CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00490		59802	5

Contractor Legal Entity Name	Edison Vendor ID
DentaQuest USA Insurance Company, Inc.	222275

Amendment Purpose & Effect(s)

Scope Updates

Amendment Changes Contract End Date: ☐ YES ☒ NO **End Date:** April 29, 2024

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): $0.00

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2019	$475,027.00	$475,027.00			$950,054.00
2020	$2,850,162.00	$2,850,162.00			$5,700,324.00
2021	$7,853,137.00	$17,859,086.00			$25,712,223.00
2022	$7,853,137.00	$17,859,086.00			$25,712,223.00
2023	$30,664,228.00	$62,049,598.00			$92,713,826.00
2024	$30,664,228.00	$62,049,598.00			$92,713,826.00
TOTAL:	**$80,359,919.00**	**$163,142,557.00**			**$243,502,476.00**

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

Crystal G. Allen

Digitally signed by: Crystal G. Allen
DN: CN = Crystal G. Allen email = Crystal.G.Allen@tn.gov C = US O = TennCare OU = TennCare/Budget
Date: 2022.10.25 13:00:47 -06'00'

CPO USE

Speed Chart (optional)	Account Code (optional)

AMENDMENT #5
OF CONTRACT 59802
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF TENNCARE
AND
DENTAQUEST USA INSURANCE COMPANY, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Division of TennCare, hereinafter referred to as the "State" or "TennCare" and DentaQuest USA Insurance Company, Inc., hereinafter referred to as the "Contractor". For good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

1. Contract Section A.17 is deleted in its entirety and replaced with the following:

A.17. Key Staff

The Contractor shall maintain sufficient levels of staff, including supervisory and support staff, with appropriate training, work experience, and expertise to perform all contract requirements on an ongoing basis and be available to attend meetings as requested by TennCare. Key Staff personnel shall be assigned solely to work on matters arising under this Contract unless specific permission to the contrary is given by TennCare. The Contractor shall request approval from the State for all Key Staff candidates prior to assigning them to work on this Contract. The State may, in its sole discretion, require the Contractor's proposed Key Staff candidates to interview with the State. The State shall have the discretion to approve or disapprove of the Contractor's and any of its subcontractor's Key Staff, or to require the removal or reassignment of any Contractor's employee or subcontractor personnel found unacceptable to the State for work under this Contract only. Unless otherwise approved in advance in writing by the State, all of Contractor's Key Staff shall be full time staff who are one hundred percent (100%) dedicated to working on this Contract and may not hold more than one (1) Key Staff position at the same time. Unless specifically stated to the contrary in Section A.17, key staff are required to be physically located in the Davidson County Tennessee office. Key Staff shall include but are not limited to the following positions:

a. DBM Project Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Project Director one hundred percent (100%) dedicated to this Contract who has day-to-day authority to manage the total project. The Project Director shall be readily available to TennCare staff during regular working hours. The Project Director shall be physically located in the Contractor's Tennessee location as specified in Contract Section A.15.

b. DBM Dental Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Dental Director one hundred percent (100%) dedicated to this Contract who has day-to-day authority to manage the clinical aspects of the project. A dentist who is licensed by the Tennessee Board of Dentistry, in good standing, and physically located in the State of Tennessee shall serve as full-time DBM Dental Director to oversee and be responsible for the proper provision of medically necessary covered services for enrollees. The DBM Dental Director shall be closely involved in the monitoring of program integrity, quality, utilization management and utilization review, provider corrective action, site visits, credentialing processes, and Performance Improvement Projects (PIPs). The DBM Dental Director shall serve on the Peer Review Committee as chairperson, and on the Quality Monitoring Program (QMP) Committee and Credentialing Committee. The DBM Dental

Director shall attend all TennCare Dental Advisory Committee (TDAC) meetings and be on the quarterly meeting agenda when needed to present recommendations regarding changes to clinical guidelines.

