may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to enrollees, which shall be followed by the Contractor, if TennCare determines that it is in the best interest of the TennCare Program or if necessary to comply with federal or judicial requirements. However, Contractor shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, Contractor shall not be required to comply with such guidelines or rules during any period of such inapplicability.

A.18 QUALITY OF CARE

A.18.1 Quality and Appropriateness of Care. Contractor shall prepare for TennCare approval a written description of a quality monitoring/quality improvement (QM/QI) program, a utilization review program and peer review program to include policies and procedures outlining the objectives, scope, activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of dental services. The written program shall include an outcomes measurement tool for reporting and measuring results. The plan(s) shall describe who is responsible and the role of the Dental Director in utilization review.

A.18.2 QM/QI Meeting Requirements. The Contractor shall provide the TennCare Dental Director with ten (10) days advance notice of all regularly scheduled meetings of the Quality Monitoring/Quality Improvement Committee and Peer Review Committee. To the extent allowed by law, the Dental Director of TennCare, or his/her designee, may attend the QM/QI meetings at his/her option. In addition, written minutes shall be kept of all meetings of the QM/QI Committee. A copy of the written minutes for each meeting shall be forwarded to TennCare as required in Section A.19.6. of this Agreement.

A.18.3 Peer Review Committee. The Contractor shall establish a Provider Peer Review Committee which shall meet regularly (no less than quarterly) to review the processes, outcomes and appropriateness of dental care provided to enrollees. The Contractor will submit the names of proposed members to TennCare within sixty (60) days after the execution date of this Agreement. The Contractor's Dental Director shall be the committee chairperson. The Committee shall include at least five (5) Participating Dental Providers who file at least twenty-five (25) TennCare claims per year. This requirement will be waived for the first six (6) months of the contract period if the Contractor can prove an equivalent mechanism for provider peer review during that period.

a. The Committee shall review and recommend appropriate remedial action for any Participating Dental Provider who has provided inappropriate care.
b. The Committee shall coordinate with TennCare's Office of Quality Assurance regarding imposition of any sanctions against a Participating Dental Provider who has provided inappropriate care, including termination. The Office of Quality Assurance should notify the Tennessee Board of Dentistry when indicated.
c. The Committee shall coordinate with TennCare in regard to issues involving fraud or abuse by any Participating Dental Provider as specified in Section E.32.

d. The Committee shall coordinate with the Dental Benefits Manager and TennCare regarding any issues involving recoupment.

e. The Committee shall review and recommend appropriate action on appeals or inquiries provided by Members, Participating Dental Providers, TennCare or other persons regarding quality of care, access or other issues related to TennCare's Dental Program.

A.18.4 Advisory Committee. The Contractor shall participate in an Advisory Committee empowered to review and make recommendations to the Contractor and TennCare concerning the dental program. The Committee shall meet on a schedule established by TennCare. The Committee shall consist of not more than twenty (20) members, two (2) of whom shall be appointed by the Contractor. The Contractor will submit the names of proposed members to TennCare within sixty (60) days after the execution of the Agreement. TennCare shall appoint all other committee members. Members may be selected from dentists serving TennCare members and other parties interested in improving oral health care in Tennessee. TennCare shall also appoint the committee chairperson. The Committee shall review and make recommendations regarding other policies of Contractor regarding services provided under this Agreement.

A.18.5. Credentialing. Contractor is responsible for ensuring that dentists and other oral health professionals, who are under contract to the organization, are qualified to perform their duties. Contractor is responsible for provider selection policies and procedures that cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Contractor is responsible for primary credentialing of providers in accordance with specifications outlined in Attachment IV, Standard IX. If there are changes made to the TennCare credentialing process that are outside the scope of existing contracts, the Contractor will be notified and those additional requirements would have to be satisfied at the Contractor's next scheduled re-credentialing of the provider or when a new provider is added.

A.18.6 Performance Reviews. Contractor shall cooperate with any performance review conducted by TennCare, including providing copies of all records and documentation arising out of Contractor's performance of obligations under the Agreement. Upon reasonable notice, TennCare may conduct a performance review and audit of Contractor to determine compliance with the Agreement. At any time, if TennCare identifies a deficiency in performance, the Contractor will be required to develop a Corrective Action Plan to correct the deficiency including an explanation of how TennCare members will continue to be served until the deficiency is corrected.

A.19. REPORTING REQUIREMENTS

A19.1 Data Base. In order to meet information system requirements and to support the timely provision of ad hoc report requests that may be made by TennCare, Contractor shall maintain a current data base, in a format acceptable to TennCare, capable of retrieving data on short notice. At a minimum, the database shall include the following data:

Member Name;
Member Identification Number (SSN);
Member MCO;
Dates of Service;
Specific service provided by procedure ADA Code;
Servicing Provider Number (Medicaid #);
Participating Dental Provider Name;
Payment status;

Billed Charge Amount;
Allowed Amount;
Payment Amount;
Received Date;
Payment Date; and
Any other data element required by common dental practice, ADA Guidelines, federal or state law.

Data stored in the database shall be current through the prior week.

A.19.1 Report Requirements. Contractor shall provide to TennCare a Monthly Claim Activity Report, a Monthly Batch Claim Operations Report, a Monthly Encounter Data Report, a Monthly Claims Lag Triangle and a Monthly Provider Data Report with the data elements and in the format and medium (including electronic) requested by TennCare. Record layout and other information about report submission is available at the TennCare Information Systems Library. Contractor shall also provide such additional reports, or make revisions in the data elements or format of the reports upon request of TennCare without additional charge to TennCare. TennCare shall provide written notice of such requested revisions of format changes in a Notice of Required Report Revisions. Contractor shall maintain a data gathering and storage system sufficient to meet the requirements of this Agreement. TennCare may impose liquidated damages or monetary sanctions under Section E.4 and Attachment I of the Agreement based upon Contractor's failure to timely submit Standard Reports in the required format and medium. In addition, Contractor shall provide the following reports:

A.19.2 Referral Time. Contractor shall submit a monthly report on the number of requests for assistance to obtain an appointment as specified in Section A.6.4. The first report under this Agreement, covering the month of January 2006, shall be due on February 28, 2006. Thereafter, reports shall be due thirty (30) days after the end of each calendar month. The report shall provide sufficient information to allow TennCare to determine the number of requests by county and the time required to locate a Participating Dental Provider willing to serve the Member who is seeking an appointment for Covered Services.

A.19.3 Audited Financial Statements and Income Statements. Contractor shall provide to TennCare copies of its annual audited financial statements no later than ninety (90) days after the end of the calendar year and Quarterly Income Statements no later than thirty (30) days after the end of each calendar quarter.

A.19.4 EPSDT Outreach Reports. Contractor shall provide an annual EPSDT Outreach Report that describes the outreach activities completed in the preceding year, results of those activities, lessons learned, and how future activities will be modified to incorporate lessons learned.

A.19.5 Response Time Reports. Contractor shall provide TennCare with a monthly report of response times on Contractor's Member Services and Provider Services telephone lines. The target answer time for these lines is 30 seconds and the benchmark will be 60 seconds. The first report will be due for the month of January 2006 and will be due by February 28, 2006. Thereafter, reports will be due thirty (30) days after the end of the calendar month.

A.19.6. Meeting Reports. Contractor shall submit the minutes of its Utilization Review Committee meetings, Quality Assurance Committee meetings and the Peer Review Committee meetings on a calendar quarter basis, due thirty (30) days after the end of each quarter. If no meetings occurred during the quarter, that fact shall be reported.

A.19.7 Non-discrimination Compliance Information. The Contractor shall demonstrate compliance with Federal and State regulations of Title VI of the Civil Rights Act of 1964 as outlined in Attachment III.

A.19.8 Satisfaction Surveys. Contractor shall conduct, at a minimum, an annual Member Satisfaction Survey and an annual Provider Satisfaction Survey. The Contractor shall obtain approval from TennCare prior to conducting Member and Provider Satisfaction Surveys. Further, the Contractor shall submit a report to TennCare identifying key findings.

A.19.9 Public Filings. Contractor shall promptly furnish TennCare with copies of all public filings, including correspondence, documents and all attachments on any matter arising out of this Agreement.

A.19.10 Enrollee Cost Share Reporting: The Contractor shall report enrollee cost-sharing liabilities on a quarterly basis in the manner and form described by TennCare.

A.20 ENROLLMENT AND DISENROLLMENT

A.20.1. Enrollment. TennCare is responsible for the enrollment of enrollees in the Contractor's plan.

a. The Contractor shall accept daily eligibility data from the State (DCS or TennCare Select for Immediate eligibility for children in state custody).

b. The Contractor shall accept the enrollee in the health condition the enrollee is in at the time of enrollment.

c. Enrollment shall begin at 12:01 a.m. on the effective date that the enrollee is enrolled in the Contractor's plan and shall end at 12:00 midnight on the date that the enrollee is disenrolled pursuant to the criteria in TennCare policy and/or TennCare rules and regulations. Women who are determined presumptively eligible are given immediate TennCare eligibility and a temporary identification form to confirm eligibility pending the issuance of a regular identification card by their selected MCO. The purpose of this temporary identification/eligibility confirmation form is to enable the women to access prenatal care at the earliest possible time. The Contractor shall be responsible for arranging for the provision of services and payment of all covered services during presumptive period of enrollment. In order to give children entering into DCS custody adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility, the Contractor shall accept notice from DCS and/or TennCare Select of TennCare "immediate" eligibility. If the child is not currently enrolled, the Contractor shall immediately build a forty-five (45) day eligibility record effective on the date the child was placed in state custody and identify the child as a child in state custody. The Contractor shall be responsible for arranging for the provision of services and payment of all covered services during immediate eligibility period of enrollment.

In regards to EPSDT reporting, the Contractor will continue to only report on those children whose TennCare eligibility status is permanent, who are assigned to the DBM.

A.20.2. Disenrollment. TennCare is responsible for the disenrollment of enrollees from the Contractor's plan. The Contractor shall not disenroll enrollees. The Contractor, may, however, provide TennCare with any information it deems appropriate for TennCare'S

use in making a decision regarding loss of eligibility or disenrollment of a particular Member.

a. No enrollee shall be disenrolled from a health plan for any of the following reasons: Adverse changes in the enrollee's health; Pre-existing medical conditions; High cost medical bills, a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); or Failure or refusal to pay applicable cost-sharing fees, except when TennCare has approved such disenrollment.

b. The Contractor's responsibility for disenrollment shall be to inform TennCare promptly when the Contractor knows or has reason to believe that an enrollee may satisfy any of the conditions for disenrollment described in TennCare policy and/or TennCare rules and regulations.

Actions taken by TennCare cannot be grieved by the Contractor.

A.21 THIRD PARTY LIABILITY

A.21.1. The Contractor may not withhold payment for services provided to a member if third party liability or the amount of liability cannot be determined, or payment will not be available within a reasonable time.

A.21.2. All funds recovered from third parties will be treated as offsets to claims payments.

A.21.3 The Contractor shall provide any information necessary to assist and shall cooperate in any manner necessary as requested by TennCare, with a Cost Recovery Vendor at such time that TennCare acquires said services.

A.21.4 If the Contractor has determined that third party liability exists for part or all of the services administered directly by the Contractor the Contractor shall make reasonable efforts to recover from third party liable sources the value of services rendered. This may be accomplished through the Contractor's provider network and does not require the Contractor to directly recover from third party sources.

A.21.5 If the Contractor has determined that third party liability exists for part or all of the services provided to an enrollee by a provider, the Contractor shall pay the provider only the amount, if any, by which the provider's allowable claim exceeds the amount of third party liability.

A.21.6 Cost sharing responsibilities permitted pursuant to Section A.1.3 of this Agreement shall not be considered third party resources for purposes of this requirement.

A.21.7 The Contractor shall provide third party resource (TPR) data to any provider having a claim denied by the Contractor based upon a TPR.

A.21.8 Third party resources shall include subrogation recoveries. The amount of any subrogation recoveries collected by the Contractor outside of the claims processing system shall be the property of the State. On a monthly basis, the Contractor shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported.

A.22 PROVIDER PAYMENT

A.22.1 Provider Payment Process

a. Dental Service Payments. The Contractor is not at financial risk for the provision of covered benefits to enrollees. The Contractor shall prepare checks for payment on at least a weekly basis, unless an alternative payment schedule is approved by TennCare. The Contractor shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 48 hours in advance of distribution of provider checks. The State shall release funds in the amount to be paid to the providers to the Contractor. Funds shall be released within 48 hours of receipt of notice. In turn, the Contractor shall release payments to providers within 24 hours or receipt of funds from the State.

b. Interest. Interest generated from the deposit of funds for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the Contractor's bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.

c. Subrogation Recoveries. The amount of provider payments specified in Section A.22.1.a shall be net of third party recoveries captured on the Contractor's claims processing system prior to notification of TennCare of the amount to be paid. The amount of any subrogation recoveries collected by the Contractor outside of the claims processing system shall be the property of the State. On a monthly basis, the Contractor shall report to the State the amount of any subrogation recoveries collected outside the claims processing system during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported.

d. IRS Form 1099. Contractor shall prepare and mail Internal Revenue Service ("IRS") Form 1099 on behalf of Providers who receive payments under this Agreement. Contractor shall provide a hard copy and, if requested, a magnetic tape transfer of Form 1099 information to TennCare for subsequent delivery to the entity responsible for reporting such Form 1099 information to the IRS.

e. Service Dates. Except where required by the Contractor's Agreement with TennCare or by applicable federal or state law, rule or regulation, the Contractor shall not make payment for the cost of any medical care provided prior to the effective date of eligibility in the Contractor's plan. The Contractor shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the Contractor's plan.

f. Covered Services. The State shall only assume responsibility for payment of providers for the provision of covered services as specified in Section A.1.2 of this Agreement and payment of providers or enrollees in response to a directive from TennCare or an Administrative Law Judge. Otherwise, in the event the Contractor makes payment for a non-covered service, the State shall not be responsible for the payment of said service.

g. Cost-Sharing. Payments for covered services specified in Section A.1.2 shall not include payment for enrollee cost-sharing amounts.

A.22.2 Allowable Rates .TennCare has established the fee schedule for this contract which is attached at Attachment VI. Claims will be paid at the lesser of billed charges or the TennCare fee schedule. Contractor shall not deviate from the approved reimbursement rates, unless TennCare provides written permission to do so.

