REISSUE OF CONTRACT

between

THE STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

AND

PREMIER BEHAVIORAL HEALTH, L.L.C.

This CONTRACT is entered into by and between the State of Tennessee, Department of Mental Health and Developmental Disabilities, hereinafter referred to as **"TDMHDD"**, and **Premier Behavioral Health, L.L.C.** hereinafter referred to as the "**Contractor**", for the provision of covered mental health and substance abuse services to **Enrollees** in **the TennCare Partners Program** and to certain other persons identified by **TDMHDD**, as described below.

WHEREAS, mental health and substance abuse services are covered under the current **TennCare** Program; and

WHEREAS, **TDMHDD** provides additional mental health services outside the managed care portion of the **TennCare** Program which are funded by **TennCare**, as well as additional mental health services outside the **TennCare** Program which are funded with State and/or federal funds; and

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

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

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

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

WHEREAS, it is the intent of **TDMHDD** to contract with Behavioral Health Organizations (BHOs) for the purpose of delivering mental health and substance abuse services covered by the **TennCare Partners Program** as well as certain services for specified non-Enrollees; and

WHEREAS, the purpose of this CONTRACT is to assure Tennesseans of quality mental health and substance abuse services while controlling the cost of such mental health and substance abuse services; and

WHEREAS, consistent with waivers granted by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (DHHS), the State of Tennessee has been granted the authority to pay a monthly prepaid capitated amount to BHOs for rendering or arranging necessary mental health and substance abuse services to persons currently enrolled in the State of Tennessee's **TennCare** Program, which includes Tennesseans who are Medicaid-eligible under the previous Medicaid Program and non-Medicaid-eligible Tennesseans who are uninsured or are uninsurable as well as certain non-**TennCare** individuals who are described within the body of this CONTRACT hereinafter referred to as the "**TennCare Partners Program**"; and

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

WHEREAS, the **Contractor** is a Behavioral Health Organization (BHO), has met qualifications established by **TDMHDD**, is capable of providing or arranging for mental health care and substance abuse services to covered persons for whom it has received prepayment, and is engaged in said business and is willing to do so upon and subject to the terms and conditions hereof; and

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

SECTION 1. PREAMBLE

1.1 Titles

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

1.2 Notice

All notices required to be given under this CONTRACT shall be given in writing, and shall be sent by United States Certified Mail, Postage Prepaid, Return Receipt Requested, in person, or by other means, so long as proof of delivery and receipt is given to the appropriate party at the address given below, or at such other address (or addresses) as may be provided by notice given under this Section:

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

Premier Behavioral Systems of Tennessee, L.L.C.
Ann Boughtin, General Manager
Premier Behavioral Systems of Tennessee, L.L.C.
222 Second Avenue North, Suite 220
Nashville, Tennessee 37201

1.3 Entire CONTRACT

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

1.4 Amendments

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

If significant changes are made in the scope of services under the **TennCare Partners Program** (other than Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandated services as provided by this CONTRACT), as mandated by court order or by actions of the Congress, the State, the State Legislature, CMS, DHHS or any agency of the State government, **TennCare** shall review and adjust the capitation amount accordingly subject to the availability of State appropriations for the mandate. **TennCare** shall be solely responsible for determining whether court orders or other actions constitute significant changes in the scope of services under the **TennCare Partners Program** and the amount of any adjustment to be applied. The **Contractor** shall have the right to provide notice of termination within twenty-one (21) calendar days of receipt of a court order mandating changes under the **TennCare Partners Program**. If the **Contractor** elects to provide written notice of termination, said termination shall be effective 180 calendar days from the date of receipt by **TDMHDD** and the **Contractor** shall comply with all requirements of Section 5.1.2 and 6.18 as directed by **TennCare**.

1.5 Incorporation by Reference

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

1.6 Order of Precedence

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

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

1.6.2 This CONTRACT, and any amendment to this CONTRACT.

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

1.6.4 The Partners Program Proposal submitted by **TDMHDD** to CMS.

1.6.5 The BHO Application submitted by the **Contractor**.

1.6.6 Technical specifications provided to the **Contractor**.

1.7 Definitions

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

1.8 Applicability of this CONTRACT

All terms, conditions, and policies stated in this CONTRACT apply to staff, agents, officers, sub**contractor**s, providers, volunteers and anyone else acting for or on behalf of the **Contractor**. **TennCare Enrollees** and certain non-**TennCare** eligibles identified by **TDMHDD** are the intended third party beneficiaries of contracts between the State and behavioral health organizations and of any subcontracts or provider contracts entered into by behavioral health 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 **TDMHDD** or the State of Tennessee by **Enrollees** beyond any that may exist under state or federal law.

1.9 Fraud and Abuse

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

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

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

1.9.1 <u>Reporting and Investigating Fraud and Abuse</u>

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

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

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

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

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

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

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

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

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

1.9.1.9 The **CONTRACTOR** shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, the provider must comply with Section 1-9 of this Agreement.

1.9.1.10 Except as described in Section 3.4.4.8 of this Agreement, nothing herein shall require the **CONTRACTOR** to assure non-participating providers are compliant with **TENNCARE** contracts or state and/or federal law.

1.9. 2 Fraud and Abuse Compliance Plan

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

1.9.2.2 The fraud and abuse compliance plan shall:

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

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

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

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

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

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

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

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

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

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

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

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

1.9.2.5 The **CONTRACTOR** shall submit an annual report to the Bureau of TennCare, Office of Contract Compliance and Performance, summarizing the results of its fraud and abuse compliance plan and other fraud and abuse prevention, detection, reporting, and investigation measures as required by section 1-9 of this Agreement. The report should cover results for the year ending June 30 and be submitted by September 30 each year. The information in this report shall be provided in accordance with and in a format as described in the **CONTRACTORS** approved compliance plan.

1.10 Administration and Management

The **Contractor** shall be responsible for the administration and management of all aspects of this CONTRACT and the health plan provided here under. This includes all subcontracts, provider contracts, employees, agents, and anyone acting for or on behalf of the **Contractor**. All subcontracts and revisions thereto, as defined in Attachment A of this CONTRACT, shall be approved in advance by **TennCare** and must contain either a copy of the Quality of Care Monitors or incorporate the Quality of Care Monitors by reference and must specify that the sub**Contractor** adhere to the Quality of Care Monitors. Provider contracts, as defined in Attachment A of this CONTRACT, shall not require **TennCare** prior approval but must contain all of the items listed in Section 3.9.2 of this CONTRACT.

However, no subcontract, provider contract or other delegation of responsibility terminates or reduces the legal responsibility of the **Contractor** to **TDMHDD** to assure all activities under this CONTRACT are carried out.

SECTION 2. TENNCARE PARTNERS PROGRAM DESCRIPTION

2.1 Overview

The **TennCare Partners Program** is designed to complement the **TennCare** Program implemented through the State's Section 1115(a) waiver (No. 11-W-0015/4). The purpose of the **TennCare Partners Program** is to provide mental health and substance abuse services to all **TennCare Enrollees** and certain non-**TennCare** individuals. The **TennCare Partners Program** is delivered through BHOs operating under contract to **TDMHDD**.

2.2 Eligibility for Covered Services Under the TennCare Partners Program

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

2.2.1 Enrollees

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

2.2.1.1 TennCare Medicaid Enrollees

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

2.2.1.2 TennCare Standard Enrollees

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

2.2.2 Judicials

The **Contractor** shall provide court-ordered mental health evaluation and treatment services to the following **Judicials** who are identified by **TDMHDD:** persons who are not **Enrollees** in the **TennCare Partners Program**, or who have not been determined to be **State-Only Enrollees** by **TDMHDD**, and have been court ordered to receive services identified in Section 2.5.5. **Judicials** are entitled only to coverage of those

mental health evaluation and treatment services required by the statute or court order under which the individuals were referred.

2.2.3 State-Onlys

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

will not have coverage through a **TennCare** managed care organization (MCO). **TennCare** assigns **State-Only Enrollees** to BHOs.

2.3 Enrollment Guidelines

2.3.1 Enrollment of TennCare Eligibles

Persons who are **TennCare** eligible will be automatically enrolled in the **TennCare Partners Program**. All enrollment, disenrollment, and re-enrollment policies of **TennCare** apply to **TennCare Enrollees** participating in the **TennCare Partners Program**. **TennCare Enrollees** will be assigned to one of the BHOs participating in the **TennCare Partners Program** in accordance with Section 2.3.2 below.

2.3.2 Assignment to BHOs

2.3.2.1 **TennCare Partners Program Enrollees** will be assigned to the BHOs in the following manner:

a. **Enrollees** enrolled in the **TennCare** Program will be assigned to a BHO, including the **Contractor**, based on the **TennCare** Managed Care Organization (MCO) in which s/he is enrolled. **TennCare** will assign each MCO to a BHO.

b. **Priority Enrollees** will be assigned to the BHOs including **Contractor,** by **TennCare**.

2.3.2.2 **TennCare** will make a reasonable effort to assign families to the same BHO. The **Contractor** will accept **Enrollees** assigned to its plan by **TennCare**. These **Enrollees** will be accepted in the health condition they are in at the time of enrollment. **TDMHDD** and **TennCare** reserve the right to change an **Enrollee's** BHO assignment when such a change is determined to be in the best interests of **TDMHDD** and or **Enrollees**.

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

2.3.2.4 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.

2.3.3 Choice of Providers by Enrollees

The **Contractor** shall allow each **Enrollee** to choose his/her own mental health care and substance abuse service providers from the providers participating in the

Contractor's provider network, subject to the capacity of the providers to accept **Enrollees**.

2.3.4 Judicials

Judicials will be assigned to BHOs participating in **the TennCare Partners Program** by **TDMHDD**. Their assignment as **Judicials** will end when the court ordered mental health service as described in Section 2.5.5 has ended, or the person is identified as eligible for the **TennCare Partners Program**.

2.3.5 The **Contractor** shall accept individuals in the order in which they apply without restriction, (unless authorized by the Regional Administrator), up to the limits set under the CONTRACT.

2.4 Disenrollment from the TennCare Partners Program

2.4.1 Disenrollment Guidelines

The **Contractor** will discontinue covered services to **Enrollees** who are disenrolled from the TennCare Partners Program in accordance with TennCare Rule 1200-13-13-.03 and 1200-13-14-.03 of the Tennessee Department of Finance and Administration (TDFA). Regardless of the procedures followed, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the **Enrollee** or the **Contractor** files the request. The **Contractor** may request disenrollment of an **Enrollee** in accordance with the above listed rules.

2.4.2 Unacceptable Reasons for Disenrollment

An **Enrollee** may not be terminated from the **TennCare Partners Program** or a designated BHO plan solely for any of the following reasons:

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

2.4.2.2 Pre-existing medical conditions; or

2.4.2.3 High cost medical bills.

2.4.2.4 **Enrollee's** utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his special needs.

2.4.3 Effect of Disenrollment on Capitation Payments

Payment of capitation payments shall cease effective the date of disenrollment and the **Contractor** shall have no further responsibility for the care of the **Enrollee**. Except as

indicated below, disenrollment shall not be made retroactively and the **Contractor** shall not be required to refund any capitation payments legitimately paid pursuant to this CONTRACT.

2.4.3.1 Fraudulent Enrollment by the Enrollee

If an **Enrollee** in the **TennCare Partners Program** is disenrolled under Subsection 2.4.1 because s/he falsified the application for the **TennCare Partners Program** and approval was based on false information, payment of capitation payments shall cease effective the date of disenrollment. However, the **Contractor**, at its discretion, shall refund to **TennCare** all capitation payments **TennCare** has made on behalf of the person who fraudulently enrolled in the **TennCare Partners Program**, and the **Contractor** shall pursue full restitution for all payments the **Contractor** has made for covered services while the person was fraudulently enrolled in the **Contractor's** plan.

2.4.3.2 Fraudulent Enrollment by the Contractor

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

2.4.4 Contractor's Responsibilities for Disenrollment

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

2.5 Services Covered Under the TennCare Partners Program

2.5.1 Covered Services

The **Contractor's** service system shall provide a uniform and consistent continuum of quality behavioral health services statewide that includes the active involvement of the

BHO's Advisory Board. The **Contractor** shall provide court ordered services as described in Section 2.5.5 for persons designated to receive specific mental health services as **Judicials** as described in Section 2.2.2. The **Contractor** must provide service categories and covered services that meet the standards described in Attachment B. In accordance with TENNderCare requirements, the **Contractor** shall provide all medically necessary mental health and substance abuse services to children under the age of twenty-one (21), as specified in Section 2.5.7, whether or not such

services are covered under the **TennCare Program** State Plan and whether or not the child who is in need of the service is a **Priority Enrollee**.

Effective July 1, 2002, the **Contractor** shall not be responsible for the payment of behavioral health related services provided to **Enrollees** by a TennCare Primary Care Provider under contract to a TennCare MCO.

Effective April 1, 2003, the **Contractor** shall no longer distinguish between **Basic Enrollees** and **Priority Enrollees** for the purpose of determining eligibility for covered services; all persons enrolled in **TennCare** shall be eligible for covered services as specified in Section 2.5.1.1.

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

2.5.1.2 Modifications to the TennCare Waiver

The **Contractor** shall provide services identified in Table 1: Covered Behavioral Health Benefits for persons identified as **TennCare Medicaid**, **TennCare Standard**, or **State-Onlys** in need of behavioral health services. The **Contractor** shall only provide court ordered services as described in section 2.5.5 for

persons designated to receive specific mental health services as **Judicials** as described in section 2.2.2. The BHO is not responsible for payment of services provided by a PCP with a behavioral health primary diagnosis.

Table 1: Covered Behavioral Health Benefits

Benefit	TennCare Medicaid, State-Only and Standard Coverage
Psychiatric Inpatient Hospital Services (including physician services)	As medically necessary
Outpatient Mental Health Services (including physician services)	*As medically necessary*

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

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

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

2.5.2 Accessibility and Availability of Services:

2.5.2.1 The **Contractor** shall make services, service locations and service sites available and accessible in terms of timeliness, amount and duration. The **Contractor**'s provider network shall contain a sufficient number of appropriately qualified providers to insure the access standards for geographic access (travel distance), response time for contacting active consumers in an urgent situation, and maximum time for admission to the service stated in Attachment B are met for all **Enrollees** in the **Contractor**'s plan. Emergency mental health and substance abuse services shall be available twenty-four (24) hours a day, seven (7) days a week.

2.5.2.2 Minimum standards for this CONTRACT are:

2.5.2.2.1 The **Contractor** must provide all of the services defined as covered in Section 2.5 of this CONTRACT.

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

2.5.2.2.2.1 In the event that the **Contractor** is unable to meet the standards specified in Attachment B for inpatient or residential care due to a lack of available resources in the State, the **Contractor** must propose an alternative service package(s), which may include the use of intensive home-based services, for **Enrollees** who reside in the affected area. Once approved by **TDMHDD**, the alternative service package may be offered to **Enrollees**. The alternative service package must be discussed and accepted by the **Enrollee** and his/her family or legal guardian prior to the provision of said services. A lack of available resources means that there is no resource in the state as opposed to no resource participating in the **Contractor**'s network, or an insufficient number of providers to provide adequate capacity.

2.5.2.2.2.2 In the event that a **Enrollee** requires inpatient care and the **Enrollee** has refused the alternative service package, or an **Enrollee** requires 24 hour residential care and the travel distance to the closest inpatient/residential facility exceeds the travel standards specified in Attachment B, the **Contractor** shall provide transportation regardless of

whether or not the **Enrollee** has access to transportation. If the **Enrollee** is a child who needs to be accompanied by an adult, transportation must be provided for both the child and adult.

2.5.2.2.2.3 Upon receipt of a written notice of a network deficiency from **TDMHDD**, the **Contractor** shall submit a corrective action plan specifying how the **Contractor** will insure the timely provision of care until such time as the network deficiency is cured, and, if the network deficiency is due to a lack of available resources in the State, a strategy for recruiting additional providers with the appropriate expertise to address the network deficiency, if warranted as determined by **TDMHDD**, based on the number of **Enrollee**s in need of the service in the area of the network deficiency. It is the responsibility of the **Contractor** to recruit providers with the appropriate expertise to address the network deficiency. The **Contractor** agrees by execution of this CONTRACT that no additional

funding is necessary in order to satisfy this requirement, and under no circumstances shall additional funding be sought.

2.5.2.3 The **Contractor** must have a mechanism in place to allow **Enrollees** to directly access a specialist as appropriate for the **Enrollee's** condition and identified needs as deemed medically necessary to meet the access requirements contained in Section 2.5.2.1 and Attachment B of this CONTRACT.

2.5.2.4 The **Contractor** shall insure it provides accessible and available services covered under this CONTRACT for all **Enrollees**, including those belonging to special groups. These special groups include, but are not limited to, the following:

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

2.5.2.4.2 Individuals who are dually diagnosed with both mental health and alcohol and drug abuse disorders;

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

2.5.2.4.4 Homeless individuals;

2.5.2.4.5 Persons involved with the juvenile or adult judicial system;

2.5.2.4.6 The geriatric population;

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

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

2.5.2.5 The **Contractor** must assure appropriate services in the categories of (1) Mental Health Case Management, (2) 24-hour Residential Treatment, (3) Housing and Other Residential Care, (4) Specialized Outpatient and Symptom Management Services, (5) Psychiatric Rehabilitation Services, and (6) Specialized Crisis Services are addressed in the development of the mental health case management service plan for each person who is a **Priority Enrollee**. Unless it is documented that service need in that service category is not indicated for the individual **Priority Enrollee**, the **Contractor** must offer appropriate service in each category to each **Priority Enrollee.**

Except as otherwise required in this CONTRACT, the **Contractor** shall not be responsible for coverage of treatment services to any **Enrollee** when the need for treatment services is the result of factors other than the **Enrollee's** mental health or substance abuse treatment needs.

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

2.5.3 Mental Health and Substance Abuse Maximum Lifetime Limitations

Benefit	**Maximum Lifetime Benefits**
Inpatient and Outpatient Substance Abuse Benefits	Under age 21: No lifetime limit for medically necessary benefits Age 21 and older: Non-SPMI – limited to 10 days detox, with a $30,000 limit in lifetime medically necessary benefits Age 21 and older: SPMI – **No** lifetime limit for medically necessary benefits

In accordance with federal TENNderCare regulations, these limits shall not apply to children under twenty-one (21) years of age. They also shall not apply to adults, 21 years of age or older, who have been identified as belonging in the **Priority Population.**

2.5.4 Mental Health Case Management

2.5.4.1 The **Contractor** will provide mental health case management services only through Mental Health Case Management Agencies (MHCMA) providers which are licensed by **TDMHDD** to provide mental health outpatient services.

2.5.4.2 The **Contractor** will provide mental health case management services according to mental health case management agency standards set by **TDMHDD** outlined in Attachment B. These standards include, but are not limited to, the following: the process the **Contractor** will establish for referral for mental health case management; the criteria and process for assigning a **child under age 21, including a child in State custody to mental health case management, including rationale** for how priority will be determined (this process must reflect **TDMHDD** requirements specified in Section 2.5.4.4); the criteria and process for assigning an individual to a mental health case manager; the process used to determine the intensity level of mental health case management child under age 21, including a child in State custody, will receive; the process for determining how a mental health case manager's caseload size will be determined; the identification of service need; development of a mental health case management service plan; authorization of services outlined in the mental health case management service plan; monitoring of progress; and advocacy and coordination with other agencies, particularly with primary health care providers.

2.5.4.3 The **Contractor** must offer mental health case management to all **Enrollees** in the **Contractor's** plan based on medical necessity. The accessibility and availability of these services must be thoroughly explained. Any **Enrollee** who meets the criteria outlined in Attachment B may choose to decline mental health case management services or to terminate these services once they have begun. If a child with serious emotional disturbance or mental illness is sixteen (16) years of age or older, the child has the same rights of refusal as an adult with respect to outpatient and inpatient mental health treatment, medication decisions, confidential information and participating in conflict resolution procedures with exception as provided in Title 33. However, the **Contractor** must document this refusal with a statement signed by the **Enrollee** (or the **Enrollee's** conservator, guardian, or legal custodian) which contains the following components:

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

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

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

2.5.4.3.4 Information on whom the **Enrollee** can contact in order to request mental health services in non-emergency situations.

2.5.4.3.5 A signature and date from the **Enrollee** (or the **Enrollee's** conservator or guardian) and a witness.

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

2.5.4.4 The **Contractor** must assure the continual provision of mental health case management services to children under age 21, including children in State custody, for whom mental health case management services are determined to be medically necessary under the conditions and timeframes indicated below:

2.5.4.4.1 Individuals receiving mental health case management services at the date of execution of this CONTRACT must be maintained in mental health case management until such time as the individual no longer qualifies.

2.5.4.5 The **Contractor** shall require Case Managers to involve the **Enrollee's** family or legal guardian, Primary Care Provider and other agency representatives, if appropriate, in case management activities, unless declined by the **Enrollee**. The **Contractor** must require case managers to document said refusal in the **Enrollee's** medical record.

2.5.4.6. The **Contractor** shall review the cases of **Enrollees** referred by **TennCare** Primary Care Providers, including Primary Care Providers, or the cases of **Enrollees** otherwise identified to the **Contractor** as potentially in need of case management services. The Contractor shall contact **Enrollees** under the age of 21 determined to be in need of case management on the basis of medical necessity to offer case management services, regardless of whether the **Enrollee** has been identified as a "**Priority Enrollee**".

2.5.4.7 Effective April 1, 2003, the **Contractor** shall not limit the availability of mental health case management services to persons who are diagnosed as SED or SPMI. Mental health case management services shall be provided as needed based on medical necessity to all **Enrollees**.

2.5.4.8 Abusive Utilizers of Pharmacy Services

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

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

2.5.5 Judicial Services

The **Contractor** must provide covered court ordered mental health services to **Enrollees** in the TennCare Partners Program and to **Judicials** at the direction of the court in accordance with **TDMHDD** service standards and **TDMHDD** forensic standards.

2.5.5.1 Services Required under Tennessee Law

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

2.5.5.1.1.1 Psychiatric treatment for persons found by the court to require judicial psychiatric hospitalization (Tennessee Code Annotated, §33-6, Part 4 and 5); The **Contractor** may apply medical necessity criteria to the situation after seventy-two (72) hours of emergency services, unless there is a court order prohibiting release.

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

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

2.5.5.1.1.4 Inpatient psychiatric examination for up to 48 hours for persons whom the court has ordered to be detained for examination but who have been unwilling to be evaluated for hospital admission (Tennessee Code Annotated, §33-3-607); and

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

2.5.5.1.1.6 Voluntary psychiatric hospitalization for persons who are severely impaired when determined to be medically necessary but who do not meet the criteria for emergency involuntary hospitalization, subject to the availability of suitable accommodations (TCA, 33-6, Part 3)

2.5.5.1.2 The **Contractor** must not discriminate against an **Enrollee** based on the law that may govern **Enrollee's** care.

2.5.5.1.3 The **Contractor** shall identify and assign specific staff to provide legal and technical assistance for (see 2.5.5.3.3 below) and coordination with the legal system for services provided in these categories.

2.5.5.2 Forensics

2.5.5.2.1 The **Contractor** must provide mandatory outpatient treatment for individuals found not guilty by reason of insanity following 60-90 day inpatient evaluation. Treatment can be terminated only by the court. [Tennessee Code Annotated, §33-7-303(b)]

2.5.5.2.2 The state will assume responsibility for all forensic services other than the mandatory outpatient treatment service identified in Section 2.5.5.2.1.

2.5.5.3 Other Requirements under Tennessee Law

2.5.5.3.1 The **Contractor** shall provide for the care of **Enrollees** and **Judicials** under Tennessee law requiring access to and provision of mandatory outpatient psychiatric treatment and services to persons who are discharged from psychiatric hospitals after being committed involuntarily (Tennessee Code Annotated, §33-6-201 *et seq.* and §33-7-301(b)).

2.5.5.3.2 The **Contractor** must not discriminate against an **Enrollee** or a **Judicial** based on any law that may govern the **Enrollee's** or **Judicial's** care.

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

2.5.6 Crisis Services Telephone Lines

2.5.6.1 The **Contractor** must coordinate and establish with other BHOs participating in the TennCare Partners Program one (1) widely published toll free telephone number for any individual in the general population (**Enrollees**, family members, providers, non-**Enrollees**, etc.) per Community Health Area (CHA) region as appropriate, for the purposes of immediate phone intervention by mental health staff and dispatch of mobile crisis services in the appropriate community. The same toll free telephone number may be used in multiple CHAs. This specialized telephone line will be answered by a staff person, rather than by an automated voice response system.

2.5.6.2 The **Contractor** must assure the Crisis Telephone lines are available 24-hours per day, 365 days per year.

The **Contractor** must assure the Crisis Telephone lines are linked to a mobile crisis response team and are staffed by a qualified mental health staff person for the purpose of providing immediate phone intervention **and** immediate dispatch of mobile crisis services in the appropriate community. The **Contractor** shall require mobile crisis response teams to provide face-to-face interventions in accordance with the standards specified in Attachment B.

2.5.6.3 The **Contractor** shall monitor crisis response providers and, at minimum, report rates of crisis assessments by place of service (emergency room, **Enrollee's** home, etc.), rates of diversion and rates of Regional Mental Health Institute referrals by individual crisis provider on a quarterly basis to **TDMHDD**.

2.5.7 TENNderCare

2.5.7.1 The **Contractor** shall provide any medically necessary mental health and substance abuse services covered under the federal Medicaid program to **Enrollees** under the age of twenty-one (21) eligible for said services when such services are required to correct, ameliorate or prevent from worsening mental illnesses and conditions, 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 in accordance with federal TENNderCare requirements at 42 CFR 441, Subpart B and the Omnibus Reconciliation Act of 1989. TENNderCare Services (Early and Periodic Screening, Diagnosis and Treatment of Individuals under age 21) means early and periodic screening, diagnosis and treatment of **Enrollees** under age 21 made pursuant to 42 U.S. C. Sections 1396a(a)(43), 1396d(a) and ® and 42 CFR Part 441, Subpart B to ascertain children's individual (or

individualized/or on individual basis) physical and mental defects, and providing treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered. The federal Early Periodic Screening, Diagnosis & Treatment (EPSDT) program shall be referred to as TENNderCare and all **Enrollee** and provider materials shall contain the term and logo for TENNderCare as of January 1, 2005. The **Contractor** shall be responsible for the provision of all medically necessary mental health and substance abuse services including the following:

2.5.7.1.1 Mental health and/or substance abuse assessments requested as follow-up to a TENNderCare screening;

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

2.5.7.1.3 Other necessary mental health and substance abuse services, diagnostic services, treatment, and other measures described in 42 U.S.C. Section 1396(a) to correct, ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by screening services whether or not such services are covered under the State plan; and

2.5.7.1.4 Transportation and scheduling assistance. Transportation assistance for a child includes related travel expenses, the cost of meals, and lodging in route to and from care, the cost of an attendant to accompany a child if necessary.

2.5.7.2 Mental health and substance abuse assessments shall be provided in accordance with the access standards for outpatient mental health and outpatient substance abuse services specified in Attachment B; within fourteen (14) calendar days of request or, if an urgent service, within three (3) business days of request.

2.5.7.3 The **Contractor** must provide a mental health or substance abuse assessment in response to a request from the **Enrollee'**s Primary Care Provider or other provider completing the **Enrollee's** TENNderCare screening and as specified in Section 2.5. 9.

2.5.7.4 The **Contractor** shall not require prior authorization in order for an **Enrollee** to obtain a mental health or substance abuse assessment, whether the screening is requested as follow-up to a TENNderCare screening or as an inter-periodic screening. This requirement shall not preclude the **Contracto**r from requiring notification for a referral for an assessment. Furthermore, the **Contractor** shall establish a procedure for Primary Care Providers, or other providers, completing TENNderCare screenings, to refer **Enrollees** under the age of 21 for a mental health or substance abuse assessment in order to enable the **Contractor** to complete the requirements specified in Sections 2.5.7.5 through 2.5.7.9.

2.5.7.5 The **Contractor** shall offer transportation and scheduling assistance to all children under age 21 referred for a mental health or substance abuse assessment.

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

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

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

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

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

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

2.5.7.7 The **Contractor** shall have policies and procedures in place, approved by TDMHDD, to refer **Enrollees** for other necessary health care, diagnostic services, treatment and other measures to correct, ameliorate, or prevent from worsening defects, and mental illnesses and conditions discovered by the screening service, and shall require providers to adhere to said policies and procedures, regardless of whether the required services is covered by the **Enrollee**'s BHO or MCO, and to document said referrals in the **Enrollee**'s medical record.

2.5.7.8 The **Contractor** shall direct its network providers, unless refused by the **Enrollee** in which case the **Contractor** must document the refusal, to notify the BHO in the event the provider identifies the need for other healthcare during the course of conducting a screening or assessment for which the **Enrollee** was originally referred. The **Contractor** shall contact the **Enrollee** to offer scheduling assistance and transportation. If the other health care is a MCO benefit, the **Contractor** shall contact the **Enrollee**'s MCO and inform them of the need to contact the **Enrollee** to offer scheduling assistance and transportation. The Contractor shall maintain a log of all such contacts and, at a minimum, shall record the name of the **Enrollee**, the **Enrollee's** ID number, name of the MCO contacted, date of MCO contact, time of MCO contact, and description of the required service. In the event of a dispute regarding the organization responsible for the provision of the services, the **Contractor** shall adhere to the requirements specified in Section 3.4.1.3.

2.5.7.9 The **Contractor** shall inform all **Enrollees** assigned to its plan who are under the age of 21, or their parent or guardian, of the availability of early and periodic screening, diagnostic, and treatment services within thirty (30) days of enrollment. At least annually thereafter, the **Contractor** shall conduct an outreach activity for the purpose of educating **Enrollees** about the availability of TENNderCare services.

All **Enrollee** material and a description of each outreach activity shall be submitted to **TDMHDD** for approval prior to distribution and shall be made available in accordance with the requirements specified in Section 3.6.2.

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

2.5.7.11 The **Contractor** must make available to families accurate lists of names and phone numbers of contract providers who are currently accepting **TennCare** as described in Section 3.6.7 of this CONTRACT.

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

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

2.5.8 Special Requirements Regarding Children

2.5.8.1 The **Contractor** must have a contract with each Children's Center of Excellence (COE) for provision of tertiary level medically necessary covered services to Department of Children's Services DCS custody children and children at risk of DCS custody. Such services shall include ongoing specialized care when requested by local providers managing the child's care; and case coordination of services offered. Children will be referred to the COE when required specialists with appropriate training and experience are not available. The COE can determine when a specialist can serve as a primary care provider (PCP) on special cases where this is deemed in the child's interest and the specialist is willing to accept this role. The COE can also determine whether a service which has been ordered for a DCS custody child and which has been denied by the **Contractor** can be initiated while an appeal is still pending. The **Contractor** will share its utilization guidelines with the COE to improve understanding and cooperation.

2.5.8.2 The **Contractor** must maintain a provider network with adequate capacity to deliver covered services which meet the special needs of children in state custody. Indicators of an adequate network include the following:

2.5.8.2.1 The **Contractor** has sufficient providers to be able to consistently deliver services to custody children ordered by a provider in its own network, or a COE within the timeframes set out elsewhere in the CONTRACT; and

2.5.8.2.2 The **Contractor** has within its network specialized health providers with sufficient expertise to deliver the covered services recognized in Best Practice Guidelines (BPG) as being proven effective and needed by children in custody.

2.5.8.3 Implementation Team

The Implementation Team, or any subsequently designated team by **TennCare**, shall consist of, but not be limited to representatives of **TennCare**, DCS, DOH, **Contractor**, and **TDMHDD**. The Implementation Team shall be involved in cases where children are in immediate need of covered services in order to prevent their going into custody and shall:

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

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

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

2.5.8.4 Administration and Management

Staff Requirements. The **Contractor** shall appoint a specific Department of Children's Services (DCS) liaison person or persons.

The DCS liaison person(s) will be responsible for assisting DCS to assure compliance with TENNderCare requirements and the coordination of care for children in State custody and at risk of State custody and shall support primary care providers as requested. The liaison person(s) shall be available to **TDMHDD**, **TennCare** and/or the DCS case managers, and foster families for assistance. The number of specific liaison persons identified shall be adequate at all times to cover the number of children in or at risk of State custody enrolled in **TennCare Select**.

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

2.5.8.5 Provider Network for Services to Children in State Custody

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

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

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

2.5.8.5.1.3 The **Contractor** has sufficient types and numbers of providers to

be able to consistently deliver services in a timely manner when ordered for a child by a provider in its network, or a Center of Excellence, within the timeframes set out elsewhere in this CONTRACT; and

2.5.8.5.1.4 The **Contractor** has within its network specialized behavioral health providers with sufficient expertise to deliver the covered services recognized in the **TDMHDD** Best Practice Guidelines as being proven effective and needed by children in State custody.

2.5.8.5.2 **Mental Health & Substance Abuse Services**.

In addition to the requirements specified in Section 2.5.1, the following requirements shall pertain to the coordination of mental health and substance abuse services for children in State custody:

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

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

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

2.5.8.5.3 Service Authorization

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

2.5.9 Assessments

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

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

2.5.9.2 Once an **Enrollee** is assessed as Severely and/or Persistently Mentally Ill (SPMI) or Seriously Emotionally Disturbed (SED), the **Contractor** must reassess the **Enrollee** at least every twelve (12) months, or sooner

if an individual's CRG/TPG status has changed to a degree which would cause a difference in rating. The **Contractor** shall not limit the number of assessments that may be completed.

2.5.9.3 The **Contractor** shall identify persons in need of CRG/TPG assessments. The **Contractor** shall use the assessments to identify persons who are Severely and/or Persistently Mentally Ill (SPMI) or Seriously Emotionally Disturbed (SED) for reporting and tracking purposes, in accordance with the definitions contained in Attachment A. Failure to complete the assessments within the timeframes indicated in this Section, to utilize **TDMHDD**-certified raters, or to complete the assessments in accordance with **TDMHDD** policies and procedures may result in the application of liquidated damages in accordance with Section 5.3.3. The **Contractor** shall not, however, be held accountable for the timely reassessment of **Enrollees** who have not utilized behavioral health services in the past 90 calendar days.

2.5.10 Services Not Covered

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

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

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

2.5.11.1 24-hour psychiatric residential treatment services, only while children are in DCS legal custody. 24-hour psychiatric residential services do not include psychiatric inpatient facility services, which shall remain the responsibility of the **Contractor**;

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

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

SECTION 3. Contractor Responsibilities

3.1 General

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

Effective upon the date of the Agreed Notice of Administrative Supervision issued by the Tennessee Department of Commerce and Insurance (TDCI), the **Contractor** shall operate under the supervision of the TDCI in accordance with Tennessee Code Annotated 56-9-501 *et. seq.* and 56-51-144 in order to ensure the uninterrupted delivery of medically necessary behavioral health services to TennCare **Enrollees**. During such time as the **Contractor**'s plan is placed under the supervision of the TDCI, the **Contractor** shall administer this Agreement in accordance with Medical Management Policies and Procedures in place as of the execution date of this Amendment or as amended herein, unless otherwise directed or approved by TennCare. Furthermore, the **Contractor** shall freeze provider reimbursement rates as of December 31, 2002, unless otherwise approved or directed to modify reimbursement rates by TennCare. The **Contractor** shall obtain prior written approval from TennCare before modifying any medical management policies and procedures, Provider Agreement or Subcontract.

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

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

3.1.3 The **Contractor** shall provide interpreter services 24 hours a day, seven days a week. Interpreter services should be available in the form of in-person interpreters, sign language or access to telephonic translation assistance, such as the ATT universal line. The **Contractor** shall provide in-person interpreters for languages spoken by 5% or more of the population, as determined by the TennCare Bureau.

3.2 Contractor Qualifications

The **Contractor** must comply with the following requirements at the inception of this CONTRACT and at all times during the life of this CONTRACT:

3.2.1 Agree to on-site review by **TDMHDD** before final execution of this CONTRACT;

3.2.2 Agree to accept all **Enrollees** and **Judicials** assigned to the **Contractor** whatever reason and a reasonable number of **Enrollees** from any failed **Contractor** pursuant to Section 3.4.7 of this CONTRACT;

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

3.2.4 Meet and maintain the administrative requirements of Tennessee Department of Commerce and Insurance (TDCI) as specifically set forth in this CONTRACT or applicable statute;

3.2.5 Establish and maintain adequate risk reserves, as specified in Section 3.3.2;

3.2.6 Be appropriately licensed, if required by the laws of Tennessee, to ensure the **Contractor**'s financial viability to perform its obligations under this CONTRACT to operate within the State of Tennessee. Pursuant to TCA 56-51-105, the CONTRACTOR shall be licensed as a Prepaid Limited Health Services Organization;

3.2.7 Be properly registered with the Secretary of State to do business in Tennessee;

3.2.8 Have adequate and appropriate general liability, professional liability, and workers compensation insurance for the protection of consumers and families, staff, facilities, and the general public;

3.2.9 Have documented experience with private and public mental health and substance abuse service delivery systems and their **Enrollees**;

3.2.10 Provide evidence of successful experience with other similar contracts;

3.2.11 Maintain a sufficiently staffed and working office within the State of Tennessee, including a full-time Tennessee-based administration as described in Section 3.7 specifically identified to administer the day-to-day business and programmatic activities of this CONTRACT;

3.2.12 Demonstrate the capacity to develop, manage, and maintain good local/regional relations with providers to enhance provider recruitment and retention, as evidenced by the Provider Relations Plan described in Section 3.8.4;

3.2.13 Measure and report utilization, cost, quality, and patient satisfaction data through a management information system that supports the specific administrative and clinical decision making required for delivery of mental health and substance abuse services;

3.2.14 Provide high quality administrative and clinical leadership in the provision of mental health and substance abuse services.

3.2.15 Implement a Quality Monitoring Plan (QMP) in accordance with **TDMHDD** requirements;

3.2.16 Interact effectively with providers in all regions of the State covered by the **Contractor**;

3.2.17 Maintain service accessibility and availability through the existence of a current Statewide network of appropriately licensed and credentialed mental health and substance abuse providers capable of providing 24-hour comprehensive mental health and substance abuse services to a minimum of 400,000 **Enrollees**;

3.2.18 Produce acceptable provider contracts and letters of referral with mental health and substance abuse providers which are at a minimum one (1) year in duration, with cancellation clauses of no less than 60 days consistent with the terms of this CONTRACT and any amendments thereto.

3.2.19 Provide mental health case management in accordance with standards set by **TDMHDD**;

3.2.20 Identify persons in need of CRG/TPG assessments, providing these assessments promptly and accurately, and following up on identifications with treatment plans and re-assessments as necessary;

3.2.21 Manage mental health and substance abuse provider networks: recruit, credential, enroll, train, and manage providers and maintain positive provider relationships;

3.2.22 Make smooth transitions of consumers from one provider to another when there are changes in providers;

3.2.23 Determine that all providers have adequate and appropriate insurance coverage and/or sovereign immunity in all necessary areas;

3.2.24 Provide adequate telephone availability of mental health and substance abuse professionals 24-hours a day, 7 days a week;

3.2.25 Provide appropriate and effective mental health services to the special populations described in Section 2.5.2.4;

3.2.26 Meet access and availability requirements for services defined in Attachment B and as referenced in Section 2.5.2;

3.2.27 Utilize standardized billing forms and procedures for all transactions.

3.2.28 Maintain sufficient information systems (IS) capability to provide **Enrollee** eligibility information to participating providers.

3.2.29 Have the ability to accept electronic billing from providers.

3.2.30 Pay or appropriately deny 90% of the total number of clean claims (for which no further written information or substantiation is required in order to make payment) from both contract and non-contract providers within thirty (30) calendar days of receipt. The **Contractor** shall also 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 as described in Section 3.13.2;

3.2.31 Demonstrate commitment to **Enrollee** involvement in treatment decisions;

3.2.32 Provide for involvement of **Enrollee** advocacy from both consumers and their families and provide opportunities for advocacy groups to review plan and service performance;

3.2.33 Provide a responsive appeal process, both formal and informal; as specified in Section 3.5;

3.2.34 Provide specialized crisis services and coordinate with other BHOs participating in the TennCare Partners Program to provide one (1) widely published toll free number for the general population per CHA region for the purposes of providing immediate phone intervention and immediate dispatch of mobile crisis services in the appropriate community, as specified in Section 2.5.6 (the same toll-free number may be used in multiple CHAs). This specialized telephone line will be answered by a staff person, rather than by an automated voice response system;

3.2.35 Measure mental health and substance abuse outcomes, and evaluate improvement in mental health status, **Enrollees'** functioning and sense of well-being, and report performance measures specified in Attachment E on a timely basis;

3.2.36 Conduct mental health and substance abuse health outcome research studies;

3.2.37 Routinely assess provider and **Enrollee** satisfaction and demonstrate this information is used to improve services; and

3.2.38 Capture and submit individual encounter records to **TennCare** for each service provided to **Enrollees** regardless of provider reimbursement arrangement in accordance with Section 3.12.4;

3.2.39 Mutually agree to such other requirements as may be reasonably established by TennCare, TDCI, or **TDMHDD**.

3.2.40 The **Contractor** shall require each physician to have a unique identifier.

3.3 Basic Organizational Requirements

3.3.1 Administrative Requirements

The **Contractor** shall provide to the TennCare Division of TDCI evidence of compliance with the following:

3.3.1.1 Provide to TDCI all documents and information listed in Tennessee Code Annotated §56-32-203(b) except the complaint procedure set forth in Tennessee Code Annotated §56-32-203(b)(11) must also comply with Section 3.5 of this CONTRACT.

3.3.1.2 Provide to TDCI full and complete disclosure of any financial interest held by an officer or a director of the BHO with any provider that may contract with the BHO.

3.3.1.3 Provide to TDCI for approval pro formas of all provider contracts, evidences of coverage under Tennessee Code Annotated, §56-32-207, and member handbooks the **Contractor** proposes to offer **Enrollees**.

3.3.1.4 Provide to TDCI a description of the appeal system to be implemented by the **Contractor**, which must comply with Section 3.5 of this CONTRACT.

3.3.1.5 Agree to be covered and bound by Tennessee Code Annotated, § 56-32-206, with respect to Section 3.3.3 of this CONTRACT. However, should the **Contractor** be or become a licensed HMO in Tennessee, the **Contractor** must fully comply with Tennessee Code Annotated, §56-32-206.

3.3.1.6 Agree to be covered and bound by Tennessee Code Annotated, § 56-32-207.

3.3.1.7 Agree to be covered and bound by Tennessee Code Annotated, §56-32-209.

3.3.1.8 Agree to be covered and bound by Tennessee Code Annotated, §56-32-210, with respect to Section 3.5 of this CONTRACT. However, should the **Contractor** be or become a licensed HMO in Tennessee, the **Contractor** must fully comply with Tennessee Code Annotated §56-32-210.

3.3.1.9 Agree to be covered and bound by Tennessee Code Annotated, §56-32-211.

3.3.1.10 Agree to be covered and bound by Tennessee Code Annotated, §56-32-213.

3.3.1.11 Agree to be covered and bound by Tennessee Code Annotated, §56-32-222.

3.3.1.12 Provide to TDCI a detailed statement verifying the **Contractor** is financially responsible and may reasonably be expected to meet its obligations under this CONTRACT to **Enrollees** and to **Judicials**.

3.3.1.13 A **Contractor** shall also agree to file a notice with TDCI describing any material modification of the documents and information reported to TDCI regarding above Sections 3.3.1.1, 3.3.1.2, 3.3.1.3, 3.3.1.4 and 3.3.1.5. Such notice shall be filed with TDCI prior to any modification and, if TDCI does not disapprove of the modification within thirty (30) calendar days of filing, then the modification shall be deemed approved.

3.3.2 Financial Requirements

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

3.3.2.1 Establish and maintain a minimum net worth equal to the greater of (1) three million dollars ($3,000,000), or (2) an amount totaling five percent (5%) of the first one hundred fifty million dollars ($150,000,000) of the TennCare revenue earned by the **Contractor** under this CONTRACT for the prior calendar year, plus three percent (3%) of the TennCare revenue earned by the **Contractor** under this CONTRACT in excess of one hundred fifty million dollars ($150,000,000) for the prior calendar year. This net worth shall be determined by statutory accounting principles utilized by TDCI in regulating HMOs licensed in the State of Tennessee. Furthermore, in determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to TDCI. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated. The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses. The **Contractor** shall adhere to the

aforementioned standards regarding net worth or net worth standards set forth by applicable law, whichever is less stringent.

3.3.2.2 Establish and maintain a positive working capital (current assets exceed current liabilities), which shall be determined by the use of statutory accounting principles utilized by TDCI in regulating HMOs licensed in Tennessee.

3.3.2.3 Establish and maintain a deposit of six hundred thousand dollars ($600,000), plus an additional deposit of two hundred thousand dollars ($200,000) for each twenty million dollars ($20,000,000) or fraction thereof of the TennCare revenue earned by the **Contractor** under this CONTRACT in excess of forty million dollars ($40,000,000) as reported on the most recent annual financial statement filed with the TennCare Division of TDCI and verified by TennCare. The deposit required to be maintained on any revenues earned under this CONTRACT in excess of forty million dollars shall be established and maintained within thirty (30) calendar days after the annual financial statement of the **Contractor** is due to be filed with the TennCare Division of TDCI. These deposits shall be maintained in a controlled custodial account with TDCI or with any trustee or organization acceptable to TDCI and shall consist of cash, securities, or any combination of these acceptable to TDCI. This deposit shall be considered an asset in calculating the **Contractor**'s minimum net worth outlined in Section 3.3.2.1. of this CONTRACT. In any year in which the accumulated deposit of the **Contractor** is more than the amount required to be maintained by the **Contractor** by the terms of this Section, at the **Contractor**'s request TDCI shall reduce the previous accumulated deposit by the amount the deposit exceeds the deposit required by this Section. This amount shall be used and shall be considered held in trust to protect the interests of the **Contractor**'s **Enrollees** and to ensure continuation of health care services to such **Enrollees** if the **Contractor** fails to perform its duties under this CONTRACT. If the **Contractor** is placed voluntarily in rehabilitation or liquidation, then the **Contractor** agrees this deposit shall immediately prior to the filing of the rehabilitation or liquidation proceeding vest in the State of Tennessee. The state shall then use its funds in this deposit to pay for the continuation of health care services to **Enrollees** and **Judicials** during the first one hundred eighty (180) days after the filing of the rehabilitation or liquidation, with any remaining amount distributed to pay first the costs of any state rehabilitation or liquidation proceeding and second the unsecured claims of **Enrollees**, **Judicials** and providers of the **Contractor** on a pro rata basis. The **Contractor** shall adhere to the aforementioned standards regarding deposit requirements or deposit requirements set forth by applicable law, whichever is more stringent.

3.3.3 Fidelity Bonds

The **Contractor** shall obtain the following fidelity bonds:

3.3.3.1 A fidelity bond on **Contractor** employees and officers in an amount of not less than $500,000.

3.3.3.2 Proof of coverage must be submitted to **TDMHDD** within sixty (60) calendar days after execution of this CONTRACT or prior to the delivery of health care, whichever comes first.