c. Staff Dentist for the TennCare ECF CHOICES DBM Program - The Contractor shall designate and maintain, subject to TennCare approval, a full-time staff dentist reporting to the DBM Dental Director. The Staff Dentist shall be primarily focused on benefits provided under the TennCare ECF CHOICES DBM Program but may also support the CoverKids DBM Program and the TPPOHP DBM Program as time permits. The Staff Dentist shall be licensed by the Tennessee Board of Dentistry, be in good standing, and physically located in the State of Tennessee. The Staff Dentist shall have at least five (5) years of experience directing dental services for people with I/DD or have completed a residency or certification program specific to the provision of dental services for people with I/DD and at least two (2) years of experience providing dental services for people with I/DD and demonstrate to TennCare the ability to lead and direct adult dental services for the TennCare ECF CHOICES DBM Program. The Staff Dentist shall be responsible for the clinical oversight of TennCare ECF CHOICES DBM Program adult dental benefits, including, but not limited to, quality, utilization management and utilization review, site visits and credentialing of providers for the TennCare ECF CHOICES DBM Program dental network, development of clinical practice standards and clinical policies and procedures, PIPs pertaining to the TennCare ECF CHOICES DBM Program, provider corrective actions, leadership in training and development of the TennCare ECF CHOICES DBM Program dental provider network, and development of statewide capacity to provide dental services to individuals with I/DD broadly, including children with I/DD receiving dental services pursuant to EPSDT or the CoverKids DBM Program, and participation in meetings as requested by TennCare. The Staff Dentist shall be hired no later than sixty (60) calendar days prior to TennCare Programs Go-Live Date.

d. EPSDT Outreach Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, a full-time EPSDT Outreach Coordinator, physically located in Tennessee, whose primary duties include development and implementation of the Contractor's strategy to increase enrollee utilization of dental services by TennCare enrollees under the age of twenty-one (21) years of age.

e. PCDH and Member Outreach Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Patient Centered Dental Home (PCDH) and Member Outreach Coordinator physically located in Tennessee whose primary duties will support key areas of the TennCare and Contractor's Dental Strategy and increased utilization of high-value preventative dental services. At a minimum, the Coordinator will support outreach, coaching, and education to TennCare Patient Centered Dental Homes; and the coordinator will support member outreach and engagement, particularly focusing on hard-to-reach patient populations and underutilizing TennCare enrollees. TennCare and the Contractor will jointly design the scope of responsibilities and high-value activities that the Coordinator will conduct in alignment with the TennCare and Contractor's Dental strategy. TennCare and the Contractor will mutually agree upon start date for this position but no later than six (6) months after go-live.

f. Client-Partner Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, one full-time (1 FTE) person physically located in Tennessee to coordinate dental services between the DBM and MCO specific to the TennCare

Adult Dental DBM Program. The Client-Partner Coordinator position shall not be filled with any person concurrently employed by the Contractor as the MCO-DBM Coordinator. Prior to program implementation and thereafter through the duration of this Contract, the Client-Partner Coordinator shall develop and maintain, a system for data exchange with the MCOs and the Contractor, which shall include, at minimum, functionality to exchange the following information: referrals; treatment plans; stratification of proposed treatment plan procedures; authorizations; and other information as determined necessary by TennCare for the TennCare Adult Dental DBM Program.

g. Regulatory Compliance Manager – The Contractor shall designate and maintain, subject to TennCare approval, a full-time Regulatory Compliance Manager, physically located in Tennessee. The Regulatory Compliance Manager shall possess a thorough knowledge regarding investigations related to provider fraud and abuse in the TennCare program and will be the key staff handling day-to-day provider investigation related to inquiries from TennCare and TBI MFCU.

h. Provider Network Director – The Contractor shall designate and maintain, subject to TennCare approval, a Provider Network Director, physically located in Tennessee, responsible for network development and management to ensure that there is a statewide dental network adequate to make services, service locations and service sites available and accessible in accordance with the terms and conditions for access and availability outlined in the Contract, The Provider Network Director shall coordinate with other areas of the Contractor's organization that may impact provider recruitment, retention or termination. The Provider Network Director will also ensure that the provider enrollment file and the Insure Kids Now (IKN) files are accurate and delivered to TennCare timely. The Provider Network Director shall have a provider service line staffed adequately to respond to providers' questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in this Contract.