A.23 FINANCIAL REQUIREMENTS

If during the life of this Agreement, TennCare directs the Contractor to operate as a risk-bearing entity for dental services, the Contractor shall establish and maintain all financial reserves required by the Tennessee Department of Commerce and Insurance of HMOs, Third Party Administrator or Prepaid Limited Health Services Organizations licensed by the State of Tennessee, including, but not limited to, the reserves required by Tennessee Code Annotated, Section 56-32-212 as amended or Section 56-51-136 as amended. The Contractor shall demonstrate evidence of its compliance with this provision to the Tennessee Department of Commerce and Insurance, TennCare Division, in the financial reports filed with that Department by the Contractor. The Contractor must notify the State of any person or corporation that has 5% or more ownership or controlling interest in the entity and such person or corporation must submit financial statements. The Contractor, unless a Federally Qualified HMO, must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the debts if the entity becomes insolvent.

A.24. PERFORMANCE OBJECTIVES

A.24.1 Administration and Management

The following performance indicators related to administration and management have been identified for on-going monitoring. The Contractor's failure to meet these benchmarks shall result in the Contractor being required to implement a corrective action plan or application of intermediate sanctions or liquidated damages as specified in Section E.4 and Attachment I of this Agreement.

Claims Payment Accuracy	Monthly Claims Activity Report	# of claims paid accurately upon initial submission	100 percent	97% accuracy upon initial submission
Approximate Waiting Time for Provider Response	Monthly Response Time Report	Average response time on provider services line	Average response time of 30 seconds	Average response time of 60 seconds
Abandonment rate for Member Services lines	Monthly Response Time Report	Percent of calls not answered; callers hang up while in queue	0 percent	Less than 5 percent of calls not answered
Approximate Waiting Time for Member Response	Monthly Response Time Report	Average Response Time on Member Services Line	Average response time of 30 seconds	Average response time of 60 seconds

A.24.2 The following performance indicators related to EPSDT have been identified for on-going monitoring. The Contractor's failure to meet these benchmarks shall result in the Contractor being required to implement a corrective action plan as described in Section A.18.6.

EPSDT	Encounter data; TennCare enrollment data	Dental Screening Percentage (DSP) for TennCare children receiving any dental service age 3 & older divided by TennCare children age 3 and older utilizing CMS 416 Health Screen Methodology.	80% screening	10 Percentage point increase in DSP over previous year, or outreach efforts reasonably calculated to ensure participation of all children who have not received screenings.

A.24.3 Performance Guarantees. The Contractor agrees TennCare may assess penalties for failure to meet the Performance Guarantees specified below in addition to the intermediate sanctions and liquidated damages specified in Section E.4 and Attachment I. Penalties for failure to meet a performance guarantee shall not be passed on to a provider and/or subcontractors unless the penalty was caused due to an action or inaction of the provider and/or subcontractors. All penalties shall be considered an administrative cost to the Contractor.

Network Adequacy	1. Monthly Provider listing	1. Time and travel distance as measured by GeoAccess	1. Provider network includes sufficient numbers and geographical disbursement of providers in order to satisfy the Terms and Conditions for Access of the TennCare Waiver	1. $25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis. The penalty may be lowered to $5,000 in the event that the Contractor provides a corrective action plan that is

				accepted by TennCare
	2. Most recent monthly provider listing and random phone surveys conducted by TennCare on a quarterly basis	2. Network validation	2. At least 90% of records for participating providers on the most recent monthly provider listing can be used to contact the provider and confirm the provider is participating in the DBM's network	2. $25,000 if less than 90% of records can be used to contact the provider and confirm participation on a quarterly basis. The penalty may be lowered to $5,000 in the event that the Contractor provides a corrective action plan that is accepted by TennCare, or waived if the Contractor submits sufficient documentation to demonstrate 90% of providers are participating

A. 25. OBLIGATIONS OF THE STATE

A.25.1 Program Rules and Procedures. TennCare shall provide Contractor, as necessary for the Performance of the Contractor obligations, the rules, policies and procedures regarding the benefits and claims payments applicable to coverage under the Dental Program.

A.25.2 Enrollment and Disenrollment. TennCare shall also be responsible for enrollment of eligible persons in the Contractor's plan and for disenrollment of ineligible persons from the Contractor's plan. TennCare will arrange for the Contractor to have updated eligibility information in the form of on-line computer access and will notify the Contractor when TennCare determines that there is any change in an enrollee's demographic information.

A.25.3 Verification of Eligibility. TennCare provides a means for dental providers to verify Member eligibility on line. The Contractor may provide additional means of eligibility verification to its contracted dentists.

A.25.4 Payment to Contractor. TennCare shall pay Contractor pursuant to Section C.1 of this Agreement for Contractor's performance of all duties and obligations hereunder. No additional payment shall be made to Contractor by TennCare for the services required under this Agreement, the RFP, and the Contractor's Proposal, including all attachments.

B. CONTRACT TERM

B.1. Contract Term. This contract shall be effective for the period commencing on October 1, 2005 and ending on September 30, 2008 subject to TennCare Readiness Review approval and approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services and provided there is continuous approval of the TennCare 1115 waiver by the Centers for Medicare and Medicaid Services during this time period. TennCare shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

B.2. Term Extension. TennCare reserves the right to extend this Contract, in increments of one (1) year each, for an additional two (2) years, provided that TennCare notified Contractor in writing of its intention to do so at least ninety (90) days prior to the Contract expiration date. If the extension of the Contract necessitates additional funding beyond that which was included in the original Contract, the increase in TennCare's maximum liability will also be effected through an amendment to the Contract and shall be based upon rates negotiated with the Contractor for the extension period. Extension of the Contract is also contingent upon continuous approval of the TennCare 1115 waiver by the Centers for Medicare and Medicaid Services during these time periods. Renegotiations may be made for good cause, only at the end of the contract period and for modification(s) during the contract period, if circumstances warrant, at the discretion of the State.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Twelve Million Three Hundred Forty-Three Thousand Nine Hundred Eighty Dollars ($12,343,980.00). The Service Rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The Service 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 Service 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.

The maximum liability of the State for compensation and services provided to enrollees under the provider agreements shall be defined annually. At such time that the State's incurred expenditures are projected under this contract to reach fifty percent (50%) of the annual maximum liability for compensation and services provided to enrollees, the Contractor shall notify the State and the Contractor and the State agree to re-evaluate the terms of this Contract to determine if an amendment to this contract is required to

effect adjustments that must be made (provider fee schedule adjustments, etc) in order to assure the maximum liability for the State for compensation and services provided to enrollees is not exceeded.

C.2. Compensation Firm. The Service 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.

C.3. Payment Methodology. The Contractor shall be compensated based on the Service 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. The Contractor shall be compensated based upon the following Service Rates at the conclusion of the readiness review at which time the Contractor transition period will conclude and actual assumption of services from previous Contractor will begin. Beginning January 1, 2006, the Contractor shall be compensated based on a fixed fee per member per month as specified below. Each month payment to the Contractor shall be equal to the number of enrollees certified by TennCare multiplied by the administrative fee for the appropriate enrollee category. The Contractor's payment shall be based on enrollment at the lst day of each month of the contract period. Monthly compensation will not be adjusted upward or downward during the month based on fluctuating eligibility unless the fluctuation is due to a mass transfer of enrollees, in which case the Contractor will be compensated for those individuals on the date of transfer. Payment shall be made by the fifth working day of each month.

EFFECTIVE DATES	* ADMINISTRATIVE FEE PER CHILD (Under Age 21) ELIGIBLE FOR THE FULL DENTAL BENEFIT PACKAGE
October 1, 2005 – September 30, 2008 **	$ .59 pmpm

* PMPM: Per Member Per Month
**Although Contract Effective date is October 1, 2005, actual delivery of services begins January 1, 2006 after conclusion of three month readiness review

RENEWAL OPTION RATES	
October 1, 2008 - September 30, 2010	$ .59 pmpm

*PMPM: Per Member Per Month

C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

C.5. Payment of Invoice. The payment of the invoice by the State shall not prejudice the State's right to object to or question any invoice or matter in relation thereto. Such payment by the State shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

C.6. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this contract, not to constitute proper remuneration for compensable services.

C.7. Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any 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.8. Automatic Deposits. The Contractor shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits) Form." This form shall be provided to the Contractor by the State. Once this form has been completed and submitted to the State by the Contractor all payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee shall be made by Automated Clearing House (ACH). The Contractor shall not invoice the State for services until the Contractor has completed this form and submitted it to the State.

C.9 The Contractor shall allow for periodic review of records to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs incurred are in accordance with this Agreement. The Contractor shall provide the auditor access to all information necessary to perform the examination.

Further, TennCare, the Centers for Medicare and Medicaid Services (CMS), or their agents shall at least annually monitor the operation of the Contractor for compliance with the provisions of this Agreement and applicable federal and state laws and regulations. Such monitoring activities shall include, but are not limited to, inspection of Contractor's facilities, auditing and/or review of all records developed under this Agreement including periodic medical audits, appeals, enrollments, disenrollments, termination, utilization and financial records, reviewing management systems and procedures developed under this Agreement and review of any other areas or materials relevant to or pertaining to this Agreement. Because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes, emphasis will be placed on case record validation during periodic monitoring visits to project sites. TennCare shall prepare a report of its findings and recommendations and require the Contractor to develop corrective action plans as appropriate.

C.10 The Contractor shall maintain all records and files regarding the submission of Claims and corresponding payments for five (5) years and provide data that may be required for regulatory, audit insurance and other business purposes.

D. STANDARD TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Contract until it is approved by the appropriate State officials in accordance with applicable Tennessee State laws and regulations.

D.2. Modification and Amendment. This Contract may be modified only by a written amendment executed by all parties hereto and approved by the appropriate Tennessee State officials in accordance with applicable Tennessee State laws and regulations. This Agreement shall be amended automatically without action by the parties whenever required by changes in state and federal law or regulations. In the event of a Partial Default, the Agreement shall be amended automatically to conform with written notices from TennCare of the Contractor regarding the effect of the Partial Default upon this Agreement. No other modification or change of any provision of the Agreement shall be

made or construed to have been made unless such modification is mutually agreed to in writing by the Contractor and TennCare and incorporated as a written amendment to this Agreement prior to the effective date of such modification or change.

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 sixty (60) days written notice before the effective termination date. The Contractor shall be entitled to receive 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, they shall contain, at a minimum, sections of this Contract pertaining to "Conflicts of Interest" and "Nondiscrimination" (sections D.6. and D.7.). 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, subcontractors, or consultant to the Contractor in connection with any work contemplated or performed relative to this Contract.

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 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. Records. The Contractor shall maintain documentation for all charges against the State 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.9. 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.10. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.11. 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.12. Independent Contractor. The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint ventures, 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.13. State Liability. The State shall have no liability except as specifically provided in this Contract.

D.14. 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, acts of God, riots, wars, strikes, epidemics or any other similar cause.

D.15. State and Federal Compliance. The Contractor shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.

D.16. 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.17. 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.18. 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.19. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

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 facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below or to such other party, facsimile number, or address as may be hereafter specified by written notice.

The State:

Deputy Commissioner
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, Tennessee 37243
(615) 507-6482 (Phone)
(615) 741-0882 (fax)

The Contractor:

Steven J. Pollock, President
Doral Dental of Tennessee, LLC
12121 N. Corporate Parkway
Mequon, WI 53092

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the day of delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the fax machine at the receiving location and receipt is verbally confirmed by the sender if prior to 4:30 p.m. CST. Any communication by facsimile transmission shall also be sent by United States mail on the same date of the facsimile transmission.

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. Breach. A party shall be deemed to have breached the Contract if any of the following occurs:

— failure to perform in accordance with any term or provision of the Contract;
— partial performance of any term or provision of the Contract;

— any act prohibited or restricted by the Contract, or
— violation of any warranty.

For purposes of this contract, these items shall hereinafter be referred to as a "Breach."

a. Contractor Breach— The State shall notify Contractor in writing of a Breach.

(1) In event of a Breach by Contractor, the state shall have available the remedy of Actual Damages and any other remedy available at law or equity.

(2) Liquidated Damages— In the event of a Breach, the State may assess Liquidated Damages. The State shall notify the Contractor of amounts to be assessed as Liquidated Damages. The parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for a Breach by Contractor as said amounts are likely to be uncertain and not easily proven. Contractor hereby represents and covenants it has carefully reviewed the Liquidated Damages contained in above referenced, Attachment 1 and agree that said amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of Breach, and are a reasonable estimate of the damages that would occur from a Breach. It is hereby agreed between the parties that the Liquidated Damages represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the liquidated damage amount is in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or other section of this Contract.

The State may continue to withhold the Liquidated Damages or a portion thereof until the Contractor cures the Breach, the State exercises its option to declare a Partial Default, or the State terminates the Contract. The State is not obligated to assess Liquidated Damages before availing itself of any other remedy. The State may choose to discontinue Liquidated Damages and avail itself of any other remedy available under this Contract or at law or equity; provided, however, Contractor shall receive a credit for said Liquidated Damages previously withheld except in the event of a Partial Default.

(3) Partial Default— In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor.

In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material from Contractor. The

State shall make the final and binding determination of said amount.

The State may assess Liquidated Damages against the Contractor for any failure to perform which ultimately results in a Partial Default with said Liquidated Damages to cease when said Partial Default is effective. Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken

(4) Contract Termination— In the event of a Breach, the State may terminate the Contract immediately or in stages. The Contractor shall be notified of the termination in writing by the State. Said notice shall hereinafter be referred to as Termination Notice. The Termination Notice may specify either that the termination is to be effective immediately, on a date certain in the future, or that the Contractor shall cease operations under this Contract in stages. In the event of a termination, the State may withhold any amounts which may be due Contractor without waiver of any other remedy or damages available to the State at law or at equity. The Contractor shall be liable to the State for any and all damages incurred by the State and any and all expenses incurred by the State which exceed the amount the State would have paid Contractor under this Contract. Contractor agrees to cooperate with the State in the event of a Contract Termination or Partial Takeover.

b. State Breach— In the event of a Breach of contract by the State, the Contractor shall notify the State in writing within thirty (30) days of any Breach of contract by the State. Said notice shall contain a description of the Breach. Failure by the Contractor to provide said written notice shall operate as an absolute waiver by the Contractor of the State's Breach. In no event shall any Breach on the part of the State excuse the Contractor from full performance under this Contract. In the event of Breach by the State, the Contractor may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure as described herein operates as a waiver of the State's Breach. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the written notice of Breach shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

E.5. Partial Takeover. The State may, at its convenience and without cause, exercise a partial takeover of any service which the Contractor is obligated to perform under this Contract, including but not limited to any service which is the subject of a subcontract between Contractor and a third party, although the Contractor is not in Breach (hereinafter referred to as "Partial Takeover"). Said Partial Takeover shall not be deemed a Breach of Contract by the State. Contractor shall be given at least 30 days prior written notice of said Partial Takeover with said notice to specify the area(s) of service the State will assume and the date of said assumption. Any Partial Takeover by the State shall not alter in any way Contractor's other obligations under this Contract. The State may withhold from amounts due the Contractor the amount the Contractor would have been paid to deliver the service as determined by the State. The amounts shall be withheld effective as of the date the State assumes the service. Upon Partial Takeover, the Contractor shall have no right to recover from the State any actual, general, special,

incidental, consequential, or any other damages whatsoever of any description or amount.