3.3.4 Insurance

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

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

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

TDMHDD shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible is the sole responsibility of the **Contractor**.

Failure to provide proof of coverage, prior to commencement of work in connection with this CONTRACT may result in termination of this CONTRACT.
The **Contractor** further agrees to pay all taxes incident to this CONTRACT.

3.3.5 Ownership and Financial Disclosure

The **Contractor** shall disclose to **TDMHDD**, the Tennessee Comptroller General or the Center for Medicare and Medicaid Services (CMS), full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the Federal Title XX programs in accordance with federal and State requirements, including Public Chapter 379 of the Acts of 1999. This disclosure shall be made at times and on forms prescribed by the **TDMHDD** agency, but no less frequently than on an annual basis to be provided no later than March 1 of each calendar year. The following information shall be disclosed:

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

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

3.3.5.3 The identity of any person who has an ownership or control interest in the **Contractor**, or is an agent or managing employee of the **Contractor** and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs.

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

TDMHDD and/or the Secretary of United States Department of Health and Human Services may request information to be in the form of a consolidated financial statement.

3.4 Responsibilities Regarding Provision of Specific Services

3.4.1 Coordination of Services

3.4.1.1 The **Contractor** must assure active coordination between the following: mental health and substance abuse services; mental health care and primary health care; inpatient and outpatient care; and the child and adult mental health delivery system. This coordination must occur according to **TDMHDD** established guidelines for the following:

3.4.1.1.1 DCS for the purposes of providing covered mental health and substance abuse services to TennCare eligible children and youth in the custody of DCS in such a way as to facilitate the state's efforts to provide a full range

of appropriate and effective services to these children and youth.

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

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

3.4.1.1.4 TDFA TennCare, for the purposes of interfacing with and assuring continuity of care.

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

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

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

3.4.1.1.8 Civil, criminal, and juvenile courts for the purposes of fulfilling statutory requirements of Tennessee Code Annotated for mental health and substance abuse services referenced in Section 2.5.5.

3.4.1.1.9 TDMHDD State and Regional Policy and Planning Councils for the purposes of providing information necessary for fulfilling the duties of T.C.A. Title 33, Chapter 1, Part 4; T.C.A. Title 33, Chapter 2, Part 2; and other planning duties involving the councils and **TDMHDD.**

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

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

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

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

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

3.4.1.2.5 Description of how service plans will be coordinated between mental health and substance abuse service providers;

3.4.1.2.6 Description of the provision of cross-training of mental health and substance abuse providers.

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

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

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

3.4.1.2.8.2 Discharges cannot occur without a realistic discharge plan in which the **Enrollee** has participated (an outpatient visit must be scheduled before discharge which assures access to proper physician/medication follow-up; also, a housing site must be secured prior to discharge);

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

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

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

3.4.1.2.8.5 The **Contractor** shall identify and develop community alternatives to inpatient hospitalization for those individuals who are receiving inpatient psychiatric facility services but who no longer require acute inpatient care and who could leave the facility if appropriate community or residential care alternatives were available in the community. In the event the **Contractor** does not provide appropriate community alternatives, the **Contractor** shall remain financially responsible for the continued inpatient care of these individuals. The **Contractor** shall provide quarterly summary reports on the use of these alternatives in a format to be prescribed by **TDMHDD**.

3.4.1.2.8.6 The **Contractor** shall have responsibility to provide a discharge plan as outlined above in Section 3.4.1.2.8. Liquidated Damages may be assessed in accordance with Section 5.3.3 when the **Contractor** fails to provide a written discharge plan or provides a defective discharge plan where an **Enrollee** files a complaint after being discharged due to an inadequate discharge plan or where an **Enrollee** appeals and the basis of the appeal is the discharge plan.

3.4.1.2.8.7 The **Enrollee's** Primary Care Provider must be notified when an **Enrollee's** level of care changes and the **Enrollee** is a child in State custody.

3.4.1.2.9 Coordination of physical health care and mental health care, including:

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

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

3.4.1.2.9.3 Maintenance of confidentiality; and

3.4.1.2.9.4 A description of the types of training activities to be provided and a schedule of training activities. At a minimum, information must be provided to primary health care providers on a quarterly basis; **Enrollees**, families, and providers of mental health and substance abuse services must be involved in at least two of the training activities yearly.

3.4.1.3 Coordination with TennCare MCOs

All mental health related services and substance abuse services specified in Section 2.5 of this CONTRACT provided to **Enrollees** shall be the responsibility of the **Contractor**. However, effective July 1, 2002, behavioral health related services provided to **Enrollees** by an MCO Primary Care Provider shall not be the responsibility of the **Contractor**. As some MCO Primary Care Providers may appropriately treat or manage an **Enrollee's** behavioral health condition, and in an effort to minimize administrative complexities for those Primary Care Providers (PCPs), the MCO shall be responsible for services provided to **Enrollees** by their network PCPs. Accordingly, the MCO shall direct its network PCPs to submit claims for covered services with a **primary** behavioral diagnosis code, defined as ICD-9-CM 290.xx – 319.xx (and subsequent revisions thereto), to the MCO for payment. The MCO is also responsible for the costs and provision of covered services that are not mental health or substance abuse services.

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

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

The MCO and BHO shall assure active coordination between primary health care and mental health/substance abuse care, including case management and continuity of care services. The MCO and BHO shall cooperate with the State's efforts to facilitate delivery of mental health services to the ***TennCare*** *population and shall agree to abide by the MCO/BHO Coordination Provisions outlined herein for purposes of interfacing with each other and assure coordination of care, case management and continuity of care for purposes of coordinating appropriate health care.*

3.4.1.3.1 Operating Principles

The CONTRACTOR shall support the MCO and all of its providers in their delivery of behavioral health services to all **TennCare** members by, but not limited to, providing advice, consultation, and assistance in coordinating the delivery of behavioral health services. Coordinating the delivery of behavioral health services to **TennCare** members is the primary responsibility of the BHO. To ensure such coordination, the BHO shall identify a staff member to serve as lead for coordination of services with each MCO and shall notify the respective MCOs, TDMHDD, and the Bureau of **TennCare** of the name, title, telephone number and other means of communicating with that coordinator. Each MCO shall be responsible for communicating that information to all of its providers, including PCPs. With respect to specific member services, including transfer of responsibility for services from the PCP to the BHO, resolution of problems shall be carried out between the PCP (or MCO representative) and the BHO coordinator. Should systemic issues arise, the MCO and the BHO agree to meet and resolve these issues. In the event that such issues cannot be resolved, the MCO and the **BHO** shall

meet with **TDMHDD** and **TennCare** to reach final resolution of matters involved. Final resolution of system issues shall occur within 90 days from referral to **TDMHDD** or **TennCare.**

3.4.1.3.2 Resolution of Requests for Authorization for non-PCPs delivering Behavioral Health services. The **BHO** 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. **BHO** 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 **BHO** and MCO. The **BHO** 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 21 days or less of the provider's request for prior authorization and immediately after receiving the request for prior authorization for urgent requests. The **BHO** and MCO will establish a coordination committee to address all issues of care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Agreement. The parties will attempt in good faith to resolve any dispute and communicate the 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 21 days and shall comply with the Grier Revised Consent Decree.

3.4.1.3.3 Claim Resolution Authorization for non-PCPs delivering Behavioral Health services. The **BHO** 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 **BHO** and MCO (parties). The **BHO** and MCO shall provide the other party, **TDMHDD**, and **TennCare** with a list of its Claim Coordinators and telephone number(s) at which each Claim Coordinator may be contacted.

When either party receives a 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 **BHO** 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 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 BHO and MCO for resolution immediately. A meeting shall be held among the Chief Executive Officers or their designee(s), of the parties within ten (10) calendar days after the meeting of the Claims Coordination Committee, unless the parties agree to meet sooner.

If the meeting between the CEOs, or their designee(s), of the **BHO** 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 **BHO'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. ("Decision"). The "Decision" may reflect a split payment responsibility that will designate specific proportions to be shared by the MCO and the **BHO** 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.

3.4.1.3.4 **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 a **TennCare** member. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim must be approved or disapproved based on the definition of emergency medical services specified in this Agreement.

3.4.1.3.5 **Emergencies.** Prior authorization shall not be required for emergency services.

3.4.1.3.6. **Hold Harmless**. The parties agree that neither party will hold, nor allow their respective contracted providers to hold, any **TennCare** member responsible for any payment, except for any applicable co-payments.

3.4.1.3.7 **Claims Processing Requirements**. All claims must be processed in accordance with the requirements of the MCOs and **BHOs** respective Agreements with the State of Tennessee.

3.4.1.3.8 **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.

3.4.1.3.9 **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.

3.4.1.3.10 **Confidentiality**. The **BHO** 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 **BHO** and MCO standards. These standards will apply to both **BHO's** and MCO's providers and staff. If either party believes that the standards require updating, or operational changes are needed to enforce the standards, the parties agree to meet and resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

The **BHO** and MCO shall assure all materials and information directly or indirectly identifying any current or former **Enrollee** which is provided to or obtained by or through the MCO's or **BHO's** performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, Section 4-21 of this Agreement, Title 42, Part 2, Code of Federal Regulations, and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to **TDMHDD**, the **TennCare** Bureau, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former **Enrollee** or potential **Enrollee**.

Strict standards of confidentiality of records and information shall be maintained in accordance with applicable State and Federal law. All material and information, regardless of form, medium or method of communication, provided to the **Contractor** by the State or acquired by the **Contractor** on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable State and Federal law, State and Federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the **Contractor** to safeguard the confidentiality of such material or information in conformance with applicable

State and Federal law, State and Federal rules and regulations, departmental policy, and ethical standards.

The **Contractor's** obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the **Contractor** of this CONTRACT; previously possessed by the **Contractor** without written obligations to the State to protect it; acquired by the **Contractor** without written restrictions against disclosure from a third party which, to the **Contractor's** knowledge, is free to disclose the information; independently developed by the **Contractor** without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit the **Contractor** to disclose any information that is confidential under Federal or State law or regulations, regardless of whether it has been disclosed or made available to the **Contractor** due to intentional or negligent actions or inactions of agents of the State or third parties.

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

3.4.1.3.11 Access to Service. The MCO agrees and recognizes that the **BHO** shall agree through its contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or 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.

3.4.1.4 Services to Prevent Children from Entering State Custody

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

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

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

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

3.4.1.4.4 These circumstances result in the child entering State custody.

3.4.2 TennCare Cost-Sharing for Services

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

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

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

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

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

1. If the services are not covered by the TennCare program and, prior to providing the services, the provider informed the enrollee that the services were not covered. The provider is required to inform the enrollee on the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgement in writing prior to rendering service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills a BHO for the service that has been

provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or

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

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

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

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

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

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

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

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

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

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

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

3.4.3 Continuity of Care

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

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

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

3.4.3.3 A mechanism for assuring confidentiality;

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

3.4.3.5 A requirement that within fifteen (15) calendar days after receipt or issuance of a termination notice, a notice be given to the **Enrollee**

which includes an explanation of why the current provider is no longer available, a listing of new providers and how to contact them, the procedure the **Enrollee** needs to follow in order to change providers, and the effective date of change;

3.4.3.6 A requirement that proper and timely notice be given to the current provider so proper termination can occur between the **Enrollee** and provider;

3.4.3.7 For individuals in transition to new providers in the **TennCare** Partners Program, reference to the following:

3.4.3.7.1 Development of a termination plan which addresses the clinical and interpersonal dynamics of the relationship the individual has with the current provider and how a new relationship will be developed with the new provider; and

3.4.3.7.2 Establishment of a schedule which allows for appropriate termination from the present provider (including **Enrollee** involvement in establishing the schedule);

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

3.4.3.7.3.1 Children in State custody;

3.4.3.7.3.2 Children at risk of State custody;

3.4.3.7.3.3 Children who are seriously emotionally disturbed;

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

3.4.3.7.3.5 Persons who have addictive disorders;

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

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

Minimum time required before a transition in providers is permitted:

Mental Health Case Management	3 months
Psychiatrist	3 months
Outpatient therapy	3 months
Psychosocial rehabilitation;	3 months

supported employment

Inpatient or residential treatment; 6 months
supportive housing

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

3.4.4 Out-of-State and Out-of-Plan Use

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

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

3.4.4.2 The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Attachment A of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency medical services does not meet the definition herein and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTORS process and timeframes for

reconsideration. In the event a provider disagrees with the CONTRACTORS decision to disapprove a claim for emergency medical services, the provider may pursue the independent review process for disputed claims as provided by T.C.A. Section 56-32-226, including but not limited to, BHO reconsideration.

3.4.4.3 The **Contractor** must include provisions governing the referral and payment for covered services provided to an **Enrollee** by a non-contract provider at the request of a contract provider. The **Contractor** must require the out-of-plan provider to accept the **Contractor** payment, plus applicable co-payments and special fees, as payment in full for the service(s) by regulation in accordance with **TennCare** Rule 1200-13-13-.08(1) and 1200-13-14-.08(1) of TDFA.

3.4.4.4 Should the **Contractor** not be able to provide necessary services covered under the contract to a particular **Enrollee**, the **Contractor** must adequately and timely cover these services out of network for the **Enrollee** for as long as the **Contractor** is unable to provide them. The **Contractor** must require the out-of-plan provider to seek authorization for services and accept the **Contractor** payment as payment in full for the service(s) in accordance with **TennCare** Rule 1200-13-12-.08(1) of TDFA. The **Contractor** may deny payment for non-authorized services provided by out-of-plan providers.

3.4.4.5 The **Contractor** shall not make payment to non-participating providers for non-covered services.

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

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

3.4.4.7 The **Contractor** is not liable for the TennCare cost of non-covered services or the TennCare cost of services ordered and obtained from non-contract providers.

3.4.4.8 No **Contractor** shall regularly make reimbursement payments to non-contract providers for non-emergency services without subjecting those providers to the same credentialing and approval process required by **TDMHDD** for contract providers. The term "regularly" means no more than ten (10) such payments to any non-contract provider for non-emergency services over any continuous twelve (12) month period. Any non-contract provider "regularly" providing non-emergency services must be credentialed and recredentialed by the **Contractor** in accordance with Section 3.8 within thirty (30) calendar days after the event occurs requiring such approval.

3.4.4.9 Non-contract providers who regularly receive payments from the **Contractor** need not sign a contract with the **Contractor.** However, if non-contract providers regularly used by the **Contractor** are not credentialed as provided in Subsection 3.4.4.8, then the **Contractor** shall make no further payments to them.

3.4.5 Advance Directives

The **Contractor** shall comply with federal requirements concerning advance directives as described in 42 CFR 422.128 and 489 Subpart I, and as described in Tennessee Code Annotated, §§32-11-105, 34-6-201 through 34-6-215, and 68-11-201 through 68-11-224, and as stipulated by the **Enrollee**.

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

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

The **Contractor** shall require all laboratory testing sites providing services under this CONTRACT have either a (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The **Contractor** shall comply with the provisions of CLIA 1988 at such time that HCFA mandates the enforcement of the provisions of CLIA.

3.4.7 Acceptance of Enrollees from Failed BHO Plans

The **Contractor** must agree to accept a reasonable number of **Enrollees** from any failed **BHO** plan, including any plan which is terminated in whole or in part, may become insolvent, or discontinues service in an area for any reason. The term "reasonable", subject to the discretion of **TDMHDD**, means at a minimum the total number of **Enrollees** from a failed **BHO** plan divided by the number of remaining **BHOs** in the **TennCare** Partners Program. The transfer of membership may occur at any time during the calendar year. All transferred **Enrollees** must receive the same benefit package they would have received had they been assigned to the **Contractor**'s plan initially. Monthly capitation rates for transferred **Enrollees** must be the same as paid to the **Contractor** for other **Enrollees** enrolled in the **Contractor**'s plan. No **Enrollee** from a failed **BHO** plan shall be transferred retroactively to the **Contractor**'s plan. For purposes of this requirement, the **Contractor** is not responsible for any mental health and substance abuse services incurred by such **Enrollees** before the effective date of transfer to the **Contractor**'s plan.

3.4.8 Emergency Mental Health and Substance Abuse Treatment Services

3.4.8.1 The **Contractor** shall provide coverage for inpatient and outpatient mental health and substance abuse treatment services, furnished by a qualified provider, needed to evaluate or stabilize an emergency medical condition found to exist using the prudent layperson standard. Regulation 422.2 of the Code of Federal Regulations places prudent layperson within the definition of emergency medical condition as follows: "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. This entire definition should be considered when making a determination of whether an **Enrollee** acted appropriately in seeking emergency care. Once the individual's condition is stabilized, the **Contractor** may require authorization for inpatient admission or follow-up care. The **Contractor** shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgement of a prudent layperson.

The **Contractor** shall impose no restrictions on coverage of emergency services. Payment for the services rendered to evaluate or stabilize the emergency medical condition may not be denied for lack of notification within ten (10) calendar days of presentation for emergency services.

However, the **Contractor** may require authorization for inpatient services or follow-up care, once the individual's condition is stabilized.

3.4.8.2 If an emergency screening examination leads to a clinical determination by the examining mental health or substance abuse treatment professional that an actual emergency medical condition exists, the **Contractor** shall pay for both the services involved in the screening examination and the services required to stabilize the **Enrollee**. The **Contractor** shall be required to pay for all mental health and substance abuse treatment related emergency services which are medically necessary until the clinical emergency is stabilized. This includes all mental health and substance abuse treatment services necessary to assure, within reasonable medical probability, no material deterioration of the **Enrollee's** condition is likely to result from, or occur during, discharge of the **Enrollee** or transfer of the **Enrollee** to another facility. If there is a disagreement between the hospital and the **Contractor** concerning whether the **Enrollee** is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgement of the attending physician(s) actually caring for the patient at the treating facility prevails and is binding on the **Contractor**. The **Contractor**, however, may establish arrangements with a hospital whereby the **Contractor** may send one of its own physicians with appropriate emergency room

privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the **Enrollee**, provided that such arrangement does not delay the provision of emergency mental health or substance abuse treatment services.

3.4.8.3 The **Contractor** shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature.

3.4.8.4 When an **Enrollee's** primary care provider instructs the **Enrollee** to seek emergency mental health or substance abuse treatment services, the **Contractor** shall be responsible for payment for the medical screening examination and for other medically necessary emergency mental health and substance abuse treatment services, without regard to whether the **Enrollee** meets the prudent layperson standard.

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

- Post-stabilization care services pre-approved by the **Contractor**; or
- Post-stabilization care services not pre-approved by the **Contractor** because the **Contractor** did not respond to the provider of post-stabilization care services' request for pre-approval within one (1) hour after being requested to approve such care, or could not be contacted for pre-approval.
- If the **CONTRACTOR** and the treating physician cannot reach an agreement concerning the **Enrollee's** care and a physician representing the **CONTRACTOR** is not available for consultation. The treating physician shall continue with the continuity of care of the **Enrollee** until a physician representing the **CONTRACTOR** is reached or the **CONTRACTOR** attains at least one criteria detailed in this section to terminate the **CONTRACTORS** financial responsibility.

The **Contractor** can choose not to cover post-stabilization care services out-of-network except in the above stated circumstances. The **Contractor** shall limit charges to **Enrollees** for Post-Stabilization Care Services to an amount no greater than what the organization would charge the **Enrollee** if he/she had obtained the services through the **Contractor.**

The **Contractor'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**'s care;
- A plan physician assumes responsibility for the **Enrollee**'s care through transfer;
- The **Contractor's** representative and the treating physician reach an agreement concerning the **Enrollee**'s care; or
- The **Enrollee** is discharged.

3.4.9 Retroactive Eligibility

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

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

2. The **CONTRACTOR** shall include provisions governing the payment for medically necessary covered services provided to an enrollee by a non-contracted provider or non-referred provider for services received by an enrollee any time when TennCare determines that the enrollee is eligible for TennCare and has enrolled the individual in the CONTRACTORS plan and the enrollee could not have known which BHO they were enrolled in at the time of service.

3. The effective date of enrollment may occur prior to the BHO being notified of the enrollee becoming a member of the plan. When this situation arises, the BHO shall not deny medically necessary services provided during this period of eligibility for lack of prior authorization or lack of referral. Likewise, the **CONTRACTOR** shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which BHO the enrollee was enrolled in during the timely filing period. However, in such, cases the BHO may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

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

3.4.10 Prior Authorization for Covered Services

3.4.10.1 General Rule

The **CONTRACTOR** and/or its sub-contractor's shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services, have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, and consult with the requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR, sub-contractor's or an agent, payment for the pre-approved service shall not be denied based on the lack of medical necessity, assuming that the enrollee is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted. Prior authorization shall not be required for emergency services. Prior authorization requests shall

be reviewed subject to the guidelines described in TennCare Rules 1200-13-13 and 1200-13-14 which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of a BHO to act timely upon a request. The CONTRACTOR must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of utilization management (UM) decision making. The CONTRACTOR must have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

3.4.10.2 At time of Enrollment

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

3.4.10.3 Notice of Adverse Action Regarding Prior Authorization Requests

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

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

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

3.4.10.4 Appeals related to Prior Authorization Denials

If an enrollee appeals a prior authorization denial and the provider did not submit medical records to the CONTRACTOR as a part of the prior authorization determination process, upon request by TENNCARE, the CONTRACTOR shall go to the provider's office, if necessary, and obtain the medical records for TennCare's use in deciding the appeal.

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

3.5 Appeals and Complaints

Members shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including, but not limited to, a provider with the member's written consent. Complaint shall mean a member's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall inform members of their complaint and appeal rights, in the member handbook in compliance with the requirements in Section 3.6.2.1. The CONTRACTOR shall have internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees or court orders governing the appeals process.

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

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

3.5.1 Appeals

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

3.5.1.1 The CONTRACTOR shall have a contact person who is knowledgeable of appeal procedures to direct all appeals, whether the appeal is verbal or the member chooses to file in writing to TENNCARE. Should an enrollee choose to appeal in writing, the enrollee will be instructed to file via mail or fax to the designated TENNCARE P.O. Box or fax number for medical appeals.

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

phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.

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

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

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

3.5.1.6 Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form.

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

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

3.5.1.9 The Contractor shall require providers to display notices of member's right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The Contractor shall ensure that providers have correct and adequate supply of public notices.

3.5.1.10 Neither the Contractor nor TennCare shall prohibit or discourage any individual from testifying on behalf of a member.

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

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

3.5.1.13 The Contractor shall provide general and target education to providers regarding expedited appeals (described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.

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

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

3.5.1.16 The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (i.e. therapeutic duplication, etc.)

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

If it is determined by TENNCARE that violations regarding the appeal guidelines have occurred by the CONTRACTOR, TENNCARE shall require that the CONTRACTOR submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by TENNCARE, including an acceptable corrective action plan, shall result in the CONTRACTOR being subject to liquidated damages as described in Section 5.3.3.2 of this Agreement.

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3.6 Marketing and Enrollee Materials

3.6.1 Marketing

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

3.6.2 **Enrollee** Materials

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

3.6.2.1 Member Handbooks

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

Agreement and any and all federal and state laws, rules and regulations and include:

3.6.2.1.2 A table of contents;

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

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

3.6.2.1.5 A description of TennCare cost share responsibilities for **Enrollees** must include an explanation that providers and/or the **Contractor** may utilize whatever legal actions that are available to collect these amounts. Furthermore, the information shall indicate that the enrollee may not be billed for covered services except for the amounts of the specified TennCare cost sharing responsibilities and of their right in the event that they are billed;

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

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

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

3.6.2.1.9 Appeal procedures as described in Section 3.5 of this CONTRACT;

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

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

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

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

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

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

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

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

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

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

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

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

3.6.2.2 Identification Card

Each enrollee shall be provided an identification card, which identifies the enrollee as a participant in the TennCare Partners Program within thirty (30) calendar days of notification of enrollment into the CONTRACTORS plan or prior to enrollee's beginning effective date. The identification card must comply with all state and federal requirements. Once the identification card has been approved by TENNCARE the CONTRACTOR shall submit five (5) printed sample cards of the final product, unless otherwise specified by TENNCARE, to the TennCare Marketing Coordinator within thirty (30) working days from the print date. Photo copies may not be submitted as a final product. Prior to modifying an approved identification card the CONTRACTOR shall submit for approval by TENNCARE a detailed description of the proposed modification. The identification card may be issued by the CONTRACTOR, subject to prior approval of the format and content by TENNCARE, or the identification card may be issued by TENNCARE in a format and content mutually agreed upon by the CONTRACTOR and TENNCARE. Regardless of whether the identification card is issued by the CONTRACTOR or TENNCARE, all expenses associated with production and mailing of the identification card shall be the responsibility of the CONTRACTOR. Identification cards must be submitted to **TennCare, TDMHDD and TDCI** for prior approval.

3.6.2.3 Explanation of Benefits

The **Contractor** shall give a full written explanation of the **Contractor's** plan to the **Enrollee** within thirty (30) calendar days after notification of their enrollment in the plan, including but not limited to a member handbook as described in Section 3.6.2.1 of this CONTRACT. In addition to the information described above, this written explanation shall, at a minimum, also include:

3.6.2.3.1 Effective date of enrollment;

3.6.2.3.2 Names, locations, telephone numbers, office hours and non-English languages spoken by current network providers and identification of providers accepting new patients. The provider listing shall be updated at least quarterly to reflect changes in the provider network. The **Contractor** must assure that, at least one month prior to and throughout the open enrollment period, all communication and/or materials representing the **Contractor's** provider network accurately reflect the **Contractor's** provider network that will be available to **Enrollee** on the **Enrollee's** effective date. The **Contractor** must re-distribute the provider listing to **Enrollees** who are enrolled for at least twelve (12) consecutive months; and

3.6.2.3.3 All other information as required by CMS.

3.6.2.4 Quarterly Newsletter

The **Contractor** shall, at a minimum, distribute on a quarterly basis a newsletter to all **Enrollees** which is intended to educate **Enrollees** to the managed care systems, encourage proper utilization of services, and inform **Enrollees** of service availability. The **Contractor** shall include the following information in each newsletter:

3.6.2.4.1 Specific articles or other specific information as described and requested by **TennCare and/or TDMHDD**. Such requests by **TennCare and/or TDMHDD** shall be limited to two hundred (200) words and shall be reasonable, including sufficient notification of information to be included;

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

3.6.2.4.3 A notice to **Enrollees** of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1975, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.E. 97-35), and a

Contractor phone number for doing so. The notice in the newsletter shall be in English and in Spanish; and

3.6.2.4.4 **TENNderCare** information, including but not limited to, encouragement to obtain screening and other preventive care services; and

3.6.2.4.5 Not more than one hundred and 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 **TDMHDD**, ten (10) final copies of the newsletter and the date that the information was mailed to **Enrollees** along with an invoice of other type of documentation to indicate the date and volume of the quarterly newsletter mailing.

3.6.3 Permissible Communication Activities

The **Contractor** shall not engage in any solicitation of prospective **Enrollees** and shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. The following communication activities are permitted for purposes of educating or communicating with current **Enrollees**:

3.6.3.1 Distribution of general information through mass media;

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

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

3.6.4 Prior Approval Process for Enrollee Materials

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

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

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

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

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

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

3.6.5 Written Material Guidelines

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

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

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

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

3.6.5.4.1 The Seal of the State of Tennessee;

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

3.6.5.4.3 The word "free" can only be used if the service is no cost to all **Enrollees**. Only **Enrollees** who meet Medicaid eligibility requirements, as provided in the **TennCare** Rules and Regulations, are exempt from TennCare cost sharing responsibilities. If

Enrollees have TennCare cost share responsibilities, the services are not free. Any conditions of payments must be clearly and conspicuously disclosed in close proximity to the "free" good or service offer.

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

3.6.5.6 Within ninety (90) calendar days of notification from **TennCare**, all vital **Contractor** documents must be translated and available to each Limited English Proficiency group identified by **TennCare** that constitutes five percent (5%) of the **TennCare** population or 1,000 **Enrollees**, whichever is less.

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

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

3.6.6 Failure to Comply with Enrollee Material Requirements

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

3.6.6.1 Revocation of previously authorized materials or activities;

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

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

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

3.6.7 Provider Directory

The **Contractor** shall be responsible for distributing provider directories to new **Enrollees** within thirty (30) calendar days of receipt of notification by **TennCare** of enrollment in the **Contractor's** plan or prior to enrollee's beginning effective date. The **Contractor** shall also be responsible for redistribution of updated provider information on an annual basis. The provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network providers, identification of providers accepting new patients, emergency services settings and post stabilization service locations. **Enrollee** provider directories, and any revisions thereto, shall be submitted to **TDMHDD** for approval prior to distribution to **Enrollees**. Each submission shall include a paper and an electronic copy. The text of the directory shall be in Microsoft Word or Adobe

(PDF) format. In addition, the provider information used to populate the **Enrollee** provider directory shall be submitted as a TXT file or such format as otherwise approved by **TDMHDD** and be produced using the same extract process as the actual **Enrollee** provider directory.

It shall be acceptable for the **Contractor** to mail one (1) provider directory to each address listed for the **Enrollee's TennCare** case number when there is more than one (1) new **Enrollee** assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to

Enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual **Enrollee** regardless of whether or not a provider directory has been previously mailed to **Enrollees** in the existing case.

3.7 Staff Requirements

3.7.1 General Requirements Plan

The **Contractor** must maintain a sufficiently staffed and working office within the State of Tennessee, including a full-time Tennessee-based administration specifically identified to conduct the day-to-day business and programmatic activities of this CONTRACT.

At a minimum, the **Contractor** must employ in its Tennessee office the following: director of operations, director of finance, medical director, quality improvement director, **Enrollee** advocate, care managers, and customer service representatives.

3.7.1.1 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.

3.7.1.2 The staffing for the plan covered by this CONTRACT must be capable of fulfilling the requirements of this CONTRACT. The minimum staff requirements are as follows:

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

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

3.7.1.2.3 A full-time administrator (project director) specifically identified with overall responsibility for the administration of this CONTRACT. This person shall be at the **Contractor**'s officer level, shall have signature

authority, and must be approved by **TDMHDD**. The administrator shall be responsible for the coordination and operation of all aspects of the CONTRACT;

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

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

3.7.1.2.6 A provider licensed in the State of Tennessee who has at least five years of experience in treating children with mental health disorders who are also developmentally disabled. This person shall be responsible for authorizing services for persons with mental health disorders who are also developmentally disabled;

3.7.1.2.7 A provider licensed in the State of Tennessee who has at least five years of experience in treating persons with substance abuse disorders. This person shall be responsible for authorizing services for persons with substance abuse disorders;

3.7.1.2.8 A staff qualified, medically trained personnel, consistent with accreditation standards of NCQA, JCAHO or

URAC whose primary duties are to assist in evaluating claims for medical necessity; and

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

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

3.7.1.2.11 **TennCare** and/or **TDMHDD** may establish Technical Advisory Groups (TAGs) as needed to address issues in key areas of the program. These TAGs will consist of key stakeholders including **TennCare** and/or **TDMHDD, TennCare** MCO staff and the **Contractor**'s staff. Areas around which TAGs may be formed include, but are not limited to: Coordination of Care; Fraud and Abuse; Quality Improvement; EPSDT; Financial Reporting; and, Claims Processing.

3.7.1.2.12 The **Contractor** shall identify a specific Department of Children's Services (DCS) liaison person or persons, in writing, to **TDMHDD** and the DCS upon execution of this CONTRACT. The liaisons will assist DCS with care coordination for children in or at risk of State custody and will have the responsibility for facilitating the timely delivery of services covered by the **Contractor**. Assistance with care coordination will include identifying providers, scheduling appointments, and coordinating transportation (if appropriate), when requested. The name, title, address and contact numbers (phone, fax, etc.) for each DCS liaison shall be given to **TDMHDD** and DCS providers. DCS liaisons shall be

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

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

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

3.7.1.2.15 The **Contractor** shall employ a Consumer Advocate in its Tennessee Business Office.

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

3.7.2 Training

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

3.7.3 Telephone Access for Enrollees and Providers

3.7.3.1 The **Contractor** must provide a published toll-free telephone number that is answered in the **Contractor**'s Tennessee administration office by staff who are trained to respond to requests, concerns, and questions from **Enrollees**, family members, and providers. Staff must be available to answer telephone calls from 7:00 a.m. Central time until 7:00 p.m.

Central time seven days a week. After these peak hours, calls must be answered promptly, but can be routed to other locations.

3.7.3.2 **Contractor** must provide procedures to insure all **Enrollees** and network providers receive the above telephone number, including publishing the number in member handbooks as specified in Section 3.6.2.1 and in newsletters as referenced in Section 3.6.

3.7.3.3 The **Contractor** must also participate in the implementation of a toll-free crisis line for the general Tennessee population, as described in Section 2.5.6.

3.8 Provider Requirements

3.8.1 Licensure of Provider Sites

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

3.8.2 Licensure of Provider Staff

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

3.8.3 Credentialing Manual

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

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

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

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

3.8.3.3 The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application and signed Provider Agreement. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to their provider files in their claims processing system or deny the application and assure that provider is not included in the CONTRACTORS' network.

3.8.3.4 Appeals process for network providers who are dropped from the network or for whom sanctions are imposed.

3.8.3.5 The **Contractor** shall provide a written description of its credentialing criteria to providers upon request.

3.8.4 Provider Relations Plan

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

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

3.8.4.2.1 The full time employment of at least seven Tennessee-based provider relations specialists (one located in each of the seven designated mental health planning regions) who are available to providers at least Monday through Friday (excluding holidays), 8:00 a.m. to 5:00 p.m. Central time;

3.8.4.2.2 The establishment of a published 24-hour a day, seven days a week telephone number available only to network providers which offers provider assistance, including service authorization, clinical consultation, issue resolution, and information; the telephone must be answered on all business days in the Tennessee administrative office from 7:00 a.m. until 7:00 p.m. (Central time); after these peak hours, the telephone must be answered promptly, but can be routed to other locations;

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

3.8.4.2.4 An annual provider satisfaction survey conducted with any necessary incentives to insure a minimum response rate of 50% of the **Contractor's** providers; a plan for addressing and resolving problems which are identified by the survey process; and a means for reporting survey results and related plans of correction and/or results of plans of correction to **TDMHDD** on an annual basis; and

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

3.8.5 Provider Networks

In establishing and maintaining the network, they shall consider the following:

- The anticipated Medicaid enrollment,
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP,
- The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services,
- The numbers of network providers who are not accepting new Medicaid patients,
- 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** shall provide the following information for **TDMHDD**'s approval:

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

listing can be found in Attachment D.1 of this CONTRACT. Failure of the **Contractor** to provide monthly updates may result in the application of liquidated damages as described in Section 5.3.3 and Attachment E.

3.8.5.2 A statement documenting each facility/individual listed in response to Section 3.8.5.1 is properly licensed, certified, accredited, designated, approved, and/or meets required standards for the provision of those services which require certain licensure, certification, accreditation, approval, and/or compliance with standards.

3.8.6 Provider Network Composition Requirements

3.8.6.1 The **Contractor** shall recruit, credential, evaluate, and monitor providers with an appropriate combination of skills experience, and specialties to constitute a provider network capable of providing covered benefits to **Enrollees** as specified in Attachment B.

3.8.6.2 The **Contractor** shall include in its network providers capable of screening, assessing and treating the special populations identified in Section 2.5.2.4.

3.8.6.3 Inpatient Facilities

The **Contractor** shall maintain a sufficient network of facility providers with the capability of providing the benefits required under this CONTRACT to all eligible individuals as described in Section 2.2 of this CONTRACT. In the event the **Contractor** terminates an arrangement with a facility provider, the **Contractor** shall continue to provide care for all eligible individuals who are receiving care from that hospital provider at the time of termination until such time as the **Contractor** can reasonably transfer the **Enrollee** to a service and/or network provider without interrupting service delivery.

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

3.8.6.4 Safety Net Providers

The **Contractor** is encouraged, to the extent possible and practical, to contract for the provision of behavioral health services with the Community Mental Health Centers (CMHCs) and Mental Health Case Management Agencies (CMHCMA) designated by **TDMHDD** for the provision of mental health services in the community and with

substance abuse providers under contract with DOH. Where these safety net providers are not used, the **Contractor** must demonstrate to the satisfaction of **TDMHDD** that both adequate capacity and an appropriate range of services exist to serve the expected enrollment in each service area.

3.8.6.5 Centers of Excellence for Children

The **Contractor** must contract with each Center of Excellence (COE) in their grand region(s) for children in or at risk of state custody identified by the State for the provision of services to children in or at risk of state custody. Services to be provided by the COE must include: behavioral health assessments; care plan development; provider consultations; specialty services and assistance with care coordination of services specified in the child's care plan.

3.8.6.6 Residential Treatment Facilities

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

3.8.6.7 Outpatient Mental Health and Substance Abuse Providers

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

3.8.7 Payment Requirements

The CONTRACTOR shall assure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements have not been obtained by the CONTRACTOR in accordance with 42 CFR 455.100 through 106 and Section 3.9.2 of this Agreement.

3.9 Requirements Regarding Contracts and Subcontracts

3.9.1 Subcontracts

The **Contractor** shall be responsible for the administration and management of all aspects of this CONTRACT and the health plan covered there under including all subcontracts. No subcontract, provider agreement or other delegation of responsibility

terminates or reduces the legal responsibility of the **Contractor** to **TDMHDD** to assure that all activities under this CONTRACT are carried out in conformity with the terms and conditions of this CONTRACT.

The **Contractor** shall provide or assure the provision of all covered services specified under this CONTRACT. All subcontracts must fulfill the requirements of 42 CFR 438.6(1) that are appropriate to the service or activity delegated under the subcontract. Any proposed subcontracts the **Contractor** wishes to enter into for performance of any of the work required under this CONTRACT must be submitted to **TennCare** for prior written approval. No proposed subcontract of the **Contractor**, which provides for the direct or indirect provision of covered services to an **Enrollee**, shall be approved if that subcontract requires the sub**contractor** to assume financial risk that is not related to services either directly or indirectly furnished by that sub**contractor** to **Enrollees** in the **TennCare Partners Program**. The term "indirectly" shall have the same meaning as set forth in Section 3.9.2.43 below.

No work shall commence under any subcontract between the **Contractor** and a potential sub**contractor** without the written approval of **TennCare**. Provider contracts developed by sub**contractors** must meet all the conditions set out in

Section 3.3.1.3 , Section 3.4.1.3.10, and Section 3.18 of this CONTRACT. The **Contractor** shall provide the following appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract:

- the **Enrollee's** right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing;
- the **Enrollee's** right to file appeals and their requirements and timeframes for filing;
- the availability of assistance in filing;
- the toll-free numbers to file oral appeals;
- the **Enrollee's** right to request continuation of benefits during an appeal or State fair hearing filing and, if the **Contractor's** action is upheld in a hearing, the **Enrollee** may be liable for the cost of any continued benefits; and
- any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

Contracts, subcontracts, and subgrants of amounts in excess of $100,000 shall contain a provision which requires compliance with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC 1857 (h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

Contracts shall recognize mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).

Contracts shall contain a statement that federal funds have not been used for lobbying.

All contracts must specify the functions and/or services to be furnished by the subcontractors and the **Contractor** must determine that the functions and/or services to be furnished are within the scope of the subcontractors' professional/technical practice. All contracts must provide for monitoring, whether announced or unannounced, of services rendered and sponsored by the **Contractor**. The contracts must specify that the **Contractor** shall monitor the quality of services delivered under the CONTRACT and initiate corrective action where necessary. All contracts must require that the subcontractor comply with corrective action plans initiated by the **Contractor**.

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

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

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

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

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

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

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

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

3.9.2 Provider Contracts

The **Contractor** shall provide or assure the provision of all covered services specified under this CONTRACT. The **Contractor** may provide these services directly or may enter into contracts with qualified providers and provider subcontracting entities or organizations that will provide services to the **Enrollee** in exchange for payment by the **Contractor** for services rendered. The **Contractor** shall evaluate the prospective subcontractors' ability to perform the activities to be delegated.

The **Contractor** shall have a written agreement with the subcontractor that specifies the activities and the report responsibilities delegated to the subcontractor; and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

The **Contractor** shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by **TDMHDD** consistent with industry standards or state PIHP laws and regulations.

The **Contractor** shall identify deficiencies or areas for improvement, and the sub-**Contractor** shall take corrective action.

The **Contractor** may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

Provider agreements and amendments thereto do not require prior approval by **TDMHDD** before taking effect; however, the **Contractor** shall not execute provider agreements with providers who have been excluded from participation in federal programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the **TennCare** program. Further, all pro forma provider agreements and revisions thereto and any material modifications thereof must be approved in advance by the Tennessee Department of Commerce and Insurance, **TennCare** Division.

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

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

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

All provider agreements executed by the **Contractor**, and all provider contracts executed by subcontracting entities or organizations, pursuant to this Section shall, at a minimum, meet the following requirement and no other terms or conditions agreed to by the **Contractor** and provider shall negate or supersede the following requirements.

3.9.2.1 Be in writing;

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

3.9.2.3 Specify within in the provider contract that the provider contract and its attachments contain all the terms and conditions agreed upon by the parties;

3.9.2.4 Require the provider not to enter into any subsequent contracts or subcontracts for any of the work contemplated under the provider contract without approval of the **Contractor**;

3.9.2.5 Identify all populations covered by the provider contract, especially those populations covered under the TennCare Program and the TennCare Partners Program;

3.9.2.6 Specify the provider may not refuse to provide medically necessary covered services to a TennCare Partners Program **Enrollee** covered under this CONTRACT for non-medical reasons or for failure to pay applicable co-payments, or special fees. In accordance with Section 3.4.2.3, the provider may not charge **Enrollees** for missed appointments unless otherwise approved by TennCare or **TDMHDD**. The provider shall not be required to accept or continue treatment of an **Enrollee** with whom the provider, in good faith, determines he/she cannot establish and/or maintain a professional relationship;

3.9.2.7 Specify the functions and/or services the provider and determine the functions and/or services to be provided are within the scope of his/her professional/ technical practice;

3.9.2.8 Specify the amount, duration and specific services required of the provider to be no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid;

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

3.9.2.10 If the provider performs laboratory services, the provider must meet all applicable requirements of CLIA of 1988 at such time HCFA mandates the enforcement of the provisions of CLIA, as stated in Section 3.4.6.

3.9.2.11 Require that an adequate record system be maintained and that all records be maintained for no less than five (5) years from the close of the Agreement or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions).

All agreements shall include a statement that as a condition of participation in TennCare, enrollees shall give the TENNCARE Bureau, TENNCARE, TDMHDD, the Office of the Comptroller, and

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

Require that medical records requirements found in Section 3.12.15 be included in provider agreements and that medical records are maintained at site where medical services are rendered. Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records.

The provider agreement must contain the language described in Sections 3.12.19 and 3.14.2 of this Agreement;

3.9.2.12 Require any and all records be maintained for a period not less than five (5) years from the close of the CONTRACT and retained further if the records are under review or audit until the review or audit is complete. These records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of the **Contractor**, **TDMHDD**, TDCI, HCFA or **TennCare**. Prior approval for the disposition of records must be requested from **TDMHDD** if the provider contract is continuous;

3.9.2.13 Provide that TENNCARE, TDMHDD, TDCI, HHS, HHS OIG, Comptroller, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means, any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and

when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of PHI to health oversight agencies, including, but not limited to, OIG, TBI MFCU, HHS, OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, TDMHDD, TDCI, OIG, TBI MFCU, HHS OIG, DOJ, Office of the Comptroller, may use these records and information for administrative, civil or criminal investigations and prosecutions;

3.9.2.14 Provide for monitoring, whether announced or unannounced, of services rendered to **Enrollees** and to **Judicials** sponsored by the **Contractor**;

3.9.2.15 Whether announced or unannounced, provide for participation and cooperation in any internal and external quality monitoring/quality improvement review (QM/QI), utilization review, peer review and appeal procedures established by the **Contractor** and/or **TDMHDD**;

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

3.9.2.17 Require the provider to comply with corrective action plans initiated by the **Contractor**;

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

3.9.2.19 Require safeguarding of information about **Enrollees** according to applicable state and federal laws and rules and as described in Section 6.14 of this CONTRACT;

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

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

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

3.9.2.23 Provide for payment and appropriate denial of claims submitted by the provider in accordance with Section 3.13.2 of this CONTRACT between the **Contractor** and **TDMHDD**;

3.9.2.24 Specify the provider shall accept payment or appropriate denial made by the **Contractor** (or, if applicable, payment by the **Contractor** supplementary to the **Enrollee's** third party payor) as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the **Enrollee**, his or her parents or guardians, spouses, or other legally responsible persons;

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

3.9.2.26 Require the provider to secure general liability, professional liability, and workers compensation insurance coverage as is necessary to adequately protect the plan's **Enrollees** and the **Contractor** under this CONTRACT. The provider shall provide such insurance coverage throughout the term of the provider contract and upon execution of the provider contract furnish the **Contractor** with written verification of the existence of such coverage. The amount of the insurance shall be in accordance with Section 3.3.4;

3.9.2.27 Specify both the **Contractor** and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the **Contractor** plan;

3.9.2.28 Provide the contract incorporates by reference all applicable federal and state laws or regulations, and revisions of such laws or regulations shall automatically be incorporated into the contract as they become effective. The **Contractor** shall require the provider contracts adhere to the HIPAA regulations as further detailed in Section 3.18 and to the Confidentiality regulations as further detailed in Section 3.4.1.3.10. In the event changes in the contract as a result of revisions in applicable federal or state law materially affect the position of either party, the **Contractor** and provider agree to negotiate such further amendments as may be necessary to correct any inequities;

3.9.2.29 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the contract termination date, or early termination of the contract and such change shall only be valid

when reduced to writing, duly signed and attached to the original of the contract, unless **TennCare** shall approve an alternative procedure;

3.9.2.30 Specify both parties recognize in the event of termination of this CONTRACT for any of the reasons described in Section 5.1. of this CONTRACT, the provider contract shall terminate immediately and the provider shall immediately make available to **TDMHDD**, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the CONTRACT. The provision of such records shall be at no expense to **TDMHDD**;

3.9.2.31 Include provisions for resolution of disputes by arbitration, mediation or other dispute resolution mechanisms including judicial resolution. Specify that the **TennCare** Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the **BHO** as provided at T.C.A. 56-32-226(b).

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

3.9.2.33 State the provider shall not receive more than one hundred five percent (105%) of the rate negotiated between the **Contractor** and provider as the final payment amount, so any incentive or bonus paid the provider by the **Contractor** shall not exceed five percent (5%) of the rate negotiated between the **Contractor** and the provider.