E.6. Termination Plan. The Contractor must have a termination plan to be implemented in the event the contract between TennCare and the Contractor is terminated for any of the above stated reasons. Records must be retained in accordance with the requirements of 45 CFR 74 (3 years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original 3 year period ends.

E.7. Annual Report and Audit. The Contractor shall prepare and submit, within nine (9) months after the close of the reporting period, an annual report of its activities funded under this Contract to the commissioner or head of the contracting agency, the Tennessee Comptroller of the Treasury, and the Commissioner of Finance and Administration. The annual report for any Contractor that receives $500,000 or more in aggregate federal and state funding for all its programs shall include audited financial statements. All books of account and financial records shall be subject to annual audit by the Tennessee Comptroller of the Treasury or the Comptroller's duly appointed representative. When an audit is required, the Contractor may, with the prior approval of the Comptroller, engage a licensed independent public accountant to perform the audit. The audit contract between the Contractor and the licensed independent public accountant shall be on a contract form prescribed by the Tennessee Comptroller of the Treasury. Any such audit shall be performed in accordance with generally accepted government auditing standards, the provisions of OMB Circular A-133, if applicable, and the *Audit Manual for Governmental Units and Recipients of Grant Funds* published by the Tennessee Comptroller of the Treasury. The Contractor shall be responsible for reimbursement of the cost of the audit prepared by the Tennessee Comptroller of the Treasury, and payment of fees for the audit prepared by the licensed independent public accountant. Payment of the audit fees of the licensed independent public accountant by the Contractor shall be subject to the provisions relating to such fees contained in the prescribed contract form noted above. Copies of such audits shall be provided to the designated cognizant state agency, the State Contracting Department, the Tennessee Comptroller of the Treasury, and the Department of Finance and Administration and shall be made available to the public.

E.8. Independent Review of the Contractor. In accordance with Chapter 4 of the waiver approved by the Centers for Medicare and Medicaid Services may select a PRO, Private Accreditation Organization or an External Quality Review Organization (EQRO) to provide a periodic or an annual independent review of the Contractor. The results of the review shall be provided to TennCare and to the Contractor and shall be available, on request, to the Department of Health and Human Services, the Office of Inspector General and General Accounting Office.

E.9. State Ownership of Work Products. The State shall have all ownership right, title, and interest, including ownership of copyright, in all work products created, designed, developed, derived, documented, installed, or delivered to the State under this Contract. The State shall have royalty-free and unlimited rights to use, disclose, reproduce, or publish, for any purpose whatsoever, all said work products. The Contractor shall furnish such information and data upon request of the State, in accordance with the Contract and applicable State law.

E.10. Performance Bond. Upon approval of the Contract by all appropriate State officials in accordance with applicable State laws and regulations, the Contractor shall furnish a performance bond in the amount equal to Two Million Dollars ($2,000,000.00), guaranteeing full and faithful performance of all undertakings and obligations under this Contract for the initial Contract term and all extensions thereof. The bond shall be in the

manner and form prescribed by the State and must be issued through a company licensed to issue such a bond in the State of Tennessee.

The Contractor shall obtain the required performance bond in form and substance acceptable to the State and provide it to the State no later than September 16, 2005. Failure to provide the performance bond prior to the deadline as required shall result in contract termination.

In lieu of a performance bond, a surety deposit in the sum of two million dollars ($2,000,000.00) may be substituted if approved by the State prior to its submittal.

E.11. Printing Authorization. The Contractor agrees that no publication coming within the jurisdiction of *Tennessee Code Annotated*, Section 12-7-101, *et. seq.*, shall be printed unless a printing authorization number has been obtained and affixed as required by *Tennessee Code Annotated*, Section 12-7-103 (d).

E.12. Incorporation of Additional Documents. Included in this Contract by reference are the following documents:

a. The Contract document and its attachments
b. All Clarifications and addenda made to the Contractor's Proposal
c. The Request for Proposal and its associated amendments
d. Technical Specifications provided to the Contractor
e. The Contractor's Proposal

In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these documents shall govern in order of precedence detailed above.

E.13. Work-Papers Subject to Review. The Contractor shall make all audit, accounting, or financial analysis work-papers, notes, and other documentation available for review by the Comptroller of the Treasury or his representatives, upon request, during normal working hours either while the analysis is in progress or subsequent to the completion of this Contract.

E.14. Lobbying.

A. Definitions

(1) Lobbying means to communicate, directly or indirectly, with any official in the legislative or executive branch, for pay or for any consideration, for the purpose of influencing any legislative action or administrative action. (T.C.A. § 3-6-102(13))

(2) Public Official means any elected official, appointed official, or employee of:

(a) A federal, State or local unit of government in the U.S.

(a) A government corporation. (2 U.S.C.A. § 1602(15)(A) and (B))

(3) Official in the Executive Branch means the governor, any member or the governor's staff, any member or employee of a state regulatory commission, including, without limitation, directors of the Tennessee regulatory authority, or any member or employee of any executive department or agency or other state body in the executive branch. (T.C.A. § 3-6-102(16))

(4) Official in the Legislative Branch means any member, member-elect, any staff person or employee of the General Assembly or any member of a commission established by and responsible to the General Assembly or either house thereof who takes legislative action. This includes the Secretary or State, Treasurer, and Comptroller of the Treasury and any employee of such offices. (T.C.A. § 3-6-102(17))

B. The Contractor further certifies by signing this Agreement, to the best of its knowledge and belief, that Federal funds have not been used for lobbying in accordance with 45 CFR 93.100 and 31 U.S.C.A. 1352. Regardless of funding source, lobbyist compensation cannot be directly or indirectly contingent on 1) the passage or defeat of a bill related to TennCare or sister health departments, 2) the number of covered TennCare enrollees, 3) or the amount of TennCare reimbursement to a vendor. Certification from the Contractor must include the following:

(1) No appropriated funds may be expended by the recipient of this Agreement to pay 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, an elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS or any other federal agency in connection with this Agreement or subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the Contractor which receive reimbursement through this Agreement from the Contractor.

(2) The Contractor must certify annually by filing a TennCare Disclosure of Lobbying Activities Form (Attachment VII) with TennCare and the TennCare Oversight Committee that the Contractor is in compliance with all state and federal laws relating to conflicts of interest and lobbying. This form must be signed by the Chief Executive Officer of the Contractor or his/her designee and must be received by TennCare and the TennCare Oversight Committee no later than December 31 of each year beginning with December 31, 2005. The certification must include any and all subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the Contractor which receive reimbursement through this Agreement from the Contractor. The certification must also include signed copies of any contracts or agreements as well as a list of individual entities who have been lobbied or influenced.

Failure by the Contractor to comply with the provisions herein shall result in termination of the Contract and/or liquidated damages as provided in Section D.4 and Attachment I.

E.15. Offer of Gratuities. By signing this Agreement, the Contractor signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially from this procurement. This Agreement may be terminated by TennnCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, his agent, or employees and may result in termination of the Agreement and/or liquidated damages as provided in Section D.4 and Attachment I of this Agreement.

E.16. Public Funding Notice. All notices, informational pamphlets, press releases, research reports, signs, and similar public notices prepared and released by the Contractor relative to this Contract shall include the statement, "This project is funded under an agreement with the State of Tennessee." Any such notices by the Contractor shall be approved by the State.

E.17. Prohibited Advertising. The Contractor shall not refer to this Contract or the Contractor's relationship with the State hereunder in commercial advertising in such a manner as to state or imply that the Contractor or the Contractor's services are endorsed.

E.18. Confidentiality of Records. Strict standards of confidentiality of records shall be maintained in accordance with the law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of State 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 law and ethical standards.

The Contractor will be deemed to have satisfied its obligations under this section by exercising the same level of care to preserve the confidentiality of the State's information as the Contractor exercises to protect its own confidential information so long as such standard of care does not violate the applicable provisions of the first paragraph of this section.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

E.19. Copyrights and Patents. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims or suits which may be brought against the State for infringement of any laws regarding patents or copyrights which may arise from the Contractor's performance of this Contract. In any such action brought against the State, the Contractor shall satisfy and indemnify the State for the amount of any final judgment for infringement. The Contractor further agrees it shall be liable for the reasonable fees of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Contractor to the State. The State shall give the Contractor written notice of any such claim or suit and full right and opportunity to conduct the Contractor's own defense thereof.

E.20. Public Accountability. If this Contract involves the provision of services to citizens by the Contractor on behalf of the State, the Contractor agrees to establish a system through which recipients of services may present grievances about the operation of the service program, and the Contractor agrees to display a sign stating:

"NOTICE: This Contractor is a recipient of taxpayer funding. if you observe an employee

engaging in any activity which you consider to be illegal or improper, please call the State Comptroller's toll free hotline: 1-800-232-5454"

Said sign shall be displayed in a prominent place, located near the passageway(s) through which the public passes to receive State funded services.

E.21. Environmental Tobacco Smoke. Pursuant to the provisions of the federal "Pro-Children Act of 1994" and the Tennessee "Children's Act for Clean Indoor Air of 1995," the Contractor shall prohibit smoking of tobacco products within any indoor premises in which services are provided pursuant to this Contract to individuals under the age of eighteen (18) years. The Contractor shall post "no smoking" signs in appropriate, permanent sites within such premises. This prohibition shall be applicable during all hours, not just the hours in which children are present. Violators of the prohibition may be subject to civil penalties and fines. This prohibition shall apply to and be made part of any subcontract related to this Contract.

E.22. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Contractor to the State.

In the event of any such suit or claim, the Contractor shall give the State immediate notice thereof and shall provide all assistance required by the State in the State's defense. The State shall give the Contractor written notice of any such claim or suit, and the Contractor shall have full right and obligation to conduct the Contractor's own defense thereof. Nothing contained herein shall be deemed to accord to the Contractor, through its attorney(s), the right to represent the State of Tennessee in any legal matter, such rights being governed by ***Tennessee Code Annotated***, Section 8-6-106.

E.23. Tennessee Consolidated Retirement System. The Contractor acknowledges and understands that, subject to statutory exceptions contained in ***Tennessee Code Annotated***, Section 8-36-801, *et. seq.*, the law governing the Tennessee Consolidated Retirement System, provides that if a retired member returns to State employment, the member's retirement allowance is suspended during the period of 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 may be required to repay to the Tennessee Consolidated Retirement System the amount of retirement benefits the Contractor received from the Retirement System during the period of this Contract.

E.24. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal or State department or agency;

b. 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;

c. are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and

d. 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.25. Date/Time Hold Harmless. As required by ***Tennessee Code Annotated*** Section 12-4-118, the Contractor shall hold harmless and indemnify the State of Tennessee; its officers and employees; and any agency or political subdivision of the State for any breach of contract caused directly or indirectly by the failure to computer software or any device containing a computer processor to accurately or properly recognize, calculate, display, sort or otherwise process dates or times.

E.26. Effect of the Federal Waiver on this Agreement. The provisions of this Agreement are subject to the receipt of and continuation of a federal waiver granted to the State of Tennessee by the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Should the waiver cease to be effective, the State shall have the right to immediately terminate this Agreement. Said termination shall not be a breach of this Agreement by TennCare and TennCare shall not be responsible to the Contractor or any other party for any costs, expenses, or damages occasioned by said termination.

E.27 Exigency Extension. At the option of the State, the Contractor agrees to continue services for the Department when TennCare determines that there is a public exigency that requires the contracted services to continue. Continuation of services pursuant to this section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) days notice shall be given by TennCare before this option is exercised. During any periods of public exigency, the Contractor shall be reimbursed at the rate in place immediately prior to the exigency extension.

E.28. Contractor Qualifications. At the inception of this Agreement and at all times during the life of this agreement, the Contractor shall be appropriately licensed to operate within the State of Tennessee. If during the life of this Agreement TennCare directs the Contractor to operate as a risk bearing entity for dental services, Contractor shall be at all times material licensed in the State of Tennessee as an Insurance Company pursuant to TCA Section 56-2-101 *et seq.*, a Health Maintenance Organization pursuant to TCA Section 56-32-201 *et seq.*, a Prepaid Licensed Health Services Organization, pursuant to TCA 56-51-101, *et seq.*, or as a Dental Service Plan pursuant to TCA Section 56-30-101 *et seq.* The Contractor must maintain its license as a Third Party Administrator, not withstanding any other licensure requirements, until such time as TDCI notifies the Contractor otherwise.

E.28.1 Disclosures. The Contractor shall disclose to TennCare full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the Federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379 of the Acts of 1999. This disclosure shall be made at time and on forms prescribed by TennCare but no less frequently than on an annual basis to be

provided no later than January 1 of each calendar year. TennCare and/or the US Department of Health and Human Services may request information to be in the form of a consolidated financial statement. The following information shall be disclosed:

E.2 8.1.a. The name and address of each person with an ownership or control interest in the disclosing entity or in any provider or subcontractors in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest.

E.28.1.b The identity of any provider or subcontractors with whom the Contractor has had business transactions totaling more than one thousand dollars ($1,000) during the twelve (12) month period ending on the date of the disclosure.

E.28.1.c. The identify 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.

E.29. Action by the Department of Commerce & Insurance. The parties acknowledge that the Contractor is licensed to operate in the State of Tennessee, and is subject to regulation, examination and supervision by the Tennessee Department of Commerce and Insurance.

E.30. Applicability of this Agreement. All terms, conditions, and policies stated herein apply to staff, agents, officers, subcontractors, providers, volunteers and anyone else acting for or on behalf of the Contractor. TennCare enrollees are the intended third party beneficiaries of contracts between the state and managed care organizations and of any subcontracts or provider agreements entered into by managed care organizations with subcontracting providers and, as such, enrollees are entitled to the remedies accorded to third party beneficiaries under the law. This provision is not intended to provide a cause of action against the Bureau of TennCare or the State of Tennessee by enrollees beyond any that may exist under state or federal law.

E.31. HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this contract.

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA.

c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by HIPAA and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA. This provision shall not apply if information received by the State under this Contract

is NOT "protected health information" as defined by HIPAA, or if HIPAA permits the State to receive such information without entering into a business associate agreement or signing another such document.

E.32. Tennessee Bureau of Investigation Medicaid Fraud and Abuse Unit (MFCU) Access to Contractor and Provider Records Office of TennCare Inspector General Access to Contractor, Provider, and Enrollee Records

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, MFCU and TennCare OIG shall be health oversight agencies as defined at 45 C.F.R. §§ 164.501 and 164.512(d) and 65 F.R. § 82462. When acting in their respective capacities as health oversight agencies, MFCU and TennCare OIG do not need authorization to obtain enrollee protected health information (PHI). Because MFCU and TennCare OIG will request the information mentioned above for health oversight activities, "minimum necessary" standards do not apply to disclosures to MFCU or TennCare OIG that are required by law. See 45 C.F.R. §§ 164.502(b)(2)(iv), 164.502(b)(2)(v), and 164.512(d).

The Contractor shall immediately report to MFCU all factually based known or suspected fraud, abuse, waste and/or neglect of a provider or Contractor, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return money allowed or paid on claims known to be false or fraudulent. The Contractor shall not investigate or resolve the suspicion, knowledge or action without informing MFCU, and must cooperate fully in any investigation by MFCU or subsequent legal action that may result from such an investigation.

The Contractor and all its health care providers who have access to any administrative, financial, and/or medical records which relate to the delivery of items or services for which TennCare monies are expended, shall, upon request, make them available to MFCU or TennCare OIG. In addition, the MFCU must be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, during normal business hours, except under special circumstances when after hour admission shall be allowed. MFCU shall determine any and all special circumstances.

The Contractor and its participating and non-participating providers shall report TennCare enrollee fraud and abuse to TennCare OIG. The Contractor and/or provider may be asked to help and assist in investigations by providing requested information and access to records. Shall the need arise, TennCare OIG must be allowed access to the place of business and to all TennCare records of any TennCare Contractor or health care provider, whether participating or non-participating, during normal business hours.

The Contractor shall inform its participating and non-participating providers that as a condition of receiving any amount of TennCare payment, the provider must comply with this Section of this Contract regarding fraud, abuse, waste and neglect.

E.32.a. Prevention/Detection of Provider Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

E.32.b. Fraud and Abuse Compliance Plan

E.32.b.(1) The Contractor shall have a written Fraud and Abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit. The Contractor's specific

internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the TennCare Program Integrity Unit within ninety (90) days of the effective date of this Agreement. The TennCare Program Integrity Unit shall provide notice of approval, denial, or modification to the Contractor within thirty (30) days of review. The Contractor shall make any requested updates or modifications available for review to TennCare and/or the TennCare Program Integrity Unit as requested by TennCare and/or the TennCare Program Integrity Unit within thirty (30) days of a request. The State shall not transfer their law enforcement functions to the Contractor. At a minimum the written plan shall:

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

ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract:

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

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

iv. Contain provisions for the confidential reporting of plan violations to the designated person as described in item 3 below;

v. Contain provisions for the investigation and follow-up of any compliance plan reports;

vi. Ensure that the identities of individuals reporting violations of the plan are protected;

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

viii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to the TennCare Program Integrity Unit;

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

E.32.b(2) The Contractor shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG).

E.32.b(3) The Contractor shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

E.32.b(4) The Contractor shall submit an annual report to the TennCare Program Integrity Unit that includes summary results of fraud and abuse tests performed as required by 1-5.b.1.iii. and detailed in the Contractor's Fraud and Abuse compliance plan. The report should cover results for the year ending June 30 and be submitted by September 30 each year. This information in this report shall be provided in accordance with and in a format as described in the Contractor's approved compliance plan.

E.33. Solvency. The Contractor must provide assurances that Medicaid enrollees will not be liable for the Contractor's debt if the DBM becomes insolvent. The Contractor must cover the continuation of services to enrollees for the duration of the period for which payment has been made.

E.34. Conflict of Interest

The Contractor warrants that during the term of this Agreement no payments shall be paid to the following:

(1) any State or federal officer, including but not limited to

a. a member of the State Legislature, or
b. a member of Congress, or
c. any immediate family member of any State or federal officer; or

(2) any State or federal employee or any immediate family member of a State or federal employee unless otherwise authorized in writing by the Commissioner, Tennessee Department of Finance and Administration. Immediate family members may be exempted if State or federal officer or employee discloses such relationship to TennCare and the TennCare Oversight Committee. The applicability of this section includes, but is not limited to, any and all arrangements and/or agreements, written or verbal, that result in the Contractor making a payment or providing a gift in exchange for services or supplies.

The Contractor must certify annually by filing a TennCare Disclosure of Lobbying Activities Form (Attachment VII) with TennCare and the TennCare Oversight Committee that the Contractor is in compliance with all state and federal laws relating to conflicts of interest and lobbying, having made diligent inquiry of all subcontractors and/or persons receiving payment or gifts from Contractor pursuant to this Agreement. This form must be signed by the Chief Executive Officer of the Contractor or his/her designee and must be received by TennCare and the TennCare Oversight Committee no later than December 31 of each year beginning with December 31, 2005. The certification must include any and all subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the Contractor which receive reimbursement through this Agreement from the Contractor. The Chief Executive Officer acknowledges that he/she is responsible for ensuring that internal controls are in place to prevent and detect potential conflicts of interest and that due diligence was performed before providing certification of compliance. Any changes by the Contractor relating to the disclosure of

conflicts of interest or lobbying must be disclosed to TennCare within five (5) business days of the date of the change. (Refer to E.14, lobbying activities).

This Agreement may be terminated by TennCare if it is determined that the Contractor, its agents or employees offered or gave gratuities of any kind to any official, employee or immediate family member of an employee of the State of Tennessee, including a member of the State legislature. This Agreement may be terminated by TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, his agent, or employees.

Failure to comply with the provisions required herein shall result in liquidated damages in the amount of one-hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of this Agreement as described in Section E.4 and Attachment I, Liquidated damages, and subject to termination of this Agreement.

The Contractor shall be responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and include the substance of this clause in all agreements, subcontracts, provider agreements, and any and all agreements that result from this Agreement between Contractor and TennCare.

E.35. State and Federal Compliance. The Contractor agrees to comply with all applicable federal and state laws and regulations, and court orders, including Constitutional provisions regarding due process and equal protection of the laws and including but not limited to:

E.35.a. Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

E.35.b. Title 45 CFR, Part 74, General Grants Administration Requirements.

E.35.c. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. 7401, et seq.).

E.35.d. Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d) and regulations issued pursuant thereto, 45 C.F.R. Part 80.

E.35.e. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e) in regard to employees or applicants for employment.

E.35.f. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 C.F.R. Part 84.

E.35.g. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.

E.35.h. Omnibus Budget Reconciliation Act of 1981, P.E.. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.

E.35.i. Americans with Disabilities Act of 1990, 42 U.S.C. Section 12101 et seq., and regulations issued pursuant thereto, 28 C.F.R. Parts 35, 36.

E.35.j. Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare and/or Medicaid program.

E.35.k. Tennessee Consumer Protection Act, T.C.A. Section 47-18-101 et seq.

E.35.l. The CMS waiver and all Special Terms and Conditions which relate to the waiver.

E.35.m Executive Orders, including Executive Order 1 effective January 26, 1995.

E.35.n. The Clinical Laboratory Improvement Act (CLIA) of 1988.

E.35.o. Requests for approval of material modification as provided at TCA 56-32-201 etc .seq.

E.35.p. Title IX of the Education Amendments of 1972 (regarding education programs and activities)

E.35.q. The Rehabilitation Act of 1973

E.35.r. The Balanced Budget Act of 1997 Section 422.208 and 422.210

E.35.s. EEO Provisions

E.35.t. Copeland Anti-Kickback Act

E.35.u. Davis-Bacon Act

E.35.v. Contract Work Hours and Safety Standards

E.35.w. Rights to Inventions Made Under a Contract or Agreement

E.35.x. Byrd Anti-Lobbying Amendment

E.35.y. Debarment and Suspension

E.36. Offer of Gratuities

By signing this Agreement, the Contractor signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially from this procurement. This Agreement may be terminated by TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, his agent, or employees and may result in termination of the Agreement and/or liquidated damages as provided in Attachment I of this Agreement.

IN WITNESS WHEREOF:

DORAL DENTAL OF TENNESSEE, LLC

Steven J. Pollock, President — Date: 9/14/05

DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE:

M. D. Goetz, Jr., Commissioner — Date: 9/19/05

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr., Commissioner — Date

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury — Date: 9/28/05

ATTACHMENT I

LIQUIDATED DAMAGES

It is acknowledged by TennCare and the Contractor that in the event of failure to meet the requirements provided in this Agreement and all documents incorporated herein, TennCare will be harmed. The actual damages which TennCare will sustain in the event of and by reason of such failure are uncertain, are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the Contractor shall be subject to damages and/or sanctions as described below. It is further agreed that the Contractor shall pay TennCare liquidated damages as directed by TennCare and not to exceed the fixed amount as stated below; provided however, that if it is finally determined that the Contractor would have been able to meet the Agreement requirements listed below but for TennCare's failure to perform as provided in this Agreement, the Contractor shall not be liable for damages resulting directly therefrom.

I. TennCare may impose any or all of the sanctions below upon TennCare's reasonable determination that the Contractor fails to comply with any corrective action plan (CAP) or is otherwise deficient in the performance of its obligations under the Agreement, provided, however, that TennCare only impose those sanctions it determines to be appropriate for the deficiencies identified. TennCare may impose intermediate sanctions on the Contractor simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe or numerous.

Intermediate sanctions may include application of liquidated damages as described in Section E.4.a.ii.

II. **Liquidated Damages**

Reports and Deliverables

For each day that a report or deliverable is late, incorrect, or deficient, the Contractor shall be liable to TennCare for liquidated damages in the amount of $100 per work day per report or deliverable. Liquidated damages for late reports shall begin on the first day the report is late. Liquidated damages for incorrect reports (except ad hoc or on-request reports involving provider network information), or deficient deliverables shall begin on the sixteenth day after notice is provided from TennCare to the Contractor that the report remains incorrect or the deliverables remain deficient; provided, however, that it is reasonable to correct the report or deliverable within fifteen (15) calendar days. For the purposes of ad hoc or on-request reports involving provider network information, liquidated damages for incorrect reports shall begin on the first day the report is determined by TennCare to be incorrect. For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due in accordance with the following schedule, unless otherwise specified elsewhere in this Agreement:

DELIVERABLES	DATE AGREED UPON BY THE PARTIES
Monthly Reports	20th of the following month.
Quarterly Reports, excluding SURS	30th of the following month.
Annual Reports	Ninety (90) calendar days after the end of the contract year. (September 30th)
On Request Reports	Within three (3) working days from the date of request when reasonable unless otherwise specified by TennCare.

Ad Hoc Reports		Within ten (10) working days from the date of the request when reasonable unless otherwise specified by TennCare.

Program Issues

Liquidated damages for failure to perform specific responsibilities as described in this Agreement are shown below. Damages are grouped into three categories: **Class A** violations, **Class B** violations and **Class C** violations.

Class A violations are those which pose a significant threat to patient care or to the continued viability of the TennCare program.

Class B violations are those with pose threats to the integrity of the TennCare program, but which do not necessarily imperil patient care.

Class C violations are those which represent threats to the smooth and efficient operation of the TennCare program but which do not imperil patient care or the integrity of the TennCare program.

CLASS	PROGRAM ISSUES		DAMAGE
A.1	Failure to comply with claims processing as described in A.13 of this Agreement including making timely responses to provider requests for payment and/or claims information		$10,000 per month, for each month that TennCare determines that the Contractor is not in compliance with the requirements of A.13 of this Agreement.
A.2	Failure to respond to a request by DCS or TennCare to provide service(s) to a child in DCS custody or at risk of entering DCS custody		$1000 per occurrence
A.3	Failure to comply with obligations and timeframes in the delivery of EPSDT screens and related services		$1000 per occurrence
A.4	Denial of a request for services to a child in DCS custody or at risk of entering DCS custody when the services have been reviewed and authorized by the TennCare Chief Medical Officer		$1000 per occurrence
A.5	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TennCare to do so or within a longer period of time which has been approved by TennCare upon a plan's demonstration of good cause.		$500 per day beginning on the next calendar day after default by the plan.
A.6	Services wrongfully withheld where enrollee was not receiving the		$1,000 per occurrence

	service and the enrollee went without coverage of the disputed service while an appeal on the service was pending.		
A.7	Failure to comply with the notice requirements of the TennCare rules and regulations or any subsequent amendments thereto, and all court orders governing appeal procedures, as they become effective.		$500 per calendar day for each day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TennCare
A.8	Failure to provide continuation or restoration of services where enrollee was receiving the service as required by the TennCare rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective.		$500 per occurrence.
A.9	Failure to forward an expedited appeal to TennCare in twenty-four (24) hours or a standard appeal in five (5) days.		$500 per calendar day.
A.10	Failure to comply with marketing and communication limitations including, but not limited to use of unapproved and/or disapproved marketing and communication material.		$1000 per occurrence.
B.1	Failure to provide listings of participating dentists to enrollees as required by this Agreement		$500 per calendar day.
B.2	Failure to complete or comply with corrective action plans as required by TennCare		$500 per calendar day for each day the corrective action is not completed or complied with as required.
B.3	Failure to comply with Conflict of Interest requirements as described in Section E.34.		110% of the total amount of compensation paid by the Contractor to inappropriate individuals as well as termination of this agreement.
B.4.	Failure to submit Disclosure of Lobbying Activities Form by Contractor as specified in Section E.34.		$250 per calendar day.
B.5.	Failure to comply with Offer of Gratuities constraints described in Section E.15.		110% of the total benefit provided by the Contractor to inappropriate individuals and possible termination of the Agreement for Breach as described in Section E.4.