The provider contract shall specify the provider shall be liable for a portion of any excess benefit costs associated with the provision of services pursuant to the provider contract and shall describe the methodology to be used in the allocation of such excess benefit costs. The provider contract shall also specify the provider shall not be required to absorb any amount of the **Contractor**'s excess administrative and/or management fees;

3.9.2.34 Specify the provider shall be required to accept **TennCare** reimbursement amounts for services provided under the contract between the provider and **Contractor** to **TennCare** Partners Program **Enrollees** and shall not be required to accept **TennCare** reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the **Contractor**;

3.9.2.35 Specify the provider must adhere to the Quality of Care Monitors included in this CONTRACT as Attachment C. The Quality of Care

Monitors shall be included as part of the provider contract between the **Contractor** and the provider;

3.9.2.36 Specify that a provider shall have one hundred and twenty (120) calendar days from the date of rendering a service to file a claim with the **Contractor** except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an **Enrollee** is enrolled in the 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;

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

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

3.9.2.39 Specify the provider contract must number contract pages in sequential order;

3.9.2.40 Specify the provider submit to the **Contractor** the necessary information so the **Contractor** can determine the average unit costs pursuant to Section 3.12.5.4;

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

3.9.2.42 Specify that the contract is not exclusive with respect to any service or geographic area.

3.9.2.43 No agreement executed between the **Contractor** and a provider shall require the provider to assume financial risk for the provision of services which are not directly or indirectly furnished by that provider to an **Enrollee** in the **TennCare Partners Program**. The term indirectly means the provider retains ultimate management and control over the services furnished to **Enrollees** in the **TennCare Partners Program**. The **Contractor** may request the **TennCare** Division of TDCI to provide, in advance, a written opinion whether a proposed contract provision is in compliance with this section, and the **TennCare** Division of TDCI must respond to any such request within thirty (30) calendar days after receipt of the request by the **TennCare** Division of TDCI. **TDMHDD**, in addition to any and all remedies set forth in this CONTRACT, may also commence an action against the

Contractor in accordance with Section 6.11 of this CONTRACT to recover from the **Contractor** any losses incurred by a provider as a result of the **Contractor**'s breach of this section. Any amounts recovered by **TDMHDD** which are for losses incurred by a provider as a result of the **Contractor**'s breach of this section shall be returned without interest to the provider.

3.9.2.44 Require that the provider display notices of the **Enrollee's** right to appeal any adverse action affecting services in public areas of their facility(s) in accordance with **TennCare** rules, subsequent amendments, or any and all court orders;

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

3.9.2.46 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**.

3.9.2.47 There shall be no requirement that requires the **Contractor** to contract with providers beyond the number necessary to meet the needs of its **Enrollees**, precludes them from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude them from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to **Enrollees**.

3.9.2.48 **The Contractor** shall make sure 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**.

3.9.2.49 The **Contractor** shall provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract:

- the **Enrollee's** right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing;
- the **Enrollee's** right to file grievances and appeals and their requirements and timeframes for filing;
- the availability of assistance in filing;
- the toll-free numbers to file oral grievances and appeals;
- the **Enrollee's** right to request continuation of benefits during an appeal or State fair hearing filing and, if the **Contractor's** action is

upheld in a hearing, the **Enrollee** may be liable for the cost of any continued benefits; and
any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

3.9.2.50 The contractor must include in its agreements with providers a statement prohibiting Physician Incentive Plans.

3.9.2.51 Specify that the CONTRACT is not exclusive with respect to any service or geographic area.

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

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

3.9.2.54 Require the provider to comply and submit to the **Contractor** disclosure of information in accordance with the requirements specified in 42 CFR, Part 455, Subpart B.

3.9.2.55 Require the provider to comply with fraud and abuse requirements described in Section 1-9 of this Agreement;

3.9.2.56 Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to, a provider's failure or refusal to respond to the CONTRACTORS request for information, the request to provide medical records, credentialing information, etc., at the CONTRACTORS discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

3.9.3 Network Notice Requirements

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

Failure to comply with notice requirements described herein may result in liquidated damages as described in Section 5.3.3.2 of this Contract.

3.9.4 Other Provider Terminations

The CONTRACTOR shall notify TennCare of any provider termination and submit a copy of one of the actual member notices mailed as well as an electronic listing identifying each member to whom a notice was sent within five (5) business days of the date the member notice was sent as required in Section 3.9.3. In addition to the member notice and electronic listing, documentation from the CONTRACTORS' mail room or outside vendor indicating the quantity and date member notices were mailed shall be sent to TENNCARE as proof of compliance with the member notification requirements. The CONTRACTOR shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TENNCARE. If the termination was initiated by the provider, said notice shall include a copy of the provider's notification to the Contractor.

Furthermore, if termination of the CONTRACTORS' provider agreement with any provider group, whether or not the termination is initiated by the provider or the CONTRACTOR, places the CONTRACTOR out of compliance with Section 2.5.2.2 of this CONTRACT, such termination shall be reported to the CONTRACTOR, in writing to the TENNCARE and TDMHDD in the standard format used to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

3.10 Enrollee Involvement

3.10.1 The **Contractor** must submit for **TDMHDD** approval its policies and procedures with respect to **Enrollee** involvement. These policies and procedures must include, at a minimum, the following elements:

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

3.10.1.2 The requirement that **Enrollee** education materials include statements regarding the **Enrollees**' right to involvement in treatment decisions, their ability to choose and change service providers, and a description of how this requirement will be met;

3.10.1.3 The requirement that provider education include materials regarding the rights of **Enrollees** to be involved in treatment decisions and a description of how this requirement will be met;

3.10.1.4 A description of the quality monitoring activities to be used to measure provider compliance with the requirement for **Enrollee** involvement in treatment planning; and

3.10.1.5 **Enrollee** satisfaction surveys prior to implementation. The **Contractor** shall be responsible for conducting and reporting the results of these surveys to **TDMHDD** annually no later than December 31st. The **Contractor** shall no longer be responsible for conducting these surveys after calendar year 2004.

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

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

3.10.3.1 The Advisory Committee must be comprised of at least 51% consumer and family representatives, of which the majority must include families of adults with Serious and/or Persistent Mental Illness and families of children with Serious Emotional Disturbances;

3.10.3.2 There must be equal geographic representation;

3.10.3.3 There must be cultural and racial diversity;

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

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

3.10.3.6 Meetings must be held at least quarterly;

3.10.3.7 Reimbursement for travel is paid by the **Contractor**;

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

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

3.10.3.10 The Contractor shall require providers to inform children and adolescents for whom residential treatment is being considered, and their parents or guardians, and adults for whom inpatient treatment is being considered, of all their options for residential and/or inpatient placement, alternatives to residential and/or inpatient treatment and the benefits, risks and limitations of each in order that they can provide informed consent.

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

3.11 Quality Monitoring/Quality Improvement Program

3.11.1 The **Contractor** must implement a Quality Monitoring Plan in accordance with **TDMHDD** requirements as referenced in Attachment C.

3.11.2 The **Contractor** must provide the **TDMHDD** Office of Managed Care (OMC) with ten (10) business days advance notice of all regularly scheduled meetings of the Quality Assurance/Quality Improvement Committee and Peer Review Committee. To the extent allowed by law, the **TDMHDD** Office of Managed Care, or OMC designee, may attend the Quality Assurance/Quality Improvement Committee and/or Peer Review Committee meetings at OMC option. In addition, written minutes shall be kept of all meetings of the Quality Assurance/Quality Improvement Committee. A copy of the written minutes for each meeting shall be available on file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site External Quality Review Organization (EQRO) review. The **Contractor** is subject to annual, external independent reviews of the quality outcomes, timeliness of, and access to, the services covered under this CONTRACT.

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

3.11.3 The **Contractor** must maintain national accreditation by National Committee for Quality Assurance, Joint Commission Accreditation Hospital Organizations (JCAHO), URAC (Utilization Review Accreditation Committee), or another nationally recognized accrediting body which is acceptable to **TDMHDD.**

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

3.11.5 Focused Clinical Studies

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

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

3.11.5.1.1 Study topic;

3.11.5.1.2 Target population;

3.11.5.1.3 Study design;

3.11.5.1.4 Timeline for data collection;

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

3.11.5.1.6 Instruments/tools to be used;

3.11.5.1.7 Performance measures, relevant benchmarks and source documentation, expected baselines, and anticipated findings;

3.11.5.1.8 Analytic plans and assumptions;

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

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

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

3.11.6 Utilization Management

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

3.11.6.2 The **Contractor**'s Medical Director shall be responsible for overseeing utilization management so that authorization decisions are based on all relevant medical information available about the individual **Enrollee** and are in accordance with standards of care approved by **TDMHDD**.

The **Contractor** shall not impose utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each **Enrollee** and his or her medical history. This provision shall not limit the **Contractor's** ability to establish procedures for the determination of medical necessity, so long as determinations of medical necessity are consistent with the definition of medical necessity as described in this CONTRACT and based upon an **Enrollee's** individual needs and medical history and based upon substantial and material evidence.

3.11.6.3 The **Contractor's** Medical Director or physicians under the direct supervision of the Medical Director shall review all denials of care for behavioral health services. Any physician who reviews denials of care must meet the minimum qualifications specified in Section 3.7.1.2.5.

3.11.6.4 The **Contractor** shall have written utilization management policies and procedures that clearly define service authorization in a manner that at least includes a managed care **Enrollee's** request for the provision of a service and specifies:

3.11.6.4.1 services that are available upon direct request;

3.11.6.4.2 services that require prior authorization;

3.11.6.4.3 services that require additional review;

3.11.6.4.4 services that require concurrent review;

3.11.6.4.5 circumstances that warrant retrospective review; and

3.11.6.4.6 special procedures for management of high cost and high-risk cases.

3.11.6.5 The Contractor shall not require prior authorization for mental health or substance abuse assessments;

3.11.6.6 The Contractor shall instruct and assist network providers to verify individuals' eligibility prior to providing any service. The only exception to this requirement is when a person requests services for an emergency medical condition. In the event of an emergency medical condition, network providers shall provide immediate medical services.

3.11.6.7 The **Contractor** shall have established procedures that ensure that authorization decisions are made within established time standards by professionals with appropriate credentials and experience who have been trained in the application of criteria for the determination of medical necessity, as defined in Section 2.5.1.1.

3.11.6.8 The **Contractor** shall implement a system for authorization of ongoing behavioral health treatment that includes authorization by experienced behavioral health professionals who function within their scope of practice. The staff persons required in Section 3.7.1.2.6 and 3.7.1.2.7, shall be responsible for authorizing services for persons with mental health disorders who are also developmentally disabled, and persons who have substance abuse disorders.

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

3.11.6.10 Authorization decisions shall be communicated to the provider of care being authorized within forty-eight (48) hours of the decision. Qualified mental health professionals rendering authorization decisions for the **Contractor** shall consult with the requesting providers when medically necessary.

3.11.6.11 The **Contractor** shall provide the medical necessity criteria specified in this CONTRACT and any best practice guidelines identified by **TDMHDD** to its network physicians and utilization reviewers.

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

3.11.6.13 The **Contractor** shall submit to **TDMHDD** and implement clinical care standards and practice guidelines that are based on national guidelines or promulgated by professional medical associations or other expert committees. The **Contractor** shall disseminate the guidelines to all affected providers and, upon request to **Enrollees** and **Potential Enrollees**.

3.11.6.14 The **Contractor** shall provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any **Enrollee**.

3.11.6.15 The **Contractor** must notify the requesting provider of any decision to deny a request for authorization of a service, or to authorize a service in an amount, duration, or scope that is less than requested. It is not required that the notice be in writing, but the **Contractor** must be able to produce proof or documentation of notice to the requesting provider.

3.11.6.16 The **Contractor** shall insure that decision for utilization management, **Enrollee** education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

3.12 Records and Reporting Requirements

3.12.1 General Requirements

3.12.1.1 The **Contractor** is responsible for generating all transactions/transaction files and complying with all the reporting requirements established by TennCare. Each transaction must be date/time stamped. TennCare shall provide the **Contractor** with the appropriate reporting formats, record layouts**,** instructions, submission tables, and technical assistance when required. TennCare reserves the right, at its discretion, to require the **Contractor** to recreate, reconstruct or re-sort records/reports/transaction files using the same or different reporting formats, record layouts, instructions, and submission timetables as specified by TennCare. Requests to recreate, reconstruct or re-sort such reports/files will be considered Ad Hoc reports/files or continuous reports/files and shall be due within time periods specified by TennCare. The minimum data elements required for transaction files are described in Attachment D of this CONTRACT.

3.12.1.2 The **Contractor** must submit to TennCare all required transaction files utilizing the Electronic Data Interfaces (EDI) of the IBM International Network (IBMIN) unless otherwise stated by TennCare. The **Contractor** will be responsible for <u>all</u> costs involved with the IBMIN, including setup, software, account ID, and transmit cost both to and from the "mailbox" whether opened by the **Contractor** or by the State.

3.12.1.3 The **Contractor** must provide TennCare with quarterly files for comparisons between TennCare or TennCare databases and the **Contractor**'s database. The **Contractor** shall reconcile any discrepancies.

3.12.1.4 The **Contractor** shall be responsible for its Information Systems concerning all aspects for (1) System Backups, (2) Off-site security storage of same System Backups, (3) System Restores, (4) Disaster Recovery Plan and Procedures, and (5) all security needs and considerations. The **Contractor** is responsible for all documentation and procedures concerning all five (5) of these items, insuring they are kept up-to-date, accurate, and accessible.

3.12.1.5 **TennCare** has the right to obtain a free, legal, licensed copy(s) of the **Contractors**' software, physical data base structure(s), and ongoing upgrades as available relating to admissions/intake, patient tracking, all components of billing, and any other aspect of the **Contractor's** system software considered useful to **TennCare** and the providers it supports. It will be **TennCare's** choice as to which **Contractor's** software best satisfies **TennCare** needs and operating system environment. **TennCare** has the right to choose all the software from one particular **Contractor** without receiving any protest whatsoever from any other **BHO**. It is not the intention of **TennCare** the other **Contractors** will be required to use this software. This software will be made available to HCFA upon request.

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

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

		unless otherwise specified by **TDMHDD**.

3.12.1.7 The **Contractor** must retain records in accordance with 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.)

3.12.2 Provider Enrollment Reporting

The **Contractor** shall furnish to **TDMHDD** at the time of application a listing of all providers enrolled in the **Contractor**'s provider network including, but not limited to, agencies and individual physicians, mental health case managers, psychologists, licensed clinical social workers, registered nurses, nurse practitioners, certified alcohol and drug abuse counselors, other mental health or substance abuse professionals, hospitals, etc. This listing shall include regularly enrolled providers, specialty or referral providers, and any other provider which may be enrolled for purpose of payment for services provided out-of-plan. This

information shall be reported in a standardized format as specified by **TDMHDD** and transmitted electronically to **TDMHDD** on a monthly basis. The minimum data elements required for this listing may be found in Attachment D.1 of this CONTRACT.

3.12.3 Enrollee Assessment Reporting

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

3.12.4 Enrollee Encounter Reporting

The **Contractor** shall furnish to **TennCare** information regarding individual encounters (individual units of service provided to **Enrollees**). Encounter information will be submitted for all covered services as listed in Section 2.5, regardless of provider reimbursement methodology. In the event that services are bundled for the purpose of payment, the **Contractor** shall require the provider to submit unbundled services in the necessary format to support the Contractor's obligation to submit encounter data for each individual unit of service. This information shall be reported in a standardized format as specified by **TDMHDD** and transmitted electronically to **TennCare** on a

monthly basis. The minimum data elements required to be provided are identified in Attachment D.4 of this CONTRACT.

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

3.12.5 Enrollee Information, Weekly Reporting

The **Contractor** shall submit weekly reports in an electronic format, unless otherwise specified or approved by TennCare in writing, which shall serve as the source of information for a change in the **Enrollee's** TennCare information. Such information shall serve as the source of information for a change in the **Enrollee's** address and/or selection of MCO plan. This report shall include **Enrollees** who move outside the **Contractor's** service area as well as **Enrollees** who move to a new address within the Contractor's service area. The **Contractor** agrees to work with the State to devise a methodology to use returned mail to identify **Enrollees** who have moved and whose whereabouts is unknown.

Within 90 days of notification from **TennCare**, the **Contractor** shall also be required to include in this report, any information which is known by the **Contractor** that may affect an **Enrollee's TennCare** eligibility and/or TennCare cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of uninsurability including limited coverage and exclusionary riders to policies, whether or not the **Enrollee** is incarcerated, or resides outside the State of Tennessee. The minimum data elements required for this report can be found in Attachment D of this CONTRACT. This notice may be accomplished through a written form or as an electronic media update, as mutually agreed upon by the **Contractor** and **TennCare**.

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

- Recipient SSN
- Type of coverage (inpatient, out patient, pharmacy, dental, vision, etc).
- Policyholder SSN, if available
- Policyholder's relationship to the recipient
- TennCare Carrier number, Carrier name and address, if available
- Policy number
- Begin and end dates of policy

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

3.12.6 Enrollee Verification Information on Request

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

3.12.7 Financial Reporting

3.12.7.1 The **Contractor** shall file with the **TennCare** Division of TDCI an annual report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations, on or before March 1 of each calendar year, which report is currently required to be filed by all licensed health maintenance organizations pursuant to Tennessee Code Annotated, §56-32-208. The annual report shall also contain an income statement detailing the **Contractor's** fourth quarter and year-to-date revenues and expenses incurred as a result of the **Contractors** participation in the State of Tennessee's **TennCare Partners Program**. The **Contractor** in preparing this annual report shall comply with any and all rules and regulations of TDCI related to the preparation and filing of this report. Furthermore, the medical loss ratio report required in Section 3.15.8 must be filed with and reconciled to the NAIC annual statement.

3.12.7.2 The **Contractor** shall file with the **TennCare** Division of TDCI a quarterly financial report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations. These quarterly reports shall be filed on or before June 1 (covering first quarter of the current year), September 1 (covering second quarter of current year), December 1 (covering third quarter of current year), of each calendar year.

Each quarterly report shall also contain an income statement detailing the **Contractor**'s quarterly and year-to-date revenues earned and expenses incurred as a result of the **Contractor's** participation in the State of Tennessee's **TennCare Partners Program**. The medical loss ratio report required in Section 3.15.8 must be filed with and reconciled to the September NAIC quarterly report. The actuarial certification shall be prepared in accordance with the National Association of Insurance Commissioners guidelines.

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

3.12.7.4 The **Contractor** shall report monthly to **TDMHDD** summary reports of cost for providing each definable unit of service reported in accordance with Section 3.12.4 for two dual eligible categories (Medicare/ **TennCare** Medicaid and Medicare/ **TennCare** Standard). These reports shall be due by the 21st of the month two months following the period being reported. The State shall be responsible for providing the **Contractor** with information needed to identify these dual eligible **Enrollees**. The **Contractor** is not relieved from this obligation because the **Contractor** has any subcontracts for the provision of any such unit of service, regardless of the method of payment to the subcontractor(s). Cost data for dual eligible **Enrollees** shall be reported electronically using the report format provided in Attachment D.8 or as later revised.

3.12.7.5 Payment for Out-of-Plan Emergency Providers

The **Contractor** shall report to **TennCare** the average payment rate paid to out-of-plan emergency providers by January 31 of each calendar year for the prior year.

3.12.7.6 Cost Avoidance Value Reporting

The **Contractor** shall report all claim adjusted amounts due to TPL coverage or Medicare coverage on a frequency and in a format and media described by **TennCare.** The **Contractor** shall calculate cost savings in categories described by **TennCare.**

3.12.8 Case Management Reporting

The **Contractor** shall also submit a summary of all **Enrollees** receiving case management services to **TDMHDD** on a quarterly basis. The minimum data elements required to be provided are identified in Attachment D.5.

3.12.9 Crisis Response Reporting

In accordance with Section 2.6.6, the **Contractor** shall monitor crisis service providers and report information to **TDMHDD** on a quarterly basis for those indicators listed in Attachment D.6 and Attachment E. All measures shall be reported separately for adults ages eighteen (18) years and over and children under eighteen (18) years. All information shall be reported for each individual crisis service provider in a standardized format as specified by **TDMHDD.**

3.12.10 Enrollee TennCare Cost-Sharing Liabilities

In accordance with Section 3.4.2, the **Contractor** shall track and report to **TennCare** the amount of **Enrollee** TennCare cost-sharing liabilities. This information shall be reported in a standardized format as specified by **TennCare** on a monthly basis.

3.12.11 Focused Studies

In accordance with Section 3.11.5, the **Contractor** is required to conduct at least three focused clinical studies. The **Contractor** shall submit a hard copy report of the study design, analysis and results, for each continuous focused study to **TDMHDD** on an annual basis.

3.12.12 Monthly Claims Activity Reporting

The **Contractor** shall provide claims processing status reports to **TDMHDD** on a monthly basis. This information shall be reported in a standardized format as specified by **TDMHDD**. At a minimum, this report shall include:

1. The number of unpaid claims in inventory by service type;
2. An aging of unpaid claims by service type;
3. The average time from receipt to final payment of claim by service type;
4. The approximate value of unpaid claims by service type.

3.12.13 Monthly Telephone Activity Reporting

The **Contractor** shall provide a Telephone Activity report to **TDMHDD** on a monthly basis. At a minimum, this report shall include:

1. Number of telephone calls;
2. Abandonment rate for telephone calls;
3. The approximate waiting time for response;
4. Number of provider phone calls for prior authorization;
5. The approximate waiting time spent on the phone in queue for providers requesting prior authorization; and
6. The number of provider complaints received, either in writing or by phone.

3.12.14 Medical Loss Ratio Report

The Medical loss ratio report shall be submitted monthly on a cumulative year to date basis using the forms in Attachment D.9. The **Contractor** shall report all medical expenses and capitation payments received from **TennCare** and complete the supporting claims lag tables. Monthly expenditures shall be reported on a rolling basis by provider groupings including but not limited to (i) direct payment to providers for covered medical services, (ii) capitated payments to providers and (iii) subcontractors for covered medical services. The **Contractor** will submit these reports monthly, due by the 21st of the following month. The **Contractor** will also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report must reconcile to NAIC filings.

3.12.15 Medical Records Requirements

The CONTRACTOR shall maintain, and shall require contracted providers and sub-contractor's to maintain medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. Medical records are to be maintained at the site where medical services are provided for each member enrolled under this Agreement. The CONTRACTOR shall have policies and distribute policies to practice sites that address:

3.12.15.1. Confidentiality of medical records;

3.12.15.2 Medical record documentation standards;

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

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

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

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

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

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

3.12.16 30/60 Inpatient Report

The **CONTRACTOR** shall report quarterly to **TDMHDD** information on psychiatric inpatient facility services for the purpose of determining appropriate funding sources for lengthy hospitalizations. The report shall include **Enrollees** with a single paid inpatient stay greater than 30 calendar days and **Enrollees** with a total of 60 or more calendar days within a calendar year, regardless of the number of admissions. **TennCare** shall specify the time periods to be contained within the reports and the report format.

3.12.17 Assessments Reporting

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

On a quarterly basis the **CONTRACTOR** shall submit a Rejected CRG/TPG Assessments Report that provides, by agency, the number of rejected CRG/TPG assessments and the unduplicated number of and identifying information for the unapproved raters who completed the rejected assessments. This report shall be submitted in the format specified by **TDMHDD.**

3.12.18 IMD Out-of State Report

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

3.12.19 Availability of Records

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

complete access to all records pertaining to the medical care or services provided to TennCare enrollees.

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

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

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

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

3.12.19.3.b Maintaining full cooperation and open authority for claims processing systems access and mailroom visits by TDCI or designated representatives or any authorized entity of the state or federal government, and to cooperate fully with detail claims testing for claims processing system compliance.

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

3.12.20 Business Continuity and Disaster Recovery Reports

The **Contractor** shall submit a high level summary of their baseline *Business Continuity and Disaster Recovery (BC-DR) Plan* or make it available at Contractor's local Tennessee site for review and approval as specified by **TennCare**. The **Contractor** shall communicate a high level summary of proposed modifications in the BC-DR plan or make it available at Contractor's local Tennessee site at least fifteen (15) calendar days prior to their proposed incorporation. Such modifications shall be subject to review and approval by **TennCare**.

3.13 Accounting Requirements

3.13.1 General Requirements

The **Contractor** shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this CONTRACT and any other costs and expenditures made under the CONTRACT.

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

3.13.2 Claims Processing

The **Contractor** shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically. To the extent that the **Contractor** compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the **Contractor** shall process, as described herein, the provider's claims for covered benefits provided to **Enrollees** or **Judicials** consistent with applicable **Contractor** policies and procedures and the terms of this CONTRACT.

The **Contractor** shall ensure that ninety percent (90%) of claims for payment for services delivered to an **Enrollee** or a **Judicial** (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the 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** or a **Judicial**. "Pay" means that the **Contractor** shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the **Contractor**. "Process" means the **Contractor** must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial.

If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. If requested by the provider, the **Contractor** shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as capitation payments generated and paid by the BHO. The status report shall contain appropriate explanatory remarks related to payment or denial of the claim.

To the extent that the provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the contract between the provider and the **Contractor** or subcontractor, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or (iii) if the **Contractor** is required to compensate the provider directly, within five (5) calendar days after receipt of the capitation payment and supporting Remittance Advice information from **TennCare.**

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

Failure to meet claims processing requirements may result in the application of liquidated damages and other remedies as described in Section 5.3.3 and Attachment E.

3.13.3 Resolution of All Previous Claims Processing Issues

When applicable, the **Contractor** shall be required to appropriately process all backlogged claims in accordance with time frames specified TDMHDD. For purposes of this requirement, backlogged claims include, but are not limited to, all claims which have been received but not processed to final and correct disposition and the resolution of each and every payment dispute related to the provision of service.

At its discretion, the state will assess the current status of the **Contractor's** claims processing performance to determine if changes in claims processing procedures have been made and if performance has improved to acceptable levels.

Failure by **Contractor** to comply with any of the claims processing requirements stated in Section 3.13.2 of this contract will result in the state issuing a sixty (60) day notice of termination of the contract between the State and the **Contractor** in accordance with Section 5.1 of the contract. Termination of the contract shall not preclude the state from exercising any other remedies available under the contract.

3.13.4 Audit Guidelines

The State and the **Contractor** agree the State may develop comprehensive audit guidelines for the monitoring of **Contractor**'s claims processing performance and include these audit guidelines in a future amendment to this contract. These claims processing audit guidelines may consist of specified performance criteria and liquidated or other damages for **Contractor**'s failure to meet the specified performance criteria. The State and **Contractor** agree the **Contractor** shall have an opportunity to participate in the development of these claims processing audit guidelines.

3.14 Monitoring and Audit Requirements

3.14.1 Audit Requirements

The **Contractor** shall also cause an audit of its business transactions to be performed by a licensed certified public accountant, including but not limited to, the financial transactions made under this CONTRACT.

Such audit shall be performed in accordance with the National Association of Insurance Commissioners (NAIC) Annual Statement Instructions regarding the Annual Audited Financial Report. There are three (3) exceptions to the aforementioned statement instructions:

3.14.1.1 The **Contractor** shall submit to the Tennessee Department of Commerce and Insurance, **TennCare** Division, the audited financial statements covering the previous calendar year by May 1 of each calendar year.

3.14.1.2 Any requests for extension of the May 1 submission date must be granted by the Comptroller of the Treasury pursuant to the "Contract to Audit Accounts".

3.14.1.3 The audit report shall include an income statement addressing the **TennCare** operations of the **Contractor**.

The agreement for such audits shall be subject to prior approval of the Comptroller of the Treasury and must be submitted on the standard "Contract to Audit Accounts". In the event that terms included in the standard contract to audit accounts differ from those contained in this CONTRACT, this CONTRACT takes precedence. These financial reporting requirements shall supersede any other reporting requirements made of the **Contractor** by the Tennessee Department of Commerce and Insurance (TDCI), and TDCI shall enact any necessary rule or regulation to conform with this provision of the CONTRACT.

3.14.2 Audit Requirements

The CONTRACTOR and its providers, subcontractors and other entities receiving monies originating by or through TennCare shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section 1-9 of this Agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for any authorized federal, state, including, but not limited to TENNCARE, TDMHDD, OIG, TBI MFCU, DOJ and the HHS OIG, and Comptroller personnel during the Agreement period and five (5) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the Agreement period, these

records shall be available at the CONTRACTORS chosen location in Tennessee subject to the approval of TENNCARE and/or TDMHDD. If the records need to be sent to TENNCARE and/or TDMHDD, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR, subcontractor or provider records must be requested and approved by TDMHDD.

3.14.3 Accessibility of Records for Monitoring

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

3.14.4 Independent Review

TDMHDD may select a private review organization or an external quality review organization (EQRO) to provide a periodic or annual independent review to include quality outcomes, timeliness of, and access to, the services covered under the CONTRACT. The results of the review shall be provided to **TDMHDD** and to the **Contractor** and shall be available, on request, to the United States Department of Health and Human Services, the Office of Inspector general and General Accounting Office.

3.15 Fiscal Management

3.15.1 General Requirements

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

3.15.2 Contractor Payments

The **Contractor** agrees to accept the capitation payments and payments for program enhancements remitted by **TennCare** as payment in full for all services provided pursuant to this contract, including all administrative and management fees and profits, in accordance with Section 4.7 of this CONTRACT.

However, the **Contractor** shall only be allowed to retain ten percent (10%) of the monthly amount paid by **TennCare** for administrative and management fees and profits, with the remaining 90% of the capitation payments and payments for program enhancements being made available for providing or arranging direct mental health and substance abuse services to **Enrollees** and payment of any applicable premiums tax by the **Contractor** to the State.

Any and all benefit costs in excess of the amounts allowed pursuant to this CONTRACT shall be the responsibility of the **Contractor** as specified in Section 4.7 of this CONTRACT**.** TDMHDD shall not be liable for any excess benefit costs distributed as a reduction to contract providers. Any administrative and management fees and profits exceeding the 10% limitation shall be borne by the **Contractor.**

The second and third paragraphs of Section 3.15.2 Contractor Payments, do not apply under the gain / loss sharing arrangement in Section 4.7.2.2.

3.15.3 Contractor 's Management Fee Deleted / This Section Reserved

3.15.4 THIS SECTION INTENTIONALLY LEFT BLANK

3.15.5 Return of Funds

The **Contractor** must return to **TennCare** any overpayments due or funds disallowed under this CONTRACT. Such funds shall be considered **TennCare** funds and shall be refunded to **TennCare**. The refund shall be due within thirty (30) calendar days after notification to the **Contractor** by **TennCare** unless this deadline is extended by **TennCare** in writing.

3.15.6 Interest

During the MLR risk sharing period, ten percent (10%) of the interest income will be used to reduce the State's portion of shared losses above ninety-one percent (91%) MLR or be added to the State's share of the gains below eighty-five percent (85%) MLR. If the MLR is between 85% - 91%, the interest income remains with the **CONTRACTOR.**

3.15.7 Third Party Resources

The CONTRACTOR shall be required to seek and collect third party subrogation amounts regardless of the amount available or believed to be available as required by federal guidelines. The amount of provider payments shall be net of third party recoveries captured on the CONTRACTOR'S claims processing system prior to notification of TennCare of the amount paid. The CONTRACTOR shall post all third party payments to claim level detail by enrollee. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall be retained by the CONTRACTOR, but shall be credited against the CONTRACTOR'S Medical Expenses for purposes of determining the Medical Loss Ratio pursuant to the gain and loss sharing under Section 4.7.2.2 of this Contract. On a monthly basis, the CONTRACTOR shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. Further, the CONTRACTOR shall provide any information necessary in a format and media described by TennCare and shall cooperate as requested by TennCare, with TennCare and/or a Cost Recovery Vendor at such time that TennCare acquires said services.

Failure to seek, make reasonable effort to collect and report third party recoveries shall result in liquidated damages as described in Section 5.3.3 of this Agreement. It shall be the CONTRACTOR'S responsibility to demonstrate, upon request, to TennCare that reasonable effort has been made to seek, collect and/or report third party

recoveries. TennCare shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated.

3.15.8 Medical Loss Ratio

For the period June 7, 2001 through December 31, 2001, the **Contractor** is required to achieve medical loss ratio of no less than 88.25%* of capitation payments received from **TennCare** while new accountability measures are being developed. At such time as accountability measures are developed, implemented and it is determined by the State that said accountability measures are being met by the **Contractor**, the State may eliminate this requirement as an accountability measure for future Fiscal Years. The intent of the 88.25%* medical loss ratio is that 88.25%* of the capitation rate will be spent on covered services as defined in Attachment B of the CONTRACT for eligible **TennCare Partners Program Enrollees**. Medical loss ratio shall be reported monthly with cumulative year to date calculation using the form specified by TDCI.

The **Contractor** shall report all behavioral health expenses and capitation payments including payments for program enhancements received from **TennCare**. Monthly expenditures shall be reported by provider groupings including but not limited to (i) direct payments to providers for covered services, (ii) capitated payments to providers and (iii) subcontractors for covered services. The **Contractor** will submit these reports monthly, due by the 21st of the following month to TDMHDD and TDCI. The **Contractor** will also file this

report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. A reconciliation of the MLR report to the NAIC filing must be included.

The medical loss ratio requirement will be monitored monthly and reconciled annually to determine compliance. In the event the **Contractor** has not distributed the applicable minimum required percentage of its capitation rate for any month and it appears that the **Contractor** will not ultimately reach its target, as determined during monthly monitoring, the State may require the **Contractor** to submit a corrective action plan in compliance with Attachment H. In addition to the remedies specified in Attachment H, the State may order the **Contractor** to distribute to providers the difference between the applicable minimum medical loss ratio and the percentage distributed including projected distributions for incurred but not reported claims.

An assessment of the **Contractor's** medical loss ratio will be made within ninety (90) days after the end of the calendar year and as otherwise needed for BHOs participating in the optional profit/loss risk-banding program to finalize the risk-banding settlement calculation.

*Effective January 1, 2002, the minimum medical loss ratio requirement will be 88.00%.

3.15.9 Subrogation (Casualty) Recovery

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

3.16 Notification of Legal Action Against the Contractor

The **Contractor** shall provide to the Commissioner of **TDMHDD** and to the Deputy Commissioner of the **TennCare** Division of TDCI 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**. Records of persons with serious emotional disturbance or mental illness must be maintained in conformity with Tennessee Code Annotated, §33-3-104(2). Records of persons whose confidentiality is protected by 42 CFR Part 2 must be maintained in conformity with that rule or Tennessee Code Annotated, §33-3-104, whichever is more stringent. The **Contractor** shall ensure all tasks related to the provider contract are performed in accordance with the terms of this CONTRACT.

3.17 Non-Discrimination Compliance

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

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

3.17.2 On a quarterly basis, a listing of all complaints/appeals filed by employees, **Enrollees** or sub**contractor**s 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 party's relationship to the BHO, the circumstances of the complaint and the resolution of the complaint.

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

3.17.4 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 3.17.3) and shall be sorted by CSA. Each provider type (e.g. physician, dentist, etc.) shall be reported separately within the CSA. Primary care providers shall be reported separately from other physician specialties. The **Contractor** is required to request this information from all providers. Provider response is voluntary. The **Contractor** is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding participation in the **Contractor's** provider network or in determination of compensation amounts.

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

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

3.17.6.1 A listing of the interpreter/translator services utilized by the **Contractor** in providing services to **Enrollees**. The listing shall provide the full name of interpreter/translator services, address of services, phone number of services, hours services are available and be sorted by CSA.

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

3.17.8 The **Contractor** shall develop a written procedure for the provision of language interpretation and translation services for **Enrollees**. The **Contractor** shall provide instruction for its staff, including but not limited to the designated staff person for Title VI, and all direct service subcontractors regarding the procedure.

3.18 Compliance with Health Insurance Portability and Accountability Act (HIPAA) Requirements

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

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

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

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

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

3.18.1.4 The **Contractor** shall agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of this CONTRACT and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between **TennCare** and the **Contractor** to a halt, if for any reason the **Contractor** cannot meet the requirements of this Section, **TennCare** may terminate this CONTRACT in accordance with Section 5.2;

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

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

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

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

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

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

3.18.1.11 The **Contractor** shall make available to **TennCare** within twenty one (21) calendar days of notice by **TennCare** to the **Contractor** such information as in the **Contractor's** possession and is required for **TennCare** to make the accounting of disclosures required by 45 CFR § 164.528. At a minimum, the **Contractor** shall provide **TennCare** with the following information:

a. the date of disclosure

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

c. a brief description of the Protected Health Information disclosed, and

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

3.18.1.12 In the event that the request for an accounting of disclosures is submitted directly to the **Contractor**, the **Contractor** shall within two (2) days forward such request to **TennCare**. It shall be **TennCare's** responsibility to prepare and deliver any such accounting requested. Additionally, the **Contractor** shall institute an appropriate record keeping process and procedures and policies to enable the **Contractor** to comply with the requirements of this Section;

3.18.1.13 The **Contractor** shall make its internal policies and procedures, records and other documentation related to the use and disclosure of Protected Health Information available to the Secretary of Human Services for the purposes of determining compliance with the HIPAA regulations.

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

3.18.1.15 The **Contractor** shall agree, if feasible, to the return or destruction of all Protected Health Information received from, created, or received by the **Contractor**;

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

3.18.1.17 The **Contractor** shall set up appropriate mechanisms to ensure minimum necessary access of their staff to Protected Health Information;

3.18.1.18 The **Contractor** shall create and implement policies and procedures to address present and future HIPAA regulation requirements;

3.18.1.19 The **Contractor** shall provide an appropriate level of training to its staff and **Enrollees** regarding HIPAA related policies, procedures, **Enrollee** rights and penalties;

3.18.1.20 The **Contractor** shall be allowed to use and receive information from **TennCare** where necessary for the management and administration of this CONTRACT and to carry out business operations;

3.18.1.21 The **Contractor** shall be permitted to use and disclose PHI for the **Contractor's** own legal responsibilities.

3.18.2 In accordance with HIPAA regulations, **TennCare** shall, at a minimum, adhere to the following guidelines:

3.18.2.1 **TennCare** shall make its individually identifiable health information available to **Enrollees** for amendment and access as specified and restricted under the federal HIPAA regulations.

3.18.2.2 **TennCare** shall set up policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding plan administration and oversight.

3.18.2.3 **TennCare** shall adopt a mechanism for resolving any issues of non-compliance as required by law.

3.18.2.4 **TennCare** shall establish similar HIPAA data partner agreements with its subcontractors and other business associates.

3.19 Management Information Systems (MIS) Requirements

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

3.19.1.1 Eligibility and enrollment;

3.19.1.2 Claims processing;

3.19.1.3 Encounter data submissions;

3.19.1.4 Service authorization and care coordination;

3.19.1.5 Utilization management;

3.19.1.6 Provider network information;

3.19.1.7 EPSDT tracking;

3.19.1.8 Performance and outcome reporting;

3.19.1.9 Financial reporting;

3.19.1.10 Appeals and complaint processing; and

3.19.1.11 Provider profiling.

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

3.19.3 The claims processing subsystems must have the capability to process claims in accordance with the requirements specified in Section 3.13.2.

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

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

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

3.19.7 The **Contractor** shall operate a systems that tracks EPSDT activities for each enrolled child by name and identification number and allows the **Contractor** to track the status of the child with respect to behavioral health referrals.

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

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

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

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

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

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

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

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

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

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

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

3.19.14.5 Dial-up access into production regions is prohibited.

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

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

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

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

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

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

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

3.19.16.6 Eligibility Validation – The systems must confirm the **Enrollee** or **Judicial** for whom a service was provided was eligible on the date the

service was incurred and approve for payment only those claims for eligible **Enrollees** and **Judicials**.

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

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

3.19.16.9 Managed Care Organizations (MCOs)– The systems must reject claims that should rightly be processed and paid by an **Enrollee's** MCO for any and all physical health treatments.

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

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

3.19.19 The systems must comply with the following specific security measures:

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

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

3.19.19.3 Manual procedures that provide secure access to the systems with minimal risk.

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

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

3.19.19.6 Systems operation functions must be segregated from systems development duties.

3.19.20 The **Contractor** must submit evidence that they have a Business Continuity/Disaster Recovery Plan for their central processing site for prior approval with the execution of this CONTRACT. **TennCare** has thirty (30) calendar days to respond. If requested, test results of the plan must be made available to **TennCare**. The plan must be able to meet the requirements of any applicable state and federal regulations, the **TennCare** Bureau and Tennessee's Office of Information Resources (OIR).

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

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

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

3.19.21.3 Smoking must be prohibited at the site.

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

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

3.19.21.6 The site must be protected by an automatic fire suppression systems.

3.19.21.7 The site must be backed up by an un-interruptible power source systems.

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

(a) Regardless of the architecture of its Systems, the CONTRACTOR shall develop and be continually ready to invoke a BC-DR plan that is reviewed and prior approved by TENNCARE. TENNCARE shall provide guidance to the CONTRACTOR regarding its BC-DR plan in a Standard Operating Procedure.

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

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

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

(e) The CONTRACTOR shall submit a baseline BC-DR plan to TENNCARE and communicate proposed modifications as required in Section 3.12.20.

SECTION 4. TDMHDD Responsibilities

4.1 General Responsibilities

TDMHDD's responsibilities for the monitoring of this CONTRACT are set forth in a Memorandum of Understanding with the **TennCare** Bureau. The **Contractor** acknowledges that **TennCare** has ultimate authority and responsibility for the oversight of this CONTRACT and shall comply with all notices and direction received from **TennCare** related to the administration of this CONTRACT.

4.2 Interpretations

Any dispute between the **Contractor** and **TDMHDD** concerning the clarification, interpretation and application of any provision of this CONTRACT or any federal and State laws and regulations governing or in any way affecting this CONTRACT shall be resolved by **TDMHDD**. When a clarification, interpretation and application is required, the **Contractor** will submit written requests to **TDMHDD**. **TDMHDD** will contact the appropriate agencies in responding to the request. Any clarifications received pursuant to requests for clarification or interpretation shall be forwarded upon receipt to the **Contractor**. Nothing in this Section shall be construed as a waiver by the **Contractor** of any legal right it may have to contest the findings of either the State or federal governments or both as they relate to the clarification, interpretation and application of statute, regulation, and/or policy.

4.3 Eligibility and Enrollment

TDMHDD and **TennCare** shall be responsible for verifying the eligibility, enrollment and, disenrollment of **Enrollees** from the **Contractor's** plan.

4.3.1 TennCare Enrollees

TennCare shall be responsible for verifying the eligibility of all **TennCare Medicaid** and **TennCare Standard Enrollees** and for assigning them to and disenrolling them from the **Contractor's** Plan.

TDMHDD shall be responsible for determining the eligibility of all non-**Enrollees** in the **TennCare Partners Program.** All such persons must first have applied for **TennCare** benefits and been denied or not yet approved for enrollment by **TennCare** on the basis of eligibility for **TennCare Medicaid** or **TennCare Standard**. **TDMHDD** shall be responsible for enrolling these persons in the **TennCare Partners Program**. **TennCare** shall be responsible for assigning these persons to a BHO.

4.3.2 Judicials

TDMHDD shall be responsible for temporarily assigning all **Judicials** to the **Contractor's** plan. In the event a **Judicial** is referred by a court of competent jurisdiction, the referral shall be construed as if the referral was a temporary assignment by **TDMHDD**. The **Contractor** shall be responsible only for the services as prescribed under the terms of this CONTRACT or as required by the statute or court order under which the **Judicial** was referred. The preceding sentence notwithstanding, the **Judicial** shall not be considered as an **Enrollee** in the **Contractor's** plan.

Except for **Judicials**, **TennCare** shall arrange for the **Contractor** to have daily updated eligibility information in the form of on-line computer access. **TennCare** shall also arrange for the **Contractor** to receive a daily list of all the **Enrollees** who become ineligible or disenrolled from the **Contractor's** plan or who have been determined to have moved out of the State of Tennessee.

4.4 Approval Process

At any time that approval of **TDMHDD** is required in this CONTRACT, such approval shall not be considered granted unless **TDMHDD** issues its approval in writing. Should **TDMHDD** not respond in the required amount of time, as set forth in Attachment F, the **Contractor** shall not be penalized with either liquidated damages or a withhold as a result of implementing the item awaiting approval. However, failure by **TDMHDD** to assess liquidated damages or withholds shall not preclude **TDMHDD** from requiring the **Contractor** to rescind or modify the "item" if it is determined by **TDMHDD** to be in the best interest of the **TennCare Partners Program**. Material requiring **TDMHDD** approval includes, at a minimum, the following:

4.4.1 The **Contractor's** provider network and any additions and deletions;

4.4.2 In accordance with Section 3.6, all materials to be used in educating or communicating with existing **Enrollees**;

4.4.3 The **Contractor's** *pro forma* agreement(s) with providers and any amendments thereto;

4.4.4 Any subcontracts which may be proposed for any services other than the services and benefits provided to **Enrollees**;

4.4.5 Appeal procedures;

4.4.6 Reporting templates and procedures;

4.4.7 Indemnity language in provider agreements if different from the standard indemnity language found in Section 6.12 of this CONTRACT or the *pro forma* agreements which are reviewed in accordance with Section 4.4.3 above;

4.4.8 Quality Assurance/Quality Improvement procedures, including utilization management criteria and credentialing criteria;

4.4.9 Focused clinical study topics;

4.4.10 Fraud and Abuse Compliance Plan;

4.4.11 Insurance and bonding plans;

4.4.12 Disaster Recovery Plan;

4.4.13 Transition Plan in accordance with Section 5.1.3.1.

4.5 Inspections and Monitoring

4.5.1 Facility Inspection

TDMHDD, **TennCare**, TDCI, CMS, or any agents of these agencies may conduct on-site inspections of all health facilities and service delivery sites to be utilized by the **Contractor** in fulfilling the obligations under this CONTRACT. Inspections may be made at any time during the term of this CONTRACT and without prior notice.

4.5.2 Monitoring

TDMHDD, in its daily activities, shall monitor various aspects of the **Contractor's** health plan for compliance with the provisions of this CONTRACT. Further, **TDMHDD**, TDCI and CMS, or their agents, shall at least annually monitor the operation of the **Contractor** for compliance with the provisions of this CONTRACT and applicable federal and State laws and regulations.

Such monitoring activities shall include, but are not limited to, inspection of **Contractor**'s facilities, auditing and/or review of all records developed under this CONTRACT, including periodic medical audits, appeals, enrollments, disenrollments, termination, utilization and financial records, review of management systems and procedures developed under this CONTRACT and review of any other areas or materials relevant to or pertaining to this CONTRACT. The monitoring agency shall prepare a report of its findings and recommendations and require the **Contractor** to develop corrective action plans as appropriate.

4.6 Responses to Enrollees

4.6.1 Appeals

TennCare shall establish and maintain an informal review process and formal appeal procedures whereby, any **Enrollee** or anyone authorized to act on their behalf may grieve or appeal an adverse action by the **Contractor** in accordance with Section 3.5. The **Contractor** specifically acknowledges, in accordance with 1200-13-13-.11 and 1200-13-14-.11 of the **TennCare** Rules of TDFA , it is bound by the decision of **TennCare**, whether as the result of an informal review or formal appeal, and shall not appeal any decision rendered by **TennCare**.