C.1	Employment of licensed personnel		$250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulations.
C.2	Failure to comply in any way with staffing requirements as described in Section A.3. of this Agreement		$250 per calendar day for each day that staffing requirements as described in Section A.3. of this Agreement are not met.
C.3	Failure to report provider notice of termination of participation in the Contractor's plan		$200 per day.

III. Payment of Liquidated Damages

It is further agreed by TennCare and the Contractor that any liquidated damages assessed by TennCare shall be due and payable to TennCare within thirty (30) calendar days after Contractor receipt of the notice of damages and if payment is not made by the due date, said liquidated damages may be withheld from future payments by TennCare without further notice. It is agreed by TennCare and the Contractor that the collection of liquidated damages by TennCare shall be made without regard to any appeal rights the Contractor may have pursuant to this Agreement; however, in the event an appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by TennCare will be immediately returned to the Contractor. With respect to Class B and Class C violations, the due dates mentioned above may be delayed if the Contractor can show good cause as to why a delay should be granted. TennCare has sole discretion in determining whether good cause exists for delaying the due dates.

Liquidated damages as described herein shall not be passed to a provider and/or subcontractors unless the damage was caused due to an action or inaction of the provider and/or subcontractors. Nothing described herein shall prohibit a provider and/or a subcontractors from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractors caused the damage by an action or inaction. All liquidated damages imposed pursuant to this Agreement, whether paid or due, shall be paid by the Contractor out of administrative and management costs and profits.

ATTACHMENT II

Evidence of Coverage and Enrollee Material

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

I. A. Member Handbooks. The Contractor shall develop and update their member handbook when major changes occur within the TennCare program, the DBM or upon request by TennCare. The member handbooks shall contain the actual date it was printed either on the handbook or on the first page within the first page of the handbook. Member handbooks must be distributed to enrollee within thirty (30) days of receipt of notice of enrollment in the DBM plan. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the Contractor to mail one (1) member handbook to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to enrollee. Should a single individual be enrolled and be added into an existing case, a member handbook new or updated must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to enrollee in the existing case. However, upon notice by TennCare of benefit changes, the Contractor shall make the appropriate revisions to (2) separate versions of the Contractor's TennCare Member Handbook for the specific population being serviced for the purpose of describing Medicaid Benefits to the Medicaid populations and Standard benefits to the Standard population. All revisions must be approved prior to dissemination. The Contractor shall submit an electronic file and ten (10) printed final versions of the final product to the TennCare Marketing Coordinator within thirty (30) working days from the print date. If the print date exceeds thirty (30) working days from the date of approval, the Contractor shall submit a written notification to the TennCare Marketing Coordinator to specify a print date. Photo copies may not be submitted as a final product. When large distributions of the member handbook occur, the Contractor must submit to TennCare the date the information was mailed to the enrollees along with an invoice or a specific document to indicate the date and volume of handbooks mailed. Each member handbook shall, at a minimum, be in accordance with the following guidelines:

I.A.1. Must be in accordance with all applicable requirements as described in this Attachment.

I.A.2. Shall include a table of contents;

I.A.3. Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment.

I.A.4. Shall include a description of services provided including limitations, exclusions and out-of-plan use;

I.A.5. Shall include a description of cost share responsibilities for non Medicaid eligible individuals including an explanation that providers and/or the DBM may utilize whatever legal actions that are available to collect these amounts;

I.A.6. Shall include information about preventive services for children, to include a listing of preventive services and notice that preventive services are at no cost and without cost share responsibilities.

I.A.7. Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to providers outside of the plan. The handbook should advise members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan and any co-payment requirements would be the same as if this provider were in the plan;

I.A.8. 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;

I.A.9. Shall include appeal procedures as described in Section A.17. of the pro forma contract;

I.A.10. Shall include notice to the enrollee that in addition to the enrollee's right to file an appeal for actions taken by the Contractor, the enrollee shall have the right to request reassessment of eligibility related decisions directly to the Department of Human Services.

I.A.11. Shall include written policies on member rights and responsibilities.

I.A.12. Shall include written information concerning advance directives as described in the Code of Federal Regulations, 42 CFR 489 Subpart I and in accordance with 42 CFR 417.436.(d);

I.A.13. Shall include the toll free telephone number for TennCare with a statement that the enrollee may contact the plan or TennCare regarding questions about TennCare. The TennCare Family Assistance Service Center number is 1-866-311-4287.

I.A.14. 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; and

I.A.15. Shall include information educating enrollees of their rights and necessary steps to amend their data in accordance with HIPAA regulations.

I.A.16. Shall include other information on requirements for accessing services to which they are entitled under the contract including factors such as physical access and non-English languages spoken as required in the Balanced Budget Act of 1997, Section 438.10(f)3.

I.A.17. Shall include notice to the enrollee of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P/E/ 97-35) and a complaint form on which to do so.

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

I.B.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;

I.B.2 the procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and

I.B.3 For TennCare Medicaid enrollees, EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services.

Not more than one hundred twenty (120) calendar days shall elapse between dissemination of this information. In order to satisfy the requirement to distribute the quarterly newsletter to all enrollees, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the enrollee's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to enrollees, the Contractor shall also submit to TennCare an electronic file and five (5) final printed originals of the newsletter and the date that the information was mailed to enrollees along with an invoice or other type of documentation to indicate the date and volume of the quarterly newsletter mailing.

I.B.4 Shall include notice to the enrollee of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.E. 97-35) and a Contractor contact phone number for doing so. The notice shall be in English and Spanish.

1.C. Provider Directory. The Contractor shall be responsible for distributing provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the plan. The Contractor shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. The provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network providers, and identification of providers accepting new patients. Enrollee provider directories, and any revisions thereto, shall be submitted to TennCare for approval prior to distribution to enrollees. Each submission shall include a paper and an electronic copy. The text of the directory shall be in Microsoft Word or Adobe (PDF) format. In addition, the provider information used to populate the enrollee provider directory shall be submitted as a TXT file or such format as otherwise approved by TennCare and be produced using the same extract process as the actual enrollee provider directory. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the Contractor to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.

The Contractor may choose to provide a modified provider listing to enrollees who are only eligible for the limited Dental Benefits as described in Section A.1.2.3 of this

Agreement. However, all provider directories shall be approved by TennCare prior to the Contractor's distribution.

II. **Permissible Communication Activities**: The following enrollee communication activities shall be permitted under this contract pending approval of a communication/outreach/access plan describing the time(s), place(s), intent, audience and other relevant information requested by TennCare.

II.A. Distribution of general information through mass media;

II.B. Telephone calls, mailings and home visits to current enrollees of the Contractor only for the sole purpose of educating current enrollees about services offered by or available through the Contractor;

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

III. **Prohibited Communication Activities**: The following information and activities are prohibited:

III.A. 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;

III.B. Overly aggressive solicitation, such as repeated telephoning;

III.C. Gifts and offers of material gain or financial gain as incentives;

III.D. Compensation arrangements that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;

III.E. Direct solicitation of potential enrollees; and

III.F. In accordance with federal requirements, independent marketing agents shall not be used in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions.

III.G. Seeking to influence enrollment in conjunction with the sale or offering of any private insurance.

IV. **Written Material Guidelines**

IV.A. All materials shall be worded at a 6th grade reading level, unless TennCare approves otherwise.

IV.B. All written materials shall be clearly legible with a minimum font size of 12pt.with the exception of member I.D. cards, and unless otherwise approved by TennCare.

IV.C. All written materials shall be printed with an assurance of non-discrimination in both English and Spanish.

IV.D. The following shall not be used on communication material without the written approval of TennCare:

IV.D.1 The Seal of the State of Tennessee;

IV.D.2 The TennCare[sm] name unless the initials "SM" denoting a service mark, is superscripted to the right of the name;

IV.D.3. The word "free" can only be used if the service is no cost to all members.

IV.E. All documents and the member handbook must be translated and available in Spanish. Within ninety (90) days of notification from TennCare, all vital documents must be translated and available to each Limited English Proficiency group identified by TennCare that constitutes five percent (5%) of the TennCare population or 1,000 enrollees, whichever is less.

IV.F. All written materials shall be made available in alternative formats for persons with special needs or appropriate interpretation services shall be provided by the Contractor.

IV.G. The Contractor shall develop a written procedure for the provision of language interpretation and translation services for enrollees with Limited English Proficiency. The Contractor shall provide for those enrollees, language help-lines with specific numbers. The Contractor shall provide instruction for its staff and all direct service sub-Contractors regarding the procedure.

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

ATTACHMENT III

Non-discrimination Compliance Information

No person, on the grounds of handicap and/or disability, age, race, color, religion, sex, or national origin, shall be excluded from participation in, except as specified in Section A-1 of this Agreement, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this Agreement or in the employment practices of the Contractor. The Contractor shall, upon request, show proof of such non-discrimination and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.

In order to demonstrate compliance with Federal and State regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.E. 97-35), the Contractor shall:

1. Designate a staff person to be responsible for Title VI non-discrimination compliance on behalf of the Contractor. The designated staff person shall be identified by name in writing to TennCare within thirty (30) days of the effective date of this Agreement. The Contractor does not have to require that non-discrimination compliance be the sole function of the designated staff person.

    a. In respect to any period of time that the Contractor does not have a designated staff person responsible for Title VI compliance it shall be reported to TennCare in writing, to the attention of the Director of Non-discrimination Compliance within ten (10) calendar days of the commencement of such period of time. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported to TennCare, to the attention of the Director of Non-discrimination Compliance within ten (10) calendar days of the change.

    b. The Contractor's non-discrimination compliance coordinator shall develop a written procedure for the provision of language interpretation and translation services for enrollees with Limited English Proficiency. The Contractor shall provide instruction for its staff, including but not limited to, the designated staff person for Title VI, and all direct service sub-Contractors regarding the procedure.

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

    d. On a quarterly basis, a summary listing totaling the number of supervisory personnel by race/national origin and sex. The Contractor is required to request this information from all Contractor staff. Contractor staff response is voluntary. The Contractor is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts. Such listing shall separate categories for total supervisory personnel by; number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/national origin as indicated by staff and

number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/national origin females as indicated by staff.

e. On an annual basis, a summary listing by CSA of servicing providers which includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race/ethnic origin (to be indicated as in Attachment III, Section 1.d above) and shall be sorted by CSA. Each provider type (e.g. general dentists, oral surgeon, etc.) shall be reported separately within the CSA. The Contractor is required to request this information from all providers. Provider response is voluntary. The Contractor is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the Contractor's provider network or in determination of compensation amounts.

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

g. On a quarterly basis, a listing of all requests for translation/interpretation services by requesting enrollee.

(1) Each request reported will identify by name and member identification number the enrollee for which translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter.

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

(1) A listing of the interpreter/translator services utilized by the Contractor in providing services to enrollees with Limited English Proficiency. The listing shall provide the full name of interpreter/translator services, address of services, phone number of services, hours services are available and be sorted by CSA.

i. On an annual basis, the Contractor's Title VI Compliance Plan and Assurance of Non-discrimination.

ATTACHMENT IV

GUIDELINES FOR INTERNAL QUALITY MONITORING PROGRAMS OF ORGANIZATIONS CONTRACTING WITH TennCare

Each Organization which contracts with TennCare (also referred to as the State) shall have in place an internal quality monitoring system. Internal Quality Monitoring programs (QMPs) consist of systematic activities, undertaken by the organization itself to monitor and evaluate the care delivered to enrollees according to predetermined, objective standards, and to effect improvements as needed. The following guidelines will be used to establish State standards for internal QMPs for TennCare Contractors.

The guidelines were derived from three sources:

- The National Committee for Quality Assurance (NCQA) Quality Assurance Managed Care Organization Surveyor Guidelines, 2000;
- The National Association of HMO Regulators/National Association of Insurance Commissioners' Recommended Operational Requirements for HMO Quality Assurance Programs, adopted by the NAIC/NAHMOR Joint Task Force, December, 1988;
- The CMS Office of Prepaid Health Care's Quality Assurance Standards for HMOs and CMPs Contraction with the Medicare Program, dated November, 1989;

as detailed in "A HEALTH CARE QUALITY IMPROVEMENT SYSTEM FOR MEDICAID COORDINATED CARE", U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Health Care Financing Administration Medicaid Bureau, December 23, 1992.

SECTION I

GUIDELINES FOR INTERNAL QUALITY MONITORING PROGRAMS OF ORGANIZATIONS CONTRACTING WITH TENNCARE

STANDARD I: WRITTEN QMP DESCRIPTION

The organization has a written description of its QMP. This written description meets the following criteria:

A. Goals and Objectives - The written description contains a detailed set of QM objectives which are developed annually and include a timetable for implementation and accomplishment.

B. Scope -

1. The scope of the QMP is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care.

2. The QMP methodology provides for review of the entire range of care provided by the organization, by assuring that all demographic groups, care settings, (e.g., surgery centers, ambulatory care including that provided in private practice offices) and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review.

C. Specific Activities - The written description specifies quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities are clearly identified and are appropriate.

D. Continuous Activity - The written description provides for continuous performance of the activities, including tracking of issues over time.

E. Provider Review - The QMP provides for:

1. Review by dentists and other dental professionals of the process followed in the provision of dental services; and

2. Feedback to dental professionals and organization staff regarding performance and patient results.

F. Focus on Dental Outcomes - The QMP methodology addresses dental outcomes to the extent consistent with existing technology.

G. The QMP guidelines must be disseminated to all affected providers and, upon request, to enrollees and potential enrollees.

STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT & IMPROVEMENT

The QMP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.

The QMP has written guidelines for its quality of care studies and related activities which include:

A. Specification of dental services delivery areas to be monitored -

1. The monitoring and evaluation of care reflects the population served by the Contractor in terms of age groups, disease categories, and special risk status.

2. For the TennCare population, the QMP monitors and evaluates, at a minimum, care and services in certain priority areas of concern selected by the State. These may be taken from among those identified by the Centers for Medicare and Medicaid (CMS) (formerly Health Care Financing Administration/HCFA), or other sources as deemed necessary by TennCare.

3. At its discretion and/or as required by TennCare, the Contractor's QMP also monitors and evaluates other important aspects of care and services.

B. Use of Quality Indicators -

Quality indicators are measurable variables relating to a specified dental services delivery area, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area.

1. The Contractor identifies and uses quality indicators including those specified in Clinical and Health Services Delivery Areas of Concern that are objective, measurable, and based on current knowledge and clinical experience.

2. For the priority areas selected by the state from the CMS Bureau's list of priority demtal services delivery areas of concern, or other sources as deemed necessary by the State, the organization shall monitor and evaluate quality of care through studies which include, but are not limited to, the quality indicators also specified by the CMS Bureau or by the State.

3. Methods and frequency of data collection are appropriate and sufficient to detect need for program change.

C. Use of Clinical Care Standards/Practice Guidelines -

1. The QMP studies and other activities monitor quality of care against dental service delivery standards or practice guidelines specified for each area identified in "STANDARD II, A," above.

2. The standards/guidelines are based on reasonable scientific evidence and are developed or reviewed by plan providers.

3. The standards/guidelines focus on the process and outcomes of dental care delivery, as well as access to care.

4. A mechanism is in place for continuously updating the standards/guidelines.

5. The standards/guidelines shall be included in provider manuals developed for use by dental providers or otherwise disseminated to providers as they are adopted.

6. The standards/guidelines address preventive dental services.

7. Standards/guidelines are developed for the full spectrum of populations enrolled in the plan.

8. The QMP shall use these standards/guidelines to evaluate the quality of care provided by the Contractor's providers, whether the providers are organized in groups or as individuals.

D. Analysis of Clinical Care and Related Services -

1. Appropriate clinicians monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related services. For quality issues identified in the QMP's targeted clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines.

2. Multidisciplinary teams are used, where indicated, to analyze and address systems issues.

E. Implementation of Remedial/Corrective Actions -

The QMP includes written procedures for taking appropriate remedial action whenever, as determined under the QMP, inappropriate or substandard services are furnished, or services that should have been furnished were not.

These written remedial/corrective action procedures include:

1. specification of the types of problems requiring remedial/corrective action;

2. specification of the person(s) or body responsible for making the final determinations regarding quality problems;

3. specific actions to be taken;

4. provision of feedback to appropriate dental professionals and staff;

5. the schedule and accountability for implementing corrective actions;

6. the approach to modifying the corrective action if improvements do not occur;

7. procedures for terminating the affiliation with the dental professional.

F. Assessment of Effectiveness of Corrective Actions -

1. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.

2. The Contractor assures follow-up on identified issues to ensure that actions for improvement have been effective.

G. Evaluation of Continuity and Effectiveness of the QMP -

1. The Contractor conducts a regular examination of the scope and content of the QMP to ensure that it covers all types of services in all settings, as specified in STANDARD I-B-2.

2. At the end of each year, a written report on the QMP is prepared, which addresses: QM studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP.

3. There is evidence that QM activities have contributed to reasonable improvements in the care delivered to members such that the level of care provided is that which is recognized as acceptable professional practice in the respective community in which particular providers practice.

STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY

The Governing Body of the organization is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the Contractor. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

A. Oversight of QMP - There is documentation that the Governing Body has approved the overall QMP and an annual QM plan.

B. Oversight Entity - The Governing Body has formally designated an accountable entity or entities within the organization to provide oversight of QM, or has formally decided to provide such oversight as a committee of the whole.

C. QMP Progress Reports - The Governing Body routinely receives written reports from the QMP describing actions taken, progress in meeting QM objectives, and improvements made.

D. Annual QMP Review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QMP which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered, to assess acceptability.

E. Program Modification - Upon receipt of regular written reports from the QMP delineating actions taken and improvements made, the Governing Body takes action when appropriate and directs that the operational QMP be modified on an ongoing basis to accommodate review findings and issues of concern within the organization. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Monitoring/Improvement.

STANDARD IV: ACTIVE QM COMMITTEE

The QMP delineates an identifiable structure responsible for performing QM functions within the organization. This committee or other structure has:

A. Regular Meetings - The structure/committee meets on a regular basis with specified frequency

to oversee QMP activities. This frequency is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case are such meetings less frequent than quarterly.

B. Established parameters for Operating - The role, structure and function of the structure/committee are specified.

C. Documentation - There are records documenting the structure's/committee's activities, findings, recommendations and actions.

D. Accountability - The QMP committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.

E. Membership - There is active participation in the QM committee from dental plan providers, who are representative of the composition of the plan's providers and shall include as a non-voting member, a representative of the TennCare Office of the Dental Director.

STANDARD V: QMP SUPERVISION

There is a designated senior executive who is responsible for program implementation. The organization's Dental Director has substantial involvement in QM activities.

STANDARD VI: ADEQUATE RESOURCES

The QMP has sufficient material resources, and staff with the necessary education, experience, or training, to effectively carry out its specified activities.

STANDARD VII: PROVIDER PARTICIPATION IN THE QMP

A. Participating dentists are kept informed about the written QM plan.

B. The organization includes in all its provider contracts and employment agreements, for both dentists and non-dentist providers, a requirement securing cooperation with the QMP.

C. Contracts specify that hospitals and other Contractors will allow the Contractor access to the medical records of its members.

STANDARD VIII: DELEGATION OF QMP ACTIVITIES

The Contractor remains accountable for all QMP functions, even if certain functions are delegated to other entities. If the Contractor delegates any QM activities to Contractors:

A. There is a written description of: the delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the Contractor.

B. The Contractor has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

C. There is evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

STANDARD IX: CREDENTIALING AND RECREDENTIALING

The QMP contains the following provisions to determine whether dentists and other dental care professionals, who are licensed by the State and who are under contract to the organization, are qualified to perform their services.

A. Written Policies and Procedures - The Contractor has written policies and procedures for the credentialing process, which includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, re-certifying and/or reappointment of practitioners.

B. Oversight by Governing Body - The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.

C. Credentialing Entity - The plan designates a credentialing committee or other peer review body which makes recommendations regarding credentialing decisions.

D Scope – The Contractor shall identify those practitioners to be credentialed that fall under its scope of authority and action. Practitioners to be credentialed shall include, at a minimum, all dentists included in the Contractor's literature for members, as an indication of those practitioners whose service to member is contracted or anticipated. The Contractor shall submit a plan to the TennCare Bureau outlining the process which it shall employ to ensure appropriate and timely credentialing of all providers participating in the dental plan. In all contracts with health care professionals, the Contractor must comply with the requirements specified in the Balanced Budget Act of 1997, Section 438.214.

E. Process - The initial credentialing process obtains and reviews verification of the following information, at a minimum:

1. Primary Verification

a. the practitioner holds a current valid license to practice within the State;

b. valid DEA or CDS certificate, as applicable;

c. confirmation of highest level of education and training received;

d. professional liability claims history (past five (5) years) from the National Practitioner Data Bank and the State Board of Dentistry; and

e. any sanctions imposed by Medicare, Medicaid, TennCare and/or the Tennessee Board of Dentistry.

f. good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.)

g. any revocation or suspension of a state license, DEA/BNDD number, or CDS certificate.

2. Secondary Verification (self reported)

a. work history – past five (5) years. Verbal explanation for gaps greater than six (6) months, written explanation for gaps greater than one (1) year;

b. the practitioner holds current, adequate malpractice insurance according to the plan's policy;

c. any curtailment or suspension of medical staff privileges (other than for incomplete medical records);

d. any censure by the State or County Dental Association;

e. the application process includes a statement by the applicant and an investigation of said statement regarding:

(1) any physical or mental health problems that may affect current ability to provide dental care;

(2) any history of chemical dependency/substance abuse;

(3) history of loss of license and/or felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity; and

(5) current malpractice coverage and limits; and

(6) an attestation to correctness/completeness of the application.

3. Any information obtained will be evaluated to determine whether any or all of said information would impact a practitioner's ability to conform to the standards established by the Contractor in accordance with the requirements placed on the Contractor by TennCare per Section A.1.1. of the Agreement. The Contractor may decide, based on information obtained in the credentialing process, not to contract with a provider.

4. There is an initial visit to each dentist's office, including documentation of a structured review of the site and dental record keeping practices to ensure conformance with the Contractor's standards.

F. Recredentialing - A process for the periodic reverification of clinical credentials (recredentialing, reappointment, or recertification) is described in the organization's policies and procedures.

1. There is evidence that the procedure is implemented at least every three years.

2. There is verification of State licensure at least every three years,

3. The Contractor conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all dentists to decide whether to renew the

participating dentist agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing on items listed in "F-1" through "F-2.c" above, and item "F-2.g" as well.

4. The recredentialing, recertification or reappointment process also includes review of data from:

   a. member complaints;

   b. results of quality reviews;

   c. utilization management;

   d. member satisfaction surveys; and

   e. reverification of hospital privileges and current licensure.

G. Reporting Requirement - There is a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.

H. Appeals Process - There is a provider appellate process for instances where the Contractor chooses to reduce, suspend or terminate a practitioner's privileges with the organization.

STANDARD X: ENROLLEE RIGHTS AND RESPONSIBILITIES

The Contractor demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

A. Written Policy on Enrollee Rights - The organization has a written policy that recognizes the following rights of members:

   1. to be treated with respect, and recognition of their dignity and need for privacy;

   2. to be provided with information about the organization, its services, the practitioners providing care, and members' rights and responsibilities;

   3. to be able to choose dentists within the limits of the plan network, including the right to refuse care from specific practitioners;

   4. to participate in decision-making regarding their dental care;

   5. to voice complaints or appeals about the organization or care provided;

   6. to be guaranteed the right to request and receive a copy of his or her dental records, and to request that they be amended or corrected as specified in 45 CFR part 164;

   7. to be guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

   8. to be free to exercise his or her rights, and that that exercise of those rights does not adversely affect the way the DBM and it's providers or the State agency treat the enrollee.

9. to be guaranteed the right to receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand.

B. Written Policy on Enrollee Responsibilities - The organization has a written policy that addresses members' responsibility for cooperating with those providing dental care services. This written policy addresses members' responsibility for:

1. providing, to the extent possible, information needed by professional staff in caring for the member; and

2. following instructions and guidelines given by those providing dental care services.

C. Communication of Policies to Providers - A copy of the organization's policies on members' rights and responsibilities is provided to all participating providers.

D. Communication of Policies to Enrollees/Members - Upon enrollment, members are provided a written statement that includes information on the following:

1. rights and responsibilities of members;

2. benefits and services included and excluded as a condition of membership, and how to obtain them, including a description of:

   a. any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to services obtained outside the system; and

   b. the procedures for obtaining out-of-area coverage;

3. provisions for after-hours and emergency coverage;

4. the organization's policy on referrals for specialty care;

5. charges to members, if applicable, including:

   a. policy on payment of charges; and

   b. co-payment and fees for which the member is responsible;

6. procedures for notifying those members affected by the termination or change in any benefits, services, or service delivery office/site;

7. procedures for appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization;

8. procedures for changing practitioners;

9. procedures for voicing complaints and/or appeals and for recommending changes in policies and services.

E. Enrollee/Member Complaint and Appeal Procedures - The organization has a system(s), linked to the QMP, for resolving members' complaints and appeals. This system includes:

1. procedures for registering and responding to complaints and appeals in a timely fashion

(organizations should establish and monitor standards for timeliness);

2. documentation of the substance of complaints or appeals, and actions taken;

3. procedures to ensure a resolution of the complaint or appeal;

4. aggregation and analysis of complaint and appeal data and use of the data for quality improvement; and

5. an appeal process for adverse actions.

F. Enrollee/Member Suggestions - Opportunity is provided for members to offer suggestions for changes in policies and procedures.

G. Steps to Assure Accessibility of Services - The Contractor takes steps to promote accessibility of services offered to members. These steps include:

1. the points of access to dental services, specialty care, and hospital or ambulatory surgical center services are identified for members; and

2. at a minimum, members are given information about:

a. how to obtain services during regular hours of operations;

b. how to obtain emergency and after-hours care; and

c. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care.

H. Written Information for Members -

1. Member information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood.

2. Written information is available, as needed, in the languages of the major population groups served. A "major" population group is one which represents at least 10 percent of a plan's population or 3,000 enrollees, whichever is less. All vital documents and the member handbook is available in Spanish. All vital documents are also available to Limited English Proficiency groups identified by TennCare that constitutes five percent (5%) of the TennCare population or 1,000 enrollees, whichever is less.

I. Confidentiality of Patient Information - The organization acts to ensure that the confidentiality of specified patient information and records is protected.

1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records.

2. The organization ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the dental care organization.

3. The organization shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless:

a. it is required by law;

b. it is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or

c. it is necessary in compelling circumstances to protect the health or safety of an individual.

4. Any release of information in response to a court order is reported to the patient in a timely manner.

5. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.

J. Treatment of Minors - The Contractor has written policies regarding the appropriate treatment of minors.

K. Assessment of Member Satisfaction - The Contractor conducts periodic surveys of member satisfaction with its services.

1. The surveys include content on perceived problems in the quality, availability, and accessibility of care.
2. As a result of the surveys, the Contractor:

a. identifies and investigates sources of dissatisfaction;

b. outlines action steps to follow-up on the findings; and

c. informs providers of assessment results.

3. The Contractor reevaluates the effects of the above activities.

STANDARD XI: STANDARDS FOR AVAILABILITY AND ACCESSIBILITY

The Contractor has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and member service lines). Performance on these dimensions of access are assessed against the standards.

STANDARD XII: STANDARDS FOR FACILITIES

A. The Contractor maintains standards for facilities in which patients receive ambulatory care. These standards address:

1. compliance with existing State and local laws regarding safety and accessibility;

2. availability of emergency equipment;

3. storage of drugs; and

4. inventory control for expired medications.

B. A requirement for adherence to these standards is contained in all of the Contractor's provider contracts.

STANDARD XIII: DENTAL RECORD STANDARDS

A. Accessibility and Availability of Dental Records -

1. The organization shall include provisions in provider contracts for appropriate access to the dental records of its enrollees for purposes of quality reviews conducted by the Secretary, TennCare agencies, or agents thereof.