4.6.2 Consumer Affairs

TDMHDD shall maintain an Office of Consumer Affairs in order to respond to member inquiries and complaints.

4.7 Payment Terms and Conditions

4.7.1 Maximum Liability and Allocation of Funds to this Contract

This CONTRACT is subject to appropriation and availability of state and federal funds. In no event shall the maximum liability of the State for the **TennCare Partners Program** in the Middle and West Grand Regions (and East Region for special Children's populations), exceed Two Hundred Twelve Million, Three Hundred Seventy Six Thousand Nine Hundred Dollars ($212,376,900) for the contract period of July 1, 2006 through June 30, 2007. In the event the participant enrollment is greater than the projected enrollment used to develop the maximum liability, TDMHDD will pay the Contractor for each enrollee at per member per month rate in Section 4.7.2. The State reserves the right in its sole, absolute and unfettered discretion to equitably allocate the total available funds for payment for services under this CONTRACT from the total State and federal sums available for the payment for services in the entire State. The State shall notify Contractor of any changes in funding or any changes in the allocation of funding as soon as possible. If the CONTRACT maximum would be exceeded, as a result of an increase in enrollment, a change in mix of enrollment among rate cells or any rate adjustment determined by the independent actuarial analysis under contract with the State pursuant to Section 4.7.2, or there is a reduction in the total available funds for the payment of services under this CONTRACT, the State and the **Contractor** shall negotiate in good faith to reduce CONTRACT expenditures to the

CONTRACT maximum level or the State shall adjust the CONTRACT maximum liability to accommodate the aforementioned circumstances in consultation with the independent actuary. In the event of a reduction in available funds or increase in expected costs due to enrollment growth or shift, the State may adjust the range of covered services in lieu of an increase in funding.

Such required benefit adjustments will be developed in consultation with the independent actuary. This CONTRACT does not obligate the State to pay a fixed minimum amount and does not create in the **Contractor** any rights, interests or claims of entitlement in any funds otherwise available but not allocated by the State to this CONTRACT. In no event shall the maximum liability of the State under this CONTRACT exceed the **Contractor's** allocated portion of the total available State and federal funds as determined by the State.

The **Contractor** is not entitled to be paid the maximum liability for any period under the CONTRACT or any extensions of the CONTRACT. The maximum liability represents available funds for payment to the **Contractor** and does not guarantee payment of any such funds to the **Contractor** under this CONTRACT. The **Contractor** shall be paid in accordance with the rates detailed herein.

The payments as calculated under Section 4.7.2 section shall constitute the entire compensation due the **Contractor** for the service and all of the **Contractor's** obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, profit, and all other direct and indirect costs incurred or to be incurred by the **Contractor**.

The payments specified in Section 4.7 of this Agreement, as amended, shall represent payment in full. TennCare shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as a Prepaid Limited Health Services Organization in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at Tennessee Code Annotated *§ 56-32-201* et seq. or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at Tennessee Code Annotated § 56-51-101 et seq. or any subsequent amendments thereto.

4.7.2 Payment Methodology

The **Contractor** shall be compensated based on the rates herein for the payment rate categories authorized by the State. Payments shall be subject to withholds as set forth in the Agreement. The rates in Table 2 shall be applicable from January 1, 2006 through June 30, 2006.

The rates in Table 1 shall be applicable from August 1, 2005 through December 31, 2005.

Table 1: Rates

PAYMENT RATE CATEGORY	PER MEMBER/ PER MONTH RATE
Priority Population age 0-12	$211.29
Priority Population age 13-17	$368.25
Priority Population age 18 and above	$296.68
Non-Priority Population age 0-12	$3.82
Non-Priority Population age 13-17	$19.25
Non-Priority Population age 18 and above	$10.52

The rates include the ten-percent (10%) administrative fees and the two-percent (2%) premium taxes. If the CONTRACT is extended for an additional period or periods as amended by Section 6.18.4 of this CONTRACT, the **Contractor** shall be compensated based upon the payment rate categories detailed above subject to adjustment as determined by annual independent actuarial analysis and subject to State appropriations.

Table 2: Rates

PAYMENT RATE CATEGORY	PER MEMBER/ PER MONTH RATE
Priority Population age 0-12	$214.62
Priority Population age 13-17	$375.20
Priority Population age 18 and above	$303.60
Non-Priority Population age 0-12	$3.90

Non-Priority Population age 13-17	$19.71
Non-Priority Population age 18 and above	$10.91

These rates include the ten percent (10%) for administrative fees and the two percent (2%) for premium taxes.

The **Contractor** shall be compensated based on the rates herein for the payment rate categories authorized by the State. Payments shall be subject to withholds as set forth in the CONTRACT. The rates in Table 3 shall be applicable from July 1, 2006 through June 30, 2007.

Table 3: Rates

PAYMENT RATE CATEGORY	**PER MEMBER/ PER MONTH RATE**
Priority Population age 0-12	247.63
Priority Population age 13-17	387.67
Priority Population age 18 and above	349.20
Non-Priority Population age 0-12	2.63
Non-Priority Population age 13-17	14.46
Non-Priority Population age 18 and above	6.49
State Only & Judicials	324.60

The **Contractor** shall be compensated based on the rates herein for the payment rate categories authorized by the State. Payments shall be subject to withholds as set forth in the CONTRACT. The rates in Table 4 shall be applicable from September 1, 2006 through June 30, 2007.

Table 4: Rates

PAYMENT RATE CATEGORY	PER MEMBER/ PER MONTH RATE
Priority Population age 0-12	$249.46
Priority Population age 13-17	$390.87
Priority Population age 18 and above	$351.56
Non-Priority Population age 0-12	$2.65
Non-Priority Population age 13-17	$14.59
Non-Priority Population age 18 and above	$6.55
State Only & Judicials	$326.47

TennCare shall make monthly payments to the **Contractor** for its satisfactory performance and provision of covered services under this CONTRACT. Each payment shall be paid on or before the fifth (5th) business day of each month. Prior to August 1, 2005, each monthly payment to the **Contractor** shall be equal to the number of **Enrollees** residing in the **Contractor's** plan as assigned by priority status. As of August 1, 2005, each monthly payment to the **Contractor** shall be equal to the number of **Enrollees** residing in the **Contractor's** plan as assigned to six (6) categories, multiplied by the appropriate rates for the **Enrollee** categories as set out above. These payments shall be less any adjustments which may include set-offs, withholds for penalties, damages, liquidated damages, or adjustments based upon a change of **Enrollee** status or partial takeover as provided under any section of this CONTRACT. Payment adjustments shall be accomplished through the monthly payment reconciliation process. Each payment shall be calculated as follows:

4.7.2.1 Calculation of Capitation Payments

Counting Enrollees

For the period beginning August 1, 2005, and each month thereafter, **TennCare** will calculate the number of **Enrollees** in the **Contractor's** plan. For assignment to a **Contractor's** plan for payment purposes only, an **Enrollee's** residence shall be conclusively determined to be the region of residence recorded in the **TennCare** eligibility system at the time the capitation payment is calculated and the capitation payment shall not be retroactively adjusted to reflect a different region of residence. This provision is applicable only for determination of applicable rate payment and is not applicable to any other consideration, such as applicable plan or duration of enrollment in any plan.

Payment Rate Category
TennCare will determine the appropriate capitation payment rate category to which each **Enrollee** is assigned for payment purposes under this CONTRACT. The payment amount owed the **Contractor** for each **Enrollee** shall be determined by dividing the appropriate capitation rate category by the number of days in the month and then multiplying the quotient of this transaction by the number of days the enrollee was enrolled in the plan.

Payment Rate Category Assignment
TennCare's assignment of an **Enrollee** to a capitation payment rate category is for payment purposes under this CONTRACT, only, and is not an "adverse action" or determination of the benefits to which an **Enrollee** is entitled under **the TennCare Partners Program**, **TennCare** Rules, policies and procedures, the **TennCare** Waiver or relevant court orders.

Payment Rate Category Adjustment For Non-Utilizers of Services
Enrollees who are priority participants as defined in this CONTRACT, who have not received behavioral health services as reported pursuant to Section 3.12.4 and Attachment D of this CONTRACT (excluding a CRG/TPG Assessment), within the preceding twelve (12) months from the date of the calculation of the monthly payment, or who have not had a CRG/TPG assessment within the preceding twelve (12) months from the date of the calculation of the monthly payment, shall be assigned to a non-priority population rate category for payment purposes under this CONTRACT.

Retroactive Adjustments Due to Enrollee Status
Except as set forth in this section above, the State has the discretion to retroactively adjust the capitation payment for any **Enrollee** if **TennCare** determines an incorrect payment was made to the **Contractor** or to accurately reflect payments that should have been made.

Should **TennCare** determine after the capitation payment is made that an **Enrollee's** capitation rate category had changed or the **Enrollee** was deceased, **TennCare** shall retroactively adjust the payment to the **Contractor** to accurately reflect the **Enrollee's** capitation rate category for the period. **TennCare** shall retroactively adjust the payment to the **Contractor**, not to exceed twelve (12) months. **TennCare** and the **Contractor** agree that the twelve (12) month limitation described in this paragraph is applicable only to retroactive capitation rate payment adjustments and shall in no way be construed as a determination of the effective date of eligibility or enrollment in the **Contractor's** plan.

If a provider seeks reimbursement for a service provided during a retroactive period of eligibility, the **Contractor** shall assess cost-sharing responsibilities in accordance with the appropriate cost-sharing schedules in effect on the date of service for which reimbursement is sought.

4.7.2.2 Profit/Loss Risk Banding

Effective January 1, 2006, the terms of the **CONTRACTOR'S** shared risk responsibility shall be:

The **CONTRACTOR'S** Risk shall be defined by the Medical Loss Ratio (MLR). The **CONTRACTOR** is at 100% risk for all Medical Expenses incurred in the performance of this Agreement that fall between and including 85% MLR and 91% MLR. **TennCare** and the **CONTRACTOR** agree to share in all MLR gains and losses as defined below:

1. **Losses**: For Medical Expenses in excess of 91% MLR, **TennCare** and the **CONTRACTOR** will each assume 50% of the Medical Expenses in excess of the 91% MLR.

2. **Gains:** For Medical Expenses that fall below 85% MLR, **TennCare** and the **CONTRACTOR** will each share 50% of the Medical Expense savings.

Under the terms of the risk arrangement, there is no minimum MLR requirement. Except for Medical Expense savings below an MLR of 85%, all capitation payments shall be retained by the CONTRACTOR.

Reconciliation will occur ninety (90) days following the end of the first twelve (12) months and again in six (6) month cycles thereafter, until all medical claims for this Contract period are paid.

4.7.3 Cash Flow Withholds, Retention of Cash Flow Withholds and Permanent Withholds

As an incentive for compliance with the terms and conditions of this CONTRACT, there is established this system of cash flow withholds and retention. The amount due for the first monthly payment, and for each month thereafter, calculated pursuant to Section 4.7.2 shall be reduced by the appropriate cash flow withhold percentage amount and set aside for distribution to the **Contractor** in the next regular monthly payment, unless retained as provided below. No interest shall be due to the **Contractor** on any sums withheld or retained under this section. The provisions of this section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this CONTRACT.

4.7.3.1 Except as further provided below, the applicable cash flow withhold percentage amount shall be ten percent (10%) (which shall be the maximum cash flow withhold percentage amount) for the first six months following the service start date, and for any consecutive six-month period following **Contractor's** receipt of a notice of compliance deficiency correction as described in Section 4.7.3.5. If, during any consecutive six (6) month period following the service start date, the **Contractor** shall not have received a notice of compliance deficiency as

described in Section 4.7.3.5, the cash flow withhold percentage amount shall be reduced to five percent (5%).
If, during any consecutive six (6) month period following a reduction of the monthly cash flow withhold amount to five percent (5%), the **Contractor** shall not have received a notice of compliance deficiency as described in Section 4.7.3.5, and shall not have been assessed any liquidated damages, the cash flow withhold percentage amount shall be reduced to two and one-half percent (2.5%).

4.7.3.2 **Contractor** shall receive a notice of compliance deficiency as described in Section 4.7.3.5, below, the applicable cash flow withhold percentage amount shall not be decreased and it shall be the maximum cash flow withhold percentage amount.

4.7.3.3 The State may retain monthly cash flow withhold amounts attributed to the month following **Contractor's** receipt of the notice of compliance deficiency and shall not distribute such sums retained for so long as the compliance deficiencies described in any notice of compliance deficiency for that month shall continue and shall not have been corrected and acknowledged in a notice of compliance deficiency correction.

4.7.3.4 Except as provided below, upon receipt of a notice of compliance deficiency correction as described in Section 4.7.4.5, retained cash flow withhold amounts attributed to one or more notices of compliance deficiency referred to in the notice of correction shall be distributed to the **Contractor** in the next following regular monthly payment, provided there are no other outstanding notices of compliance deficiency that have not been corrected, except for the regular cash flow withhold amount at the appropriate withhold percentage amount as calculated in Section 4.7.3.2.

4.7.3.4.1 The monthly cash flow withhold amount shall be the maximum monthly cash flow withhold amount, following any notice of compliance deficiency set out in Section 4.7.3.5 and may not be reduced until the **Contractor** shall have maintained six (6) consecutive months without a notice of compliance deficiency as described in Section 4.7.3.5.

4.7.3.4.2 Any monthly retained cash flow withhold amount that is retained for six (6) months, counting the first month after the **Contractor** shall have received a notice of compliance deficiency as cause for retention of the next monthly cash flow withhold amount as the first month, may, in the discretion of the State, be declared a

permanent withhold ineligible for future distribution and shall not be paid to the **Contractor**, in addition to any other remedies available to the State.

4.7.3.5 Notices

4.7.3.5.1 Notice of Compliance Deficiency

No monthly cash flow withhold amount may be retained by the State unless the **Contractor** shall receive a written notice in advance, as stipulated by Section 4.7.3.5.2, of the payment day. The notice shall be titled "notice of compliance deficiency and cause for retention of monthly cash flow withhold amount" and shall specify compliance deficiencies that must be corrected before the State will distribute the monthly cash flow withhold amount as set out in Section 4.7.3.

4.7.3.5.2 Notice of Compliance Deficiency Correction

Upon acceptance of **Contractor's** correction of the deficiency or deficiencies subject of a notice of compliance deficiency described above, the State shall provide to **Contractor** a notice to acknowledge its acceptance of the **Contractor's** action, and authorization of distribution of any retained monthly cash flow withhold amount associated with the notice of compliance deficiency. If there are no other outstanding notices of compliance deficiency, the next monthly regular payment to **Contractor** following the date of this notice shall be counted as the first month for purposes of determining the six (6) month periods described in Section 4.7.3.1.

4.7.3.6 Compliance deficiencies that may cause the State to retain a monthly cash flow withhold may be based upon **Contractor's** non-compliance with any provision of this CONTRACT including but not limited to deficient performance of the following terms and conditions:

4.7.3.6.1 The requirements of Section 2.5, as they relate to provision of covered services;

4.7.3.6.2 The requirements of Sections 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.8, 3.15 and 5.1.2.9;

4.7.3.6.3 The Quality Monitoring and Quality Improvement Program, as referenced in Section 3.11 and Attachment C;

4.7.3.6.4 The Records and Reporting Requirements, specified in Section 3.12;

4.7.3.6.5 The **TennCare** Waiver, any applicable amendments thereto, and any Special Terms and Conditions imposed upon the **TennCare** Waiver or any amendments thereto.

4.7.4 Other Payment Adjustments

The failure of **TennCare** to make any of the following payment adjustments, which are in addition to the amount(s) withheld in accordance with Section 4.7.2, shall not prejudice **TDMHDD's** right or in any way prevent **TennCare** from making the adjustment(s) at any future date.

4.7.4.1 Liquidated Damages

TennCare may reduce payments to the **Contractor** by the amount of any liquidated damages not received from the **Contractor** by **TennCare** on or before the date the liquidated damages are to be paid. **TennCare**, at its discretion, may withhold from any later payments due the **Contractor** any subsequent liquidated damages payable to **TennCare**. (See Section 5 of this CONTRACT.)

4.7.4.2 Actual Damages

TennCare may reduce payments to the **Contractor** by the amount of actual damages, including incidental and consequential damages, resulting from any breach of this CONTRACT by the **Contractor**. (See Section 5 of this CONTRACT.)

4.7.4.3 Cost of Partial Breach

TennCare may reduce payments to the **Contractor** by the amounts determined in accordance with Section 5.2.3.7 of this CONTRACT.

4.7.4.4 Amounts Due State

TennCare may withhold from any payment due the **Contractor** any other amounts due the State by the **Contractor**, including but not limited to, any amount due **TDMHDD** or **TennCare** as the result of any state or federal audit or examination of the **Contractor**.

Any adjustments made pursuant to Section 4.7.4 and amounts owed to **TDMHDD** or **TennCare** as damages or as cost to cure a breach or provide any defaulted services shall not be counted in determining the percentage of the capitation payments paid for the provision of covered services and payment of premiums tax in accordance with Section 3.15.2.

4.7.5 Changes in Scope of Services

If significant changes are made in the scope of services, including but not limited to both covered services and administrative requirements, under the **TennCare Partners Program**, as mandated by court orders or actions of the Congress, the State, the State Legislature, CMS, DHHS or any agency of the State government, **TDMHDD** shall review and adjust the capitation amount accordingly as determined by an independent actuarial analysis under contract with the State, subject to the availability of State appropriations for the mandate. In the event that the proposed adjustment as determined by the independent actuarial analysis would cause the CONTRACT maximum to be exceeded, **TDMHDD** and the **Contractor** shall negotiate in good faith changes in the scope of services to offset the additional costs incurred as a result of these changes. The State shall notify **Contractor** as soon as possible in advance of any such changes and shall seek the prior approval of CMS.

4.7.6 Required Certification of Data and Documents

Documents and data submitted to the State under Section 3.12 of this CONTRACT must be certified in accordance with federal requirements of 42 CFR 438.602, et seq. and this section as follows*:*

4.7.6.1 Any documents or data that are required to be submitted to the State by the **Contractor** under this CONTRACT, including but not limited to data which contains or consists of enrollment information or encounter data must be certified in conformity with this subsection;

4.7.6.2 Each time a required document or data is submitted it must be accompanied by a concurrent, original written certificate, unless an appropriate alternate electronic certification procedure is agreed upon in advance; and

4.7.6.3 The data must be certified by any one of the following: the **Contractor's** Chief Executive Officer, the Chief Financial Officer, or an individual who reports directly to either of those officers and who has been identified in a prior written notice to **TDMHDD**, as a person possessing delegated authority to sign for either of those officers; and

4.7.6.4 The certificate must be in substantially the following form: "I, _____, do hereby attest that, based upon the best of my knowledge, information and belief, the _____ [document/data] submitted herewith is accurate, complete and truthful.

SECTION 5. Remedies

5.1 Termination

In the event of the termination of this CONTRACT, either at the expiration and non-renewal of this CONTRACT or as an early termination prior to the expiration of this CONTRACT, neither party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred under this CONTRACT prior to the effective date of such early termination. The **Contractor** shall also not be relieved of its responsibilities for payment or appropriate denial of payment for all services provided to **Enrollees** in accordance with this CONTRACT and the provider contracts. **TDMHDD or TennCare** shall have no responsibilities for any liabilities incurred by the **Contractor** which arise as a result of its performance under this CONTRACT.

5.1.1 Termination Procedure

Written notice may be given in the case of the expiration and non-renewal of this CONTRACT and shall be given in the case of the early termination of this CONTRACT. The notice shall be to the person designated in accordance with Section 1.2. In the event the notice does not comply with the terms of this agreement, the notice shall still be effective in all respects; however, **Contractor** may request clarification of the notice, and such request shall not affect the effectiveness or date of the notice.

5.1.1.1 Notice of Expiration

In the event of the expiration and the non-renewal of this CONTRACT, **TDMHDD** may cause to be delivered to the **Contractor** a written Notice of Expiration. The Notice of Expiration may specify or otherwise include at least the date of the Notice of Expiration and any requirements, consistent with Section 5.1.3, which are or are not to be imposed. The Notice of Expiration may be utilized if in the judgment of **TDMHDD** Sections 5.1.3.1.1 through 5.1.3.1.3 should be exercised or Section 5.1.3.2 is deemed applicable.

5.1.1.2 Notice of Termination

In the event of an early termination of this CONTRACT, the party initiating the termination shall render written notice of termination to the other party by Certified Mail, Return Receipt Requested, or in person with proof of delivery. The Notice of Termination shall specify or otherwise include the date of the Notice of Termination, the effective date of the early termination, cite the provision of this CONTRACT giving the right to terminate, the circumstances giving rise to termination, and any conditions of the termination, not inconsistent with the terms of this CONTRACT. In the event of termination for any reason, **TDMHDD** shall have the option of requiring the performance of the requirements of Section 5.1.2 (or their written waiver) or imposing any conditions of early termination not inconsistent with this CONTRACT.

5.1.2 Requirements of Termination

Unless otherwise specified below, the clauses in this Section shall apply to all terminations of this CONTRACT. After receipt of the Notice of Termination, if required, and except as directed by **TDMHDD** in writing or as otherwise required in Section 5, the **Contractor** shall:

5.1.2.1 Stop work under this CONTRACT in whole, or in part, immediately or in stages, as specified in the Notice of Termination;

5.1.2.2 Enter into no further subcontracts or provider contracts, except as necessary for the **Contractor** to fulfill its obligations under this CONTRACT as of the effective date of the early termination;

5.1.2.3 At the request of **TDMHDD**, assign to **TDMHDD** or its designee, in the manner and to the extent required by **TDMHDD**, all rights, title and interest of the **Contractor** under the terminated subcontracts and provider contracts, in which case **TDMHDD** or its designee shall have the right, at its discretion, to settle or pay any of the claims arising out of the continuation of and the termination of such subcontracts and provider contracts;

5.1.2.4 If not otherwise required under Section 5.1.3, complete performance under this CONTRACT, or in the case of an early termination, to the extent required under the Notice of Termination;

5.1.2.5. Submit a termination plan to **TennCare** for review, which is subject to **TennCare** approval. This plan must, at a minimum, contain the provisions in Sections 5.1.3 and 6.18, as appropriate. The **Contractor** shall agree to make revisions to the plan as necessary in order to obtain approval by **TennCare**; and

5.1.2.6 Prior to the submission of a final invoice, settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts and provider contracts;

5.1.2.7 Take such action as may be necessary, or as **TDMHDD** may direct, for the protection of property related to this CONTRACT which is in possession of the **Contractor** and in which **TDMHDD** has or may acquire an interest;

5.1.2.8 Promptly make available to **TDMHDD**, or to such other party as **TDMHDD** shall designate, any and all records, whether medical or financial, related to the provision of services to or on behalf of the **Enrollees**; such records shall be in a form which, at the sole discretion of **TDMHDD**, is usable by the party to whom the records are sent; such records shall be provided at no expense to **TDMHDD**;

5.1.2.9 Promptly provide all information necessary to **TDMHDD** or another Contractor acting on behalf of **TDMHDD** for reimbursement of any outstanding claims at the time of termination; such records shall be provided at no expense to **TDMHDD**.

5.1.3 Continuity of Services

The **Contractor** expressly acknowledges the services provided under this CONTRACT must be continued without interruption and, upon expiration or the early termination of this CONTRACT, a successor, either an agency of the State of Tennessee or another **Contractor**, may continue such services. The **Contractor** agrees to cooperate with any successor to effect an orderly and efficient transition to a successor.

5.1.3.1 Unless written notice to the contrary is received from **TDMHDD**, the **Contractor** agrees to the following:

5.1.3.1.1 The **Contractor** shall negotiate in good faith a Transition Plan with a successor to determine the nature and extent of the services to be provided by the successor and the **Contractor**. The Transition Plan shall be subject to the approval of **TDMHDD**. If **TDMHDD** does not approve the Transition Plan or if the parties cannot agree to the terms and conditions of the Transition Plan within fifteen (15) calendar days following the date of the Notice of Termination or the Notice of Expiration, or any other time period specified in writing by **TDMHDD**, **TDMHDD** shall determine the terms and conditions of the Transition Plan. The **Contractor** and the successor, as affirmed under this CONTRACT, expressly agree to abide by the terms and conditions of the Transition Plan as determined by **TDMHDD**.

5.1.3.1.2 The **Contractor** shall retain and make available sufficient qualified and experienced personnel during the transition period to ensure that the terms and conditions of this CONTRACT and of the Transition Plan are met.

5.1.3.1.3 The **Contractor** shall provide and continue to perform such services which are not inconsistent with the terms of this CONTRACT and which can reasonably be expected to be provided or performed in order to effect an orderly and efficient transition to a successor.

5.1.3.2 The Contractor agrees to the following only if written notice is

received from TDMHDD:

The **Contractor** shall continue to serve or arrange for the provision of services to the **Enrollees** for a transition period of sixty (60) calendar days from the later of the effective date of the termination or of the Transition Plan or until all the **Enrollees** can be transferred to another **Contractor's** plan.

During this transition period, **TennCare** shall continue to make payments to the **Contractor** in accordance with Section 4.7 of this CONTRACT.

5.1.4 Final Invoice

The **Contractor** shall submit the final invoice for payment to **TennCare** no more than one hundred fifty (150) calendar days after the effective date of any termination. If the **Contractor** fails to do so, all rights to payment are waived. **TennCare** will not honor any requests submitted after the one hundred fifty (150) day period.

5.1.5 Final Payment

The final payment due the **Contractor** under the terms of this CONTRACT shall be paid within thirty (30) calendar days after the final approvable invoice is submitted within the one hundred fifty (150) day period specified in the preceding Section 5.1.4, subject to the following limitations:

5.1.5.1 The final payment may be withheld until **TDMHDD** receives from the **Contractor** all reports and information required pursuant to this CONTRACT and all written and properly executed documents as reasonably required by **TDMHDD** as the result of the termination.

5.1.5.2 The amount of the final payment may be reduced by the following:

5.1.5.2.1 Any other adjustment payable to **TennCare** in accordance with Section 4.7.3;

5.1.5.2.2 Any amounts owed to any Sub**contractors** or service providers and not paid or appropriately denied by the **Contractor** as of the date of the final payment;

5.1.5.2.3 Any amounts paid to Sub**contractors** or service providers in accordance with Section 5.1.2.6 to settle or pay any of the claims arising out of the termination of such subcontracts and provider contracts;

5.1.5.2.4 Any payment by **TDMHDD** or **TennCare** determined to have been erroneously paid;

5.1.5.2.5 Any financial liability payable to **TDMHDD** or **TennCare** as the result of audits completed after the effective date of the termination of this CONTRACT;

5.1.5.2.6 Except for termination due to the expiration and non-renewal of this CONTRACT and early termination in accordance with Sections 5.1.6.3 through 5.1.6.5, any damages sustained by **TDMHDD** as the result of the early termination;

5.1.5.2.7 In the case of any default, any cost incurred by **TDMHDD**, including legal fees and court cost incurred by the Office of the Attorney General, to enforce any provision of this CONTRACT or to collect any amount owed **TDMHDD**; and

5.1.5.2.8 Any interest charged on the amount reduced from the payment(s) due the **Contractor**; the interest shall be computed on such amount(s) at the same rate that the Tennessee Department of Revenue receives on the payment of delinquent taxes as set forth at Tennessee Code Annotated § 67-1-801(a).

5.1.5.3 **TDMHDD** or **TennCare** shall give the **Contractor** prior written notification, stating the reasons for and the amount and the anticipated date of any such deduction from the final payment made under Section 5.1.5.2, and shall give the **Contractor** the right to object to the basis or amount of the deduction.

5.1.5.4 If the **Contractor** and **TDMHDD** or **TennCare** fail to agree on the amount of the final payment, **TDMHDD** or **TennCare** shall determine on the basis of the information available, the amount, if any, due the **Contractor**.

5.1.6 Reasons Supporting Termination

The CONTRACT may be terminated for any of the following reasons:

5.1.6.1 **Termination by Expiration and Non-Renewal**

In the event this CONTRACT expires and is not renewed with the **Contractor**, this CONTRACT shall terminate in accordance with Section 5.1.1.1.

5.1.6.2 Termination by Mutual Consent

TDMHDD and the **Contractor** may terminate this CONTRACT at any time by written mutual consent. Both parties shall sign the Notice of Termination which shall include, inter alia, the date of termination. **TDMHDD** shall inform all affected **Enrollees** of their disenrollment from the plan provided by the **Contractor** and their reassignment to another plan.

5.1.6.3 Termination by TDMHDD for Convenience

TDMHDD may terminate this CONTRACT immediately at any time by written notice given to the **Contractor** at least ninety (90) days before the effective date of such early termination. **TennCare** shall inform all affected **Enrollees** of their disenrollment from the plan provided by the **Contractor** and their reassignment to another plan. Termination for convenience of **TDMHDD** shall include, but not be limited to, a material change in ownership of the **Contractor** or the **Contractor's** failure to maintain the experience criteria listed in Section 3.1 of the BHO application. For purposes of this section, "material change in ownership" means a change in ownership prohibited under Tennessee Code Annotated Section 56-32-222 for an HMO licensed in Tennessee.

5.1.6.4. Termination by TDMHDD for the Unavailability of Funds

This CONTRACT is subject to appropriation and availability of State and/or federal funds. In the event funds are not appropriated or are otherwise unavailable, **TDMHDD** reserves the right to immediately terminate this CONTRACT upon written notice given to the **Contractor**. **TennCare** shall inform all affected **Enrollees** of their disenrollment from the plan provided by the **Contractor** and the reasons for their not being reassigned to another plan. The termination shall not be a breach of this CONTRACT by **TDMHDD** and **TDMHDD** shall not be responsible to the **Contractor** or any other party for any costs, expenses, or damages occasioned by the termination.

5.1.6.5 Termination by TDMHDD due to the Expiration, Suspension or Termination of the TennCare Waiver

This CONTRACT is subject to the continuation of the **TennCare** Waiver, Section 1115(a) Demonstration Project. In the event the TennCare Waiver expires or is suspended or terminated for whatever reason, **TDMHDD** reserves the right to immediately terminate this CONTRACT upon written notice to the **Contractor**. The termination shall not be a breach of this CONTRACT by **TDMHDD** and **TDMHDD** shall not be responsible to the **Contractor** or any other party for any costs, expenses, or damages occasioned by the termination. **TennCare** shall inform all affected **Enrollees** of their disenrollment from the plan provided by the **Contractor** and the reasons for their not being reassigned to another plan.

5.1.6.6 Termination due to the Contractor's Insolvency

5.1.6.6.1 The **Contractor** must, during the term of this CONTRACT, demonstrate sufficient financial capital to perform its obligations under this CONTRACT. If **TDMHDD** reasonably determines the **Contractor**'s financial condition is not sufficient to allow the **Contractor** to provide the services as described, **TDMHDD** may terminate this CONTRACT in whole or in part, immediately or in stages.

5.1.6.6.2 For the purposes of this Section, the **Contractor** shall be presumed to be insolvent and in a condition hazardous financially to **Enrollees**, creditors and the public, under any of the following circumstances:

5.1.6.6.2.1 The **Contractor** cannot demonstrate to the satisfaction of **TDMHDD** the **Contractor** has established and maintained the financial requirements set forth in Section 3.3.2 of this CONTRACT; or

5.1.6.6.2.2 A trustee, receiver or liquidator for all or a substantial part of the **Contractor's** property is appointed, or proceedings for bankruptcy, reorganization, arrangement or liquidation is instituted by or against the **Contractor**.

5.1.6.6.2.3 In the event the **Contractor** meets any of the above circumstances of insolvency or enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the **Contractor** shall notify **TDMHDD** by the quickest means possible, with written notification of the insolvency or bankruptcy being given within five (5) calendar days of the **Contractor**'s meeting the circumstances of insolvency or the initiation of the proceedings relating to the bankruptcy filing. In the case of insolvency, the notification shall include the circumstance of insolvency and the date the **Contractor** met the circumstance of insolvency. In the case of bankruptcy, the notification shall include the date on which the bankruptcy petition was filed and the identity of the court in which the bankruptcy petition was filed.

The **Contractor**'s insolvency or the filing of a petition in bankruptcy by or against the **Contractor** shall constitute grounds for termination for cause in accordance with Section 5.1.6.7, except the Notice of Breach and any cure periods as specified in Section 5.2.2 shall not be available to the **Contractor**.

This provision is not intended to imply the state concedes the **Contractor** may file a bankruptcy petition under federal bankruptcy laws.

5.1.6.6.3 **Enrollees** shall not be held liable for the **Contractor's** debt in the event of the **Contractor's** insolvency nor shall any **Enrollee** be held liable for any bill, charge, or reimbursement owed to any provider for services provided to an **Enrollee** other than applicable cost sharing responsibilities.

5.1.6.7 Termination by TDMHDD for Other Causes

TDMHDD may also terminate this CONTRACT if it is determined the **Contractor** has breached the CONTRACT, as described in Section 5.2.

5.1.6.8 Termination by Contractor

This CONTRACT shall be valid for the period specified in Section 6.18 of the CONTRACT. The **Contractor** shall have the right six (6) months prior to the expiration of this CONTRACT to provide **TDMHDD** written notice of intent to terminate this CONTRACT one hundred and eighty (180) calendar days from the date of written notice received by **TDMHDD**. Such written notice may be either hand-delivered to **TDMHDD** with a signed statement from **TDMHDD** staff acknowledging receipt or may be mailed by Certified Mail, Return Receipt Requested. The written notice shall specify the last date of operation, such date being at least one hundred and eight (180) days from the documented receipt of the notice of termination. The **Contractor** shall comply with all terms and conditions in this CONTRACT during the close-out period.

5.1.6.9 In the event TennCare makes a determination, at its sole discretion, to unify the service delivery system currently provided by separate BHO and MCO contracts, TennCare may terminate this Agreement without further obligation, upon appropriate notice as provided in this Agreement.

5.2 Breach By Contractor

5.2.1 The **Contractor** shall be deemed to have breached this CONTRACT if any of the following occurs:

5.2.1.1 The **Contractor** submitted incorrect, misleading or falsified information

as part of or in addition to its BHO Application or in response to questions concerning the **Contractor**'s BHO Application or any such additional information. **TDMHDD** shall, at its own discretion, determine whether or not the incorrect, misleading or falsified information would have altered the selection of the **Contractor** as a **Contractor** under this CONTRACT;

5.2.1.2 The **Contractor** no longer meets the applicable conditions or qualifications which were submitted as part of the BHO Application;

5.2.1.3 The **Contractor** fails to perform in accordance with any term or provision of this CONTRACT or any applicable law or regulation;

5.2.1.4 The **Contractor** renders only partial performance of any term or provision of this CONTRACT;

5.2.1.5 The **Contractor** engages in any act prohibited or restricted by this CONTRACT or by State or federal statute, rule or regulation; or

5.2.1.6 The **Contractor** fails to qualify for, or has had revoked, a license required to operate in the State of Tennessee or is suspended, debarred or otherwise becomes ineligible or excluded from participation in any covered service in accordance with Title 45, Code of Federal Regulations, Part 76, or any statute or rule of the State of Tennessee or in any other state, which in the opinion of **TDMHDD,** would result in the **Contractor** having its license suspended or revoked or failing to become licensed or being suspended, debarred or ineligible or excluded from entering into this CONTRACT if the cause for such action had occurred in Tennessee.

5.2.2 Notice of Breach

In the event of breach by the **Contractor**, **TDMHDD** shall provide the **Contractor** written Notice of breach. The Notice of Breach shall specify the date of the notice, each specific breach or term of this CONTRACT with which the **Contractor** has not complied, and any corrective action which must be taken by **Contractor** to cure each breach or non-compliance. The **Contractor** shall be allowed twenty (20) calendar days from the date of the Notice of Breach to cure each breach or non-compliance, unless the breach is one of those specified in Section 5.3.3; in this case **TDMHDD** shall provide **Contractor** a Notice of Breach but no cure period shall be applicable unless expressly provided in Section 5.3.3. Notwithstanding any provision herein to the contrary, in the event the Notice of Breach does not comply with the terms of this CONTRACT, the notice shall still be effective in all respects; however, the **Contractor** may request a clarification of such notice. Any such defect, request or clarification shall not affect the effectiveness or date of the Notice.

If the **Contractor** disagrees with the determination of breach or noncompliance or designated corrective action described in the notice, the **Contractor** shall nevertheless implement the corrective action, without prejudice to any rights the **Contractor** may have to later dispute the finding of noncompliance or designated corrective action.

The requirement for a Notice of Breach and any cure periods shall be available to the **Contractor** only in the event of breach under Section 5.2.1. In the event of repeated breaches of the same general nature, no Notice of Breach and opportunity to cure is required.

5.2.3 Remedies for Breach

In the event the **Contractor** fails to cure the breach within the time period provided, **TDMHDD** shall have available any one or more of the following remedies in addition to or in lieu of any other remedies set out in this CONTRACT or available by law. Failure to comply with these remedies may result in the immediate termination of this CONTRACT by **TDMHDD**, and the Notice of Breach and the cure periods as specified in Section 5.2.2 shall not be available to the **Contractor**.

5.2.3.1 **TDMHDD** may initiate recovery of actual damages, including incidental and consequential damages, and any other remedy available by law or equity.

5.2.3.2 **TDMHDD** may require the **Contractor** to prepare a plan to correct cited deficiencies and to immediately, or within the time frames specified by **TDMHDD**, implement such plan.

5.2.3.3 **TDMHDD** may recover any and all liquidated damages provided for in this CONTRACT.

5.2.3.4 **TDMHDD** may require the **Contractor** to obtain a performance bond in the amount of the average of one (1) month's capitation payment, excluding any adjustments made in accordance with Section 4.7.3, as determined by **TDMHDD**, and any liquidated damages assessed against the **Contractor** and not paid as of the effective date of the performance bond.

5.2.3.5 **TDMHDD** may require the **Contractor** to obtain a payment bond in the amount of ninety percent (90%) of the average of one (1) month's capitation payment, excluding any adjustments made in accordance with Section 4.7.3, as determined by **TDMHDD**, and any liquidated damages assessed against the **Contractor** and not paid as the effective date of the payment bond.

5.2.3.6 Each bond which may be required under Sections 5.2.3.4 or 5.2.3.5 must be issued by one or more corporate sureties, licensed in Tennessee by the TDCI, be on a form prescribed by **TDMHDD**, have attached a

certified and current power of attorney appointing an attorney-in-fact who is licensed in and a resident of the State of Tennessee, and name **TDMHDD** as obligee or owner.

5.2.3.7 **TDMHDD** may declare a partial default; in the event **TDMHDD** declares a partial default, **TDMHDD** may, at its discretion, cure the breach and provide the defaulted service(s) itself or authorize another party to cure the breach and provide the defaulted service(s) and permanently withhold from any amounts due the **Contractor** the greater of the following:

5.2.3.7.1 Any amounts paid the **Contractor** to provide the defaulted service(s) by TennCare; and any damage incurred by the State; or

5.2.3.7.2 The cost to **TDMHDD** to cure the breach or to provide the defaulted service(s) by **TDMHDD** or by another party designated by **TDMHDD**, and any damage incurred by the state.

5.2.4 Failure to Enforce

The failure of **TDMHDD** to insist, in one or more instances, upon the performance of any term of this CONTRACT is not a waiver of **TDMHDD's** right to future performance of such term, and the **Contractor's** obligation for future performance of such term shall continue in effect.

5.3 Liquidated Damages

The parties agree due to the complicated nature of the **Contractor**'s obligations under this CONTRACT, it would be difficult or impossible to specifically ascertain or prove the amount of the damages suffered by **TDMHDD** as the result of any breach or non-compliance by the **Contractor** of its obligations under this CONTRACT.

5.3.1 Specific Acknowledgments

The **Contractor** represents and covenants the **Contractor** has carefully reviewed each specified liquidated damage described in this CONTRACT and agrees each liquidated damage is reasonable and represents probable actual damages which **TDMHDD** would sustain in the event of a breach or non-compliance.

5.3.1.1 Exclusion

The **Contractor** agrees the liquidated damages do not include any injury or damages sustained by a third party and the liquidated damages are in addition to any other amounts the **Contractor** may owe **TDMHDD**, including, but not limited to, amounts owed as overpayments, including excess administrative and management fees and profits in accordance with Section 3.15.3, amounts owed as actual damages, amounts owed to cure a partial default in accordance with Section 5.2.3.7, and amounts owed as indemnification in accordance with Section 6.12.

5.3.1.2 Date of Accrual

The **Contractor** agrees liquidated damages shall accrue on the date following the date the report or deliverable was due or the breach occurred subject to the cure period in Section 5.3.3, if any. With respect to reports and other deliverables, the submission of an incorrect report or a deficient deliverable shall be the same as if the report or deliverable had not been provided.

5.3.1.3 Failure to Enforce

The **Contractor** agrees **TDMHDD** is not obligated to assess liquidated damages before availing itself of any other remedy. **TDMHDD** may, at any time after liquidated damages have been assessed, choose to terminate one of more of the assessments of liquidated damages and avail itself of any other remedy available under this CONTRACT or by law or equity. The failure of **TDMHDD** to assess a liquidated damage or **TDMHDD**'s termination of one or more assessments of liquidated damages shall not prejudice **TDMHDD**'s right to or in any way prevent **TDMHDD** from assessing or re-assessing liquidated damages at any future date.

5.3.2 Payment

Liquidated damages shall begin to accrue in accordance with Section 5.3.1.2 and be payable on the first day of each month.

5.3.2.1 Interest

If the liquidated damages are not received by the due date, interest shall accrue in accordance with Subsection 5.1.5.2.9 and shall be effective on the date determined in accordance with Subsection 5.3.1.2.

5.3.2.2 Withholding Liquidated Damages

TennCare may, with the consent of **TDMHDD**, withhold any due and payable liquidated damages, including interest, from any amounts owed the **Contractor** and/or pursue collection of such amounts from the **Contractor**. These liquidated damages plus interest shall belong to the State.

5.3.2.3 Applicability to Capitation Payments

Assessed liquidated damages, whether paid or due, and any interest charged thereon shall be counted against the percentage for administrative and management cost and profits, and not against the percentage of the capitation payments paid for the provision of covered services and premiums taxes in accordance with Section 3.15.3

5.3.3 Schedule of Liquidated Damages

Liquidated damages shall accrue in accordance with the following schedule and all days in this Section shall be considered calendar days unless specified otherwise. In the event a cure period is authorized in accordance with Section 5.2.2 or elsewhere in this Section, and the reason for which the liquidated damage was assessed is not cured, or otherwise remains uncorrected or deficient at the end of the cure period, then actions may be pursued by the State in accordance with Sections 5.1.6.7 and 5.2.3. All records and reports with due dates that fall on a weekend day or a holiday shall be submitted on the next business day.

5.3.3.1 Records and Reports

Liquidated damages for late reports shall begin on the first day the report is late. Liquidated damages for incorrect reports (except ad hoc reports involving provider network information), or deficient deliverables shall begin on the sixteenth day after notice is provided from **TennCare** to the **Contractor** that the report remains incorrect or the deliverables remain deficient; provided, however, that it is reasonable to correct the report or deliverable within fifteen (15) calendar days.

For the purposes of ad hoc reports involving provider network information, liquidated damages for incorrect reports shall begin on the first day the report is determined by **TennCare** to be incorrect.

5.3.3.1.1	**Enrollee Records**	**Frequency or Referenced Sections**	**Amount Per Record**	**Cure**
	5.3.3.1.1.1	Daily	$100 per Day	None
	5.3.3.1.1.2	Weekly	$200 per Day	None
	5.3.3.1.1.3	Semi-Monthly	$300 per Day	5 Days
	5.3.3.1.1.4	Monthly	$500 per Day	5 Days
	5.3.3.1.1.5	Bi-Monthly	$500 per Day	10 Days
	5.3.3.1.1.6	Semi-Annual	$500 per Day	20 Days
	5.3.3.1.1.7	Annual	$500 per Day	20 Days

5.3.3.1.2	**Summary Reports**	**Frequency or Referenced Sections**	**Per Report**	
	5.3.3.1.2.1	ad hoc	$100 per Day	None
	5.3.3.1.2.2	Daily	$200 per Day	None
	5.3.3.1.2.3	Weekly	$400 per Day	None
	5.3.3.1.2.4	Semi-Monthly	$600 per Day	None
	5.3.3.1.2.5	Monthly	$600 per Day	5 Days
	5.3.3.1.2.6	Bi-Monthly	$600 per Day	10 Days
	5.3.3.1.2.7	Quarterly	$600 per Day	15 Days
	5.3.3.1.2.8	Semi-Annual	$600 per Day	20 Days
	5.3.3.1.2.9	Annual	$600 per Day	20 Days

5.3.3.1.3	**Financial Reports**	**Referenced Section(s) or Attachment**	**Per Report**	
	5.3.3.1.3.1	3.12.7.1	$600 per Day	5 Days
	5.3.3.1.3.2	3.12.7.2	$600 per Day	5 Days
	5.3.3.1.3.3	3.12.7.3	$600 per Day	5 Days
	5.3.3.1.3.4	3.14.1	$600 per Day	5 Days

5.3.3.2 Deliverables

		Referenced Section(s)	Amount	Cure
5.3.3.2.1	Crisis Services	2.5	$500 per Day	5 Days
5.3.3.2.2	Financial Disclosure in Providers	3.3.1.2 3.3.5	Amount Paid to the Provider	5 Days
5.3.3.2.3	Reserved			
5.3.3.2.4	Maintain Fidelity Bond	3.3.3.1	$500 per Day	10 Days
5.3.3.2.5	Proof of Coverage	3.3.3.2	$500 per Day	10 Days
5.3.3.2.6	Reserved			
5.3.3.2.7	Ownership and Financial Disclosure	3.3.5	$500 per Day	5 Days
5.3.3.2.8	Identification Card	3.6.2.2	$10 per Day per Enrollee	15 Days after Assignment
5.3.3.2.9	reserved			
5.3.3.2.10	reserved			
5.3.3.2.11	reserved			
5.3.3.2.12	Telephone Access	3.7.3	See Performance Measures	
5.3.3.2.13	Provider Site License	3.8.1	$5,000 per calendar day that a site is not licensed as required by applicable state law plus the amount paid to that provider site during that period.	None
5.3.3.2.14	Provider Staff License	3.8.2	$5,000 per calendar day that staff/provider/agent/subcontractor	None

			is not licensed as required by applicable state law plus the amount paid to the staff/provider/agent/subcontractor during that period.	
5.3.3.2.15	Credentialing Manual	3.8.3	$500 per Day	5 Days
5.3.3.2.16	Provider Relations Plan	3.8.4	$500 per Day	20 Days
5.3.3.2.17	Performance Measure Standards	Attachment E	See Attachment E	
5.3.3.2.18 Failure to process and pay claims in a timely manner		3.13.2	$10,000 per month for each month that TennCare determines that the CONTRACTOR is not in compliance with the requirements of this Agreement.	None
5.3.3.2.19	Reserved			
5.3.3.2.20 Failure to provide a written notice or provision of a defective notice of denial, reduction, termination, suspension, or delay of covered services.		3.5	$500 per occurrence per case	None
5.3.3.2.21 Failure to provide a written discharge plan or the provision of a defective discharge plan.		3.4.1.2.3	$1,000 per occurrence per case	None
5.3.3.2.22 Failure to provide a service or make payments for a service within five (5) calendar		2.5 3.5	$500 per day beginning on the next calendar day	None

days of a reasonable and appropriate directive from TennCare to do so or upon approval of the service or payment by the CONTRACTOR during the appeal process or within a longer period of time which has been approved by TennCare upon a plan's demonstration of good cause.		after default by the plan in addition to the cost of the services not provided.	
5.3.3.2.23 Failure to provide proof of compliance with the above to the Bureau Office of Contract Compliance and Performance (OCCP) within five (5) calendar days of a reasonable and appropriate directive from **TennCare** or within a longer period of time which has been approved by **TennCare** upon a plan's demonstration of good cause.	2.5, 3.5, 3.2.30 and 3.13.2	$500 per day beginning on the next calendar day after default by the plan	None
5.3.3.2.24 Imposing arbitrary utilization guidelines or other quantitative coverage limits.	2.5 Table 1	$500 per occurrence	None
5.3.3.2.25 Services wrongfully withheld where enrollee was not receiving the service and the enrollee went without coverage of the disputed service while an appeal on the service was pending.	3.5	An amount sufficient to at least offset any savings the Contractor achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense.	None
5.3.3.2.26 Reserved			

5.3.3.2.27 Failure to comply with the notice requirements of the TennCare rules and regulations or any subsequent amendments thereto, and all court orders governing appeal procedures as they become effective.	3.5	$500. per occurrence in addition to $500. per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this CONTRACT or required by TENNCARE	None
5.3.3.2.28 Failure to provide continuation or restoration of services where enrollee was receiving the service as required by TennCare rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective.	3.5	An amount sufficient to at least offset any savings the CONTRACTOR achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense. $500 per day for each calendar day beyond the	None

		2nd business day after an On Request Report regarding a member's request for continuation of benefits is sent by TennCare	
5.3.3.2.29 Failure to provide CRG/TPG assessments within the specified timeframes	2.5.9	$500 per month per **Enrollee**	None
5.3.3.2.30 Failure to provide CRG/TPG assessments by **TDMHDD**-certified raters or in accordance with **TDMHDD** policies and procedures	2.5.9	$500 per occurrence per case	None
5.3.3.2.31			
Failure to comply with Conflicts of Interest, Lobbying, and Gratuities requirements described in Sections 6.5, 6.6, or 6.7	6.5 6.6 6.7	110% of the total amount of the compensation paid by the **Contractor** to inappropriate individuals as described in Sections 6.5, 6.6, or 6.7 and possible termination of the CONTRACT as described in Sections 6.5, 6.6, and 6.7.	None
5.3.3.2.32			
Failure to submit **TennCare** and **TDMHDD** Disclosure of Lobbying Activities Form by **Contractor.**	6.7	$1,000.00 per day that disclosure is late.	None
5.3.3.2.33	6.6		
Failure to comply with Offer of		110% of the total	None

Gratuities constraints described in Section 6.6.		benefit provided by the **Contractor** to inappropriate individuals and possible termination of the CONTRACT for Breach as described in Section 6.6 of this CONTRACT.	

Item	Report	Referenced Section	Amount	Cure Period
5.3.3.2.34	Failure to seek, collect and/or report third party recoveries to TennCare.	3.15.7	$500. per day for each calendar day that TennCare determines the CONTRACTOR is not making reasonable effort to seek and collect third party recoveries.	None
5.3.3.2.35	Failure to obtain approval of enrollee materials.	, 3.6	For deliverables due on or after January 1, 2006: $500. for each day that TennCare determines the CONTRACTOR has provided enrollee material that has not been approved by TennCare.	None
5.3.3.2.36	Failure to comply with timeframes for providing Member Handbooks, I.D. cards, Provider Directories and Newsletters.	3.6	For deliverables due on or after January 1, 2006: $5000. for each occurrence. For purposes of this Agreement, occurrence means each instance in which Member materials are provided or should have been provided regardless of the number of Members affected at that time.	None
5.3.3.2.37	Failure to achieve and/or maintain financial reserves in accordance with TCA	3.3.2	$500. per calendar day for each day that financial requirements have not been met.	None
5.3.3.2.38	Failure to comply with fraud and abuse provisions as	1.9	$500. per calendar day for each day that the CONTRACTOR	None

	described in Section 1.9 of this Agreement		does not comply with fraud and abuse provisions described in Section 1.9 of this Agreement.	
5.3.3.2.39	Failure to require and assure compliance with Ownership and Disclosure requirements	3.9.2	$5,000. per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B.	None
5.3.3.2.40	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child at risk of entering DCS custody as described in this Agreement.	2.5	The actual amount paid by DCS and/or TENNCARE for necessary services or $1000. whichever is greater, to be deducted from monthly payments	None
5.3.3.2.41	Failure to comply with obligations and timeframes in the delivery of EPSD&T screens and related services as per this Agreement.	2.5.4 2.5.7	The actual amount paid by DCS and/or TENNCARE for necessary services or $1000. whichever is greater, to be deducted from monthly payments.	None
5.3.3.2.42	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized by the TennCare Chief Medical Officer	2.5	The actual amount paid by DCS and/or TENNCARE for necessary services or $1000. whichever is greater, to be deducted from monthly payments.	None
5.3.3.2.43	Failure to forward an expedited appeal to TennCare in twenty four (24) hours or a standard appeal in five (5) days.	3.5	$500. per calendar day	None
5.3.3.2.44	Failure to provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and	3.5	$500. per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set	None

	regulations and all court orders and consent decrees governing appeals procedures as they become effective.		forth by this Agreement or required by TennCare	
5.3.3.2.45	Failure to submit a timely corrected notice of adverse action to TENNCARE for review and approval prior to issuance to the member.	3.5	$1,000. per occurrence if the notice remains defective plus a per calendar day assessment in increasing increments of $500. ($500. for the first day, $1,000. for the second day, $1,500. for the third day, etc.) for each day the notice is late and/or remains defective.	None
5.3.3.2.46	Per the Revised Grier Consent Decree, "Systemic problems or violations of the law" (e.g. a failure in 20% or more of appealed cases over a 60 day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures as they become effective.	3.5	First occurrence: $500 per instance of such "systemic problems or violations of the law", even if damages regarding one or more particular instances have been assessed (in the case of "systemic problems or violations of the law" relating to notice content requirements, $500 per notice even if a corrected notice was issued upon request by TENNCARE). Damages per instance shall increase in $500 increments for each subsequent "systemic problem or violation of the law" ($500 per instance the first time a "systemic problem or violation of the law" relating to a particular requirement is identified; $1,000 per instance for the 2nd time a "systemic problem or violation of the law" relating to the same requirement is identified; etc.)	None
5.3.3.2.47	Systemic violations regarding any aspect of the requirements in accordance with this Agreement and the	3.5	First occurrence: $500 per instance of such systemic violations, even if damages regarding one or more	None

	TennCare rules and regulations		particular instances have been assessed. Damages per instance shall increase in $500 increments for each subsequent systemic violation ($500 per instance the first time a systemic violation relating to a particular requirement is identified; $1,000 per instance for the 2nd time a systemic violation relating to the same requirement is identified; etc.)	
5.3.3.2.48	Failure to complete or comply with corrective action plans as required by TENNCARE and/or TDMHDD	3.12.1.6	$500. per calendar day for each day the corrective action is not completed or complied with as required.	None
5.3.3.2.49	Failure to 1) provide an approved service timely, i.e., in accordance with timelines specified in the Special Terms and Conditions for Access in the TennCare Waiver or Attachment III, or when not specified therein, with reasonable promptness; or 2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service.	2.5 3.5	The cost of services not provided plus $500 per day, per occurrence, for each day 1) that approved care is not provided timely; or 2) notice of delay is not provided and/or the MCC fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service.	None
5.3.3.2.50	Failure to submit the CONTRACTORS' annual NAIC filing as described in Section 3.14 of this Agreement.	3.14	$500. per calendar day	None
5.3.3.2.51	Failure to submit the CONTRACTORS' quarterly NAIC filing as described in Section 3.14	3.14	$500. per calendar day	None

5.3.3.2.52	Failure to submit audited financial statements as described in Section 3.14	3.14	$500. per calendar day	None
5.3.3.2.53	Failure to maintain a complaint and appeal system as required in Section 3.5 of this Agreement.	3.5	$500. per calendar day	None
5.3.3.2.54	Failure to maintain required insurance as required in Section 4.4.11 of this Agreement.	4.4.11	$500. per calendar day	None
5.3.3.2.55	Reserved			
5.3.3.2.56	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments credentialing application and signed Provider Agreement as required in Section 3.8.3 of this Agreement.	3.8.3	$5000 per application that has not been approved and loaded into the CONTRACTORS' system or denied within thirty (30) calendar days of receipt of a completed credentialing application. And/Or $1000 per application per day for each day beyond thirty (30) calendar days that a completed credentialing application has not been completed as described in Section 3.6.4 of this Agreement.	None
5.3.3.2.57	Failure to maintain provider agreements in accordance with this Agreement.	3.9.2	$5000 per provider agreement found to be non-compliant with the requirements outlined in Section 3.7.2 of this Agreement.	None
5.3.3.2.58	Failure to comply in any way with staffing requirements as described in this Agreement.	3.7	$250. per calendar day for each day that staffing requirements as described in this Agreement are not met.	None
5.3.3.2.59	Failure to report provider notice of termination of	3.9.2	$200. per day	None

	participation in the CONTRACTORS' plan.			
5.3.3.2.60	Failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE.	3.1.2.4	An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TENNCARE.	None

5.4 Other Remedies

The parties shall also have any other remedies set forth in other Sections of this CONTRACT.

SECTION 6. Miscellaneous Terms and Conditions

6.1 Applicable Laws, Rules and Policies

The **Contractor** agrees to comply with all applicable federal and State laws, rules, and executive orders which include, but are not limited to:

6.1.1 Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, excepting those parts waived under the **TennCare** Waiver, Section 1115(a) Demonstration Project , the Amendment to the **TennCare** Waiver, known as the "The TennCare Partners Program", and any Special Terms and Conditions imposed on the **TennCare** Waiver and the Amendment thereto;

6.1.2 The Amendment to the **TennCare** Waiver, known as "The **TennCare Partners Program**" and any Special Terms and Conditions imposed thereon;

6.1.3 The **TennCare** Waiver, Section 1115(a) Demonstration Project, having the reference number 11-C-99638/4-03, and the Special Terms and Conditions imposed thereon, which are not in conflict with the documents specified in Sections 5.1.1 and 5.1.2;

6.1.4 Title 45, Code of Federal Regulations, Part 74, General Grants Administration Requirements;

6.1.5 Titles 4, 33, 47, 56, and 71, Tennessee Code Annotated, including, but not limited to, the **TennCare** Drug Formulary Accountability Act, Public Chapter 276 and The Standardized Pharmacy Benefit Identification Card Act.

6.1.6 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act, as amended (33 U.S.C. 1251 *et seq*.);

6.1.7 Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d) and regulations issued pursuant thereto, Title 45, Code of Federal Regulations, Part 80;

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

6.1.9 Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, Title 45, Code of Federal Regulations, Part 84;

6.1.10 The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 *et seq*., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, Title 45, Code of Federal Regulations, Parts 90 and 91;

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

6.1.12 Americans with Disabilities Act, 42 U.S.C. Section 12101 et seq., and regulations issued pursuant thereto, Title 28, Code of Federal Regulations, Parts 35 and 36.;

6.1.13 Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare and/or Medicaid program;

6.1.14 Confidentiality of Alcohol and Drug Abuse Patient Records, Title 42, Code of Federal Regulations, Part 2;

6.1.15 Federal Executive Order 11246, "Equal Employment Opportunity", as amended by federal Executive Order 11375, and as supplemented by Title 41, Code of Federal Regulations, Part 60, "Office of Federal Contract Compliance Programs. Equal Employment Opportunity, Department of Labor;

6.1.16 Tennessee Consumer Protection Act, Section 47-18-101 et seq, Tennessee Code Annotated;

6.1.17 Rules of the Tennessee Department of Health, (and as superseded by the TennCare rules of the Tennessee Department of Finance and Administration); Chapter 1200-13-13 and 1200-13-14;

6.1.18 Rules of the Department of Mental Health and Developmental Disabilities, Rule 0940, *et seq*.; and

6.1.19 Gubernatorial Executive Orders including Executive Order 1 effective January 26, 1995 and Executive Order 3 effective February 3, 2003;

6.1.20 All references in this CONTRACT or any Attachment thereto to the Tennessee Department of Mental Health and Developmental Disabilities **(TDMHDD)** shall be deemed to also be references to the Tennessee Department of Finance and Administration.

6.1.21 Copeland Anti-Kickback Act (all contracts in excess of $2,000) (18 U. S. C. 874 and 40 U.S.C. 276c)

6.1.22 Davis-Bacon Act (All contracts in excess of $2,000) (as amended 40 U.S.C. 276a to a7)

6.1.23 Contract Work Hours and Safety Standards (all contracts in excess of $2,000 for construction and $2,500 employing mechanics or laborers) (40 U.S.C. 327-333)

6.1.24 Rights to Inventions made under a contract or agreement (all contract containing experimental, developmental, or research work)

6.1.25 Byrd Anti-Lobbying Amendment (31 U.S.C. 1352)

6.1.26 Title IX of the Education Amendments of 1972

6.1.27 Contracts, subcontracts, and subgrants of amounts in excess of $100,000 shall contain a provision which requires compliance with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC 1857 (h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

6.1.28 Contracts shall recognize mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub.L. 94-165).

6.1.29 Debarment and suspension regulations in accordance with 42 CFR 438.610 and Title 45, Code of Federal Regulations, Part 76.

6.1.30 Requests for approval of material modification as provided at TCA 56-32-201 et. seq.

6.1.31 Pro-Children Act of 1994 and the Tennessee Children's Act for Clean Indoor Air of 1995.

6.2 Use of Data

TDMHDD shall have unlimited but not exclusive rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the **Contractor** resulting from this CONTRACT. **TDMHDD** shall not disclose proprietary information to the extent such information is conferred confidential status by state or federal law, except as permitted under these laws.

6.3 Waiver

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this CONTRACT may be waived except by written amendment to this CONTRACT signed by all signatories to this CONTRACT or in the event the signatory is no longer empowered to sign this CONTRACT, the signatory's replacement, and forbearance, forgiveness, or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings has occurred, the other party shall have the right to invoke any remedy available under law or equity notwithstanding any such forbearance, forgiveness or indulgence.

6.4 Severability

If any provision of this CONTRACT is determined by a court of competent jurisdiction or agreed by the parties hereto to be overly broad in duration or substantive scope, such provision shall be deemed narrowed to the broadest term or extent permitted by applicable law. If any provision of this CONTRACT or the applicability thereof to any person or circumstance is determined by a court of competent jurisdiction or agreed by the parties hereto to be unlawful, void or, for any reason, unenforceable, such determination shall not affect other provisions or applications of this CONTRACT which can be given effect without the invalid provision(s) or application; and, to that end, the provisions of this CONTRACT are held to be severable. In addition, if the laws or rules governing this CONTRACT should be amended or judicially interpreted as to render the fulfillment of this CONTRACT impossible or economically unfeasible, both **TDMHDD** and the **Contractor** will be discharged from further obligations created under the terms of this CONTRACT.

6.5 Conflicts of Interest

6.5.1 The CONTRACTOR warrants that no part of the total Agreement amount provided herein shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state or federal officer or employee of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the CONTRACTOR in connection with any work contemplated or performed relative to this Agreement unless disclosed to the

Commissioner, Tennessee Department of Finance and Administration. For purposes of Section 6.13 and its subparts of this contract, "immediate family member" shall mean a spouse or minor child(ren) living in the household.

6.5.1.1 Quarterly, by January 30, April 30, July 30, and October 30 each year, or at other times or intervals as designated by the Deputy Commissioner of the Bureau of TennCare, disclosure shall be made by the CONTRACTOR to the Deputy Commissioner of the Bureau of TennCare, Department of Finance and Administration in writing. The disclosure shall include, but not be limited to, the following:

6.5.1.1.1 A list of any state or federal officer or employee of the State of Tennessee as well as any immediate family member of a state or federal officer or employee of the State of Tennessee who receives wages or compensation from the CONTRACTOR; and

6.5.1.1.2 A statement of the reason or purpose for the wages or compensation. The disclosures shall be made by the CONTRACTOR and reviewed by TENNCARE in accordance with Standard Operating Procedures and the disclosures shall be distributed to, amongst other persons, entities and organizations, the Commissioner, Tennessee Department of Finance and Administration, the Tennessee Ethics Commission, the TennCare Oversight Committee and the Fiscal Review Committee.

6.5.1.2 This Agreement may be terminated by TENNCARE and/or the CONTRACTOR may be subject to sanctions, including liquidated damages, under this Agreement if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any state or federal officials or employees of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee if the offering or giving of said gratuity is in contravention or violation of state or federal law. It is understood by and between the parties that the failure to disclose information as required under Section 6.13 of this Agreement may result in termination of this Agreement and the CONTRACTOR may be subject to sanctions, including liquidated damages in accordance with Section 5.3 of this Agreement. The CONTRACTOR certifies that no member of or delegate of Congress, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially from this Agreement.

6.5.2 The CONTRACTOR shall include language in all subcontracts and provider agreements and any and all agreements that result from this Agreement between CONTRACTOR and TENNCARE to ensure that it is maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the

organization. Said language may make applicable the provisions of Section 6.13 to all subcontracts, provider agreements and all agreements that result from the Agreement between the CONTRACTOR and TENNCARE.

6.6. Offer of Gratuities

By signing this CONTRACT, the **Contractor** signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially from this procurement. This CONTRACT may be terminated by **TDMHDD** if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, his agent, or employees and may result in termination of the CONTRACT and/or liquidated damages as provided in Section 5.3.3.2 of this CONTRACT.

6.7 Lobbying

The CONTRACTOR certifies by signing this Agreement to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352 (See also TCA 3-6-101 *et. seq.,* 3-6-201 *et. Seq.,* and 8-50-505).

The CONTRACTOR shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

Failure by the CONTRACTOR to comply with the provisions herein shall result in termination of the Contract and/or liquidated damages as provided in 5.3.3.2 of this Agreement.

6.8 Accessibility

TDMHDD or its authorized representative shall, at all reasonable times and upon reasonable notice, have access to the **Contractor**'s premises, or such other places where services are performed under this CONTRACT, and to all financial, medical and other records to ensure compliance with the terms and conditions of this CONTRACT and to investigate any complaints or appeals reported or made to **TDMHDD**. The **Contractor** shall include a clause to this effect in all subcontracts and provider agreements.

6.9 Attorney's Fees

In the event either party deems it necessary to take legal action to enforce any provision of this CONTRACT, and **TDMHDD** prevails, the **Contractor** agrees to pay all costs and expenses of such action, including attorney's fees of the State.

6.10 Assignment

This CONTRACT and the moneys which may become due hereunder are not assignable by the **Contractor** except with the prior written approval of **TDMHDD**.

6.11 Independent Contractor

It is expressly agreed the **Contractor** and any sub**contractor**s or providers, and agents, officers, and employees of the **Contractor** or any sub**contractor**s or providers, in the performance of this CONTRACT shall act in an independent capacity and not as agents, officers and employees of **TDMHDD** or the State of Tennessee. It is further expressly agreed this CONTRACT shall not be construed as a partnership or joint venture between the **Contractor** or any sub**contractor** or provider and **TDMHDD** and the State of Tennessee.

6.12 Force Majeure

TDMHDD shall not be liable for any excess cost to the **Contractor** for **TDMHDD**'s failure to perform the duties required by this CONTRACT if such failure arises out of causes beyond the control of **TDMHDD** or is not the result of fault or negligence on the part of **TDMHDD**.

The **Contractor** shall not be liable for performance of the duties and responsibilities of this CONTRACT when its ability to perform is prevented by causes beyond its control. These acts must occur without the fault or negligence of the **Contractor**. Such acts include destruction of the facilities due to hurricanes, fires, war, riots, and other similar acts. However, in the event of damage to its facilities, the **Contractor** will be responsible for insuring swift correction of the problem so as to enable it to continue its responsibility for the delivery of health care. The failure of the **Contractor**'s fiscal intermediary, subcontractors or providers to perform any requirements of this CONTRACT shall not be considered a 'force majeure'.

6.13 Disputes and Venue

The **Contractor** specifically acknowledges the sole and exclusive remedy for any claim by the **Contractor** against **TDMHDD** arising out of the breach of this CONTRACT shall be handled in accordance with Section 9-8-301, *et seq*., Tennessee Code Annotated. The **Contractor** shall give notice to **TDMHDD** of the substance and basis of its claim thirty (30) calendar days prior to filing the claim in accordance with Section 9-8-301, *et seq*., Tennessee Code Annotated. The **Contractor** shall comply with all terms and conditions contained within this CONTRACT pending the final resolution of the contested action. The venue for any cause of action concerning any provisions of this CONTRACT or the applicability thereof shall be in Davidson County, State of Tennessee.

6.14 Indemnification

The **Contractor** agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the

part of the **Contractor**, its employees, or any person acting for or on its or their behalf relating to this Contract or the **Contractor's** failure to comply with the terms of this CONTRACT. The **Contractor** further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the **Contractor** to the State.

In the event of any such suit or claim, the **Contractor** shall give the State immediate notice thereof and shall provide all assistance required by the State in the State's defense. The State shall give the **Contractor** written notice of any such claim or suit, and the **Contractor** shall have full right and obligation to conduct the **Contractor**'s own defense thereof.

Nothing contained herein shall be deemed to accord to the **Contractor**, through its attorney(s), the right to represent the State of Tennessee in any legal matter, such rights being governed by Tennessee Code Annotated, Section 8-6-106.

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

notice of any such claim or suit and full right and opportunity to conduct the **Contractor's** own defense thereof but the State does not hereby accord to the **Contractor**, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by Section 8-6-106, Tennessee Code Annotated.

6.15 Non-Discrimination

No person on the grounds of handicap and/or disability, age, race, color, religion, sex, or national origin, shall be excluded from participation in, except as specified in Section 2 of this CONTRACT, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this CONTRACT 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.

6.16 Confidentiality of Information

The **Contractor** shall assure all materials and information directly or indirectly identifying any current or former **Enrollee** or potential **Enrollee**, which is provided to or obtained by or through the **Contractor**'s performance under this CONTRACT, whether verbal, written, tape,

or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, and Title 42, Part 2, Code of Federal Regulations, and shall not be disclosed except in accordance with those Titles or to **TDMHDD** and CMS of the United States Department of Health and Human Services, or their designees, as necessary to administrated this CONTRACT. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify any current or former **Enrollee** or potential **Enrollee**.

6.17 TDMHDD Financial Responsibility

Notwithstanding any provision in this CONTRACT to the contrary, **TDMHDD** and TennCare shall be solely responsible to the **Contractor** for the amount described herein and in no event shall **TDMHDD** or TennCare be responsible, either directly or indirectly, to any sub**contractor**, provider or any other party who may provide the services described herein or otherwise.

6.18 Limitation on Payments to Providers and subcontractors Related to the Contractor

The **Contractor** shall not pay more for services rendered by any provider or sub**contractor** related to the **Contractor** than the **Contractor** pays to unrelated providers and sub**contractor**s for similar services. A provider or sub**contractor** is considered "related" to the **Contractor** if the provider or sub**contractor** has an "ownership or control interest" or an "indirect ownership interest" in the **Contractor**, or the **Contractor** has an "ownership or control interest" or an "indirect ownership interest" in the provider or sub**contractor**. The terms "indirect ownership interest," "ownership interest" and "ownership or control interest" shall have the same meaning as set forth in 42 CFR, Sections 455.101 and 455.102. Any payments made by the **Contractor** that exceed the limitations set forth in this section shall be considered non-allowable "payments for covered services" in calculating any monetary amount required to be returned by the **Contractor** to **TDMHDD** under Section 3.15.5 of this CONTRACT. No later than July 15 of each calendar year, the **Contractor** shall submit (with the information required in Section 3.15.3 of this CONTRACT): (1) a list of all related providers and sub**contractor**s with which the **Contractor** has contracted during the preceding calendar year, and (2) a detailed explanation verifying that the payments made to such related providers and sub**contractor**s are not in excess of the amounts allowed by this section. The provisions of this section shall be effective retroactive to January 1, 1997.

6.19 Passing Withholds or Liquidated Damages to Providers or Subcontractors

The **Contractor** shall be allowed to assess liquidated damages, or all or any portion of a withhold retained by **TDMHDD** under Section 4.7.3 of this CONTRACT against any subcontractor or provider, in accordance with previously approved contract provisions and with written permission of **TDMHDD**.

6.20 Term of the CONTRACT, and Duties of Contractor upon Expiration or Termination of the CONTRACT.

6.20.1 The **Contractor**, upon expiration or termination of the CONTRACT, shall perform the obligations set forth in Section 5.1 as well as the following obligations (hereinafter referred to as "continuing obligations"), for a period to extend to twenty-four (24) months after the effective date of termination.

6.20.1.1 The **Contractor** shall complete the processing of all claims incurred during the term of the CONTRACT in the manner described in Sections 3.13.2 and 3.13.3.

6.20.1.2 The **Contractor** shall file all reports concerning the **Contractor**'s operations during the term of the CONTRACT in the manner described in Section 3.12.

6.20.1.3 The **Contractor** shall process all appeals that occurred during the term of the CONTRACT in the manner set forth in Section 3.5.

6.20.1.4 The **Contractor** shall take whatever other actions are necessary in order to ensure the efficient and orderly transition of **Enrollees** from coverage under this CONTRACT to coverage under any new arrangement developed by **TDMHDD** in the manner set forth in Section 5.1.3.

6.20.2 During the time period following expiration or termination of the CONTRACT during which the **Contractor** is completing its continuing obligations, the **Contractor** shall maintain the fidelity bonds and insurance as set forth in Sections 3.3.3 and 3.3.4.

6.20.3 Upon the expiration or termination of this CONTRACT, the **Contractor** shall submit reports to **TDMHDD** every thirty (30) calendar days detailing the **Contractor**'s progress in completing its continuing obligations under this CONTRACT. The **Contractor**, upon completion of these continuing obligations, shall submit a final report to **TDMHDD** describing how the **Contractor** has completed its continuing obligations. **TDMHDD** shall within twenty (20) calendar days of receipt of this report advise in writing whether **TDMHDD** agrees the **Contractor** has fulfilled its continuing obligations. If **TDMHDD** finds the final report does not provide evidence the **Contractor** has fulfilled its continuing obligations, then **TDMHDD** shall require the **Contractor** to submit a revised final report. **TDMHDD** shall in writing notify the **Contractor** once the **Contractor** has submitted a revised final report evidencing to the satisfaction of **TDMHDD** that the **Contractor** has fulfilled its continuing obligations.

6.20.4 The CONTRACT shall remain in effect from January 1, 2001 through June 30, 2007, subject to receipt of necessary State approvals and receipt of approval from the United States Department of Health and Human Services.

6.21 Debarment and Suspension

6.21.1 The **Contractor** certifies, to the best of its knowledge and belief, that it and its principals comply with the regulations found in Title 45, Part 76, Code of Federal Regulations, including:

6.21.2 are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;

6.21.3 have not within a three (3) year period preceding this CONTRACT been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

6.21.4 are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses detailed in section 6.19.3 of this certification; and

6.21.5 have not within a three (3) year period preceding this CONTRACT had one or more public transactions (federal, State, or local) terminated for cause or default.

6.22 Tennessee Consolidated Retirement System

The **Contractor** acknowledges and understands that, subject to statutory exceptions contained in Tennessee Code Annotated, (Section 8-36-801, *et. seq*.), the law governing the Tennessee Consolidated Retirement System, provides that if a retired member returns to State employment, the member's retirement allowance is suspended during the period of employment. Accordingly and notwithstanding any provision of this CONTRACT to the contrary, the **Contractor** agrees that if it is later determined that the true nature of the working relationship between the **Contractor** and the State under this CONTRACT is that of "employee/employer" and not that of an independent contractor, the **Contractor** may be required to repay to the Tennessee Consolidated Retirement System the amount of retirement benefits the **Contractor** received from the Retirement System during the period of this CONTRACT.

6.23 Prohibition of Illegal Immigrants

The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document as Attachment II, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the contractor and made available to state officials upon request.

b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the contractor and made available to state officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this contract.

e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.

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

CONTRACTOR

_____ _____

Russell C. Petrella, Ph.D. DATE
President
Premier Holdings, Inc. Managing Member

TENNESSEE DEPARTMENT OF MENTAL
HEALTH AND DEVELOPMENTAL DISABILITIES

_____ _____

Virginia Trotter Betts, MSN, JD, RN, FAAN DATE
Commissioner

TENNESSEE DEPARTMENT OF
FINANCE AND ADMINISTRATION:

_____ _____

M.D. Goetz, Jr. DATE
Commissioner

APPROVED:

TENNESSEE DEPARTMENT OF
FINANCE AND ADMINISTRATION:

_____ _____

M.D. Goetz, Jr. DATE
Commissioner

COMPTROLLER OF TREASURY:

_____ _____

John G. Morgan DATE
Comptroller of Treasury

ATTACHMENT A

DEFINITIONS

The terms used in this CONTRACT shall be given the meaning used in the Rules and Regulations of **TennCare** applicable to the **TennCare** Partners Program. However, the following terms when used in this CONTRACT, shall be construed and/or interpreted as follows, unless the context expressly

requires a different construction and/or interpretation. In the event of a conflict in language between the Definitions, Addendum, Attachments, and other Sections of this Agreement, the language in Sections 1 through 6 of this CONTRACT shall govern.

1. **Abuse (as adapted from definition in 42 CFR 455)** - Provider practices inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the **TennCare** program, or in reimbursement for services not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the **TennCare** program.

2. **Administrative Costs** – All costs associated with the administration of this CONTRACT. Costs of subcontractors engaged solely to perform a non-medical administrative function for the **Contractor** specifically related to securing or fulfilling the **Contractor's** obligations to **TDMHDD** under the terms of this CONTRACT (e.g., claims processing, marketing) are considered to be an "administrative cost".

3. **Adult - Continuous Treatment Team (CTT)** – comprised of a coordinated team of staff that provide a range of intensive, integrated case management, treatment, and rehabilitation services in order to maximize the consumer's level of independence, life functioning, and quality of life. Components include psychiatric services; assessment, evaluation and service planning services; medication and medication management; supporting counseling; vocational referral and linkage; social support services; and advocacy and linkage services.

4. **Adverse Action** – As affecting **TennCare** benefits include, but are not limited to, delays, denials, reductions, suspensions or terminations of **TennCare** benefits, as well as to any other acts or omissions of **TennCare** or the **Contractor** which impair the quality, timeliness or availability of such benefits.

5. **Alcohol Abuse** – A condition characterized by the continuous or episodic use of alcohol resulting in social impairment, vocational impairment, psychological dependence or pathological patterns of use.

6. **Alcohol Dependence** – Alcohol abuse which results in the development of tolerance or manifestations of alcohol abstinence syndrome upon cessation of use.

7. **Appeal Procedure** –The process for resolving an **Enrollee's** right to contest verbally or in writing, any adverse action which was taken by the **Contractor** to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the **Contractor** which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by **TennCare** Rules 1200-13-13-.11 and any and all applicable court orders.

8. **BHO Application** – the application, including all supporting material, submitted by the **Contractor** to demonstrate its ability to participate in the **TennCare Partners Program.**

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

10. **Behavioral Health Care** – Generally recognized and accepted mental health and substance abuse services.

11. **Behavioral Health Organization Advisory Council** - A culturally and racially diverse group of individuals comprised of at least fifty-one percent

12. **Benefits** – A schedule of behavioral health care services to be delivered to all **Enrollees** covered in the **Contractor's** plan developed pursuant to Section 2.5 of the CONTRACT.

13. **Best Practice Guidelines** – A set of patient care strategies developed to assist providers in clinical decision making.

14. **Behavioral Health Organization (BHO)** - An entity which organizes and assures the delivery of mental health and substance abuse services.

15. **Best Practice Guidelines** - Guidelines for provision of health and behavioral health services to children in State custody.

16. **CMS** – Centers for Medicare & Medicaid services [formerly Health Care Financing Administration (HCFA)]

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

Group 1 - Persons with Severe and Persistent Mental Illness (SPMI)
Group 2 - Persons with Severe Mental Illness (SMI)
Group 3 - Persons who were Formerly Severely Impaired and need services to prevent relapse
Group 4 - Persons with Mild or Moderate Mental Disorder
Group 5 - Persons who are not in Clinically Related Groups 1 – 4 as a result of their diagnosis being substance use disorder, developmental disorder, or V-codes

18. **Capitation** - A method of payment in which the organization delivering care provides a defined set of services to persons in a defined group for a single rate, usually calculated and paid on a per person per month basis.

19. **Children/Adolescents – Continuous Treatment Team (CTT)** – A coordinated team of staff who provide a range of intensive, integrated case management, treatment, and rehabilitation services. The general intent is to provide intensive treatment to families of children/adolescents with acute psychiatric problems in an effort to prevent the child's removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.

20. **Children At Risk of State Custody** - Children who are determined to belong in one of the following two groups:

A. Children at imminent risk of entering custody - Children who are at risk of entering state custody as identified pursuant to T.C.A. 37-5-103 (10).

B. Children at serious risk of entering custody: Children whom DCS has identified as a result of a Children's Protective Services (CPS) referral; or children whose parents or guardians are considering voluntary surrender (who come to the attention of DCS); and who are highly likely to come into custody as a result of being unable to access behavioral health services.

21. **Children's Center of Excellence (COE)** - Tertiary care academic medical center designated by the state as possessing, or being in a position to quickly develop, expertise in pediatrics, child behavioral health issues (including aggression, depression, attachment disorders and sexualized behaviors), and the unique health care needs of children in state custody.

22. **Claim** – A bill for services, a line item of service or all services for one recipient within a bill.

23. **Clarification** – A revision that is not a change or amendment to the CONTRACT but is only a revision in language to more accurately reflect the existing CONTRACT between the parties. Such clarification is a housekeeping item only, and as such, bears an effective date of the CONTRACT.

24. **Clean Claim** - A claim received by the BHO for adjudication which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid or appropriately denied by the BHO.

25. **Clinical Inquiry** - Contact regarding the status of, or information regarding, the direct care or treatment needs of an individual.

26. **Clinically Indicated** - A symptom or particular circumstance that indicates the advisability or necessity of a specific medical treatment or procedure after applying objective or standardized methods of evaluation.

27. <u>Clinically Related Groups</u>:

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

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

C. Clinically Related Group 3: Persons who are Formerly

Severely Impaired

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

D. Clinically Related Group 4: Persons with Mild or Moderate Mental Disorders

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

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

28. <u>Cold Call Marketing</u> – Any unsolicited personal contact by the **Contractor** with a **Potential Enrollee** for the purpose of marketing.

29. <u>Community Services Agency</u> - A quasi-governmental entity which provides coordination of funds or programs designed for the care of children and other citizens in the State of Tennessee.

30. <u>Community Services Area</u> – (CSA) One or more counties in a defined geographical area in which a BHO is authorized to enroll and serve TennCare members in exchange for a monthly capitation fee. There are 12 CSAs in Tennessee, eight are in rural areas and four are located in metropolitan areas.

The following geographical areas shall constitute the twelve (12) Community Services Areas in Tennessee:

Northwest CSA Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll and Benton Counties

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

31. **Comprehensive Child & Family Treatment (CCFT)** – A high intensity, time limited service designed to provide stabilization and to deter the "imminent" risk of State custody for the member. The primary goal of CCFT is to reach an appropriate point of stabilization so the member can be transitioned to CTT or other clinically appropriate services.

32. **Consumer -** An individual who uses a mental health or substance abuse service.

33. **Contract -** The **TennCare Partners Behavioral Health Contractor Agreement** is the contract entered into by **TDMHDD** on behalf of the State of Tennessee with one or more entities (referred to as BHOs) that have been issued certificates of authority by the Tennessee Department of Commerce and Insurance, under Tennessee law, to act as pre-paid limited health services organizations for the purpose of delivering mental health and substance abuse services covered by the **TennCare Partners Program** as well as certain services for specified non-**Enrollees**. The Contract is also referred to in the Operational Protocol New TennCare Waiver 2002-2007 or other predecessor documents as the Contractor Risk Agreement, Provider Risk Agreement, managed care contractor, or TennCare/BHO contract.

34. **CFR (Code of Federal Regulations)** – Regulations of the Health Care Finance Administration of the U.S. Department of Health and Human Services.

35. **CRG (Clinically Related Group) -** There are 4 clinically related groups which are mental health diagnostic categories and three of these categories include persons who have Severe and/or Persistent Mental Illnesses. A person with SPMI is an individual who has been classified as CRG 1, 2, or 3.

36. **DCS Custody Children** - Children who have been identified by DCS as belonging in one of the following groups:

A. Children in the legal and physical custody of DCS - Children in the legal and physical custody of DCS whose living arrangement is provided by DCS.

B. Children in the legal, but not physical, custody of DCS - Children who are in DCS's legal custody but who reside with parents or guardians or other caretakers.

37. **DHHS** – United States Department of Health and Human Services.

38. **Developmental Disability** means a condition based on having either a chronic disability or mental retardation.

39. **Department of Children's Services (DCS)** - The state agency having the statutory authority to provide a system of services for children in the custody of the state, or at risk of state custody.

40. **Disenrollment** - The discontinuance of an **Enrollee's** entitlement to receive covered services under the terms of this CONTRACT, and deletion from the approved list of **Enrollees** furnished by TDMHDD to the Contractor.

41. **Eligible Person** – Any person certified by **TennCare** as eligible to receive services and benefits under the **TennCare Program**.

42. **Emergency Medical Condition (as related to mental health and substance abuse treatment services)** A mental health or substance abuse condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or to result in placing another individual at immediate substantial likelihood of serious harm.

43. **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.

44. **Enrollee** - Any eligible person who has enrolled in the **Contractor's** plan in accordance with the provisions of this CONTRACT.

45. **Enrollee with Special Health Care Needs** – **Enrollees** in institutional eligibility categories, including those who are enrolled in home and community based programs as an alternative to institutional placement (except that dually eligible **Enrollees** shall be exempt from this category); and **Enrollees** in foster care.

46. **Enrollment** - The process by which an eligible person becomes a member of the **Contractor's** prepaid medical assistance plan.

47. **EPSDT (Early, Periodic Screening, Diagnosis and Treatment)** - Screening in accordance with professional standards, inter-periodic screening and diagnostic services to determine the existence of physical or mental illness or conditions in recipients under age 21; and health care, treatment, and other measures to correct or ameliorate or prevent from worsening defects and physical and mental illnesses and conditions discovered.

48. **Executive Oversight Committee** - The Committee designed by the state to have primary oversight responsibility for the implementation of a health service system for children in state custody, in accordance with the Remedial Plan and the EPSDT Consent Decree.

49. **Federal Poverty Level.**

50. **Facility** - Any premises (a) owned, leased, used or operated directly or indirectly by or for the **Contractor** or its affiliates for purposes related to this CONTRACT; or (b) maintained by a Sub**contractor** or provider to provide services on behalf of the **Contractor.**

51. **Fee For-Service** - A method of making payment for health services based on fees set for

52. **Fiscal Agent** - Any agency who processes claims for payment and performs certain other related functions.

53. **Full Time Equivalent Position**

54. **Forensics** - As generally defined by TDMHDD - Court ordered evaluation (competency to stand trial and mental condition at the time of the crime) and treatment for pre-trial defendants and evaluation and treatment for individuals found not guilty by reason of insanity. For purposes of this CONTRACT, "Forensics" is defined as court ordered outpatient services for individuals found not guilty by reason of insanity or incompetent to stand trial.

55. **Fraud** - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

56. **Grand Region** - A defined geographical region that includes specified Community Service Areas in which a **Contractor** is authorized to enroll and serve **TennCare Enrollees** in exchange for a monthly capitation fee. The following Community Service Areas constitute the three (3) Grand Regions in Tennessee:

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

57. **Health Maintenance Organization (HMO)** - An entity certified by the Department of Commerce and Insurance under applicable provisions of Tennessee Code Annotated (T.C.A.) Title 56, Chapter 32.

58. **Implementation Team** - A team of medical professionals under the direction of the Commissioner of Health who is charged with staffing the Executive Oversight Committee and overseeing the operational details of the Remedial Plan. The Implementation Team can determine if services which have been ordered for children at risk of custody and denied by the BHO are to be implemented while awaiting the results of an appeal.

59. **Interperiodic Screening** – A screening service for a child under age twenty-one (21) to determine the existence of physical and mental illness or conditions that occurs in between the times designated in the periodicity schedule for providing screens.

60. **IRS** - Drugs that are Identical, Related or Similar to LTE drugs.

61. **Judicial** - An individual who requires **Judicial Services** as specified in Section 2.6.4 of this CONTRACT, but does not meet eligibility requirements for enrollment in the TennCare Partners Program. A Judicial is not an **Enrollee** of TennCare or an **Enrollee** in the BHO plan and is entitled to BHO coverage of only those mental health evaluation and treatment services required by the statute or court order under which the individual was referred.

62. **Judicial Services** - Evaluation and treatment services required by statute as specified in Section 2.6.4 of this CONTRACT. Judicial services are provided by BHOs under the TennCare Partners Program to persons who require them by statute (specified in Section of this CONTRACT), whether they are TennCare Partners Program **Enrollees** or enter the TennCare Partners Program as Judicials.

63. **Letter of Referral** - A document developed by a BHO and a mental health or substance abuse provider which is not in the BHO's network, but which has responsibility for service to persons in the TennCare Partners Program.

64. **LTE** - Drugs that the Food and Drug Administration (FDA) considers to be Less Than Effective because there is a lack of substantial evidence of effectiveness for all labeled indications and for which there is no compelling justification for their medical need.

65. **MCO and BHO Coordination Agreement** – An agreement between the MCO and BHO that specifies roles and responsibilities of each organization designed to assure care coordination, case management and continuity of care.

66. **Mandatory Outpatient Treatment (MOT)** - Process whereby a person who was committed involuntarily and who requires outpatient treatment can be required to participate in that outpatient treatment in order to prevent deterioration in their mental condition.

67. **Marketing** - Any activity conducted by or on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade eligible persons to enroll or accept any application for enrollment in the Contractor's prepaid health plan operated pursuant to this CONTRACT.

68. **Marketing Materials** – Materials that are produced in any medium, by or on behalf of the **Contractor** that can reasonably be interpreted as intended to market to potential **Enrollees**.

69. **MCO** - Managed Care Organization (includes HMOs and PPOs).

70. **Medical Assistance or Medical Care Services** - Covered services provided to **Enrollees** of TennCare, including physical health, mental health and substance abuse services as permitted by HCFA Medicaid Demonstration Project # 11-W-00002/4 TennCare Program).

71. **Medical Expenses (sometimes referred to as "Covered Medical Services")** – Consist of the following:

a. Medical Expenses
b. Covered Services (as specified in Section 2.5 and Attachment B)
c. Services provided pursuant to EPSDT for the **TennCare** Medicaid population only
d. Case Management
e. Covered services directed by **TennCare** or an administrative law judge
f. Net impact of reinsurance coverage purchased by the BHO

For the purposes of determining the Medical Loss Ratio, Medical Expenses do not include:

a. Services Not Covered
b. Services eligible for reimbursement by Medicare
c. The activities described in or required to be conducted in Section 3 and Attachments B, C, D, E, F, G, (including, but not limited to, utilization management, utilization review activities) which are administrative costs.
d. This definition does not apply to NAIC filings.

72. **Medical Loss Ratio** – The percentage of capitation payment received from **TennCare** that is paid for medical expenses (covered medical services).

73. **Medical Management Polices and Procedures** – All policies and procedures related to the coordination and provision of services including, but not limited to:

Coordination of Care policies and procedures established in accordance with Section 3.4.3;

Continuity of care policies and procedures established in accordance with Section 3.4.5;
Out of Area or Out of Plan Use policies and procedures established in accordance with Section 3.4.6;
Enrollee Involvement policies and procedures established in accordance with Section 3.10.1; and
Quality Monitoring/Quality Improvement Program established in accordance with Section 3.11, including Utilization Management policies and procedures, established in accordance with Section 3.11.5.

74. **Medical Necessity** – Services or supplies provided by an institution, physician, or other provider that are required to identify or treat an **Enrollee's** illness, disease, or injury and which are:

a) Consistent with the symptoms or diagnosis and treatment of the **Enrollee's** illness, disease, or injury;
b) Appropriate with regard to standards of good medical practice;
c) Not solely for the convenience of an **Enrollee**, physician, institution or other provider;
d) The most appropriate supply or level of services which can safely be provided to the **Enrollee**. When applied to the care of an inpatient, **Medically Necessary** further means services for the **Enrollee's** medical symptoms or condition require the services and cannot be safely provided to the **Enrollee** as an outpatient; and
e) When applied to **TennCare Enrollees** under 21 years of age, services shall be provided in accordance with Early, Periodic Screening, Diagnosis and Treatment requirements including federal regulations as described in 42 CRF Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

75. **Medical Records** - 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. All medical histories; records, reports and summaries; diagnoses; prognoses; interpretations; physical therapy charts and notes; lab reports; other individualized medical documentation in written or electronic format; and analyses of such information.

76. **Mental Health and Substance Abuse Treatment Services (or Emergency Services)** Covered inpatient and outpatient mental health and substance abuse treatment services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard and emergency ambulance transport.

77. **Mental Health Facility** - Such facilities include an institution, treatment resource group, residence boarding home, sheltered workshop, activity center, rehabilitation center, hospital, community mental health center, counseling center, clinic, halfway house or other entity by these or other names providing mental health services.

78. **Mental Health Services** - Means the diagnosis, evaluation, treatment, residential personal care, rehabilitation, counseling or supervision of persons who have a mental illness.

79. **Mental Illness** – Means a psychiatric disorder, alcohol dependence, or drug dependence, but does not include mental retardation or other developmental disabilities.

80. **NAIC** – National Association of Insurance Commissioners.

81. **Non-Clinical Inquiry** - Contact regarding the status of, or information regarding, non-treatment areas such as eligibility, provider information, BHO information.

82. **Non-Contract Provider** - Any person, organization, agency or entity not directly or indirectly employed by or through the **Contractor** or any of its subcontractors pursuant to the agreement between the **Contractor** and TDMHDD.

82A. **Office of Inspector General (OIG) -** The Office of Inspector General investigates and may prosecute civil and criminal fraud and abuse of the TennCare program or any other violations of state law, related to the operation of TennCare administratively, civilly or criminally.

83. **Out-of-Plan Services** - Services provided by a non-CONTRACT provider.