2. Records are available to dental care practitioners at each encounter.

B. Recordkeeping - Dental records may be on paper or electronic media. The Contractor takes steps to promote maintenance of dental records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review as follows:

1. Dental Record Standards - The Contractor sets standards for dental records. These standards shall, at a minimum, include requirements for:

a. Patient Identification Information - Each page in the record contains the patient's name or patient ID number.

b. Personal/biographical Data - Personal/biographical data includes: age; sex; address; employer; home and work telephone numbers; and marital status.

c. Entry Date - All entries are dated.

d. Provider Identification - All entries are identified as to author.

e. Legibility - The record is legible to someone other than the writer. Any record judged illegible by one reviewer should be evaluated by a second reviewer. If still illegible, it shall be considered deficient.

f. Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies - NKA) is noted in an easily recognizable location.

g. Past Medical History - (for patients seen three or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For children, past medical history relates to prenatal care and birth.

h. Immunizations - (for pediatric records ages 12 and under) There is a completed immunization record or a notation that immunizations are up-to-date.

i. Diagnostic information.

j. Medication information.

k. Identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record.

l. Smoking/ETOH/Substance Abuse - (For patients 12 years and over and seen three or more times) Notation concerning cigarettes and alcohol use and substance abuse is present. Abbreviations and symbols may be appropriate.

m. Referrals and Results Thereof.

n. Emergency Care.

2. Patient Visit Data - Documentation of individual encounters must provide adequate evidence of, at a minimum:

a. History and Physical Examination - Appropriate subjective and objective information is obtained for the presenting complaints.

b. Plan of Treatment.

c. Diagnostic Tests.

d. Therapies and other Prescribed Regimens.

e. Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.

f. Consultations, Referrals and Specialist Reports - Notes from any consultations are in the record. Consultation, lab and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.

g. All Other Aspects of Patient Care, Including Ancillary Services.

C. Record Review Process -

1. The Contractor has a record review process to assess the content of dental records for legibility, organization, completion and conformance to its standards.

2. The record assessment system addresses documentation of the items listed in B, above.

STANDARD XIV: UTILIZATION REVIEW

A. Written Program Description - The Contractor has a written utilization management program description which includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to detect underutilization as well as overutilization.

C. Preauthorization and Concurrent Review Requirements - For organizations with preauthorization

or concurrent review programs:

1. The Contractor shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantative coverage limits, whether explicit or defacto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her history.

2. Preauthorization and concurrent review decisions are supervised by qualified dental professionals.

3. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating dentists as appropriate.

4. The reasons for decisions are clearly documented and available to the member.

5. There are well-publicized and readily available appeals mechanisms for both providers and patients.

6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.

7. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.

8. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

STANDARD XVI: QMP DOCUMENTATION

A. Scope - The organization shall document that it is monitoring the quality of care across all services and all treatment modalities, according to its written QMP.

B. Maintenance and Availability of Documentation - The Contractor must maintain and make available to the State, and upon request to the Secretary, studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QM activities and corrective actions.

STANDARD XVII: COORDINATION OF QM ACTIVITY WITH OTHER MANAGEMENT ACTIVITY

The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QM activity, are documented and reported to appropriate individuals within the organization and through the established QM channels.

A. QM information is used in recredentialing, recontracting and/or annual performance evaluations.

B. QM activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.

C. There is a linkage between QM and the other management functions of the dental plan such as:

1. network changes;

2. benefits redesign;

3. medical management systems (e.g., precertification);

4. practice feedback to dentists;

5. patient education; and

6. member services.

CLINICAL AND HEALTH SERVICES DELIVERY AREAS OF CONCERN, QUALITY INDICATORS, AND CLINICAL PRACTICE GUIDELINES FOR QUALITY IMPROVEMENT IN TennCare ORGANIZATIONS

I. INTRODUCTION

The section entitled "GUIDELINES FOR INTERNAL QUALITY MONITORING PROGRAMS OF ORGANIZATIONS CONTRACTING WITH TennCare" (the Guidelines) describes the activities which TennCare requires as standards for internal quality assurance programs (QMPs). The Guidelines, in part, call for TennCare Contractors responsible for administering medical/dental services to implement a systematic process of quality assessment and improvement by which the care delivered to enrollees is monitored, evaluated, and continually improved to comply with the Guidelines for internal QMPs.

II. QUALITY OF CARE STUDIES

An organization cannot monitor the care delivered to every enrollee each time he or she requires health care. Such an attempt would be beyond the organization's and State and Federal resources. As an alternative, the organization shall select certain aspects of care to monitor over a specified time period. Over subsequent time periods, monitoring will be repeated in that area to detect patterns of care over time, and new areas will be selected for initial study. Such monitoring takes place through focused quality of care studies.

Focused quality of care studies are detailed investigations of certain aspects of health care services which are designed to answer defined questions about the quality and appropriateness of care and point the way to how that care can be improved. Such focused studies are superior to random or unfocused record reviews because they provide information about care in the aggregate as opposed to information about the care received by a limited number of enrollees.

III. CLINICAL AND HEALTH SERVICES DELIVERY AREAS OF CONCERN:

Item II. A. in the "Guidelines for Internal Quality Monitoring Programs of Organizations Contracting with TennCare", states in part:

"The QMP has written guidelines for its quality of care studies...which shall include:

1. specification of clinical or health services delivery area to be monitored -

   a. The monitoring and evaluation of care reflects the population served by the organization in terms of age groups, disease categories, and special risk status.

   b. For the TennCare population, the QMP monitors and evaluates, at a minimum, care and services in certain priority areas of concern selected by the State. These may be taken from among those identified by HCFA's Medicaid Bureau, or other sources as deemed necessary by TennCare."

A review of the literature and discussion with health authorities pertaining to the prevalence and significance of health concerns has lead to the identification of the following priority clinical and health services delivery areas of concern. With the exception of the identification of pregnancy, childhood immunizations, and continuity of care, as required for continuous monitoring and evaluation by plans, the areas listed below are <u>not</u> listed in any order of priority.

Clinical areas of concern:

Dental Screening and Services for Individuals less than 21 Years of Age.

Health Services Delivery Areas of Concern:

1. Continuity/Coordination of Care (Required continual monitoring with quarterly reporting)

2. Access to Care

3. Utilization of Services

4. Health Education

5. Emergency Services

One of the health services delivery areas of concern (continuity/coordination of care) is required for <u>continuous</u> evaluation and study if applicable to the patient population. In addition, it is required that Contractor select on a quarterly basis, at least one additional area of concern to study. This may be a follow-up of a previously performed evaluation or a new study. Areas of concern may come from the above noted list, or at the discretion of the Contractor, from another source. In addition, the Contractor will perform such studies as the State may direct. Effective July 1, 2001, all entities contracted with TennCare for the provision of services to children are required to begin a continuous evaluation and study of access to EPSDT services for individuals less than twenty-one (21) years of age. A copy of the study design shall be submitted to TennCare for review and approval within ninety (90) days of the effective date of this Agreement.

IV. *CLINICAL PRACTICE GUIDELINES/STANDARDS:*

The identification of areas needing improvement and the creation of a baseline for future assessment necessitates specifying goals or standards for health services to which care actually delivered can be compared. Item II. C. in the Guidelines states, in part, that:

> "a. The QMP studies and other activities monitor quality of care against clinical or health services delivery standards or practice guidelines specified for each clinical or health services delivery area identified in II. A., above...".

Clinical care standards, practice guidelines, practice options and practice advisories are all types of "practice parameters". Practice parameters are recommendations or an agreed upon set of principles for the delivery of certain types or aspects of dental care. They are promulgated by authoritative bodies such as professional associations or ad-hoc "expert committees". Because professional judgment may often vary, there can frequently be more than one set of practice parameters addressing the same topic. However, the vast majority of dental professional organizations endorse the use of practice parameters in improving the quality of dental care.

For this reason, the Guidelines recommend monitoring quality of care using clinical care standards or practice guidelines for each clinical or health services delivery area selected by the Contractor or State for study.

For other clinical or health services delivery areas to be studied by the Contractor as part of its agreement with TennCare, the Contractor and TennCare shall agree upon the clinical practice standards or practice guidelines which are to be utilized by the Contractor in its evaluation of care. If TennCare wishes the Contractor to evaluate care in an area in which the organization has not already adopted a set of practice guidelines, the organization and TennCare will agree upon usage of existing clinical practice standards/practice guidelines based upon those already developed by authoritative bodies.

V. *QUALITY INDICATORS:*

In conducting quality of care studies, the organization assesses care through the use of objective indicators. Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered health care and/or to monitor the process or outcome of care delivered in that clinical area. Item II. B. of the Guidelines states:

> "a. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience...
>
> b. For the priority areas selected by the State from CMS Bureau's list of priority clinical and health services delivery areas of concern, or other sources as deemed necessary by the State, the Contractor shall monitor and evaluate quality of care through studies which include, but are not limited to, the quality indicators also specified by CMS Bureau or the State."

TennCare and the Contractor shall mutually determine clinical indicators to be monitored for each clinical or health services delivery area of concern. Because of its importance, continuity/coordination of care indicators shall be monitored by the organization on a continuous basis (as opposed to on a one time basis) and reported to TennCare on a Quarterly basis. At its own discretion or as directed by TennCare, the Contractor should identify, based on clinical practice guidelines described above, additional clinical indicators to be monitored for the additionally selected clinical conditions.

In addition, TennCare shall use individual encounter data and other required reports to monitor performance on an on-going basis.

ATTACHMENT V
Definitions

The terms used in this Agreement shall be given the meaning used in the Rules and Regulations of the Bureau of TennCare. However, the following terms when used in this Agreement, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between the Definitions, Addendum, Attachments, and other Sections of this Agreement, the language in Sections A through E of this Agreement shall govern.

1. Administrative Cost – All costs to the Contractor related to the administration of this Agreement. Costs of subcontractors engaged solely to perform a non-medical administrative function for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Agreement (including, but not limited to, claims processing, marketing, postage, personnel, rent) are considered to be an "administrative cost".

2. Administrative Services Fee - The per member per month amount that the Contractor will charge for provision of the services outlined in this Agreement.

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

4. Appeal Procedure - The process to resolve an enrollee's right to contest verbally or in writing, any adverse action taken by the Contractor to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by TennCare rule 1200-13-12-.11 and any and all applicable court orders. Complaint shall mean an enrollee's right to contest any other action taken by the Contractor or service provider other than those that meet the definition of an adverse action.

5. Benefits - A schedule of health care services to be delivered to enrollees covered in the Contractor's plan developed pursuant to Attachment II of this Agreement.

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

7. CFR - Code of Federal Regulations

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

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

10. CMS - Centers for Medicare and Medicaid Services (formerly HCFA).

11. Community Service Area - Community Service Area (CSA) shall mean one (1) or more counties in a defined geographical area in which the Contractor is authorized to enroll providers and serve TennCare members.

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

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

12. Covered Service - See Benefits at A.1.2 of the Agreement

13. Cultural Competence - the level of knowledge-based skills required to provide effective clinical care to patients of particular ethnic or racial groups.

14. DBM – Dental Benefits Manager.

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

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

17. Emergency Services – means covered inpatient and outpatient services that are: furnished by a provider that is qualified to furnish these services under this title and that are needed to evaluate or stabilize an emergency medical condition.

18. Emergency Medical Condition – means a medical 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 medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

19. Enrollee - A Medicaid recipient or Medicaid Waiver recipient who is currently enrolled in an MCO, PIHP, PAHP or PCCM in a given managed care program.

20. Enrollee Month – A month of health care coverage for the TennCare eligible enrolled in a Dental Plan.

21. Enrollment - The process by which a person becomes a member of the Contractor's plan through the TennCare Bureau.

22. EPSDT - The Early, Periodic Screening, Diagnosis, and Treatment services mandated by 42 U.S.C. § 1396d(e) and amended by OBRA 1989. EPSDT services shall mean:

    (a) Screening in accordance with professional standards, interperiodic screenings, and diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare enrollees under age twenty-one (21) and

    (b) Health care, treatment, and other measures, described in 42 U.S.C. § 1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.

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

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

25. FTE - Full time equivalent position.

26. Grand Region – A defined geographical region that includes specified Community Service Areas in which a Contractor is authorized to enroll providers

and serve TennCare members. The following Community Service Areas constitute the three (3) Grand Regions in Tennessee:

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

27. Handicapping Malocclusion – for the purposes of determining eligibility for orthodontia shall mean the presence of abnormal dental development that has at least one of the following:

- A medical condition and/or a nutritional deficiency with medical physiological impact, that is documented in the physician progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to medical treatment without orthodontic treatment.
- The presence of a speech pathology, that is documented in speech therapy progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to speech therapy without orthodontic treatment.
- Palatal tissue laceration from a deep impinging overbite where lower incisor teeth contact palatal mucosa. This does not include occasional biting of the cheek.

Anecdotal information is insufficient to document the presence of a handicapping malocclusion. Anecdotal information is represented by statements that are not supported by professional progress notes that the patient has difficulty with eating, chewing, or speaking. These conditions may be caused by other medical conditions in addition to the malalignment of the teeth.

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

29. Immediate Eligibility – Temporary eligibility granted to a child upon entering into DCS Custody in order to give children in DCS adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility.

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

31. Medical Record - A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, medical services ordered for the member and medical services received by the member.

32. Medically Necessary - Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:

a. Consistent with the symptoms or diagnosis and treatment of the enrollee's condition, disease, ailment or injury, and

b. Appropriate with regard to standards of good dental practice; and

c. Not solely for the convenience of an enrollee, dentist, institution or other provider; and

d. The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and

e. When applied to enrollees under 21 years of age who are eligible for EPSDT, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

33. Member - A person who is eligible for the Contractor's plan under the provisions of this Agreement with TennCare. (See Enrollee, also).

34. NAIC – National Association of Insurance Commissioners.

35. Non-Contract Provider - Any person, organization, agency, or entity that is not directly or indirectly employed by or through the Contractor or any of its subcontractors pursuant to the Agreement between the Contractor and TennCare.

36. Office of the Inspector General - A Unit established to help prevent, identify and investigate fraud and abuse within the healthcare system, most notably the TennCare system.

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

38. Potential Enrollee – A Medicaid recipient or Medicaid Waiver recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, and PCCM.

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

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

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

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

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

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

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

46. Quality Improvement (QI) - The ongoing process of responding to data gathered through quality monitoring efforts, in such a way as to improve the quality of health care delivered to individuals. This process necessarily involves follow-up studies of the measures taken to effect change in order to demonstrate that the desired change has occurred.

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

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

49. Service Site - The locations designated by the Contractor at which members shall receive oral health treatment and preventive services.

50. Services - The benefits described in Section A.1.2.

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

52. Specialty Services – Includes Pediatric Dentistry, Oral Surgery, Endodontics and Orthodontics.

53. State - State of Tennessee.

54. Subcontract - An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Agreement, (e.g., claims processing, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Agreement. Agreements to provide covered services as described in Section A.1.2. of this Agreement shall be considered Provider Agreements and governed by Section A.11 of this Agreement.