84. **Program of Assertive & Family Treatment (PACT)** - A service delivery model for providing comprehensive community-based treatment to persons with severe and persistent mental illness. It is a disciplinary mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation, and support services that persons with severe mental illnesses need to live successfully in the community.

85. **Enrollee** - An individual who is enrolled in the TennCare Partners Program by virtue of enrollment in TennCare or enrollment in a BHO only due to TDMHDD determination under Section 2.2.1.2 of this CONTRACT.

86. **Potential Enrollee** – A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program but is not yet an **Enrollee** of a specific PIHP.

87. **Post-Stabilization Care Services** – Post-Stabilization Care Services means covered services, related to an emergency medical condition that are provided after an **Enrollee** is stabilized in order to maintain the stabilized condition, or to improve or resolve the **Enrollee's** condition.

88. **Primary Care Physician** - A physician participating in the TennCare Program who is responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. 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.

89. **Primary Care Provider** - A primary care physician or registered professional nurse or physician assistant practicing in accordance with state law who participates in the TennCare Program and who is responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

90. **Primary Treatment Center (PTC)** - A center developed by DCS for the purpose of providing short-term evaluation and treatment to children who have just come into custody, children already in state custody, children who have been released from state custody and who have been recommitted, and children who are at imminent risk of entering custody.

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

92. **Priority Enrollees – Individuals who have been classified as CRG 1, 2, or 3 or TPG 2.**

For purposes of payment to the BHO, a **Priority Enrollee** is an individual who is enrolled in the TennCare Program; who has been assessed within the past twelve (12) months as belonging in Clinically Related Groups (CRGs) 1, 2, or 3 if he is 18 years old or older, or Target Population Group (TPG) 2 if he is under the age of 18. Designation as a **Priority Enrollee** expires twelve (12) months after the assessment has been completed. In order for an individual to remain a **Priority Enrollee** after the twelve (12) month period ends, he must be re-assessed as continuing to belong in CRGs 1, 2, or 3 or TPG 2 and the BHO must have provided services within the past three months. The re-assessment, like the initial assessment, expires after twelve (12) months unless another assessment is done and the above criteria continue to be met. All children under the age of 21 are eligible for medically necessary enhanced benefits in accordance with federal EPSDT requirements.

94. Priority Population

Adult: An individual age 18 and over who currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

Children and adolescents: Children and adolescents from birth up to age 18 years who currently have, or at any time during the past year have had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities and includes any mental disorder, regardless of whether it is of biological etiology.

95. Provider- An institution, facility, agency, person, corporation, partnership, or association which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the Contractor.

96. Provider Agreement or Provider Contract - An agreement between a BHO and a provider of health care services which describes the conditions under which the provider agrees to furnish covered services to the BHO's members.

97. Psychiatric Facility - Such facilities include an institution, treatment resource group, residence boarding home, sheltered workshop, activity center, rehabilitation center, hospital, community mental health center, counseling center, clinic, halfway house or other entity by these or other names providing mental health services.

98. 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.

99. 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

100. Remedial Plan for Children in Custody - The Agreed Order entered into by the state to insure the proper coordination and delivery of health services for children in custody, pursuant to the EPSDT mandate of the Medicaid Act and in accordance with the EPSDT Consent Decree.

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

A. Age from birth to age 18, and

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

C. The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, and community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and is evidenced by a Global Assessment of Functioning score of 50 or less in accordance with the DSM-IV (and subsequent revisions).

102. **Service Authorization Request** - A managed care **Enrollee**'s request for the provision of a service.

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

Criteria

A. Age 18 and over; and

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

C. The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in major life activities including basic living skills (e.g., eating, bathing, dressing); instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. This definition includes adults who would have met

functional impairment criteria during the referenced year without the benefit of treatment or other support services.

Definition of Clinically Related Groups

A. Clinically Related Group 1. Any person 18 years or older whose functioning is, or in the last six months has been, severely impaired and the duration of the impairment totals six months or longer in the past year. This person requires constant assistance or supervision with daily living activities and displays an inability to relate to others which interferes with his/her ability to work and his/her family relationships and usually results in social isolation in the community. Changes in the environment are stressful and may result in further withdrawal or dysfunction in other areas. Support is needed to insure the person's safety and survival.

B. Clinically Related Group 2. Any person 18 years of age or older whose functioning is, or in the last six months has been, severely impaired and the duration of the impairment totals less than six months in the past year. This individual has extensive problems with performing daily routine activities and requires frequent assistance. He/She has substantial impairment in his/her ability to take part in social activities or relationships which often results in social isolation in the community. The person has extensive difficulty in adjusting to change. Assistance with activities of daily living is necessary to survival in the community. This person has difficulty completing simple tasks but with assistance could work in a highly supervised setting.

C. Clinically Related Group 3. Any person 18 years of age or older whose functioning has not been severely impaired recently (within the last six months), but has been severely impaired in the past to the extent that he or she needs services to prevent relapse. This individual generally needs long term continued support. Characteristics of this population may include regular or frequent problems with performing daily routine activities. He/She may require some supervision although he/she can survive without it. This person has noticeable disruption in social relations, although he or she is capable of taking part in a variety of social activities. Inadequate social skills have a serious negative impact on the person's life; however, some social roles are maintained with support. This person can complete tasks without prompting and help and can function in the workplace with assistance even though the experience may be stressful. There is sometimes noticeable difficulty in accepting and adjusting to change, and the person may require some intervention.

104. **Service Location** **-** Any location at which an **Enrollee** obtains any mental health/substance abuse service covered by the Contractor pursuant to the terms of this CONTRACT.

105. **Services** **-** Shall mean the benefits described in Section 2.6, Attachment B, and the Quality of Care Monitors (Attachment C of this CONTRACT).

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

107. **State** **– The State of Tennessee**, including, but not limited to, , any entity or agency of the state, such as the Department of Finance and Administration, the Office of Inspector General,

the Department of Mental Retardation, the Bureau of TennCare, the Medicaid Fraud Control Unit, the Department of Mental Health and Developmental Disabilities, the Department of Children's Services, the Department of Health, the TennCare Division within the Department of Commerce and Insurance and the Office of the Attorney General.

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108. **Subcontract** - An agreement entered into by the **Contractor** with any other person or entity which agrees to perform any administrative function or service for the **Contractor** specifically related to securing or fulfilling the **Contractor's** obligations to **TDMHDD** under the terms of this CONTRACT, (e.g., claims processing, marketing, etc.) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by the CONTRACT. This definition shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the **Contractor's** obligations to **TDMHDD** under the terms of this CONTRACT. Agreements to provide covered services as described in Section 2.6 of this CONTRACT shall be considered Provider Agreements and governed by Section 3.9.2 of this CONTRACT.

109. **Subcontractor** - Any organization or person who provides any function or service for the Contractor under a subcontract.

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

111. **Target Population Group (TPG)** – Defining and classifying consumers under 18 years into target population groups involves diagnosis, currently severity of functional impairment, and presence of psychosocial issues that can potentially place them at risk of a SED. Based on these criteria, there are three target population groups.

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

B. Target Population Group 3: At Risk of a (SED)

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

C. Target Population Group 4: Persons who do not meet criteria TPG Group 2 or 3

Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis and are not currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have no psychosocial issues that can potentially place them at risk of a SED.

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

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

114. **TennCare/BHO CONTRACT** - The agreement entered into between the State of Tennessee and a BHO under the TennCare Program by which a BHO generally receives a capitation payment in return for providing defined health care services to TennCare **Enrollees**.

115. **TennCare Medicaid Enrollee** - an **Enrollee** who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as "TennCare Medicaid" in the TennCare Rules and Regulations.

116. **TennCare Representatives** – The State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this Agreement. Such entity(s) may include, but are not limited to, the TennCare Bureau, the Department of Health, the Department of Finance and Administration, the Department of Mental Health and Developmental Disabilities, the Department of Mental Retardation, the TennCare Division within the Tennessee Department of Commerce and Insurance, the Office of Inspector General and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.

117. **TennCare Select** – TennCare Select is the statewide health plan operated by the State of Tennessee (and administered by an ASO contractor) to provide coverage for children in custody, SSI eligible children, and other disability groups. This plan also serves as a backup MCO for areas of the State where there is no other TennCare MCO available.

118. **TennCare Standard Enrollee** – an **Enrollee** who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as "TennCare Standard" as described in the approved TennCare waiver beginning on July 1, 2002, and as amended by CMS on March 24, 2005, and the TennCare Rules and Regulations.

119. **TennCare Program** - A program established by the State of Tennessee, consistent with waivers granted by the Health Care Financing Administration within the United States Department of Health and Human Services, whereby the State of Tennessee has been granted the authority to pay a monthly prepaid capitated payment amount to MCOs and BHOs for rendering or arranging necessary medical services to persons who are or who would have been Medicaid-eligible under the Medicaid Program as it was administered during Tennessee's fiscal year 1992-93 and non-Medicaid-eligible Tennesseans who are uninsured or who are uninsurable and are enrolled in the TennCare Program.

120. **Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU)** - The State agency responsible for the investigation of provider fraud and abuse in the **TennCare Program**. See number #113

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

122. **Tennessee Department of Health (DOH)** - The state agency having the statutory authority to provide for health care needs in Tennessee. For the purposes of this CONTRACT, TDH shall mean the State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this CONTRACT.

123. **Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD)** Serves as the state's mental health and developmental disability authority and is responsible for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information and advocacy for persons of all ages who have mental illness, serious emotional disturbance, or developmental disabilities. For the purposes of this CONTRACT, TDMHDD shall mean the State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this **Contract.**

124. **Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) Clinical Best Practice Guidelines** – a set of patient care strategies developed by **TDMHDD** to assist providers in clinical decision making.

125. **Third Party** - 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**.

126. **Third Party Liability** – Any amount due for all or part of the cost of medical care from a third party.

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

128. **TPG - Target Population Group**, A category that includes children and adolescents with serious emotional disturbance

129. **Urgent** – An urgent condition is defined as an acute onset of a psychiatric condition which while not constituting an immediate substantial likelihood of harm to self or others will if left untreated deteriorate into a bona fide emergency.

Vital BHO Documents – Consent forms and notices pertaining to the reduction, denial, delay, suspension or termination of services.

ATTACHMENT B

ATTACHMENT B

Effective January 1, 2003, the **Contractor** shall provide services identified in the service categories in the **TennCare Medicaid Benefit Package** for **Enrollees** identified as **TennCare Medicaid Enrollees** in need of behavioral health services and provide services identified in the service categories in the **TennCare Standard Benefit Package** for persons identified as **TennCare Standard Enrollees** in need of behavioral health services, as specified in Table 1. The **Contractor** shall only provide court ordered services as described in Section 2.5.5 for persons designated to receive specific mental health services as **Judicials** as described in Section 2.2.2.

Part 1:Services Available to Adults, Children and Adolescents

Psychiatric Inpatient Facility Services.....**B-5**

Outpatient Mental Health Services **B-8**
- M.D. Services
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Inpatient/Residential Substance Abuse Treatment and Detoxification……. **B-18**

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Part 2: Services Available to Adults

All Services listed under Part 1, plus:

Mental Health Case Management.....**B-22**

24 Hour Residential Treatment.....**B-26**

Crisis Services…….....**B-29**

Psychiatric Rehabilitation Services.....**B-32**

Part 3: Services Available to Children and Adolescents

All Services listed under Part 1, plus:

Mental Health Case Management.....**B-38**
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Crisis Services……. **B-45**
Psychiatric Rehabilitation Services.....**B-48**

Attachment B

Part 1: Definitions of Covered Mental Health and Substance Abuse Services Available to Adults, Children and Adolescents

SERVICE	**Psychiatric Inpatient Facility**

DEFINITION
An inpatient psychiatric facility/unit that offers comprehensive diagnosis, treatment and care to individuals with a mental illness. The focus may be on acute or longer term care and rehabilitation.

ACCESS/AVAILABILITY REQUIREMENTS

Psychiatric Inpatient Facility Services

Geographic Access to the Service Type	Within 60 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Not applicable
Maximum Time for Admission to the Service Type	1 hour (emer invol)/48 hours (invol)/48 hours (vol)

SERVICE COMPONENTS

- **Intake**

The process of gathering information needed to screen for and/or initiate service as defined under CPT code 90801.

- **Evaluation**

Psychiatric Evaluation
A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation
An evaluation to ascertain the social situation of the individual, including such things as personal background, family background, family interactions, living arrangements, economy problems; and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

MOT Discharge
A plan which must be filed with the court, pre-discharge of an individual found not guilty by reason of insanity (NGRI) and not committable. May include court testimony.

48 Hour Evaluation
An evaluation, up to 48 hours, to determine need for treatment, including involuntary commitment.

DCS Transfer Evaluation
An evaluation within five (5) working days of transfer to a psychiatric inpatient facility from a DCS institution to determine if the statutory transfer standard was met.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and

personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**

An individualized comprehensive treatment plan, which is developed, negotiated and agreed upon by the Consumer and/or essential others. The plan should identify treatment needs necessary to achieve the Consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the Consumer and/or face to face with essential others in relation to a specific client.

- **Intervention/Therapy**

Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc. May include services provided under a mandatory treatment obligation.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples is also included if there is more than one family or couple in the session. May include services provided under a mandatory treatment obligation.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital and/or sexual relationship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, with such interviews centering on the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy Except Detoxification Purposes)
Treatment through the use of medications or drugs. May include services provided under a mandatory treatment obligation.

Education (if child)
The provision of regular and special education, by Tennessee licensed teachers, in compliance with Minimum Rules and Regulations of the Tennessee Department of Education.

ADULT STANDARDS

- meets appropriate state licensure
- JCAHO accredited
- accepts voluntary and involuntary admissions
- must comply with **TDMHDD** Rule 0940-1-1 and 0940-1-2 regarding administration of psychotropic medication
- demonstrate ability to link with other mental health providers

CHILDREN AND ADOLESCENT STANDARDS

- meets appropriate state licensure
- JCAHO accredited
- accepts voluntary and involuntary admissions
- age separated and developmental age appropriate services
- must comply with **TDMHDD** Rule 0940-1-1 and 0940-1-2 regarding administration of psychotropic medication
- demonstrate ability to link with other mental health providers

SERVICE	Outpatient Mental Health

DEFINITION
This service includes a wide array of outpatient services including, but not limited to intake, evaluation, intervention/therapy, or day treatment. The services can either be based on site or can be delivered off site (any where in the community through the Medicaid rehabilitation option).

ACCESS/AVAILABILITY REQUIREMENTS

M.D. SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours. If medication related, within 1 hour
Maximum Time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 working days.

NON-M.D. SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Within 4 hours. If medication related, within 1 hour
Maximum Time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 working days.

DAY TREATMENT/PARTIAL HOSPITALIZATION

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Not applicable
Maximum time for Admission to the Service Type	Within 14 calendar days. If urgent, within 3 working days.

SERVICE COMPONENTS

OUTPATIENT MENTAL HEALTH SERVICES
M.D. SERVICES/NON-M.D. SERVICES

- **Intake**

The process of gathering information needed to screen for and/or initiate service as defined under CPT Code 90801.

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

- **Interperiodic Screening**
  A screening service for a child under age 21 to determine the existence of mental illness or conditions that occurs in between the times designated in the periodicity schedule for providing screens

- **EPSD&T**
  Behavioral health screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for **Enrollees** under age 21.

- **Evaluation**
  Psychiatric Evaluation
  A psychodiagnostic process including such things as a medical history and mental status examination.

  Social Evaluation
  An evaluation to ascertain the social situation of the individual, including such things as personal background, family background, family interactions, living arrangements, economy problems; to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

  MOT Affidavit
  A process of filing with a court if an Mandatory Outpatient Treatment (MOT) Consumer is non-compliant with, or is in need of renewal, of MOT. May include court testimony.

  Psychological Evaluation
  An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

  CRG Assessment
  An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

  TPG Assessment
  An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

  Medical Evaluation
  A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**
An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Activity must be done face to face with the consumer and/or face to face with essential others in relation to a specific consumer.

- **Intervention/Therapy**
Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc. May include services provided under a mandatory treatment obligation.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is **more than one** family or couple in the session. May include services provided under a mandatory treatment obligation.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital and/or sexual relationship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy Except for Detoxification Purposes)
Treatment through the use of medications or drugs. May include services provided under a mandatory treatment obligation.

Co-occurring Treatment

Treatments and therapies specifically designed to simultaneously treat a mental illness and accompanying drug or alcohol abuse issues. These therapies are intended for persons who, due to the severity of both conditions, can not be treated in separate programs for these conditions.

Home and Community Treatment
These therapies are specifically designed to be delivered in the setting where the consumer is actually living or learning. These therapies provide services that address the consumer's mental illness related functioning in these settings. Settings may include but are not limited to: consumer's home, school, nursing home or other non-mental health residential treatment setting.

- **Mental Health Case Monitoring**
  A service provided to persons who are largely able to manage much of their own progress. The focus of mental health case monitoring is on psychosocial progress with an emphasis on monitoring stability and independence in the community; coordinating and linking to services; formation of a single point of resource and is a transitional service out of more intensive mental health case management. Case monitoring shall provide a minimum of one monthly contact with consumer/family either face to face or by phone.

DAY TREATMENT

- **Intake**
  The process of gathering information needed to screen for and/or initiate service as defined under CPT Code 90801.

- **Evaluation**
  Psychiatric Evaluation
  A psychodiagnostic process including such things as a medical history and mental status examination.

  Social Evaluation
  An evaluation to ascertain the social situation of the individual, including such things as personal background, family background, family interactions, living arrangements, economy problems; to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

  Psychological Evaluation
  An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

  CRG Assessment

An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination by a physician.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**
An individualized comprehensive treatment plan, which is developed, negotiated and agreed upon by the client and/or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity and duration of each required service.

Activity must be done face to face with the client and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**
Individual Intervention/Therapy
Therapeutic sessions or related counseling by individual interview, including supportive

psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis,

hypnotherapy, simpler forms of intervention, etc.

Group Intervention/Therapy
Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is more than one family or couple in the session.

Family Intervention/Therapy
Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

Couple Intervention/Therapy
Therapeutic sessions involving two people in a marital and/or sexual relationship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

Collateral Intervention/Therapy
Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents or for an aged patient by working through family members.

Medication (Chemotherapy Except for Detoxification Purposes)
Treatment through the use of medications or drugs.

- **Interpersonal Skill Training**
  Training in communication, assertion, decision making, getting along with others, making friends and appropriate expression of feelings.

- **Daily Living Skills Training**
  Training to help consumers acquire skills in shopping, budgeting, use of community resources, grooming, housekeeping, etc.

- **Leisure Skills Training**
  Activities which assist consumer to meet leisure and social needs in their community in accordance with their income and their interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the general community.

- **Education Activities**
  Activities aimed at providing the consumer with more information (i.e., current events, medication use and side effects, physical health and basic adult education).

- **Pre-Vocational Activities**
  Activities to assist the client to learn job acquisition skills (i.e., filling out job applications and interviewing for the job).

PARTIAL HOSPITALIZATION

Partial hospitalization is defined as a medically directed treatment program that offers intensive, coordinated, and structured services for adults and/or children within a stable therapeutic milieu. Partial hospitalization embraces day, evening, night, and weekend treatment programs, which employ an integrated, comprehensive and complementary schedule of recognized mental health service approaches. Partial hospitalization is designed to provide intensive treatment services for individuals who are able to be voluntarily diverted from inpatient psychiatric hospitalization or require intensive treatment after discharge from an inpatient stay. Programs are designed to serve individuals with significant impairment resulting from a psychiatric, emotional or behavioral disorder. Such programs are also intended to have a positive impact on the individual's support system.

Partial hospitalization programs may either be free standing or integrated with a broader mental health or medical program. If integrated, partial hospitalization must be a separate, identifiable, organized program representing a significant link within the continuum of comprehensive mental health services.

ADULT STANDARDS

M.D. SERVICES and NON-M.D. SERVICES

- meets appropriate state licensure
- must have 24 hour phone answering and referral
- on and off site capability
- on-going staff training
- demonstrate ability to link with other mental health providers

DAY TREATMENT

- must meet appropriate state licensure
- on-going staff training
- demonstrate ability to link with other mental health providers

PARTIAL HOSPITALIZATION

- must meet appropriate state licensure
- on-going staff training
- demonstrate ability to link with other mental health providers

CHILDREN AND ADOLESCENT STANDARDS

M.D. SERVICES and NON-M.D. SERVICES

- meets appropriate state licensure
- must have 24 hour phone answering and referral
- on and off site capability
- age and developmental age appropriate
- on-going staff training
- demonstrate ability to link with other mental health providers

DAY TREATMENT

- must meet appropriate state licensure
- on-going staff training
- demonstrate ability to link with other mental health providers
- the provision of regular and special education, by TN licensed teachers, in compliance with Minimum Rules and Regulations of the TN Dept. of Education

PARTIAL HOSPITALIZATION

- must meet appropriate state licensure
- on-going staff training
- demonstrate ability to link with other mental health providers

SERVICE	Pharmacy Services for Psychotropic Medication

DEFINITION
Psychotropic medication and pharmacy services related to dispensing this medication.

ACCESS/AVAILABILITY REQUIREMENTS

Pharmacy Services for Psychotropic Medication

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours
Maximum Time for Admission to the Service Type	Within 7 calendar days

STANDARDS
- must meet appropriate state licensure

NOTE: The State is financially responsible for all pharmacy services.

SERVICE	Lab Services Related to Psychiatric Needs

DEFINITION
Lab services related to psychiatric treatment.

ACCESS/AVAILABILITY REQUIREMENTS

Lab Services Related to Psychiatric Needs

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours
Maximum Time for Admission to the Service Type	Within 7 calendar days

STANDARDS
- must meet appropriate state licensure

SERVICE	Transportation to Covered Benefits

DEFINITION
The BHO will, except as otherwise provided in **Standards** below, assure the provision of necessary transportation for eligible recipients to and from providers in order for the eligible recipients to obtain **TennCare** covered services.

ACCESS/AVAILABILITY REQUIREMENTS

Transportation to Covered Mental Health Services

Geographic Access to the Service Type	Within 30 miles of the **Enrollee**
Response Time to Contact an Active Consumer in an Urgent Situation	Within 2 hours
Maximum Time for Admission to the Service Type	While a maximum time is not specified for non-emergency transportation, the BHO may recommend the recipient give the provider a 5 working day notice of their transportation needs whenever possible. Such notice cannot be required, however.

STANDARDS

Transportation services must meet current **TennCare** standards.

SERVICE Inpatient/Residential Substance Abuse Treatment and Detoxification

DEFINITIONS

TREATMENT
A hospital inpatient or residential facility that offers comprehensive substance abuse treatment, detoxification and care.

DETOXIFICATION
Inpatient hospital services for consumers who are experiencing or at risk of experiencing a severe withdrawal syndrome or whose treatment needs are complicated by other physical or psychiatric conditions. The goals of this service are to minimize the consumer's discomfort and other potential adverse consequences of withdrawal; encouraging the patient to complete detoxification and enter into a rehabilitation program; and, to the extent the consumer's physical and cognitive condition permits, beginning the rehabilitation process.

ACCESS/AVAILABILITY REQUIREMENTS

INPATIENT & RESIDENTIAL TREATMENT

Geographic Access to the Service Type	Within 60 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Not applicable
Maximum Time for Admission to the Service Type	2 calendar days for all inpatient services/residential services.

DETOXIFICATION

Geographic Access to the Service Type	Within 60 miles of an individual's home
Response Time to Contact an Active Client in an Urgent Situation	Not applicable
Maximum Time for Admission to the Service Type	Within 24 hours or 1 hour if an emergency

SERVICE COMPONENTS

TREATMENT

- **Intake**
  The process of gathering information needed to screen for and/or initiate service as defined under

  CPT Code 90801.

- **Evaluation**

- **Treatment Plan**
  An individualized comprehensive treatment plan, which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

  Activity must be done face to face with the client and/or face to face with essential others in relation to a specific consumer.

- **Intervention/Therapy**

DETOXIFICATION

- **Intake**
  The process of gathering information needed to screen for and/or initiate service as defined under CPT Code 90801.

- **Evaluation**

- **Treatment Plan**
  An individualized comprehensive treatment plan, which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

  Activity must be done face to face with the consumer and/or face to face with essential others in relation to a specific consumer.
- **Intervention/Therapy**

STANDARDS

TREATMENT

- must meet appropriate state licensure

DETOXIFICATION

- must meet appropriate state licensure

SERVICE	Outpatient Substance Abuse Treatment and Detoxification

DEFINITION

TREATMENT
This service includes an array of outpatient substance abuse treatment services.

DETOXIFICATION
An outpatient service for consumers withdrawing from psychoactive substances who are not at risk of a severe withdrawal syndrome or psychiatric destabilization and who live in environments that will not undermine their treatment. The goals of this service are to minimize the consumer's discomfort and other potential adverse consequences of withdrawal; encouraging the consumer to complete detoxification and enter into a rehabilitation program; and, to the extent the consumer's physical and cognitive condition permits, beginning the rehabilitation process.

ACCESS/AVAILABILITY REQUIREMENTS

OUTPATIENT TREATMENT, AND DETOXIFICATION

Geographic Access to Service Type	Within 30 miles of an individual's home.
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours
Maximum Time for Admission to Service Type	Within 24 hours for detox, within 3 calendar days for all other outpatient services

SERVICE COMPONENTS
TREATMENT

- **Intake**
  The process of gathering information needed to screen for and/or initiate service as defined under CPT Code 90801.

- **Evaluation**

- **Treatment Plan**
  An individualized comprehensive treatment plan, which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity and duration of each required service.

Activity must be done face to face with the consumer and/or face to face, with essential others in relation to a specific client.

- **Intervention/Therapy**
  Therapy may consist of outpatient services, intensive outpatient rehabilitation, or other outpatient services as needed.

DETOXIFICATION

- **Intake**
  The process of gathering information needed to screen for and/or initiate service as defined under

  CPT Code 90801.

- **Evaluation**

- **Treatment Plan**
  An individualized comprehensive treatment plan, which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

  Activity must be done face to face with the consumer and/or face to face with essential others in relation to a specific client.
- **Intervention/Therapy**

STANDARDS

TREATMENT

- Must meet appropriate state licensure.

DETOXIFICATION

- Must meet appropriate state licensure.
- Consumer can not have major psychiatric treatment needs.
- Consumer must not be at risk of severe withdrawal syndrome or psychiatric destabilization.
- Consumer must live in environments that will not undermine treatment.
- A Tennessee licensed physician must supervise the detoxification process.
- A minimum of daily re-evaluations by a Tennessee licensed physician or registered nurse.
- Consumer must participate in an outpatient service whiles/he is in the detoxification process.

Part 2: Definitions of Services Available to Adults

SERVICE	**Mental Health Case Management - ADULT**

DEFINITION

A series of actions taken by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the consumer/family accesses services. Mental health case management requires the mental health case manager and consumer/family to have a strong productive relationship which includes viewing the consumer/family as a responsible partner in identifying and obtaining the necessary services and resources. Mental health case management is provided in community settings which are accessible and comfortable to the consumer/family. The service is available 24 hours a day, 7 days a week. The service is not time limited and provides the consumer/family the opportunity to improve their quality of life.

ACCESS/AVAILABILITY REQUIREMENTS

Mental Health Case Management - Adult

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours
Maximum Time for Admission to the Service Type	Within 7 calendar days

SERVICE COMPONENTS

- **Programmatic Admissions Screening**
  The process of gathering information needed to screen for and/or initiate service.

- **Assessment**
  Mental Health Case Management Assessment
  An assessment including but not limited to: the ongoing determination of an individual's current and potential strengths, resources, and basic needs through formal and informal evaluation. Assessment activities include: intake, mental status, medication, general health, self-care, support network, living situation, employment capabilities and status, educational needs, training needs and consultation with the family. Assessing the consumer's progress with goals and choices on an on-going basis is also considered an assessment activity. Assessment, therefore is not limited to a formal process.

- **CRG Assessment**
  An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

- **Service Plan**
  An individualized comprehensive plan, which is developed, negotiated and agreed upon by the consumer and mental health case manager and/or essential others. Mental health case managers coordinate the development of the service plan. The plan should identify services and assistance necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service. Intensity of case management should be determined by the results of the case management assessment.

  Activity must be done face to face with the consumer and/or face to face with essential others in relation to a specific consumer.

- **Crisis Facilitation**
  Crisis facilitation is provided in situations requiring immediate attention/ resolution for a specific consumer or other person(s) in relation to a specific consumer. It is the process of accessing and coordinating services for a consumer in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the consumer.

- **Daily Functioning**
  The on-going monitoring of how a consumer is coping with life on a day to day basis for the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the consumer in their natural environment.

- **Assessment/Referral/Coordination**
  Accessing the needs of the consumer for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the consumer's natural environment.

- **Liaison**
  Mental health case management activity which offers to persons who are not yet assigned to mental health case management, short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

RECOMMENDED GUIDELINES

There should be two levels of mental health case management for eligible adults age 18 and older.

1. Level 1 mental health case management is the most intensive level of service. Frequent and comprehensive support is to be provided to the most severely disabled adults 24 hours per day, 7 days per week. Individuals are at high risk of future hospitalization or placement, and who need both community support and treatment interventions. Level 1 may include such models as CTT PACT, etc.

2. Level 2 mental health case management is a less intensive level of service which is recovery-oriented and available 24 hours per day, 7 days per week. Symptoms are at least partially managed in order to allow rehabilitation efforts.

Mental health case management to both a parent(s) and child in the same family, should include skills and experience needed for both ages.

Focus of the service:

The focus of Level 1 mental health case management is symptom stabilization and addressing basic needs, with an emphasis on the following:

- Obtaining basic human supports;
- Decreasing symptoms and side effects;
- Increasing periods of independence;
- Building support networks; and
- Decreasing period of crisis or severe dysfunction.

The focus of Level 2 mental health case management is psychosocial progress, with an emphasis on:

- Maximizing strengths and recovery outcomes;
- Obtaining and coordinating services and resources;
- Skills Training; and
- Provision of consistent direct support.

Service delivery:

1. Caseload size will be determined based on an average number of consumers per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1 and 2.
   - For Levels 1 and 2, no case manager will have a caseload of over 35 consumers .
   - Case load sizes for Adult CTT will be 1:20 with no CTT Case Manager having a caseload of over 20 CTT consumers.

2. Frequency and type of contact will be as follows:

   - For Level 1, a minimum of four face-to-face contacts per month, with 80% of these contacts being out of the office.
   - For Level 2, a minimum of two face-to-face contacts per month, with 80% of these contacts being out of the office.
   - For Adult CTT, a minimum of one face-to-face contact (encounter) per week, with 80% of those contacts (encounters) being out of the office.

3. The minimum qualifications for a mental health case manager will be a bachelor's degree. Supervisors should maintain a 1:30 supervisory ratio with mental health case managers.

Expected outcomes:

1. Level 1.

An increase in:

- Community tenure
- Housing stability
- Social integration
- Satisfaction

A decrease in:

- Frequency or length of hospitalization
- Symptoms and side effects
- Impairment for substance abuse
- Level of care needed or desired

1. Level 2.

An increase in:

- Community tenure
- Time spent working or in school
- Social contacts
- Personal satisfaction and independence
- Independent or semi-independent housing
- Satisfaction.

A decrease in:

- Crisis episodes
- Impairment from substance abuse

SERVICE	24 Hour Residential Treatment - ADULT 24 Hour Residential Treatment ADULT

DEFINITION
Community based facility that offers 24-hour residential care as well as treatment and rehabilitation. The focus may be on short-term crisis stabilization or on long-term rehabilitation.

ACCESS/AVAILABILITY REQUIREMENTS

24 Hour Residential Treatment - ADULT

Geographic Access to the Service Type	Within 70 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	NA
Maximum Time for Admission to the Service Type	Within 30 calendar days

SERVICE COMPONENTS

- **Programmatic Admission Screening**
  The process of gathering information needed to screen for and/or initiate service.

- **Evaluation**
  Psychiatric Evaluation
  A psychodiagnostic process including such things as a medical history and mental status examination.

  Social Evaluation
  An evaluation to ascertain the level of social functioning of an individual, including such things as personal history, family history, family interactions, living arrangements, financial problems; legal history, and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

  Psychological Evaluation
  An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

  CRG Assessment
  An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

  Medical Evaluation
  A medical/physical examination.

  Educational Evaluation
  An evaluation to determine academic interest, aptitudes, and achievements.

  Vocational and Work Evaluation
  An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**
  An individualized comprehensive treatment plan, which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

  Activity must be done face to face with the consumer and/or face to face, with essential others in relation to a specific consumer.

- **Intervention/Therapy**
  Individual Intervention/Therapy
  Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc.

  Group Intervention/Therapy
  Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is **more than one** family or couple in the session.

  Family Intervention/Therapy
  Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

  Couple Intervention/Therapy
  Therapeutic sessions involving two people in a marital and/or sexual relation-ship who are seen together as a unit. Excludes groups of couples, i.e., more than one couple in the session. (See Group Intervention/Therapy above.)

  Collateral Intervention/Therapy
  Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy Except for Detoxification Purposes)
Treatment through the use of medications or drugs.

- **Interpersonal Skill Training**
  Training in communication, assertion, decision making, getting along with others, making friends and appropriate expression of feelings.

- **Daily Living Skills Training**
  Training to help clients acquire skills in shopping, budgeting, use of community resources,

  grooming, housekeeping, etc.

- **Leisure Skills Training**
  Activities which assist clients to meet leisure and social needs in their community in accordance with their income and their interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the community at large.

- **Education Activities**
  Activities aimed at providing the client with more information (i.e., current events, medication

  use and side effects, physical health and basic adult education).

- **Pre-Vocational Activities**
  Activities to assist the consumer to learn job acquisition skills (i.e., filling out job applications

  and interviewing for the job).

ADULT STANDARDS

- meets appropriate state licensure and local housing codes
- meets accreditation standards as required by 42 CFR 441.151
- on-going staff training required

SERVICE	Crisis Services - ADULT

DEFINITION

Crisis Services

Crisis services are provided 24-hours per day 7 days per week for adults experiencing a mental health crisis, an urgent condition or a psychiatric emergency. An urgent condition is defined as an acute onset of a psychiatric condition which while not constituting an immediate substantial likelihood of harm to self or others will if left untreated deteriorate into a bona fide emergency. A psychiatric emergency is defined as an acute onset of a psychiatric condition that manifests itself by an immediate substantial likelihood of serious harm to self or others. These services include 24-hour telephone lines and crisis intervention and referral. These services will provide triage, assessment, stabilization and referral for inpatient or other aftercare services. For admission to Regional Mental Health Institutes (RMHIs), Crisis Teams are capable of performing the functions of mandatory prescreening in accordance with Title 33, Chapter 6 of Tennessee Code annotated, to ensure an effective inpatient diversion system and maintain the individual in the least restrictive environment as appropriate. Private hospitals that have been approved by TDMHDD will also accept mandatory prescreening for the crisis team. Crisis services shall not be responsible for pre-authorizing involuntary hospitalizations.

Crisis Respite - Adults

Respite services are a function of the Crisis Response Team (CRT). Services are intended to provide a safe environment and staff support for individuals who cannot stay in their homes during a crisis, and who otherwise might be hospitalized. Adult respite services should be encouraged to employ consumers as respite care staff members. Respite services must utilize appropriate unique local and regional approaches. These might include foster family-like placements, a bed in a board and care home or hotel/motel room, or support for a volunteer-staffed respite apartment.

Hospital Based Crisis Services

Crisis services, which utilize hospital emergency rooms or other acute psychiatric services based on the assessment of risk to the consumer and or the need for a medically supervised setting. Acute hospital-based services should be utilized for consumers who cannot be managed in a less restrictive setting because of a clear danger to self or others, or the presence of a medical condition which constitutes a medical emergency due to the unstable condition.

ACCESS/AVAILABILITY REQUIREMENTS

MOBILE CRISIS SERVICES

Geographic Access to the Service Type	Within 30 miles of an individual's home
Maximum Time for a Face to Face Contact for an Individual	Within 1 hour in an emergency situation and within 4 hours in an urgent situation
Maximum Time for Admission to the Service Type	Within 1 hour

CRISIS RESPITE

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 1 hour Immediate
Maximum Time for Admission to the Service Type	Within 2 hours

SERVICE COMPONENTS

Mobile Crisis Services

Screening for hospitalization

A face-to-face assessment between the consumer experiencing the crisis and the crisis staff. The assessment determines whether the consumer **does meet** the criteria for admission to an inpatient psychiatric facility and that there are no less drastic alternative available.

Crisis Intervention

A face-to-face intervention between the crisis staff and the consumer and/or significant other(s). The intervention is delivered where the consumer is experiencing the crisis and is intended to stabilize the individual to prevent the crisis from escalating.

Follow Up

A face-to-face session between the consumer and the crisis staff following the crisis intervention session. This could be a daily session for several days or once a week until the consumer can be seen in another service. Follow-up visits are to ensure the consumer is stable and has regained control of the crisis situation.

Telephone Intervention

A phone intervention between the crisis staff and the consumer and/or significant other(s). The intervention is intended to assess the need for mobile crisis response or referral to the appropriate resource if mobile response is not necessary in order to stabilize the individual in order to prevent the crisis from escalating.

Mandatory Pre-screening to RMHI

A face-to-face assessment between the consumer experiencing the crisis and the crisis staff. The assessment determines that the consumer **does meet** the criteria for admission to the RMHI and that there are no less drastic alternative available.

Telephone and Walk-in Crisis Services

Triage & Assessment

Triage activities are employed to determine the need of the consumer and the nature of the crisis. Assessments are designed to determine the risk of suicide or substantial likelihood of harm to others.

Intervention
An intervention between the crisis staff and the consumer and/or significant other(s). This may be done via telephone or, in the case of walk-in crisis, face-to-face. The intervention is intended to involve the appropriate resource necessary to stabilize the individual in order to prevent the crisis from escalating.

Referral
Actives of linking to consumer with the appropriate resources to provide care following stabilization.

Crisis Respite
Respite Plan
An individualized plan of action which is developed and agreed upon by the crisis response service, the consumer, the respite companion and/or essential others. The plan should identify services and assistance necessary to achieve the client's stated goals as well as an explanation of the availability, intensity and duration of each required service.

Respite location
The community location where respite service is being provided.

Respite staff
Trained staff who remain with a client continually during a respite episode.

ADULT STANDARDS

MOBILE CRISIS SERVICES
- must meet appropriate state licensure
- service offered 365 days a year
- 90% of face-to-face contacts occur off site
- of off-site at least 50% occur at the location where the consumer is experiencing the crisis
- one published toll-free phone number per CSA region
- 24hour service (phone and in person)
- mental health staffed telephone line
- on-going staff training
- demonstrate ability to link with other mental health providers
- for RMHI admissions, able to complete mandatory prescreening activities through mobile crisis staff trained and designated by **TDMHDD.**

CRISIS RESPITE

- must meet appropriate state licensure
- services offered 365 days a year, 24 hours a day
- encourage use of consumers/families as respite workers
- continuous respite staff provided to those in respite
- respite location includes room and board
- referral must come from crisis response and must include 24 hour crisis team back-up
- on-going staff training

SERVICE	Psychiatric Rehabilitation - ADULT

DEFINITION

Psychiatric Rehabilitation

An array of consumer-centered services designed to assist the individual to attain or maintain his or her optimal level of functioning. These services involve assessing the individual's readiness and or interest in the development of a rehabilitation plan followed by either a plan to develop readiness or a specific rehabilitation plan. These services are to assist the individual to develop or improve the skills and supports needed in order to perform as successfully and independently as possible in the living, working, learning, or socializing roles and environments of their choice.

Supported Employment

This consists of a range of services to assist consumers to prepare for, obtain, and maintain employment. This service also includes a variety of support services to the consumer, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Supported Housing

This service refers to facilities staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff support. These facilities are for persons with serious and persistent mental illnesses and are not residential treatment facilities. Supported housing is intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings with appropriate mental health supports. Supported housing does not include the payment of room and board.

Consultation and Education

This service provides information, counseling, behavior management training and early intervention strategies pertaining to childhood mental illness. This service enables school teachers, counselors and others to be sensitive to early signs of mental illness and to intervene before a crisis develops.

Peer Support

These services are consumer family based and operated providing self-help skills. Services are often provided during the evening and weekend hours.

Psychosocial Rehabilitation

A consumer-centered group of services for Service recipients to enhance and support the process of recovery. Service recipients, in partnership with staff, form goals for skill development in the areas of vocational, educational, and interpersonal growth that serve to maximize opportunities for successful community integration. Service recipients proceed with the goal development at their own pace and may continue in the program with varying intensity for an indefinite period of time

ACCESS/AVAILABILITY REQUIREMENTS

PSYCHIATRIC REHABILITATION

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	NA
Maximum Time for Admission to the Service Type	Within 14 calendar days

SERVICE COMPONENTS

SUPPORTED EMPLOYMENT (SITE BASED/SERVICE BASED)

- **Programmatic Admissions Screening**
  The process of gathering information needed to screen for and/or initiate service

- **Assessment**
  Educational Evaluation
  An evaluation to determine academic interest aptitudes and achievements.

  Vocational and Work Evaluation
  An evaluation to determine vocational interests, aptitudes and achievements.

  Rehabilitation Readiness Assessment
  An Assessment to determine the individual's current interest in and skills needed to develop or attain rehabilitation goals.

- **Service Plan**
  An individualized comprehensive plan which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify services and assistance necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

  Activity must be done face to face with the consumer and/or face to face, with essential others in relation to a specific consumer.

- **Enclave**
  A work unit provided by a licensed vocational program consisting of two (2) or more individuals with a severe and/or persistent mental illness working in normal, competitive work setting. The setting focuses on assessment, training and work experience with pay.

- **Social Support Services**
  Group and individual activities or programs provided in a low demand supportive employment.

  The service is non-clinical and is not meant to provide a treatment intervention. The service

  promotes peer support and socialization. The service might also provide an individual client with

assistance in the use of community resources and might refer and link the client to the appropriate service.

- **Pre-vocational Work Units**
  A structured work environment or program provided by the agency that focuses on assessment,

  training and work experience. The setting is located at the agency.

- **Interpersonal Skills Training**
  Training in communication, decision making, problem solving, relationship building, peer support, self responsibility and self advocacy.

- **Daily Living Skills Training**
  Teaching the skills in the place where the skills to be used as opposed to teaching the skills in the program site. Skills taught include budgeting, nutrition, safety, banking, self medication, shopping, use of transportation, etc.

- **Leisure Skills Training**
  Assisting clients to meet leisure and social needs in their community in accordance with their income and their interests. Teaching clients in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the community at large.

- **Educational Development**
  Linking the client to basic adult education opportunities, GED opportunities in the community.

- **Self Help Groups**
  Client run groups to provide companionship, mutual support and self advocacy.

- **Family Involvement**
  Reinforcement and encouragement of family members as natural support systems. Family education in crisis management, psychopharmocology and community resources. Skills are learned via staff and client participating together and mutually sharing the activity. The staff serves in the role model function by working on a task side by side with the consumer.

- **Pre-vocational Job Readiness**
  Initial contacts between the job coach and the client to help the consumer develop choices about employment and select the types of jobs preferred are considered supportive employment sessions.

- **Job Coaching**
  Assistance provided to a consumer by the staff member or "job coach" for the purpose of modifying behaviors that represent barriers for the consumer to become/maintain gainful employment.

- **Development of Job Sites**
  Activities related to the initiation and development of new employment resources, utilizing private, local, state, and/or federal resources. Emphasis is on the resource development which parallels the community at large.

- **Job Placement**
  Activities which match employer and employee needs to a particular job.

- **Employer Support**
  Contact with the Employer/Supervisor is made in relation to a specific consumer's job performance from the employer's perspective. May also include educating the employer in providing job coaching assistance to the consumer, restricted to activities directly related to the consumer's job and performed by a staff member whose major responsibilities are supported employment work functions.

- **Community Education/Advocacy**

Educational and advocacy activities related to identifying service needs.

- **Rehabilitation Plan**
  A plan developed by the consumer, in partnership with staff, to change or improve his or her role in one of the specific life domains of living, working, learning, and socializing. The plan should include the specific goal, services and supports need to achieve the goal as well as the method to be used to achieve the goal.

- **Rehabilitation Readiness Development Plan**

A plan to develop the skills needed in order to set and pursue a rehabilitation goal.

ADULT STANDARDS

PSYCHIATRIC REHABILITATION

- must meet appropriate state licensure
- at least 85% of jobs are jobs which exist normally in the community
- consumers must have realistic transportation plans
- on-going staff training
- demonstrate ability to link with other mental health providers

Part 3: Definitions of Covered Services Available Children & Adolescents

SERVICE	Mental Health Case Management CHILDREN AND ADOLESCENTS

DEFINITION
A series of actions taken by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring that the consumer/family accesses services. Mental health case management requires the mental health case manager and consumer/family. to have a strong productive relationship which includes viewing the consumer/family as a responsible partner in identifying and obtaining the necessary services and resources. Mental health case management is provided in community settings which are accessible and comfortable to the consumer/family. The service is available 24 hours a day, 7 days a week. The service is not time limited and provides the consumer/family the opportunity to improve their quality of life.

ACCESS/AVAILABILITY REQUIREMENTS

Mental Health Case Management - Children and Adolescents

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 4 hours
Maximum Time for Admission to the Service Type	Within 7 calendar days

SERVICE COMPONENTS

- **Programmatic Admissions Screening**
  The process of gathering information needed to screen for and/or initiate service.

- **Assessment**
  Mental Health Case Management Assessment
  An assessment including but not limited to: the ongoing determination of an individual's current and potential strengths, resources, and basic needs through formal and informal evaluation.

  Assessment activities include: intake, mental status, medication, general health, self-care, support network, living situation, employment capabilities and status, educational needs, training needs and consultation with the family. Assessing the consumer's progress with goals and choices on an on-going basis is also considered an assessment activity. Assessment, therefore, is not limited to a formal process.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and recency of impairment due to a mental illness.

- **Service Plan**
  An individualized, comprehensive plan which is developed, negotiated and agreed upon by the consumer and mental health case manager and/or essential others. Mental health case managers coordinate the development of the service plan. The plan should identify services and assistance necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

  Activity must be done face to face with the consumer and/or face to face with essential others in relation to a specific consumer.

- **Crisis Facilitation**
  Crisis facilitation is provided in situations requiring immediate attention/ resolution for a specific consumer or other person(s) in relation to a specific consumer. It is the process of accessing and coordinating services for a consumer in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the consumer.

- **Assessment of Daily Functioning**
  For the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the consumer in their natural environment.

- **Assessment/Referral/Coordination**
  Accessing the needs of the consumer for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the consumer's natural environment.

- **Liaison**
  Mental health case management activity which offers to persons who are not yet assigned but who are eligible, for mental health case management, short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

RECOMMENDED GUIDELINES

There should be two levels of mental health case management for children and youth.