55. SubContractor - Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Agreement.

56. TennCare - The State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this Agreement. Such entity(ies) may include, but are not limited to, the TennCare Bureau, the Department of Health, the Department of Finance and Administration, the Department of Mental Health and Mental Retardation, the TennCare Division within the Tennessee Department of Commerce and Insurance and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.

57. TennCare Medicaid Enrollee – an enrollee who qualifies and has been determined eligible for benefits in the TennCare program through Medicaid eligibility criteria as described in the Medicaid/TennCare Rules and Regulations.

58. 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".

59. Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The State agency responsible for the investigation of provider fraud and abuse in the State Medicaid Program.

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

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

ATTACHMENT VI

Provider Reimbursement Fee Schedule

The procedure codes and fees listed below **do not** represent a listing of authorized, TennCare covered services for which the Contractor is responsible to provide under the terms of the Agreement. This listing is provided in order to address required reimbursement amounts for services provided by the Contractor subject to the terms of this Agreement. Services for which the Contractor is obligated to cover in accordance with this Agreement that are not identified in the procedure codes and fees listed below shall be submitted to TennCare in accordance with Section A.22.2.a of this Agreement.

PROC	NAME OF PROCEDURE	PROVIDER FEE
DIAGNOSTIC		
Clinical Oral Examinations		
D0120	Periodic oral evaluation	$ 24.00
D0150	Comprehensive oral evaluation	$ 35.00
Radiographs		
D0210	Intraoral – complete series (including bitewings)	$ 75.00
D0220	Intraoral - periapical - lst film	$ 15.00
D0230	Intraoral – periapical - each additional film	$ 12.00
D0270	Bitewing – single film	$ 14.00
D0272	Bitewings – two films	$ 22.00
D0274	Bitewings – four films	$ 34.00
D0330	Panoramic film	$ 60.00
D0340	Cephalometric film	$ 60.00
PREVENTIVE		
Dental Prophylaxis		
D1110	Prophylaxis – adult	$ 45.00
D1120	Prophylaxis – child	$ 35.00
Topical Fluoride Treatment (Office Procedure)		
D1203	Topical application of fluoride (prophylaxis not included) – child	$ 20.00
D1204	Topical application of fluoride (prophylaxis not included) – adult	$ 20.00
Other Preventive Services		
D1351	Sealant – per tooth	$ 28.00
Space Maintenance (Passive Appliances)		
D1510	Space maintainer – fixed – unilateral	$ 175.00
D1515	Space maintainer – fixed – bilateral	$ 253.00
D1550	Recementation of space maintainer	$ 38.00
RESTORATIVE		
Amalgam Restorations (Including polishing)		
D2140	Amalgam – 1 surface – primary	$ 58.00
D2150	Amalgam – 2 surface – primary	$ 70.00
D2160	Amalgam – 3 surface – primary	$ 82.00

D2140	Amalgam – 1 surface – permanent	$ 61.00
D2150	Amalgam – 2 surface – permanent	$ 76.00
D2160	Amalgam – 3 surface – permanent	$ 88.00
D2161	Amalgam – 4+ surface – permanent	$ 101.00
Resin Restorations		
D2330	Composite – I surface – anterior– primary	$ 75.00
D2331	Composite – 2 surfaces – anterior– primary	$ 90.00
D2332	Composite – 3 surfaces – anterior– primary	$ 108.00
D2335	Composite – 4 or more surfaces or involving incisal angle (anterior) – primary	$ 143.00
D2330	Composite – I surface – anterior– permanent	$ 75.00
D2331	Composite – 2 surfaces – anterior– permanent	$ 90.00
D2332	Composite – 3 surfaces – anterior– permanent	$ 108.00
D2335	Composite – 4 or more surfaces or involving incisal angle (anterior) – permanent	$ 143.00
D2390	Composite – crown, anterior – primary	$ 165.00
D2390	Composite – crown, anterior – permanent	$ 170.00
D2391	Composite – 1 surface, posterior – primary	$ 71.00
D2392	Composite – 2 surfaces, posterior – primary	$ 89.00
D2393	Composite – 3 or more surfaces, posterior, primary	$ 112.00
D2391	Composite – 1 surface, posterior – permanent	$ 82.00
D2392	Composite – 2 surfaces, posterior – permanent	$ 100.00
D2393	Composite – 3 surfaces, posterior – permanent	$ 125.00
D2394	Composite – 4 or more surfaces, posterior – permanent	$ 173.00
Crowns – Single Restorations Only		
D2740	Crown – porcelain/ceramic substrate	$ 600.00
D2750	Crown – porcelain fused to high noble metal	$ 575.00
D2751	Crown – porcelain fused to predominately base metal	$ 544.00
D2752	Crown – porcelain fused to noble metal	$ 560.00
Other Restorative Services		
D2920	Re-cement crown	$ 50.00
D2930	Prefabricated stainless steel crown – primary tooth	$ 125.00
D2931	Prefabricated stainless steel crown – permanent tooth	$ 157.00
D2932	Prefabricated Resin crown	$ 165.00
D2933	Stainless steel crown, with resin window	$ 174.00
D2940	Sedative filling	$ 53.00
D2950	Core build up, including any pins	$ 130.00
D2951	Pin retention - per tooth, in addition to restoration	$ 36.00
D2952	Cast post and core, in addition to crown	$ 200.00
D2954	Prefabricated post and core	$ 170.00
ENDODONTICS		
Pulpotomy		
D3220	Therapeutic pulpotomy (excluding final restoration)	$ 95.00
D3221	Gross pulpal debridement – primary and permanent	$ 98.00
Endodontic Therapy on Primary Teeth		
D3230	Pulpal therapy, anterior – primary	$ 98.00
D3240	Pulpal therapy, posterior – primary	$ 98.00

Endodontic Therapy (including treatment plan, clinical procedures, and follow-up care)		
D3310	Root canal – Anterior (excluding final restoration)	$ 355.00
D3320	Root canal – Bicuspid (excluding final restoration)	$ 425.00
D3330	Root canal – Molar (excluding final restoration)	$ 519.00
Apexification/Recalcification Procedures		
D3351	Apexification/recalcification – initial	$ 201.00
D3352	Apexification/recalcification – interim	$ 91.00
D3353	Apexification/recalcification – final	$ 139.00
Apicoectomy/Periradicular Services		
D3410	Apicoectomy/Periradicular Surgery – Anterior	$ 349.00
D3421	Apicoectomy – Biscupid (first root)	$ 363.00
D3425	Apicoectomy – Molar (first root)	$ 393.00
D3426	Apicoectomy – each additional root	$ 185.00
D3430	Retrograde filling – per root	$ 136.00
PERIODONTICS		
Surgical Services (Including Usual Post Operative Services)		
D4210	Gingivectomy or gingivoplasty – four or more teeth per quadrant	$ 330.00
D4211	Gingivectomy or gingivoplasty – one to three teeth per quadrant	$ 99.00
Adjunctive Periodontal Services		
D4341	Periodonal scaling and root planing – four or more teeth per quadrant	$ 135.00
PROSTHODONTICS (REMOVABLE)		
Complete Dentures (Including Routine Post-Delivery Care)		
D5110	Complete denture – maxillary	$ 724.00
D5120	Complete denture – mandibular	$ 724.00
Partial Dentures (Including Routine Post-Delivery Care)		
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth	$ 549.00
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth	$ 554.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$ 800.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth	$ 800.00
Repairs to Complete Dentures		
D5510	Repair broken complete denture base	$ 100.00
D5520	Replace missing or broken teeth – complete denture (each tooth)	$ 85.00
Repairs to Partial Dentures		
D5610	Repair resin denture base	$ 95.00
D5620	Repair cast framework	$ 150.00
D5630	Repair or replace broken clasp	$ 125.00
D5640	Replace broken teeth – per tooth	$ 85.00
D5650	Add tooth to existing partial denture	$ 105.00
D5660	Add clasp to existing partial denture	$ 125.00
Denture Reline Procedures		
D5730	Reline complete maxillary denture (chairside)	$ 175.00

D5731	Reline complete mandibular denture (chairside)	$ 175.00
D5740	Reline partial maxillary denture (chairside)	$ 148.00
D5741	Reline partial mandibular denture (chairside)	$ 148.00
D5750	Reline complete maxillary denture (laboratory)	$ 228.00
D5751	Reline complete mandibular denture (laboratory)	$ 220.00
D5760	Reline partial maxillary denture (laboratory)	$ 213.00
D5761	Reline partial mandibular denture (laboratory)	$ 213.00
ORAL AND MAXILLOFACIAL SURGERY		
Extractions (Includes Local Anesthesia, Suturing if needed, and Routine Postoperative Care)		
D7140	Extraction – erupted tooth or exposed root	$ 68.00
Surgical Extractions (Includes Local Anesthesia, Suturing if needed, and Routine Postoperative Care)		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$ 133.00
D7220	Removal of Impacted tooth – soft tissue	$ 169.00
D7230	Removal of impacted tooth – partially bony	$ 220.00
D7240	Removal of impacted tooth – completely bony	$ 255.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$ 148.00
Other Surgical Procedures		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$ 278.00
D7280	Surgical access of an unerupted tooth	$ 204.00
D7283	Placement of device to facilitate eruption of impacted tooth	$ 37.00
D7285	Biopsy of oral tissue – hard	$ 153.00
D7286	Biopsy of oral tissue – soft	$ 143.00
Alveoloplasty-Surgical Preparation of Ridge for Dentures		
D7310	Alveoloplasty in conjunction with extractions – per quadrant	$ 133.00
D7320	Alveoloplasty not in conjuction with extractions – per quadrant	$ 182.00
Removal of Tumors, Cysts and Neoplasms		
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$ 266.00
D7471	Removal of lateral exostosis – (maxilla or mandible)	$ 154.00
D7510	Incision & drainage – intraoral	$ 121.00
Other Repair Procedures		
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	$ 208.00
ORTHODONTICS		
Comprehensive Orthodontic Treatment		
D8080	Comprehensive orthodontic treatment – adolescent – banding and records	$ 1,300.00
	Maximum comprehensive case rate of $3,600 including one set of retainers and 12 months adjustments	
Other Orthodontic Services		
D8660	Pre-orthodontic visit	$ 50.00
D8670	Periodic orthodontic treatment visit – maximum of 23 monthly payments	$ 100.00
D8680	Orthodontic retention	$ 350.00
ADJUNCTIVE GENERAL SERVICES		

Unclassified Treatment		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$ 50.00
Anesthesia		
D9220	Deep sedation/general Anesthesia – first 30 minutes	$ 233.00
D9221	Deep sedation/general Anesthesia – each additional 15 minutes	$ 79.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide)	$ 30.00
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	$ 197.00
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	$ 71.00
D9248	Non-intravenous conscious sedation	$ 89.00

ATTACHMENT VII

LOBBYING DISCLOSURE

Complete this form to disclose TennCare-related* lobbying relationships entered into or existing in the previous fiscal year. Each lobbying relationship/contract requires a separate form.

State of Tennessee
Bureau of TennCare

1. Type of Relationship: *(e.g., ongoing, one-time)*	**2. Stated Purpose of the Relationship:**	**3. Report Type:** a. Initial Filing b. Material Change **For Material Change Only:** Year _____ Quarter _____ Date of last Report _____
4. Name and Address of Reporting Entity:	**5. Total Reimbursement Paid to Lobbyist:** $	
6. Name and Address of Lobbying Registrant: *(If individual, last name, first name, MI)*	**7. Individuals Performing Services:** *(Including address if different from No. 6)*	

8. List of Individuals Lobbied:
(Including name, job title, subject matter of lobbying activity(ies) and total value of all gifts/ remuneration received)

9. "I hereby affirm that to the best of my knowledge my organization and its sub-contractors remain in compliance with state contractual requirements barring payment to state officials."

Signature: _____

Print Name: _____ Title: _____

Telephone No.: _____ Date: _____

* Disclosure is required if any portion of a lobbying relationship relates to TennCare. For those Contractors reliant on TennCare for greater than two-thirds of their total revenue in the previous fiscal year, all lobbying contracts will be presumed to be TennCare-related.

** Attach additional sheets if necessary. Include the name of the Reporting Entity and date on each additional sheet.

INSTRUCTIONS FOR COMPLETION OF LOBBYING DISCLOSURE FORM FOR THE BUREAU OF TENNCARE

This disclosure form shall be filed with TennCare and the TennCare Oversight Committee annually by the reporting entity no later than December 31 of each year, beginning on December 31, 2005; however an ongoing duty exists to amend and update all filings. All TennCare-related lobbying relationships and/or contracts should be disclosed on a separate form. Disclosure is required if any portion of funds received under a contract, grant or other relationship with TennCare was paid to a lobbyist or lobbying entity as defined by Tenn. Code Ann. 3-6-102 and as further defined in E.14 of the Agreement. For those Contractors reliant on TennCare for greater than two-thirds of their total revenue in the previous fiscal year, all lobbying contracts will be presumed to be TennCare-related. This form has been designed consistent with federal regulations, 31 U.S.C. 1352 and 42 CFR 93.100. Refer to the implementing guidance provided by the Federal Office of Management and Budget for additional information.

1. Identify the type of lobbying relationship being disclosed (*e.g. ongoing, one-time).* Use a separate form for each lobbyist contract or relationship.

2. Identify the purpose of the lobbying relationship as quoted in the contractual agreement.

3. Identify the appropriate classification of this disclosure. Any material change to information previously reported should be disclosed in an amended form within five (5) business days.

4. Enter the full name, address, city, state and zip code of the reporting entity.

5. Enter the total reimbursement paid to lobbyist in the previous fiscal year.

6. Enter the full name, job title, address, city, state and zip code of the lobbying registrant engaged by the reporting entity identified in item 4.

7. Enter the full name(s) of the individual(s) performing services and include full address if different from item 6. Enter last name, first name, middle initial (MI), and job title.

8. Enter the full name(s), job title(s) of individuals lobbied, the subject matter of the lobbying activity(ies) and the total value of all gifts/remuneration received. (See Tenn.Code Ann. 3-6-102 and Section E.14 of the Agreement for a definition of relevant lobbying activities)

9. The certifying contractor or vendor Chief Executive Officer shall sign and date the affirmation, print his/her name, title, and telephone number.