Level 1 mental health case management is the most intensive level of service. Frequent and comprehensive support is to be provided, and available 24 hours per day, 7 days per week. Children may be at imminent risk of out-of-home placement, including psychiatric hospitalization, and/or exhibiting multiple needs requiring services from multiple agencies. Intensive case management may include such models as CTT, CFT, etc.

Level 2 mental health case management is a less intensive level for children with multiple needs requiring services from more than one or more agencies.

Mental health case management to both a parent(s) and child in the same family, should include skills and experience needed for both ages.

SERVICE DELIVERY:

1. Caseload size will be determined based on an average number of consumers per case manager, with the expectation that case manager will have mixed caseloads of Level 1 and Level 2 cases.

   - For Levels 1 and 2 the average will be 1:18 with no case manager having a case load of over 30.

2. Frequency of contacts:

   - Level 1 will provide an average of 1 face-to-face contact per week with child/family and one weekly contact with systems such as school, probation, therapist.

   - Level 2 will provide an average of 2 face-to-face contact per month with the child/family and 2 per month with other systems.

   - Each C & A CTT consumer will receive a minimum of 12 contacts (encounters) per month.

   - In the event an extended contact (encounter) is delivered based on medical necessity, the first hour (and up to 1 hour and 29 minutes) will be regarded as one contact hour, the second contact hour commences at 1 hour and 30 minutes (and up to 2 hours and 29 minutes), the third contact hour commences at 2 hours and 30 minutes (and up to 3 hours and 29 minutes), etc.

3. Eighty percent of all case management services should take place outside the case manager's office.

4. The intervention plan for children in Level 1 and 2 mental health case management must have clear outcome objectives.

5. The C&Y case management model should be strengths-based and outcome driven and should adhere to the CAASP principles described in *A System of Care for Children & Youth with Severe Emotional Disturbances*, Stroul and Friedman, 1986; Stroul and Pires, 1997.

6. The C&Y case management model provides a transition from C&Y services into adult services, including adult case management services. The decision to serve an 18-year old youth via the children's case management system versus the adult system should be a provider's clinical decision. In general, a youth would be maintained in the youth system if current active case management began before the age of 18 and the youth would be expected to be discharged before the 19th birthday. Conversely, if the entry level point occurred after the age of 18, the youth would usually be served by adult case management. Transition from children's services, including case management, should be incorporated into the child's service plan.

7. All case management services must be documented in a service plan. Case management activities are correlated to expected outcomes. Outcome achievement is monitored, with progress being noted periodically in a written record.

EXPECTED OUTCOMES

1. Level 1

An increase in:

- in-home care
- social integration
- family satisfaction
- other agency/system support
- regular school attendance

A decrease in:

- out-of-house care or hospitalization
- symptoms and side effects
- level of care needed

1. Level 2

An increase in:

- social contacts
- time in school
- child and family satisfaction

A decrease in:

- crisis episodes
- family stress
- number of services required

SERVICE	24 Hour Residential Treatment CHILDREN AND ADOLESCENT

DEFINITION
Community based facility that offers 24-hour residential care as well as treatment and rehabilitation. The focus may be on short term crisis stabilization or on long-term rehabilitation.

ACCESS/AVAILABILITY REQUIREMENTS

24 Hour Residential Treatment - Children and Adolescents

Geographic Access to the Service Type	Within 70 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	N/A
Maximum Time for Admission to the Service Type	Within 30 calendar days

SERVICE COMPONENTS

- **Programmatic Admissions Screening**
  The process of gathering information needed to screen for and/or initiate service.

EVALUATION

Psychiatric Evaluation
A psychodiagnostic process including such things as a medical history and mental status examination.

Social Evaluation
An evaluation to ascertain the level of social functioning of an individual, including such things as personal history, family history, family interactions, living arrangements, financial problems; legal history, and to formulate future goals and plans; and to collect details of previous psychiatric treatment, interval history, or history of present illness up until the time of admission.

Psychological Evaluation
An evaluation of cognitive processes, emotions and problems of adjustment through such things as interpretations of tests of mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics. May include neuropsychological, developmental, psycho-sexual assessments.

CRG Assessment
An assessment mechanism for persons age 18 and older to determine an individual's level of functioning and duration of impairment due to a mental illness.

TPG Assessment
An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and duration of impairment due to a mental illness.

Medical Evaluation
A medical/physical examination.

Educational Evaluation
An evaluation to determine academic interest, aptitudes, and achievements.

Vocational and Work Evaluation
An evaluation to determine vocational interests, aptitudes, and achievements.

Mental Retardation Evaluation
An evaluation related to determining the proper placement or treatment for a person with mental retardation.

AIMS
An assessment to measure abnormal involuntary movement due to the use of psychotropic medication.

- **Treatment Plan**
  An individualized comprehensive treatment plan which is developed, negotiated and agreed upon by the consumer and/or essential others. The plan should identify treatment needs necessary to achieve the consumer's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

  Activity must be done face to face with the consumer and/or face to face, with essential others in relation to a specific consumer.

- **Intervention/Therapy**
  Individual Intervention/Therapy
  Therapeutic sessions or related counseling by individual interview, including supportive psychotherapy, relationship therapy, rational emotive therapy, insight therapy, psychoanalysis, hypnotherapy, simpler forms of intervention, etc.

  Group Intervention/Therapy
  Therapeutic sessions that use group dynamics or group interaction including group psychotherapy, group play therapy, group psychoanalysis, and psychodrama. Therapy with groups of families or married couples are also included if there is more than one family or couple in the session.

  Family Intervention/Therapy
  Therapeutic sessions with the family as a unit, where significant members of the family are seen together. Excludes groups of families, i.e., more than one family in the session. (See Group Intervention/Therapy above.)

  Collateral Intervention/Therapy

Therapeutic sessions through interviews beyond the diagnostic level with collateral persons, such interviews centering around the patient's problems without the patient himself necessarily seen. Includes intervention/therapy with a child by working with the parents, or for an aged patient by working through family members.

Medication (Chemotherapy Except for Detoxification Purposes)
Treatment through the use of medications or drugs.

Interpersonal Skill Training
Training in communication, assertion, decision making, getting along with others, making friends and appropriate expression of feelings.

- **Daily Living Skills Training**
  Training to help clients acquire skills in shopping, budgeting, use of community resources, grooming, housekeeping, etc.

- **Leisure Skills Training**
  Activities which assist clients to meet leisure and social needs in their community in accordance with their income and their interests. Teaching consumer in a normalized way (i.e., small group as opposed to an entire group outing) to participate in available leisure activities enjoyed by the community at large.

- **Education Activities**
  Activities aimed at providing the consumer with more information (i.e., current events, medication use and side effects, physical health and basic adult education).

- **Pre-Vocational Activities**
  Activities to assist the consumer to learn job acquisition skills (i.e., filling out job applications and interviewing for the job).

CHILDREN AND ADOLESCENT STANDARDS

- meets appropriate state licensure and local housing codes
- meets accreditation standards as required by 42 CFR 441.151
- age separated and developmental age appropriate services
- on-going staff training required
- the provision of regular and special education, by Tennessee licensed teachers, in compliance with Minimum Rules and Regulations of the Tennessee Department of Education.

SERVICE	Crisis Services - CHILDREN AND ADOLESCENTS

DEFINITION

Crisis Services *- C & A*

Crisis services are provided 24 hours per day 7 days per week for children/adolescents experiencing a mental health crisis, an urgent condition or a psychiatric emergency). An urgent condition is defined as an acute onset of a psychiatric condition which while not constituting an immediate substantial likelihood of harm to self or others will if left untreated deteriorate into a bona fide emergency. A psychiatric emergency is defined as an acute onset of a psychiatric condition that manifests itself by an immediate substantial likelihood of serious harm to self or others. These services will include 24-hour telephone lines and crisis intervention and referral. Regional Mental Health Institutes (RMHIs), Crisis Teams are capable of performing the functions of mandatory prescreening in accordance with Title 33, Chapter 6 of Tennessee Code Annotated, to ensure an effective impatient diversion system and maintain the individual in the least restrictive environment as appropriate. Private hospitals that have been approved by TDMHDD will also accept mandatory prescreening for the crisis team. Crisis services shall not be responsible for pre-authorizing involuntary hospitalizations.

Crisis Respite - C&A

Crisis Respite services are intended to provide immediate shelter and nurturance to those children and adolescents with emotional/behavioral problems who are in need of emergency respite. Crisis Respite services involve short term respite with overnight capacity, and are designed to provide shelter, while dealing with the child's behaviors during the time of crisis. Appropriate local approaches include facility based or home based service locations. For children and adolescents, parental or court authorization must accompany crisis respite.

Hospital Based Crisis Services

Crisis services, which utilize hospital emergency rooms or other acute psychiatric services based on the assessment of risk to the consumer and or the need for a medically supervised setting. Acute hospital-based services should be utilized for consumers who cannot be managed in a less restrictive setting because of a clear danger to self or others, or the presence of a medical condition which constitutes a medical emergency due to the unstable condition.

ACCESS/AVAILABILITY REQUIREMENTS

Crisis Services

Geographic Access to the Service Type	Within 30 miles of an individual's home
Maximum time for a Face to Face Contact for an Individual	Within 1 hour in an emergency situation and within 4 hours in an urgent situation
Maximum Time for Admission to the Service Type	Within 1 hour

Crisis Respite

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	Within 1 hour
Maximum Time for Admission to the Service Type	Within 2 hours

SERVICE COMPONENTS

- **Mobile Crisis Services**

Screening for hospitalization
A face-to-face assessment between the consumer experiencing the crisis and the crisis staff. The assessment determines whether the consumer **does meet** the criteria for admission to an inpatient psychiatric facility and that there is no less drastic alternative available.

Crisis Intervention
A face-to-face intervention between the crisis staff and the consumer and/or his/her family. The intervention is delivered where the child/adolescent is experiencing the crisis and is intended to stabilize the consumer to prevent the crisis from escalating.

Follow Up
A face-to-face session between the consumer and the crisis staff following the crisis intervention session. This could be a daily session for several days or once a week until the consumer can be seen in another service. Follow-up visits are to ensure the child/adolescent is stable and has begun receiving any necessary, appropriate services.

Telephone Intervention
A phone intervention between the crisis staff and the child/adolescent and/or his/her family. The intervention is intended to assess the need for mobile crisis response or referral to the appropriate resource if mobile response is not necessary in order to stabilize the individual in order to prevent the crisis from escalating.

Mandatory Pre-screening to RMHI
A face-to-face assessment between the client experiencing the crisis and the crisis staff. The assessment determines that the consumer **does meet** the criteria for admission to the RMHI and that there are no less drastic alternative available.

Telephone and Walk-in Crisis Services
Triage & Assessment
Triage activities are employed to determine the need of the consumer and the nature of the crisis. Assessments are designed to determine the risk of suicide or substantial likelihood of harm to others.

Intervention
An intervention between the crisis staff and the consumer and/or significant other(s). This may be done via telephone or, in the case of walk-in crisis, face-to-face. The intervention is intended to involve the appropriate resource necessary to stabilize the individual in order to prevent the crisis from escalating.

Referral
Actives of linking to consumer with the appropriate resources to provide care following stabilization.

Crisis Respite
Respite Plan
An individualized plan of action which is developed and agreed upon by the crisis response service, the client, the respite provider and/or essential others. The plan should identify services and assistance necessary to achieve the client's stated goals as well as an explanation of the availability, intensity, and duration of each required service.

Respite location
The community location where respite service is being provided.

Respite staff
Trained staff who remain with a client continually during a respite episode.

CHILDREN AND ADOLESCENT STANDARDS
Mobile Crisis Services

- must meet appropriate state licensure
- service offered 365 days a year
- 90% of face to face contacts occur off site
- of off-site at least 50% occur at the location where the consumer is experiencing the crisis
- one published toll-free phone number per CSA region
- 24 hour service (phone and in person)
- mental health staffed telephone line
- on-going staff training specific to children/adolescents for all crisis staff
- demonstrate ability to link with other mental health providers
- for RMHI admissions, able to complete mandatory prescreening activities through mobile crisis staff trained and designated by **TDMHDD**

- At least one designated trained child specialist on each crisis team.
- 24 hour availability of a child specialist

Crisis Respite

- must meet appropriate state licensure
- services offered 365 days a year
- on-going staff training
- referral must come from crisis response or an established, **TDMHDD** funded Planned Respite service and must include 24-hour crisis team back-up
- respite location includes room and board
- continuous respite staff provided to those in respite

SERVICE	Psychiatric Rehabilitation - CHILDREN AND ADOLESCENT

DEFINITION

Psychiatric Rehabilitation

Planned interventions conducted by mental health staff or others in response to a diagnosed mental health problem. These services are designed to ensure that an individual receives service in the least restrictive environment necessary to achieve successful results, improve quality of life and prevent mental health crisis. This definition assumes that in order to successfully address an individual's mental illness, other facets of the individual's being must also be considered.

Supported Employment.

This consists of a range of services to assist consumers to prepare for, obtain, and maintain employment. This service also includes a variety of support services to the consumer, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Consultation And Education

This service provides information, counseling, behavior management training and early intervention strategies pertaining to childhood mental illness. This service enables school teachers, counselors and others to be sensitive to early signs of mental illness and to intervene before a crisis develops.

Social.

These services are consumer family based and operated providing self-help skills. Services are often provided during the evening and weekend hours

ACCESS/AVAILABILITY REQUIREMENTS

Psychiatric Rehabilitation and Support Services - Children and Adolescents

Geographic Access to the Service Type	Within 30 miles of an individual's home
Response Time to Contact an Active Consumer in an Urgent Situation	NA
Maximum Time for Admission to the Service Type	Within 7 calendar days

SERVICE COMPONENTS

NOTE: SUPPORTED EMPLOYMENT SERVICES FOR CHILDREN AND ADOLESCENTS ARE DELIVERED THROUGH 24 RESIDENTIAL TREATMENT FACILITIES AND SPECIALIZED OUTPATIENT AND SYMPTOM MANAGEMENT SERVICES (DAY SERVICES).

ATTACHMENT C

STANDARDS FOR BHO QUALITY MONITORING PROGRAMS

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STANDARDS FOR INTERNAL QUALITY MONITORING PROGRAMS HEALTH ORGANIZATIONS CONTRACTING WITH THE TENNESSEE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

A Behavioral Health Organization (BHO) which contracts with the Tennessee Department of Mental Health and Developmental Disabilities (**TDMHDD**) to provide **TennCare** funded mental health services will have in place an internal quality monitoring program. The internal quality monitoring program (QMP) will consist of systematic activities undertaken by the BHO to monitor and evaluate the services delivered to its **Enrollees**. The evaluation will be based on predetermined, objective standards. The primary purpose is to assure and to continually improve the quality of behavioral health services provided.

The BHO will submit a written description of the QMP to **TDMHDD** for approval that shall address each standard specified in Attachment C. The QMP shall be submitted for approval prior to the delivery of services and annually thereafter.

The guidelines provided in this Attachment were developed using standards of **TDMHDD,** Tennessee Department of Health and the Bureau of Alcohol and Drug Abuse Services. The standards were patterned after **TennCare's** requirements for an internal quality monitoring program.

TDMHDD will monitor the BHO's compliance with the standards governing the organization's QMP. The BHO's quality monitoring program is to be evaluated using the following standards.

QMP STANDARDS

Standard I: The organization has a written description of its QMP. The written description includes:

A. Goals and Objectives: The written description contains comprehensive quality assurance/improvement goals and objectives which are developed initially, reviewed annually, and revised as needed. Included is a timetable for implementation and accomplishment of objectives. Objectives must be specific and measurable.

B. Scope:

1. The scope of the QMP is comprehensive, addressing both the quality of mental health and substance abuse services provided and the quality of non-clinical aspects of care such as competency of care, awareness, availability, accessibility, consumer family involvement, coordination, continuity of care, basic rights, confidentiality and cultural sensitivity.

2. The QMP methodology provides for a review of the entire range of mental health and substance abuse services provided by assuring that all demographic groups, clinically related/target population groups, non-target population groups, service settings (e.g., inpatient, clinic, off-site/home), and types of services (e.g., mental health case management, residential treatment, partial hospitalization, housing/ residential care, outpatient, and symptom management, specialized crisis services, and psychiatric rehabilitation and support services) are involved in the scope of the review.

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

D. Continuous Activity: The written description provides for continuous performance of quality assurance/improvement activities, including tracking of issues over time.

E. Provider Review: The QMP provides for:

1. Peer review by appropriate types of mental health and substance abuse care professionals of the processes followed in the provision of each different type of mental health and substance abuse service [e.g., reviewers of psychosocial services should include a provider(s) of psychosocial services]; and

2. Feedback to provider organizations, to mental health care and substance abuse professionals, and to **BHO** staff regarding performance and consumer outcomes.

3. Network provider participation in quality monitoring program activities.

F. Focus on Outcomes: The QMP methodology addresses the mental health and substance abuse outcomes identified by **TDMHDD** and any other outcomes identified by the **BHO**.

G. Systematic Process of Quality Assurance and Improvement: The QMP objectively and systematically monitors and evaluates the quality and appropriateness of services provided to its members and pursues opportunities for improvement on an ongoing basis.

1. The QMP has written descriptions of the processes for monitoring and evaluating the following which include the data to be collected and how data are to be analyzed and trended. For *f.* through *h.* below, the BHO will report its findings to **TDMHDD** on an annual basis.

   a. Utilization management based on criteria set forth by **TDMHDD**.
   b. Compliance with standards set by **TDMHDD** (including those set forth in this document, those referenced by this document, those referenced by the CONTRACT, and licensure standards);
   c. Measurement of performance as prescribed by **TDMHDD**;
   d. Use of clinical care standards/"best practice" guidelines which have been approved by **TDMHDD**;

e. Service denials by the **BHO**;
f. Inpatient psychiatric hospital admissions and readmissions;
g. Network provider satisfaction.
h. Satisfaction of consumers and families with the service provided through calendar year 2004. **TDMHDD** shall be responsible for these satisfaction surveys after 2004.

2. As part of the quality assurance and improvement process, cross functional teams should be established. The team's purpose would be to identify areas where improvements are needed, establish the cause of the problem, develop and implement an improved process, assess its impact and, if needed, adjust or modify the process. This approach follows the Plan-Do-Check-Act (PDCA) cycle and is presented in condensed form below.

   a. Identify and analyze the problem: The problem statement should clearly reveal the discrepancy between what is expected and what is actually happening. Some examples of sources that could be used to identify areas that need improvement are: deficiencies in complying with standards, data that indicate unmet outcomes, failure to consistently use "best practice" guidelines, consumer/family dissatisfaction as indicated by surveys, and **appeals**.

   b. Design and implement the new or modified process: After careful analysis of the problem, the team designs redesigns a process which is expected to improve the process. The change is implemented either system-wide or on a pilot basis.

   c. Measure and Assess: Data are systematically collected and analyzed to assess the impact of a new process. These data are compared to baseline data when available.

   d. Evaluate: If the data indicate that the new or modified process has improved the process, the process is kept in place. If the new or modified process is determined to be ineffective, the team reconvenes to design and implement another process.

   e. Inform Senior Management: Senior management should be kept abreast of the team's progress. The results should then be carefully documented and made a part of the organization's record.

3. The scope and content of the QMP reflect the **BHO's** delivery system and the relevant clinical issues that affect members of its covered population.

   A. The **BHO** assesses and evaluates at least three clinical issues relevant to its membership on an annual basis. The study topic and methodology are submitted to **TDMHDD** for prior approval.

      1. At least two clinical issues are selected from:

         a. high-volume diagnoses or services; or

b. high-risk diagnoses, services, or special populations, such as: persons with serious and persistent mental illnesses, persons with dual diagnoses, children in state custody.

      2. At least one clinical issues is also selected from:

         a. inpatient facility services;
         b. partial facility services; or
         c. ambulatory services

   B. The **BHO** identifies at least two clinical issues for **TDMHDD** approval in collaboration with the QI Committee.

4. The **BHO** evaluates the overall effectiveness of its QMP and demonstrates improvements in quality of clinical care and service provided to its members.

   A. The **BHO** must complete quarterly QMP Progress Reports which describe actions taken, progress made toward meeting quality assurance/improvement objectives, and improvements made.

B. The **BHO** must conduct an annual written evaluation that includes:

1. a description of Quality Improvement (QI) activities and studies that have been completed or are ongoing;

2. trended quality-of-clinical care and service performance measures and desired outcomes and progress toward achieving desired outcomes, including performance measures specified in Attachment E;

3. an analysis of demonstrated improvements in the quality of clinical care and service;

4. current areas of deficiencies and recommendations for corrective action

5. an evaluation of the overall effectiveness of the QMP.

6. utilization data; and

7. an assessment of provider accessibility and availability.

8. The **BHO** documents how QI activities have improved clinical care, preventive behavioral health services, and member services.

9. The **BHO** makes available to its members, practitioners and Advisory Board information about its QI program, and its quarterly QMP reports and annual evaluation.

10. Upon completion of the quarterly QMP reports and the annual evaluation, the **BHO** submits their full report to **TDMHDD**.

11. The **BHO** makes available the results of the quarterly QMP reports and annual written evaluation to their Advisory Board, providers, and relevant stakeholders.

C. In addition, the **BHO** submits to **TDMHDD** revised quality management and improvement plan(s) for the next contract year.

5. The findings, conclusions, recommendations, actions taken and results of the actions taken as a result of the quality assurance/improvement activities are documented and reported to appropriate individuals within the **BHO** and through the established quality assurance/ improvement channels.

a. Quality assurance/improvement information is used in recredentialing, reconstructing, and/or annual performance evaluations.

b. Quality assurance/improvement activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of **Enrollee** appeals.

c. There is a linkage between quality assurance/improvement and other management functions of the **BHO** such as network changes, service redesigns, benefits changes, and medical management system

6. The **BHO** develops an annual QI work plan or schedule of activities that includes:

a) the objectives, scope, and planned projects or activities for the year;

b) planned monitoring of previously identified issues, including issues to be tracked over time; and

c) a planned evaluation of the QI program.

H. Evaluation of the Continuity and Effectiveness of the QMP:

1. The **BHO** must conduct an annual evaluation of the scope and content of the QMP to ensure that it covers all types of services provided in all settings to all categories of enrolled individuals.

2. On an annual basis, the **BHO** must collect, analyze, and report data to **TDMHDD** regarding the number of individuals who have had more than one mental health case manager during the previous year with a breakdown of how many consumers have had two mental health case managers, three mental health case managers, and so forth. Also included with these data, should be a compilation of the reasons for changes in mental health case managers and how many individuals changed mental health case managers for each of the identified reasons.

3. At the close of each contract year, the **BHO** submits to **TDMHDD** a written report on the QMP which addresses: quality improvement studies and other activities completed; trending of data related to desired outcomes; quality improvements made during the previous year; current areas of deficiencies and recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP. In addition, the **BHO** submits to **TDMHDD** it revised QMP plan for the next contract year.

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

A. Oversight of the QMP: There is documentation that the Governing Body has approved the overall QMP plan and all subsequent revisions.

B. Oversight Entity: The Governing Body has formally designated an accountable entity or entities within the **BHO** to provide oversight of the organization's quality assurance/ improvement efforts.

C. Constituting an Advisory Board. The Governing Body has the responsibility for constituting an Advisory Board as required by **TDMHDD**. The primary purposes of the advisory board are to assist the **BHO** with its internal quality monitoring and to advise the Governing Body regarding issues around the provision of services.

D. QMP Progress Reports: The Governing Body and the Advisory Board receive, at least quarterly, written reports from the QMP which describe actions taken, progress made toward meeting quality assurance/improvement objectives, and improvements made.

E. Annual QMP Review: The Governing Body and the Advisory Board formally review on a periodic basis (but no less frequently than annually) a written report on the QMP which includes, at a minimum, studies undertaken, results, and subsequent actions; aggregate data on utilization; the quality of services provided; progress toward achieving desired outcomes; and an assessment of provider accessibility.

STANDARD III: THE QMP IDENTIFIES A COMMITTEE WHICH IS RESPONSIBLE FOR PERFORMING QUALITY ASSURANCE/ IMPROVEMENT FUNCTIONS WITHIN THE BHO AND IS ACTIVELY INVOLVED IN THE REVIEW, ANALYSIS AND ENHANCEMENT OF THE QUALITY ASSURANCE AND IMPROVEMENT PROGRAM. THE COMMITTEE HAS:

A. Regular Meetings: The committee meets on a regular basis with specified frequency to oversee QMP activities. The frequency must be sufficient to demonstrate that the committee is following up on all findings and required actions. The committee must meet at least quarterly.

B. Established Parameters for Operating: The role, structure, and functions of the committee itself are specified in writing. At a minimum, the role of the QMP Committee must include recommending policy decisions, reviewing and evaluating quality assurance/improvement activities, instituting needed actions, and ensuring appropriate follow-up.

C. Documentation: There is written documentation of the committee's activities, findings, recommendations, and actions.

D. Accountability: The QMP committee is accountable to the Governing Body and reports to it (or its designee) and the Advisory Board on at least a quarterly basis. Included in the report are the committee's activities, findings, recommendations, and actions.

E. Membership: In addition to staff identified by the **BHO**, members include provider representatives, a representative from the **TDMHDD's** Office of the Medical Director, a representative from the **TDMHDD's** Office of Managed Care, and a representative from the Department of Health's Bureau of Alcohol and Drug Abuse Services.

Standard IV: There is a designated **BHO** senior executive who is responsible for implementation and oversight of the QMP. The **BHO's** Medical Director should also have substantial involvement in the organization's quality assurance/improvement functions.

Standard V: The QMP has sufficient material resources and staff (who have the necessary education, experience, and/or training) to carry out its functions.

Standard VI: There is provider participation in the QMP.

A. the **BHO** has access to the treatment records of its **Enrollees** as permitted by State and federal confidentiality laws; and

B. the **BHO** allows open provider-patient communication regarding appropriate treatment alternatives without penalizing providers discussing medically necessary or appropriate care for the **Enrollee**.

Standard VII: The **BHO** remains accountable for all QMP functions, even if certain functions are delegated to other entities. If the **BHO** delegates any quality assurance/improvement activities to providers:

A. There is a written description of the delegated activities, the delegate's accountability for these activities, the frequency of reporting to the **BHO**, the **BHO's** process for evaluating the delegate's performance, and the remedies, including revoking the delegation agreement, if the delegate does not fulfill its obligations.

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

C. There is documented evidence of continuous and ongoing evaluation of delegated activities, including annual approval of quality assurance/improvement plans, evaluation of regular specified reports, documentation that verifies the **BHO** evaluates the delegates capacity to perform the delegated activities prior to delegation, and an annual evaluation of whether the delegate's activities are being conducted in accordance with the **BHO's** expectations and standards.

Standard VIII: The **BHO** credentials and recredentials all licensed and/or certified professional staff.

A. The **BHO** must have written "policies and procedures" in place which direct the credentialing and recredentialing of behavioral healthcare professionals with whom it contracts or employs who render services or authorize services to **Enrollees** and who fall within its scope of authority and action. Credentialing and recredentialing policies and procedures must be submitted to the **TDMHDD** Office of Managed Care for approval. Included in these are:

1. The requirement that the Governing Body or the group to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.

2. The designation of a credentialing or other peer review body which makes recommendations regarding credentialing decisions.

3. The criteria and primary source to be used to verify criteria.

4. The process used to make decisions.

5. The extent of any delegated credentialing or recredentialing arrangements.

6. The right of practitioners to review the information submitted in support of their credentialing applications.

7. The process for notification to a practitioner of any information obtained during the **BHOs** credentialing process that varies substantially from the information provided to the **BHO** by the practitioner

8. The practitioner's right to correct erroneous information.

9. The medical director or other designated health care practitioner's direct responsibility and participation in the credentialing program.

10. The process used to ensure confidentiality of all information obtained in then credentialing process, except as otherwise provided by law.

11. Alterations of the conditions of the practitioner's participation with the **BHO** based on issues of quality of care and service. These policies and procedures define the range of actions that the **BHO** may take to improve performance prior to termination.

a. The **BHO** has procedures for, and evidence of implementation of, as appropriate, reporting serious quality deficiencies that could result in a practitioner's suspension or termination to appropriate authorities.

b. The **BHO** has an appeal process for instances in which the **BHO** chooses to alter the condition of the practitioner's participation based on issues of quality of care and/or service or imposes sanctions. The **BHO** informs practitioners of the appeal process.

12. The formal selection and retention criteria that assure that providers who serve high-risk populations or who specialize in the treatment of costly conditions are not discriminated against by the **BHO**.

13. Identification of those practitioners who fall under its scope of authority and actions. At a minimum this includes: physicians and other licensed and/or certified practitioners who provide behavioral health treatment (including, but not limited to, clinical and counseling psychologists, psychological examiners, registered nurses, practical nurses, social workers, alcohol and other drug abuse counselors, professional counselors, marital and family counselors).

14. The requirements that identified practitioners are credentialed prior to providing services to **TennCare Partners Program Enrollees** and that these practitioners are recredentialed at least every three years thereafter.

15. The requirement that an identified practitioner meet the following criteria in order to be credentialed or recredentialed:

    a. is appropriately licensed and/or certified and in good standing (with no sanctions imposed against them by Medicaid, Medicare, **TennCare**, **TDMHDD**, the courts, etc.);

    b. is appropriately trained and/or has the necessary experience to occupy the identified position within the organization;

    c. has demonstrated competencies needed for adequate job performance (for recredentialling, an annual performance evaluation by the supervisor and, possibly, peer reviews will be used as well as other information such as any complaints made about the practitioner, malpractice suits filed, practitioner to practitioner or practitioner performance to benchmark comparison data, etc.); and

d. is free from health problems which could affect his/her practice;

f. in addition, in order to credential or recredential a practitioner, the organization must have adequate facilities, equipment, number and types of support personnel and any other necessary support services to support the professional in the identified position.

16. The **BHO** is required to offer an appeals process to individual clinicians who are denied credentials or for whom sanctions are imposed. The BHO is required to provide affected providers written notice of the reason for its decision.

17. When individuals providing mental health treatment services are not required to be licensed or certified, it is the responsibility of the **BHO** to assure that, based on the following applicable Tennessee Department of Mental Health and Developmental Disabilities and Department of Health licensure rules and/or programs standards, that individuals are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

    a. Mental health and substance abuse **providers**, excluding licensed and/or certified **practitioners**, who provide the following behavioral health services in the programs listed below are to be reviewed according to the appropriate state program licensure: a. Programs licensed by the Department of Mental Health and Developmental Disabilities, the Department of Health, and Department of Children's Services, as appropriate, which include: Mental Health Day Program (including day treatment and partial hospitalization), Outpatient Mental Health Services (including rehabilitation/ symptom management, crisis services, and regional intervention program), Mental Health Hospital Facilities, Mental Health Residential Treatment Facilities, Mental Health Crisis Stabilization Units, Psychosocial Rehabilitation, Diagnostic and Evaluation Centers, Wilderness Programs (day treatment component), Mental Health Case Management, Substance Abuse Residential, Substance Abuse Outpatient, and all general surgical hospitals operating a unit or program to provide mental health and/or substance abuse services.

    b. Mental health **providers**, excluding licensed and or certified **practitioners**, who provide the following mental health services are to be reviewed according to **TDMHDD** Program Standards: Crisis Respite, Housing Developer, Supported Employment, Therapeutic Foster Care, Planned Respite, Emergency Respite, and Infant Stimulation.

c. Substance abuse providers who provide the following services are to be reviewed according to the appropriate state program licensure: Medical Detoxification, Social Detoxification, Residential Rehabilitation, Adolescent and Residential Rehabilitation, Partial Hospitalization, Halfway House, Youth Day Treatment, Women's Intensive Outpatient, Outpatient, Pregnant Substance Abusers Residential Treatment, Pregnant Substance Abusers Intensive Outpatient, AIDS Outreach, Family Intervention and Referral Services, Methadone Maintenance, Life Development Center (Wilderness Program), and Dual Diagnosis Programs.

B. Practitioners are credentialed initially (prior to delivering services) and are recredentialled at least every three years.

C. The **BHO** verifies at least the following information from primary sources for the initial credentialing process:

1. A current valid license to practice as an independent behavioral healthcare practitioner at the highest level certified or approved by the state;
2. Good standing of clinical privileges at the institution designated by the behavioral healthcare practitioner as the primary admitting facility, as applicable.
3. A valid Drug Enforcement Agency (DEA) certificate (or copy);
4. Graduation from an accredited professional school or highest training program applicable to the academic degree, discipline and licensure of the behavioral healthcare practitioner;
5. Board certification, if designated by the practitioner on the application,
6. Current, adequate malpractice insurance; and
7. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

D. The recredentialing process includes verification of at least the following information:

1. A current valid license to practice as an independent behavioral healthcare practitioner at the highest level certified or approved by the state;
2. Good standing of clinical privileges at the institution designated by the behavioral healthcare practitioner as the primary admitting facility, as applicable;
3. A valid DEA certificate (or copy);
4. Board certification, if designated by the practitioner on the application (only if board certification has expired or is new since last credentialing);

5. Current, adequate malpractice insurance; and
6. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

E. The **BHO's** records indicate that prior to making a credentialing or recredentialing decision, the **BHO** receives the following information:

1. the National Practitioner Data Bank;
2. sanctions or limitations on licensure from the appropriate state agency, State Board of Medical Examiners, State Board of Licensure or Certification, or the Federation of State Medical Boards; and
3. previous sanction activity by regional Medicare and Medicaid offices and any exclusions from participation in federal programs as contained in the Excluded Provider Listing System (EPLS) maintained by the General Accounting Office (GAO) and accessible at www.epls.gov.

F. The applicant completes a written application at credentialing and recredentialing that includes a statement regarding:

1. the reasons for any inability to perform the essential functions of the position, with or without accommodation;
2. lack of present illegal drug use;
3. history of loss of license and felony convictions;
4. history of loss or limitations of privileges or disciplinary activity; and
5. an attestation as to the correctness and completeness of the application.

G. The recredentialing process also includes a review of data regarding member complaints, results of quality reviews, utilization management, consumer satisfaction surveys, and reverification, where required, of current licensure.

H. At the time of recredentialing, the **BHO** conducts site visits to the offices of its high volume practitioners.

1. The **BHO** uses objective criteria to identify and evaluate high volume practitioners.
2. The **BHO** conducts a structured review of the site to ensure conformity with the BHO's standards.
3. The **BHO** documents an evaluation of treatment record keeping practices and standards of care documented at each site to ensure conformity with the **BHO's** standards.

I. If the **BHO** delegates credentialing (and recredentialing) activities to provider organizations, there is a written description of the delegated

activities and the delegate's accountability for these activities. There is also evidence of that the delegate has accomplished the credentialing activities. The **BHO** must monitor the effectiveness of the delegate's credentialing and recredentialing process.

J. The **BHO** retains the right to approve providers and sites and to terminate or suspend individual providers. The **BHO** has policies and procedures for the suspension, reduction, or termination of practitioner privileges.

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

L. There is a provider appellate process for instances where the **BHO** chooses to reduce, suspend, or terminate a practitioner's privileges with the organization.

M. In accordance with **TDMHDD** requirements, the **BHO** has a mechanism for notifying **TDMHDD** at the time of network provider additions and deletions.

N. On an annual basis the **BHO** reassesses its provider network to assure that all providers are licensed and certified as required by state law and to assure that the composition of the provider network is such that the **BHO** is in compliance with its access and availability standards relating to geographic coverage of service sites, response time to contact an active service client in an urgent situation, and maximum time for an admission to a service. (NOTE: The **BHO's** standards must meet or exceed those set forth by **TDMHDD**.) The **BHO** will report reassessment findings to **TDMHDD** at the mid-point of each contract year and at the end of each contract year.

O. The **BHO** shall provide input to **TDMHDD** on an as-needed basis on the rater validity of individuals who administer Target Population Group (TPG) and Clinically Related Group (CRG) assessments.

P. The **BHO** must have written policies and procedures in place which direct the credentialing, and recredentialing of organizational providers with whom it contracts or employs who treat **Enrollees** and who fall within its scope of authority and action. Behavioral health care practitioners who are under contract with a specific facility and have no independent relationship with the **BHO** do not have to be individually credentialed or recredentialed by the **BHO**. Included in these are:

1. Organizational providers include, but are not limited to, entities providing mental health and/or substance abuse services in an inpatient or residential setting
2. The organization confirms the organization and their providers are in good standing with state and federal regulatory bodies and are compliant with relevant federal and state laws.
3. The organization confirms they have adequate facilities, equipment, number and type of support personnel and any other necessary support services to support the professionals in their organization.
4. The organization confirms the provider has been reviewed and approved by an accrediting body <u>or</u>
5. If the provider has not been approved by an accrediting body, the organization develops and implements standards of participation that include an on-site quality assessment.
6. At least every three (3) years, the organization confirms the organizational provider and their providers remain in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body if applicable.
7. Documentation of the formal selection and retention criteria assure organizational providers who serve high-risk populations or who specialize in the treatment of costly conditions are not discriminated against.

Q. All credentialing and recredentialing decisions are made within thirty (30) calendar days of receipt of a completed including all necessary documentation and attachments, credentialing application and a signed Provider Agreement. The organization must track the amount of time from receipt of a completed application to date of provider notification of the credentialing decision.

Standard IX: The **BHO** must ensure the provision of appropriate, specialized training of practitioners.

A. In order to improve upon the skills of practitioners delivering community mental health and substance abuse services, the **BHO** provides or requires provider organizations to provide appropriate specialized training relative only to the areas directly related to their area of responsibility which is designed for each service setting.

1. There is a written plan which directs staff training and requires that training be made available, as appropriate, in the following areas:

   a. crisis intervention and resolution, including safety procedures;

b. medications, medication management, and medication facilitation;

c. entitlements and procurement of entitlements;

d. families as a system, including strengths, stressors, dynamics, intervention techniques, and family/professional collaboration;

e. assessing and using natural support systems;

f. legal issues and mandates regarding mental illness and substance abuse (e.g., forensics, mandatory outpatient treatment, mental health codes, custody, educational rights);

g. community support systems, community-based services, community resources and linkages with these resources;

h. cultural diversity;

i. etiology, treatment, and diagnostic categories of mental illness and substance abuse;

j. etiology and treatment of alcohol and drug abuse, physical and sexual abuse, suicidal ideation, developmental disabilities, and mental retardation;

k. mental health case management principles, practices, and philosophy;

l. mental health case management assessment and mental health case management intervention techniques;

m. service planning and monitoring;

n. CRG assessment and/or TPG assessment;

o. screening for inpatient hospitalization;

p. general health care practices and medical conditions which may be associated with mental illness and substance abuse;

q. age appropriate developmental principles for the consumer populations;

r. CPR and First Aid;

s. consumer rights and consumer advocacy;

t. stress management skills for mental health case managers and other mental health service providers;

u. data management and record keeping;

v. organization policies and procedures;

w. rules, regulations, standards, policies and procedures governing the provision of **TennCare**-funded mental health services; and

x. diagnosis and treatment of individuals with dual diagnoses.

y. **TDMHDD** Best Practice Guidelines

B. Documentation of training and results of pre-tests and post-tests are maintained by the organizations with whom the individuals trained are employed;

C. Application of knowledge gained through the training is tied to the assessment of staff competency.

Standard X: The **BHO** demonstrates a commitment to treating consumers in a manner that acknowledges their rights and responsibilities.

A. The **BHO** has a written policy that recognizes the following rights of consumers:

1. to be treated with respect, dignity, and compassion regardless of state of mind or condition;

2. to be provided treatment without regard to age, race, sex, religion, ethnic background, handicap, or ability to pay;

3. to privacy and confidentiality related to all aspects of care including, but not limited to, the unwarranted disclosure of medical records, whole or in part;

4. to be protected from neglect; to be protected from physical, emotional, or verbal abuse, and from all manner of exploitation;

5. to be informed of any proposed and/or alternative treatment methods; to be informed of the risks, benefits, and consequences of treatment or non-treatment; to be informed about the risks, benefits, and side effects of his/her medication or proposed medication;

6. to participate in the development of his/her individual service plan; to participate in all decision-making regarding his/her mental health and substance abuse care including right to refuse treatment; to be involved in his/her discharge or aftercare planning;

7. to be provided quality treatment by competent staff members; to be afforded continuity of care from one service provider to another;

8. to refuse to participate partially or fully in treatment or therapeutic activities (unless participation is so ordered by the court);

9. to be provided treatment in the least restrictive setting feasible;

10. to refuse the use of any audio and/or visual techniques to record or observe the individual's activities during treatment unless written and signed consent is given;

11. to participate in cultural, educational, religious, community service, vocational, and/ or recreational activities;

12. to be provided with information about the **BHO**, its services, its providers, to be provided with the basic rights and responsibilities of **BHO** members in a way which is easily understood;

13. to be able to choose providers within the limits of the network; to be able to refuse care from specific providers;

14. to voice **grievances** about the **BHO** or services provided without fear of restraint, interference, coercion, discrimination, or reprisal;

15. to formulate advance directives; and

16. to have access to his/her records, receive a copy of his/her medical records, and to request that they be amended or corrected;.

17. to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

18. to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the **Contractor** and its provider or the State treats the **Enrollee**.

19. to make recommendations regarding the **Contractor's** member rights, responsibilities and policies.

B. The **BHO** has a written policy that addresses consumers' responsibility for cooperating with those providing mental health and substance abuse services. The written policy addresses members' responsibility for:

1. providing, to the extent possible, information needed by professional staff providing services to the consumer; and

2. following instructions and guidelines given by those providing mental health and substance abuse services.

3. to participate to the degree possible, in understanding their behavioral health problems and developing mutually agreed upon treatment goals.

C. Upon enrollment with the **BHO**, consumers are provided with a written statement that includes information on the following:

1. rights and responsibilities of consumers;

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

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

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

3. provisions for after-hours and emergency coverage;

4. the **BHO's** policy on referrals/coordination with physical health care providers;

5. charges to **Enrollees**, if applicable, including:

   a. policy on payment of charges; and

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

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

7. procedures for changing providers;

8. procedures for disenrollment; and

9. procedures for voicing complaints and/or **appeal**s and for recommending changes in policies and services.

D. The BHO has a system, linked to the QMP, for resolving consumers' complaints and for formal **appeals.** This system includes:

1. written procedures for registering and responding to complaints and **appeals** in a timely manner (the BHO should establish and monitor standards for timeliness);

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

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

4. quarterly aggregation and analysis of complaint and **appeal** data and use of the data for quality improvement; submission of findings to **TDMHDD** on quarterly basis;

5. an appeals process for **appeals**; and

6. a mechanism for reporting all unresolved complaints and concerns to **TDMHDD** on a monthly basis.

E. Opportunity is provided for consumers and their family members to offer suggestions for changes in **BHO** policies and procedures.

F. The **BHO** takes steps to promote accessibility of services offered to enrolled consumers. These steps include:

1. identification of the points of access to the comprehensive array of mental health services are identified for consumers; and

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

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

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

   c. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for the delivery of mental health services.

G. The **BHO** will provide written information to **Enrollees** which is:

1. Written in prose that is easily readable and easily understood;

2. Available, as needed, in the languages of the major population groups served. A "major" population group is one that represents at least 10% of the **Enrollees**, or 3,000 **Enrollees**, whichever is less. All vital **BHO** documents are also available to Limited English Proficiency groups identified by **TennCare** that constitute five percent (5%) of **TennCare** Population, or 1,000 **Enrollees**, whichever is less;

3. Explained to individuals who are unable to read or understand easily or explained to a consumer's parent, guardian, or other appropriate person responsible for protecting the rights of the consumer.

H. The **BHO** acts to ensure that the confidentiality of specified consumer information and records is protected.

1. The **BHO** has established in writing and enforces policies and procedures on confidentiality, including confidentiality of consumer records.

2. The **BHO** ensures that all providers have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the provider's organization.

3. The **BHO** will hold confidential all information obtained by its personnel about **Enrollees** related to their examination, care, and treatment and will not divulge it without the **Enrollee's** authorization unless:

   a. it is required by law,

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

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

4. The written consent of the consumer or his/her legal representative is considered valid only if the following conditions are met:

a. The consumer or representative is informed, in a manner understood by the consumer or his/her representative, of the specific type of information that has been requested;

b. The consumer or representative is informed that the provision of services is not contingent on his/her decision concerning the release of information to other internal or external services; and

c. The consent of the consumer or representative is acquired in accordance with applicable laws and regulations.

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

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

I. The **BHO** has written policies regarding the appropriate treatment of minors.

J. The organization conducts periodic surveys of consumer and family member satisfaction with its services.

1. The surveys include content on perceived problems with the quality, availability, and accessibility of care. Consumers and family members are also surveyed regarding their perceptions of how they have been treated by service providers.

2. The surveys assess at least a sample of:

a. each of the clinically related groups, target populations, and non-target populations;

b. family members of each of individuals in each of the clinically related group, target population, and non-target populations;

c. consumers who have filed complaints about services or providers or who have requested a change of provider; and

d. members of mental health and substance abuse consumer advocacy groups.

3. As a result of the surveys, the **BHO**:

a. identifies and investigates sources of dissatisfaction;

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

c. informs providers of assessment results.

4. Annually, survey findings and information regarding follow-up actions are made available to DMHMR.

5. The **BHO** reevaluates the effects of the activities 1.-4. above.

Standard XI: The **BHO** has established written standards for access (i.e., to routine, urgent, emergency care) which meet or exceed standards outlined in Attachment B and F and any other standards set by the **BHO** and complies with these standards.

A. Standards for access meet the following requirements:

1. Standards for timeliness of access to member services (e.g., customer service line) meet or exceed such standards as specified in Attachment B. The **BHO** continuously monitors its compliance with these standards and takes corrective action as necessary.

2. Standards for timeliness of access to care meet or exceed such standards as specified in Attachment B and E. The **BHO** continuously monitors its compliance with these standards and takes corrective action as necessary.

3. Standards for geographic access to care meet or exceed such standards as specified in Attachment B and E. The **BHO** continuously monitors its compliance with these standards and takes corrective action as necessary.

4. Quarterly reports documenting the **BHO** monitoring and corrective actions activities must be submitted to **TDMHDD** upon completion.

B. The **BHO** has written capacity standards to ensure the availability of behavioral healthcare providers and providers (including programs and services) based on the assessed needs and preferences of its member population. To this end, the **BHO**:

1. Defines the number and types of behavioral healthcare providers and providers within its delivery system, taking into consideration assessed linguistic and cultural needs and preferences. Specific goals must be developed for at least each category listed:

a. Psychiatrists;
b. Registered Nurses;
c. Mental health case managers;
d. Supported employment coaches;
e. Psychologists;
f. Licensed alcohol and drug counselors; and

g. Licensed social workers, family and marital counselors

2. Provides documentation for establishing the goals to **TDMHDD** and the Advisory Board.

3. Provides comparison information from similar public behavioral health care programs to **TDMHDD** and the Advisory Board.

4. Collects and analyzes data to measure its performance against the standards.

a. identifies opportunities for improvement and decides which opportunities to pursue;
b. implements interventions to improve its performance;
c. measures the effectiveness of the interventions; and
d. documents and reports conclusions, recommendations, actions taken, and results to its administrators, providers, Advisory Board and members and **TDMHDD**.

C. The **BHO** ensures all services, both clinical and non-clinical, are accessible to all **Enrollees**, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, homelessness and individuals with physical and mental disabilities.

D. The **BHO** ensures the hours of operation of its providers are convenient to and do not discriminate against **Enrollees**.

E. The **BHO** instructs **Enrollees** that they have the right to access emergency health care without prior authorization, consistent with the **Enrollee**'s determination of the need for such services as a prudent layperson.

F. The **BHO** maintains and monitors a network of appropriate providers, supported by written arrangements, sufficient to provide adequate access to covered services and to meet the needs of the population served, including special populations.

G. The **BHO** has written standards to ensure its referral and triage functions are appropriately implemented, monitored, and professionally managed. To this end, the **BHO**:

1. makes referral and triage decisions according to protocols that define the level of urgency and appropriate setting of care;

2. adopts referral and triage protocols that are based on sound clinical evidence and currently accepted practices within the industry (and approved by **TDMHDD** Office of the Medical Director):

*a. the **BHO** uses protocols to specifically address mental health and substance abuse referral and triage.*

*b. The **BH**O provides up-to-date protocols and guidelines to its referral and triage staff.*

3. ensures referral and triage decisions not requiring clinical judgment are determined by staff who have relevant knowledge, skills, and professional experience;

4. ensures referral and triage decisions requiring clinical judgement are determined by a licensed behavioral healthcare provider (an RN or master's level practitioner) with appropriate qualified experience;

5. ensures referral and triage decisions for persons with dual diagnosis are determined by licensed behavioral health practitioners with experience treating persons with dual diagnosis.

6. ensures referral and triage staff are supervised by a licensed behavioral healthcare provider with a minimum of a master's degree and five years of post-master's clinical experience; and

7. ensures referral and triage decisions are reviewed and supervised by licensed behavioral healthcare providers who are experienced in clinical risk management.

   a. Inpatient referral and triage decisions are overseen by a board-certified psychiatrist with appropriate qualified experience.

   b Outpatient referral and triage decisions are overseen by a licensed, doctoral level clinical psychologist with appropriate qualified experience.

Standard XII: The **BHO** maintains standards for facilities in which consumers are served.

A. This includes compliance with existing state and local laws regarding safety and accessibility (including the requirement that hospitals providing inpatient services are JCAHO accredited);

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

Standard XIII: The **BHO** is in compliance with all standards for consumer records.

A. The **BHO** will include provisions in provider contracts for appropriate access to records of its Enrollees for purposes of quality reviews conducted by the **BHO**, by **TDMHDD**, by **TennCare**, or agents thereof.

B. Records are available to practitioners at each encounter.

C. Records may be on paper or electronic media. The **BHO** takes steps to promote maintenance of consumer records in a legible, current, detailed, organized, and comprehensive manner which permits effective service provision and quality reviews as follows:

1. The **BHO** sets standards for consumer records. These standards will, at a minimum, include requirements that:

a. Information related to the provision of appropriate services to a consumer is to be included in his/her record. This information includes:

1. For individuals in the target populations, a description of the consumer's physical and mental health status at the time of enrollment. This comprehensive assessment covers:

* a psychiatric assessment which includes: description of the presenting problem, psychiatric history and history of consumer's response to crisis situations, psychiatric symptoms, five axis diagnosis of mental illness using the most current edition of DSM, mental status exam, and history of alcohol and drug abuse;

* a medical assessment which includes: screening for medical problems, medical history, and present medications, and medication history;

* Target Population Group (TPG) and Clinically Related Group (CRG) assessments are performed by persons designated by the **BHO** who have been trained by **TDMHDD** and who have passed the **TDMHDD** competency tests; these persons must use

the CRG and TPG assessment form(s) prescribed by and in accordance with the policies of **TDMHDD**; these assessments are subject to the review and approval of **TDMHDD**. [Note: CRG and TPG assessments must have been performed for all **Enrollees** within six months prior to the Partners Program implementation date.]

* a community functioning assessment or status to assess the consumer's functioning in the following domains: living arrangements, daily activities (vocational/educational), social support, financial, leisure/ recreational, physical health and emotional/behavioral health;

* an assessment of: consumer strengths, current life status, personal goals, and needs; and

* a reassessment of these areas which is performed annually or sooner if warranted by a significant change in psychiatric symptoms, medical conditions, or community functioning level.

2. The services to be provided/the individualized treatment plan which is based on the psychiatric, medical, and community functioning assessments listed above and which includes (this is applicable for members of the target population and for all others who are in receipt of mental health services for thirty days or longer):

   * documentation of medical necessity;

   * provision of either mental health case management or continuous treatment team services;

   * goals;

   * objectives and target dates;

   * action steps and responsible parties for each objective;

   * the specialized mental health and substance abuse services to be delivered (provider, location, frequency of contact, planned start date, and period of authorized services);

   * progress notes related to goals and objectives;

   * plan for prevention and/or resolution of crisis; and

   * documentation that the service plan is reviewed and revised if needed every three months by individuals responsible for its development.

3. Documentation that the rights of the consumer have been explained and are protected.

4. Documentation that the consumer and, as appropriate, his/her family members participated in the development and subsequent review of the treatment/service plan.

5. The following identifying data recorded on a standardized form:

   a. Full legal name;

   b. Home address;

   c. Home telephone number;

   d. Date of birth;

   e. Sex;

   f. Race or ethnic origin;

   g. Conservator or guardian;

   h. Education;

   i. Marital status;

   j. Type and place of employment;

   k. Date of initial contact or enrollment with **BHO**;

   l. Legal status, including relevant legal documents;

   m. Other identifying data as indicated;

   n. Date the information was gathered; and

   o. Signature of staff member gathering the information.

6. Occurrence reports and information on any unusual occurrences such as the following: (NOTE: On a monthly basis, the **BHO** must submit to **TDMHDD** all occurrence reports and their dispositions.)

   a. Treatment complications (including medication errors and adverse medication reactions);

   b. Accidents or injuries to the consumer;

c. Morbidity;

d. Death of the consumer;

e. Allegations of physical abuse, sexual abuse, and/or verbal abuse;

f. Use of physical, mechanical, and/or chemical restraints; and

g. Incidents of absence without leave.

7. Documentation, as necessary, of consumer/legal representative/family member consent for admission, treatment, evaluation, continuing care, release of records for information, or research.

8. Documentation of physical and mental diagnoses that have been made using a recognized diagnostic system.

9. Reports of laboratory, radiological, or other diagnostic procedures and reports of medical/surgical services when performed;

10. Hospital discharge summaries for all hospital admissions which occur while the consumer is enrolled with the **BHO** and for all previous admissions related to the consumer's mental illness or substance abuse.

11. Correspondence concerning the consumer's treatment and signed and dated notations of telephone calls concerning the consumer's treatment;

12. Documentation when information about the consumer is released to an individual or organization;

13. A copy of the individual's advance directive or notation that the consumer has not executed one; and

14. A discharge summary or summation summary (if the consumer dies) within fifteen days following disenrollment or death.

D. All entries in records are signed by the author and dated.

E. Records are kept for a minimum of five years after disenrollment or death of an individual.

F. There is a record review process to assess the content of the consumer records for legibility, organization, completion, and conformance to its standards listed above.

Standard XIV: The **BHO** implements a structured utilization review process.

A. The **BHO** has a written utilization management program description which includes, at a minimum, plans for compliance with utilization management criteria set by **TDMHDD**, procedures to evaluate medical necessity (including evaluation criteria and sources of information), and the process for reviewing and approving the provision of medical services.

1. The BHO ensures authorization decisions are based on all relevant medical information available about the individual **Enrollee** and in accordance with standards of care approved by **TDMHDD**. The BHO does not impose utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each **Enrollee** and his/her medical history. The **BHO's** utilization management activities are not structured so as to provide incentives to deny, limit, or discontinue medically necessary services to any **Enrollee**.

B. For preauthorization and concurrent review programs:

1. Preauthorization and concurrent review decisions are supervised by qualified mental health or substance abuse professionals.

2. Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating mental health or substance abuse professional as appropriate.

3. The reasons for decisions are clearly documented and available to the consumer.

4. There are well-publicized and readily available appeals mechanisms for both providers and consumers.

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

6. There are mechanisms to evaluate the effects of the program using data on consumer and family satisfaction, provider satisfaction, and other appropriate measures.

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

C. The program has mechanisms and plans for provider profiling using provider utilization data.

D. Written utilization management policies and procedures clearly specify:

1. services that are available upon direct request;
2. services that require prior authorization;
3. services that require additional review;
4. services that require concurrent review;
5. circumstances that warrant retrospective review; and
6. special procedures for management of high cost and high-risk cases.

E. Licensed experienced behavioral healthcare practitioners assess the clinical information used to support utilization management decisions.

1. Appropriately licensed and experienced behavioral healthcare providers supervise all review decisions.

2. A psychiatrist, doctoral level clinical psychologist, or certified addiction medicine specialist reviews any denial that is based on medical necessity.

3. The **BHO** has licensed behavioral healthcare practitioners from appropriate specialty areas to assist in making determinations of clinical appropriateness.

F. The **BHO** makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.

1. The **BHO** establishes standards for the timeliness of UM decision-making. These standards must be submitted to **TDMHDD** for their review and approval.
2. Utilization decisions are communicated to the provider of care being authorized within 48 hours of the decision.

G. The UM program is annually evaluated, approved, and revised as necessary by senior management or the QI committee.

STANDARD XV: THE BHO HAS POLICIES AND PROCEDURES TO PROMOTE AND ASSURE CONTINUITY AND COORDINATION OF BEHAVIORAL HEALTHCARE SERVICES AND COORDINATION WITH PRIMARY CARE SERVICES FOR ITS MEMBERS.

A. Policies and procedures should specify the following:

1. The individual formally designated as having primary responsibility for coordinating the **Enrollee's** care.

2. Programs for coordination of care that include coordination of plan services with community and social services generally available through contracting or non-contracting providers in the area served by the **BHO**.

3. Procedures for timely communication of clinical information among providers.

4. Measures to facilitate **Enrollees** are informed of specific behavioral health care needs that require follow up; receive, as appropriate, training in self-care and other measures they may take to promote their own health.

B. The **BHO** facilitates continuity and coordination throughout its continuum of behavioral health services. To this end, the **BHO**:

1. Exchanges information in an effective, timely and confidential manner across all levels of care and all behavioral health providers and other providers.

2. *Facilitates **Enrollees** with behavioral health disorders receive timely access and follow up to appropriate behavioral providers, including a psychiatrist for medication evaluation and psychiatric assessment.*

3. *Collects and analyzes data to evaluate continuity and coordination of care within its continuum of services.*

4. Implements interventions when appropriate to improve continuity and coordination of care within its continuum of services.

C. The **BHO** facilitates continuity and coordination of behavioral health services with general medical care. To this end, the **BHO** collaborates with relevant medical delivery systems or primary care physicians to:

1. Exchange information in an effective, timely and confidential manner, including **Enrollee** approved communications between behavioral health providers and PCPs.

2. *Promote the appropriate diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care.*

3. *Coordinate timely access for appropriate treatment and follow up for individuals with coexisting medical and behavioral disorders.*

4. Collect and analyze data to evaluate continuity and coordination of behavioral health care with medical care.

5. Implement interventions when appropriate to improve continuity and coordination of behavioral health care with medical care.

Standard XVI: There is written documentation of QMP implementation.

A. The **BHO** will document that, in accordance with its written QMP plan, it is monitoring and evaluating the quality of care across all services and all treatment modalities and to all population groups.

B. The **BHO** must maintain and make available to **TDMHDD** and to **TennCare** all studies, reports, protocols, standards, worksheets, minutes, or such documentation as may be appropriate, concerning its quality assurance/improvement activities and corrective actions.

Standard XVII: The findings, conclusions, recommendations, actions taken and results of the actions taken as a result of the quality assurance/improvement activities are documented and reported to appropriate individuals within the organization and through the established quality assurance/ improvement channels.

A. Quality assurance/improvement information is used in recredentialling, reconstructing, and/or annual performance evaluations.

B. Quality assurance/improvement activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of **Enrollee appeals**.

C. There is a linkage between quality assurance/improvement and other management functions of the BHO such as network changes, service redesigns, benefits changes, and medical management system

ATTACHMENT D

Data Reporting Requirements

REPORTING DATA ELEMENTS

Attachment D.1

Provider Enrollment Reporting

Required Data Elements for Provider Enrollment Reporting

At a minimum, the following data elements shall be collected for each provider in the BHO's network. Quarterly Updates to the Provider Network file, as follows:

Provider Network File

TennCare Identification Number
BHO Indicator
Service County
Credential Indicator
Provider DEA Number
Provider Discipline Degree
Provider Education Level
Contract Effective Date
First Name
Middle Name
Last Name
Group/Organization Name
In Plan Indicator
License Number
Type of License
Medicaid/Medicare ID Number
New Member Indicator
Phone Number
Facsimile Number
Type of Provider
Provider Specialty
Provider SSN
Provider Tax ID Number
Contract Termination Date
Provider UPIN
Service Site Address 1
Service Site Address 2
Service Site City
Service Site State
Location Code

Zip Code
Email Address
TennCare Provider Identification Number
Group Name
Service Code
Adult/Child (A/C)
License2
License3

Attachment D.2

Clinically Related Group Assessment Reporting

Required Data Elements For Clinically Related Group Assessment Of Enrollees Age 18 Years or Older

This listing shall include, at a minimum, the following data elements:

Behavioral Health Organization's ID Number
Enrollee's Last Name
Enrollee's First Name
Enrollee's Birth Date
Enrollee's Social Security Number (SSN)
Principal Diagnosis
Dual Principal/Secondary Diagnosis
Measure of **Enrollee's** Level of Functioning in Activities of Daily Living
Measure of **Enrollee's** Level of Functioning in Interpersonal Functioning
Measure of **Enrollee's** Level of Functioning in Concentration, Task Performance, and Pace
Measure of **Enrollee's** Level of Functioning in Adaptation to Change
Measure of **Enrollee's** Severity of Impairment
Measure of **Enrollee's** Duration of Mental Illness
Indicator of **Enrollee's** Former Severe Impairment
Enrollee's Need for Services to Prevent Relapse
Enrollee's Clinically Related Group (CRG)
Reason for Assessment
Date of Request for Assessment
Date of CRG Assessment
Measure of Rater's Adequacy of Information in Order to Complete Assessment
Enrollee's Current Global Assessment of Functioning (GAF) Scale Score
Enrollee's Highest GAF Scale Score (Past Year)
Enrollee's Lowest GAF Scale Score (Past Year)
Program Code
Rater's TennCare Provider ID Number

Attachment D.3

Target Population Group Assessment Reporting

Required Data Elements For Target Population Group Assessment Of Enrollees Under Age 18

This listing shall include, at a minimum, the following data elements:

Behavioral Health Organization's ID Number
Enrollee's Last Name
Enrollee's First Name
Enrollee's Date of Birth
Enrollee's Social Security Number
Principal Diagnosis
Dual Principal/Secondary Diagnosis
Enrollee's Current Global Assessment of Functioning (GAF) Scale Score
Enrollee's Highest GAF Scale Score (Past Year)
Enrollee's Lowest GAF Scale Score (Past Year)
Severity of Impairment
Serious Emotional Disturbance (SED) Status
Environmental Issues
Family Issues
Trauma Issues
Social Skills Issues
Abuse/Neglect Issues
Child at Risk of SED
Enrollee's Target Population Group (TPG)
Reason for Assessment
Date of Request for Assessment
Date of TPG Assessment
Measure of Rater's Adequacy of Information in Order to Complete Assessment
Program Code
Rater's TennCare Provider ID Number

Attachment D.4

Encounter Reporting

Required Data Elements for Encounter Information Base

At a minimum, the following data elements shall be collected for Encounter Data.

Monthly Updates to the Encounter Files, as follows:

UB92 Claims File
Provider ID
Provider specialty
Last name
First name
Middle initial
Date of birth
Recipient's social security number
Diagnosis code 1
Diagnosis code 2
Diagnosis code 3
Diagnosis code 4
Diagnosis code 5
Resubmission code
Claim number
Service from date
Service through date
Place of service
Service type
CPT/HCPCS procedure code
Procedure modifier 1
Procedure modifier 2
Procedure modifier 3
Amount paid
Date paid
Pricing level
Amount allowed
Deductible amount
Co-Insurance amount
Liability amount
Claim type
Claim received date
Co-payment amount
Withhold amount
Bill type
Admitting diagnosis
Admit date

Covered days
Non-Covered days
Patient discharge status
Revenue code
Rate
Service units
Total charge amount billed
Non-Covered charge
Attending physician ID
COB savings amount
Prepaid amount
Discount amount
Discharge date
Provider tax ID
Payment Status
Payment code 1
Payment code 2
Payment code 3
Payment code 4
Payment code 5
Former claim number
Former payment date
Provider name
BHO Indicator
Rendering provider ID

HCFA1500 Claims File

Provider ID
Provider specialty
Last name
First name
Middle initial
Date of birth
Recipient's social security number
Diagnosis code 1
Diagnosis code 2
Diagnosis code 3
Diagnosis code 4
Diagnosis code 5
Resubmission code
Former claim number
Former payment date
Claim number
Service from date
Service through date
Place of service

Service type
CPT/HCPCS procedure code
Procedure modifier 1
Procedure modifier 2
Procedure modifier 3
Amount billed
Service units
Amount paid
Date paid
Pricing level
Amount allowed
Deductible amount
Co-Insurance amount
Treatment place
Liability amount
Claim type
Claim received date
Co-payment amount
Withhold amount
Payment code 1
Payment code 2
Payment code 3
Payment code 4
Payment code 5
Provider name
Rendering provider ID
Payment status
BHO Indicator

Attachment D.5

Case Management Reporting

Required Data Elements for Case Management Reporting

Monthly updates to the Case Management File, as follows:

Appointment kept date
BHO indicator
CM agency
Case management code
Case manager name
CRG/TPG assessment code
Discharge date
Date of birth
Facility
First name
Last name
Referral code
Social Security Number
DCS Status

Attachment D.6

Required Data Elements for Mobile Crisis Response Reporting

Response time for face to face interventions
Payor source
Type of call
Number of consumers who have active case management
Number of consumers whose case manager was involved in inpatient admission
Number of consumers whose case manager was involved in diversion from inpatient admission
Number of face to face interventions off-site
Final disposition
Barriers to diversion from inpatient admission

Attachment D.7

Enrollee Information Reporting Requirements

Required Data Elements

REQUIRED DATA ELEMENTS FOR REPORTING ENROLLEE INFORMATION

This report shall include, at a minimum, the following data elements;

1. **Enrollee's** name;
2. **Enrollee's** social security number;
3. **Enrollee's** date of birth;
4. **Enrollee's** sex;
5. **Enrollee's** previous address;
6. **Enrollee's** new address; or to the extent possible, a statement or indicator that the **Enrollee**'s new address is unknown due to mail being returned for insufficient address (e.g., undeliverable, no forwarding address, etc.) if the **Enrollee's** new address is unknown;
7. Date **Enrollee** moved;
8. A statement or indicator whether the **Enrollee's** new address is within the same community service area as the former address or is in a different community service area;
9. Identity of the new BHO plan, if known, if the **Enrollee** has moved outside the former community service area and desires to change BHO plans;
10. The identity of the BHO providing notice; and
11. Other pertinent information that is known that may have an affect on an **Enrollee's** eligibility or cost sharing status.

REQUIRED ELEMENTS FOR ENROLLEE VERIFICATION REPORTING

In response to receipt of a file from **TennCare** that identifies individuals whom **TennCare** has not been successful at contacting to verify eligibility, the **Contractor** will provide a response file that will include, at a minimum, the following data elements:

1. **Enrollee's** social security number;
2. **Enrollee's** date of birth;
3. **Enrollee's** sex;
4. **Enrollee's** name; and
5. **Enrollee's** address

Attachment D.8

Dual Eligible Cost Report

Report Template

Attachment D.8.1, Sample Dual Eligible (Medicare/TennCare Medicaid) Cost Report:

Enrollment														
Payments for MH/SA Services for the Month														
UB 92 Payments by the Claims Processing System														0
HCFA1500 Payments by the Claims Processing System														0
CMHC Capitation Payments														0
Other Capitation Payments														0
Grant Payments														0
Pharmacy Payments														0
Subcontractor Payments for MH/SA Services														0
Reinsurance Payment														0
Other Payments/Adjustments to MH/SA Costs														0
Less:														
Pharmacy Rebates														0
Recoveries not Reflected in Payments by the Claims System														0
Total Payments for the month		0	0	0	0	0	0	0	0	0	0	0	0	0
Remaining IBNR for the month														0
Payments and Remaining IBNR for the month		0	0	0	0	0	0	0	0	0	0	0	0	0

Attachment D.8.2, Sample Dual Eligible (Medicare/TennCare Standard) Cost Report:

Enrollment														
Payments for MH/SA Services for the Month														
UB 92 Payments by the Claims Processing System														0
HCFA1500 Payments by the Claims Processing System														0
CMHC Capitation Payments														0
Other Capitation Payments														0
Grant Payments														0
Pharmacy Payments														0
Subcontractor Payments for MH/SA Services														0
Reinsurance Payment														0
Other Payments/Adjustments to MH/SA Costs														0
Less:														
Pharmacy Rebates														0
Recoveries not Reflected in Payments by the Claims System														0
Total Payments for the month		0	0	0	0	0	0	0	0	0	0	0	0	0
Remaining IBNR for the month														0
Payments and Remaining IBNR for the month		0	0	0	0	0	0	0	0	0	0	0	0	0

Attachment D.9

Medical Loss Ratio Report and Claims Lag Tables

Report Template

Working Document

Attachment D.9-1, Sample Medical Loss Report:

MEDICAL LOSS RATIO REPORT
ALL REGIONS

MCO

BHO Name:

Attachment D.9-2, Sample Claims Lag Tables:

Reporting Month

Year:

HCFA 1500 Payments by the Claims Processing System
UB92 Payments by the Claims Processing System

	Total Remaining IBNR Prior to January 1, 2003	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Enrollment										
TennCare Capitation Payment										
Payments for MH/SA Services for the Month										
UB 92 Payments by the Claims Processing System										
HCFA1500 Payments by the Claims Processing System										
CMHC Capitation Payments										
Other Capitation Payments										
Grant Payments										
Pharmacy Payments										
Subcontractor Payments for MH/SA Services										
Reinsurance Payment										
Other Payments/Adjustments to MH/SA Costs										
Less:										
Pharmacy Rebates										
Recoveries not Reflected in Payments by the Claims System										
Total Payments for the month		0	0	0	0	0	0	0	0	0
Remaining IBNR for the month										
Payments and Remaining IBNR for the month		0	0	0	0	0	0	0	0	0

Incurred Month/Year of Service

	Total	Pre 1-1-03	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03
Jan-03	0	0									
Feb-03	0	0									
Mar-03	0	0									
Apr-03	0	0									
May-03	0	0									
Jun-03	0	0									
Jul-03	0	0									
Aug-03	0	0									
Sep-03	0	0									
Oct-03	0	0									
Nov-03	0	0									
Dec-03	0	0									
Total Totals	0		0	0	0	0	0	0	0	0	0

Month Paid by the Claims System

Medical Loss Ratio

ATTACHMENT E

PERFORMANCE MEASURES

All performance measures are to be reported to **TDMHDD**. Performance Measures I.1 and I.2 are to be reported to **TDMHDD**, TDCI, and **TennCare**. The goal of **TennCare Partners** is to manage the proper utilization of available resources to assist Enrollees in achieving and maintaining the highest degree of behavioral health and functional capability possible. In the achievement of these goals, the opportunity to compromise the quality, availability and accessibility of services must be avoided. Especially important is the aspect of under-utilization of medically necessary services in order to reduce cost and increase the profitability of the provider. There are a number of parameters that can and should be continually monitored to assure the provision of timely quality behavioral health care to every **Enrollee**. This section specifies performance objectives to be used by **TDMHDD** to monitor administrative capabilities, service delivery, service utilization, satisfaction and outcomes. The purpose of these measures is to:

- **Administrative**:Measure the **BHOs** ability to perform administrative functions in a timely and accurate fashion.
- **Service Delivery**: Measure the **BHOs** ability to arrange or provide appropriate services in a timely fashion, where timely is consistent with the terms and conditions of the **TennCare Program** waiver.
- **Service Utilization**: Measure the **BHOs** ability to arrange or provide for appropriate utilization of services.
- **Outcome/Satisfaction**: Measure the success of the **BHO** in providing services that result in desired outcomes.

TDMHDD will monitor the **Contractor's** performance relative to the benchmark specified for each performance measure. The **Contractor** shall report all data required to monitor performance in accordance with the timeframes specified in this Section. All performance measures are to be reported by the **Contractor** to **TDMHDD**. Performance Measures I.1 and I.2 shall also be reported to TDCI and the **TennCare** Bureau. Failure to meet the benchmark may result in the application of liquidated damages as specified below and/or result in a request for corrective action. Liquidated damages are grouped into five categories:

DEFICIENCY TYPE	DEFINITION	LIQUIDATED DAMAGES
I	A performance standard which, if not met, threatens the continued viability of the **TennCare Partners Program**	$10,000 will be assessed for each Type I deficiency found at the time of review
II	A performance standard which, if not met, denotes that the BHO's provider network is not adequate in a limited area	$2,000 will be assessed for each Type II deficiency found at the time of review
III	A performance standard which, if not met, is likely to result in physical or psychological harm to a **TennCare Partner's Program Enrollee**	$1,000 will be assessed for each Type III deficiency found at the time of review
IV	A performance standard which, if not met, is likely to cause undue distress to a **TennCare Partner's Program Enrollee**	$500 will be assessed for each Type IV deficiency found at the time of review
V	A performance standard which, if not met, will prevent ongoing monitoring of BHO service delivery	$500 will be assessed for each Type V deficiency found at the time of review

I. ADMINISTRATIVE MEASURES

Administrative measures will be monitored to measure the **BHO's** ability to perform administrative functions, including member and provider services, credentialing and recredentialling, claims processing and appeals resolution, in a timely and accurate fashion.

TABLE I: ADMINISTRATIVE PERFORMANCE MEASURES

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
I.1 Timely Claims Processing	90% of claims (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of claim. 99.5% of claims are processed within sixty (60) calendar days.	A: Number of claims submitted, number of claims input, number of claims processed, number of claims paid and percentage of claims paid within thirty (30) calendar days of receipt of claim B: Number and percentage of claims processed within sixty (60) calendar days of receipt of claim	Quarterly, within thirty (30) calendar days following the end of the quarter. Each month shall be reported separately.	I For each deficient month.
I.2 Claims Payment Accuracy	97% of claims paid accurately upon initial submission	Total number of claims paid, number of claims paid accurately, and percentage of total claims paid accurately	Quarterly, within thirty (30) calendar days following the end of the quarter. Each month shall be reported separately	I For each deficient month.
I.3 Telephone Response Time	At least 95% of calls are answered by a non-recorded voice in less than 5 rings or less than 30 seconds	Number and percentage of telephone calls by length of response time (number of rings or number of seconds)	Quarterly, within thirty (30) calendar days following the end of the quarter. Each month shall be reported separately.	IV For each deficient month
I.4 Telephone Call Abandonment Rate (unanswered calls)	No more than 5% of telephone calls are abandoned	Number and percentage of telephone calls abandoned	Quarterly, within thirty (30) calendar days following the end of the quarter. Each	I For each deficient month.

			month shall be reported separately.	

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
I.5 Credentialling Processing Time	Difference between date of notification of credentialling decision and date of submission of a complete application does not exceed one hundred twenty (120) calendar days in routine situations, does not exceed sixty (60) calendar days in areas with a network deficiency	Audit of credentialling file sample **NOTE:** Sampling methodology must be approved by **TDMHDD**	Quarterly, within thirty (30) calendar days following the end of the quarter. Each month shall be reported separately.	III For each deficient month.

II. SERVICE DELIVERY

Service delivery measures are to be used to monitor the **BHO's** ability to arrange or provide appropriate services in a timely fashion, where timely is consistent with the terms and conditions of the **TennCare Program** waiver.

Note 1. **TDMHDD** will monitor access to behavioral health providers by reviewing the **BHO's** monthly provider file that is electronically submitted to **TennCare** and compare this data with the **BHO's** membership to determine the numbers and distribution of providers compared to **Enrollees** and to calculate travel distances between contracted providers and **Enrollees**.

Note 2. **TDHMDD** will monitor access to Centers of Excellence by requiring the **BHO** to contract with COEs as they are designated by the State, and requiring a copy of the fully executed provider agreement to be submitted to **TDHMDD.**

TABLE II: SERVICE DELIVERY PERFORMANCE MEASURES

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
II.1 Distance from provider to **Enrollee**	In accordance with Attachment B "Geographic Access to the Service Type".	Electronic provider listing of all participating providers including all data elements specified in Attachment D.	Quarterly within thirty (30) calendar days after the end of the quarter	II or I, dependent on number of deficiencies
II.2 Timely access to all initial appointment/ admissions	In accordance with Attachment B "Maximum Time for Admission to the Service Type" post intake assessment 90% of **Enrollees** clinically determined to need an appointment have the clinically indicated appointment scheduled within the access and availability time period.	Average time between the intake assessment appointment and the **Enrollee's** next appointment scheduled of admission by type of service; determined for each month of the quarter.	Quarterly within thirty (30) calendar days after the end of the quarter	II or I, dependent on number of deficiencies, if not cured after initial request for corrective action
II.3 Timely appointments and admissions for non-urgent care post intake assessment	In accordance with Attachment B "Maximum Time for Admission to the Service Type" post intake assessment 90% of **Enrollees** clinically determined to need a non-urgent appointment have the clinically indicated non-urgent appointment scheduled within the access and availability time period.	Number of clinically determined appointments/ admissions scheduled post intake assessment within the clinically determined time period for non-urgent care as numerator; total number non-urgent clinically determined appointments/ admissions required post intake assessment as denominator	Quarterly within thirty (30) calendar days after the end of the quarter	II or I, dependent on number of deficiencies, if not cured after initial request for corrective action

II.4 Timely appointments and admissions for urgent care post intake assessment	In accordance with Attachment B "Response Time to Contact an Active Consumer in an Urgent Situation to the Service Type" post intake assessment 90% of **Enrollees** clinically determined to need an urgent appointment have the clinically indicated urgent appointment scheduled within the access and availability time period.	Number of clinically determined appointments/ admissions scheduled post intake assessment within the clinically determined time period for urgent care as numerator; total number of urgent clinically determined appointments/ admissions required post intake assessment as denominator	Quarterly within thirty (30) calendar days after the end of the quarter	II or I, dependent on number of deficiencies, if not cured after initial request for corrective action
II.5 Percentage of crisis service recipients, excluding mandatory pre-screenings, hospitalized per month to RMHI and private psychiatric facilities	N/A	The number of non-mandatory pre-screening crisis recipients admitted to RMHI and private psychiatric facilities by the number of calls received per crisis service provider; determined for each month of the quarter	Quarterly, within thirty (30) calendar days following the end of the quarter	V

III. SERVICE UTILIZATION

Service utilization performance measures will be used to evaluate the BHO's ability to arrange or provide for appropriate utilization of services.

All measures in Table III shall be reported separately for adults ages 18 and over for SPMI and non-SPMI populations, and children under age 18 by SED and non-SED populations. Benchmarks apply in aggregate only, unless otherwise specified.

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TABLE III: SERVICE UTILIZATION PERFORMANCE MEASURES

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
III.1 Length of time between hospital/RTF discharge	1. 90% of discharged **Enrollees** have a mental health case management service scheduled within seven (7) calendar days of discharge 2. 90% of discharged **Enrollees** receive a mental health case management service within seven (7) calendar days of discharge, excluding situations involving **Enrollee** reschedules, no shows, and refusals	1.1 Number of **Enrollees** discharged by length of time between discharge and first scheduled subsequent mental health case management service, reported by inpatient facility discharging, and type of service scheduled determined for each month 1.2 Average length of time between hospital discharge and first scheduled subsequent mental health case management visit determined for each month 2.1 Number of **Enrollees** discharged by length of time between discharge and first subsequent mental health case management service reported by CMHA and type of service received determined for each month 2.2 Average length of time between hospital discharge and first subsequent mental health case management visit reported by CMHA	Monthly, by the 20th of the following month	III

		and type of service received determined for each month		

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
III.2 Average length of time between hospital/RTF discharge for a mental health diagnosis and first subsequent MD or NP visit	1. 90% of discharged **Enrollees** have an MD or NP service scheduled within fourteen (14) calendar days of discharge 2. 90% of discharged **Enrollees** are seen by an MD or NP within fourteen (14) calendar days of discharge	1.1 Number of **Enrollees** discharged with a mental health diagnosis by length of time between discharge and first scheduled subsequent MD or NP visit, reported by inpatient facility discharging 1.2 Average length of time between hospital discharge for a mental health diagnosis and first scheduled subsequent MD or NP visit 2.1 Number of **Enrollees** discharged with a mental health diagnosis by length of time between hospital discharge and first subsequent MD or NP service received, reported by outpatient provider 2.2 Average length of time between hospital discharge for a mental health diagnosis and first subsequent MD or NP service received	Monthly, by the 20th of the following month	1.1.1.1.1.1.1.1.

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	1.1.1.1.1.1.1.1.
III.3 Average length of time between hospital/RTF discharge for a substance abuse diagnosis and first subsequent appropriate substance abuse outpatient service	1. 51% of discharged **Enrollees** have an appropriate substance abuse outpatient service scheduled within seven (7) calendar days of discharge 2. 51% of discharged **Enrollees** receive an appropriate substance abuse outpatient service within seven (7) calendar days of discharge, excluding situations involving **Enrollee** reschedules, no shows, and refusals	1.1 Number of **Enrollees** discharged with a substance abuse diagnosis by length of time between discharge and first scheduled subsequent substance abuse outpatient service, reported by inpatient facility discharging 1.2 Average length of time between hospital discharge for a substance abuse diagnosis and first scheduled subsequent substance abuse outpatient service 2.1 Number of **Enrollees** discharged with a substance abuse diagnosis by length of time between hospital discharge and first subsequent substance abuse outpatient service, reported by outpatient provider and type of service 2.2 Average length of time between hospital discharge for substance abuse diagnosis and first subsequent substance abuse outpatient service	Monthly, by the 20th of the following month	1.1.1.1.1.1.1.1.

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PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	1.1.1.1.1.1.1.1.
III.4 Percentage of **Enrollees** readmitted within seven (7) calendar days of discharge from inpatient services	Not more than 10% of **Enrollees** discharged from an inpatient facility are readmitted within seven (7) calendar days of discharge	Number of **Enrollees** discharged from an inpatient facility and number and percentage readmitted within 7 calendar days of discharge determined for each month in the quarter	Quarterly, within thirty (30) calendar days after the end of the quarter	1.1.1.1.1.1.1.1.
III.5 Percentage of **Enrollees** readmitted within thirty (30) calendar days of discharge from inpatient services	Not more than 15% of **Enrollees** discharged from an inpatient facility are readmitted within thirty (30) calendar days of discharge	Number of **Enrollees** discharged from an inpatient facility and number and percentage readmitted within thirty (30) calendar days of discharge determined for each month in the quarter	Quarterly, within thirty (30) calendar days following the end of the month	III

IV. SATISFACTION & OUTCOMES

The **Contractor** shall conduct a provider satisfaction survey on at least an annual basis to measure provider perception of the **Contractor's** performance. The survey should evaluate satisfaction with level of function, improvements in functioning, and satisfaction with the organization overall. Specific measures and benchmarks are provided below. **TDMHDD** must approve all questions included in the survey, sampling methods and sample sizes.

TABLE IV: SATISFACTION AND OUTCOME PERFORMANCE MEASURES

PERFORMANCE MEASURE	BENCHMARK	REPORTING REQUIREMENT	REPORTING FREQUENCY	PENALTY
IV.1 Network providers have a satisfactory working relationship with the **BHO**	85% of respondents rate their experience with the **BHO** to be fair or better and 80% rate it as good or better	Distribution of providers by satisfaction score, reported by type of provider	Annual; no later than the last day of June	1.1.1.1.1.1.1.1.
IV.2 Network providers are satisfied with the **BHO** claims payment system	85% of respondents rate the **BHO** claims payment system as fair or better and 80% rate it as good or better	Distribution of providers by satisfaction score, reported by type of provider	Annual; no later than the last day of June	1.1.1.1.1.1.1.1.
IV.3 Network providers are satisfied with the **BHO** transportation services	85% of respondents rate the **BHO** transportation services as fair or better and 80% rate it as good or better	Distribution of providers by satisfaction score, reported by type of provider	Annual; no later than the last day of June	1.1.1.1.1.1.1.1.

ATTACHMENT F

DELIVERABLES

Deliverable Requirements

The contractor and **TDMHDD**, **TennCare** and TDCI are responsible for complying with all the deliverable requirements established by the parties. Both parties are responsible for assuring the accuracy and completeness of deliverables, as well as the timely submission of each deliverable. Both parties will agree to the appropriate deliverable instructions, submission timetables, and technical assistance as required.

I. Items requiring prior approval by **TDMHDD**, **TennCare** and/or TDCI

A. The **Contractor's** provider network and any deletions or additions; regular monthly updates of the provider network;	**TDMHDD** has fifteen (15) calendar days to respond.
B. **Participant** materials, such as Member Handbooks (Explanations of Benefits); within 15 days after execution of this CONTRACT; any time thereafter prior to distribution.	**TDMHDD** has fifteen (15) calendar days to respond.
C. Any additional benefits to be provided; prior to implementation	**TDMHDD** has fifteen (15) calendar days to respond.
D. Provider relations plan; with signed CONTRACT.	**TDMHDD** will respond prior to issuing CONTRACT.
E. **Participant** involvement plan; with signed CONTRACT.	**TDMHDD** will respond prior to issuing CONTRACT.
F. Any subcontracts which may be contract(s) for any services other than the services and benefits provided to Enrollee; prior to execution of such contract(s).	**TDMHDD** has fifteen (15) calendar days to respond.
G. Appeal procedures; with signed CONTRACT.	**TDMHDD** and **TennCare** will respond prior to executing CONTRACT.
H. Reporting procedures; as specified in the CONTRACT.	TDMHDD, **TennCare** and/or TDCI will respond prior to issuing CONTRACT.
I. Indemnity language found in provider contracts if different from the standard indemnity language found in this	**TDMHDD** and **TennCare** have fifteen (15) calendar days to respond.

CONTRACT; prior to issuing such contracts.

J. Quality Monitoring/Quality Improvement procedures; within thirty (30) days after execution of this CONTRACT; annually thereafter.	**TDMHDD** has fifteen (15) calendar days to respond.
K. Certificates of insurance and bonding with signed CONTRACT.	TDCI will respond prior to issuance of CONTRACT.
L Arbitration procedures; with signed CONTRACT.	**TDMHDD** will respond prior to issuing CONTRACT.
M. Written plan for centralized credentialing and recredentialing of providers and potential providers; with signed CONTRACT	**TDMHDD** will respond prior to issuing CONTRACT.

I. Deliverables which are the responsibility of the Contractor

A. Annual report – submitted on a form prescribed by the National Association of Insurance Commissioners	Due on or before March 1 of each calendar year to TDCI, **TennCare** Division.
B. Quarterly financial report – submitted on a form prescribed by the National Association of Insurance Commissioners.	Due on or before May 1 of each year to TDCI, **TennCare** Division
C. Audit of Business Transactions/Audited Financial Statements (including income statement)	Due on or before May 1 of each year to TDCI, **TennCare** Division
D. Written plan of changes resulting from an audit	Within fifteen (15) working days
E. Ownership and Financial Disclosure	With signed CONTRACT
F. Significant business transaction	Upon occurrence
G. Reports of appeals and resolution	Monthly, to the Office of Managed Care, **TDMHDD**
H. Appeals regarding Emergency Medical Service claims	Monthly, to the Office of Managed Care, **TDMHDD**
I. All required QI/QM reports	To the Office of Managed Care, **TDMHDD**

J. Return of funds (overpayments)	Thirty (30) calendar days following notification
K. Performance Measures Reports as specified in Attachment E	Monthly, Quarterly, Semi-Annually or Annually, as in Attachment E, to the Office of Managed Care, **TDMHDD**
L. Reports regarding the activities of the **BHO** Advisory Committee	Semi-annually, to **TDMHDD**

I. Deliverables which are the responsibility of **TDMHDD**

Reports concluding findings, recommendations and requirements from monitoring activities conducted by **TDMHDD** and/or HCFA

II. Deliverables which are the responsibility of **TennCare**

A. Weekly listing of persons enrolled in the **Contractor's** plan

B. Reports listing persons disenrolled from the **Contractor's** plan

ATTACHMENT H

STATE ONLY AND JUDICIAL COVERAGE

Deleted by Amendment # 14

ATTACHMENT I

INSTRUCTIONS FOR COMPLETION OF LOBBYING DISCLOSURE FORM FOR THE BUREAU OF TENNCARE AND TDMHDD

This disclosure form shall be filed with TennCare, TDMHDD 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 or TennCare Partners Program-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 or TDMHDD was paid to a lobbyist or lobbying entity as defined by Tenn. Code Ann. 3-6-102 and as further defined in Section 6.7 of the Agreement. For those Contractors reliant on TennCare or the TennCare Partners Program for greater than two-thirds of their total revenue in the previous fiscal year, all lobbying contracts will be presumed to be TennCare-related or TennCare Partners Program-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 6.7 of the CRA 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.

ATTACHMENT G

LOBBYING DISCLOSURE Complete this form to disclose TennCare-related or TennCare Partners Program-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 or TennCare Partners Program. For those CONTRACTORS reliant on TennCare or TDMHDD for greater than two-thirds of their total revenue in the previous fiscal year, all lobbying contracts will be presumed to be TennCare-related or TennCare Partners Program-related.

** Attach additional sheets if necessary. Include the name of the Reporting Entity and date on each additional sheet.

TENNESSEE BUREAU OF INVESTIGATION

MEDICAID FRAUD CONTROL UNIT

FRAUD ALLEGATION REFERRAL FORM

DATE: _____

TO (CIRCLE RECIPIENT): SAC BOB SCHLAFLY [*FAX (615) 744-4659]*
ASAC Stephen Phelps [*fax (731) 668-9769]*
ASAC Norman Tidwell [*fax (615) 744-4659]*

FROM: _____ (TennCare CONTRACTOR)

Contact Person: _____
Telephone: _____
E-Mail: _____

SUBJECT NAME: _____
d/b/a_____
SUBJECT ADDRESS: _____
_____
_____
_____
_____
_____
PROVIDER NUMBER(S): _____
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_____

SUMMARY OF COMPLAINT:_____
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ADDITIONAL SUBJECT INFORMATION:

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Working Document

REPORT TENNCARE RECIPIENT FRAUD OR ABUSE

Date:

Please complete as much information as possible.

Name of Recipient/Person you are Reporting _____

Other Names Used (If known) alias

Social Security Number (If known)

Date of Birth

Children's Name (if applicable) SSN, if known DOB, if known

SSN, if known DOB, if known

Spouse's Name (if applicable)

Street Address physical address

Apartment #

City, State, Zip city state zip

Other Addresses Used

Home Phone Number

area code

Work Phone Number (Please include)

area code

Employer's Name

Employer's Address

Employer's Phone #

area code

What is your complaint? (In your own words, explain the problem)describe suspected fraudulent behavior

Have you notified the Managed Care CONTRACTOR of this problem? ☐ Yes ☐ No

Who did you notify? (Please provide name and phone number, if known)name phone number dept/ business

Have you notified anyone else? ☐ No ☐ Yes name phone dept/ business

Requesting Drug Profile ☐ Yes ☐ No Have already received drug profile ☐ Yes ☐ No

If you are already working with a PID staff person, who?

***Please attach any records of proof that may be needed to complete the initial review.**

OIG/CID Investigator: your name

Phone number

STATE OF TENNESSEE
OFFICE OF TENNCARE INSPECTOR GENERAL
PO BOX 282368
NASHVILLE, TENNESSEE 37228

FRAUD TOLL FREE HOTLINE 1-800-433-3982 • FAX (615) 256-3852
E-Mail Address: www.tennessee.gov/TennCare (follow the prompts that read "Report Fraud now")

Working Document

ATTACHMENT III
COST-SHARING SCHEDULES

1. Out-of-Pocket Expenditures

The TENNCARE deductible for children, individuals and families shall be $0.00. The annual TENNCARE maximum out-of-pocket expenditures described below shall apply for both uninsured and uninsurable designations. Effective August 1, 2005 (unless otherwise directed by TENNCARE), there shall be no out-of pocket maximum amounts.

Poverty Level	Individual Maximum Annual Out-of-Pocket	Family Maximum Annual Out-of-Pocket
0%-100%	$0.00	$0.00
101% - 199%	$1,000.00	$2,000.00
200% and above	$2,000.00	$4,000.00

2. Copayments prior to January 1, 2003:

The following TENNCARE copayment schedule shall apply for both Uninsured and Uninsurable designations, based on the poverty level specified in TENNCARE rule 1200-13-12-.05(1)(c):

Poverty Level	Copayment Amounts
0%-100%	$0.00
101% - 199%	$25.00, Hospital Emergency Room (waived if admitted) $5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $15.00, Physician Specialists $5.00, Prescription or Refill $100.00, Inpatient Hospital Admission
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $25.00, Physician Specialists $10.00, Prescription or Refill $200.00, Inpatient Hospital Admission

3. **Copayment schedules effective January 1, 2003 shall be as follows:**

Poverty Level	Copayment Amounts
0%-99%	$0.00

100% - 199%	$25.00, Hospital Emergency Room (waived if admitted) $5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $15.00, Physician Specialists (including Psychiatrists) $5.00, Prescription or Refill $100.00, Inpatient Hospital Admission
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $25.00, Physician Specialists (including Psychiatrists) $10.00, Prescription or Refill $200.00, Inpatient Hospital Admission

4. **Pharmacy Copayment schedules effective August 1, 2005 (unless otherwise directed by TENNCARE) shall be as follows:**

Pharmacy Copays shall apply to all TennCare Standard enrollees as well as non-institutionalized Medicaid adults who are eligible to receive pharmacy services in the TennCare program. For dates of service on or after July 1, 2005, these pharmacy copayment amounts shall replace the pharmacy copay amounts specified in Item 3 above. All other copay amounts specified in Item 3 shall remain in effect for TennCare Standard enrollees.

Generic	$0
Brand Name	$3

Pharmacy Copayments do not apply to family planning services, pregnant women, enrollees in long term care institutions (including HCBS) or receiving Hospice care.

The CONTRACTOR is specifically prohibited from waiving or discouraging TENNCARE enrollees from paying the amounts described in this provision.

Changes in cost share responsibilities that are due to take effect August 1, 2005 may be postponed as a result of Waiver and/or Court negotiations. Changes should be implemented August 1, 2005 unless otherwise directed by TENNCARE.

ATTACHMENT J

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

SIGNATURE & DATE:

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.