i. Adult Dental Program Provider Network Director – The Contractor shall designate and maintain, subject to TennCare approval, a full-time Adult Dental Program Provider Network Director, physically located in Tennessee, responsible for network development and management to ensure that there is a statewide Adult Dental network adequate to make services, service locations and service sites available and accessible in accordance with the terms and conditions for access and availability outlined in the Contract, and a TennCare ECF CHOICES DBM Program and TennCare Adults with Intellectual or Developmental Disabilities Dental Program network of participating Dental Providers, including both traditional and preventative dental services and specialists such as oral surgeons who have experience and/or expertise in serving individuals with intellectual and developmental disabilities with preferred contracting standards as defined in Section A.21 of this Contract. The Adult Dental Program Provider Network Director shall coordinate with other areas of the Contractor's organization that may impact provider recruitment, retention or termination, including for the TennCare ECF CHOICES DBM Program, TennCare Adults with Intellectual or Developmental Disabilities Dental Program, the TennCare Staff Dentist for the ECF CHOICES DBM Program, TennCare Adults with Intellectual or Developmental Disabilities Dental Program, and TennCare Adult Dental DBM Program. The Adult Dental Program Provider Network Director will also ensure that the provider enrollment file and the Insure Kids Now (IKN) files are accurate and delivered to TennCare timely, and that

TennCare ECF CHOICES DBM Program and TennCare Adults with Intellectual or Developmental Disabilities Dental Program Participating Dental Providers are clearly identified. The Adult Dental Program Provider Network Director shall have a provider service line staffed adequately to respond to providers' questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in this Contract.

j. Provider Representatives – The Contractor shall designate and maintain, subject to TennCare approval, a minimum of five (5) full-time Provider Representatives physically located in Tennessee to educate and assist participating dental providers in working with all State DBM Programs, including, but not limited to, management of TennCare ECF CHOICES DBM Program dental benefits and benefit limits, TennCare Adults with Intellectual or Developmental Disabilities Dental Program benefits and benefit limits, CoverKids DBM Program benefits and benefit limits, TPPOHP DBM Program benefits and benefit limits, and TennCare Adult Dental DBM Program . Each of the five (5) full-time Provider Representatives shall be assigned to work in one Grand Region within the state of Tennessee and shall be completely familiar with the operation of all of the applicable State DBM Programs in their respective region. For the TennCare ECF CHOICES DBM Program and TennCare Adults with Intellectual or Developmental Disabilities Dental Program, Provider Representatives shall educate and assist TennCare ECF CHOICES DBM Program and TennCare Adults with Intellectual or Developmental Disabilities Dental Program participating dental providers in working with utilization management programs specific to TennCare ECF CHOICES DBM Program adult dental benefits, including, but not limited to, management of adult dental benefits and benefit limits, prior authorizations requests (including initial evaluation and treatment plan approval), electronic billing, compliance initiatives, or other program requirements as specified by TennCare.

k. Data Research Analyst – The Contractor shall designate and maintain, subject to TennCare approval, one (1) full-time Data Research Analyst one hundred percent (100%) dedicated to this Contract, who is responsible for generating daily, weekly, monthly, quarterly and yearly reports required by the Contract, in addition to all ad hoc requests made by TennCare, in formats requested by TennCare. The Data Research Analyst shall be an expert in data that is warehoused by Contractor on behalf of TennCare and shall be available to assist TennCare staff with Contractor's decision support systems. The Data Research Analyst shall provide expertise and assistance in provider post utilization review, establishing benchmarks for procedures prone to provider fraud and abuse that don't require prior authorization, evaluation of provider's treatment patterns, identification of provider outliers, and drawing statistically valid random sample (SVRS) of dental records, utilizing a ninety five percent (95%) confidence interval, specific to the procedure(s) where the provider is an outlier. The Data Research Analyst position is not required to be located in Tennessee office.

l. System Liaison- The Contractor shall designate and maintain, subject to TennCare approval, one (1) system liaison responsible for, but not limited to, the planning and timely coding of edits to the Contractor's system when requested by TennCare, and the quality control of such edits to ensure proper functioning within the system, and to ensure that newly entered system changes and edits do not affect existing edits within Contractor's system causing unanticipated adverse system events affecting TennCare's claims, enrollees and providers. The System Liaison shall be responsible for all testing of new

programs or modules to be used by Contractor to manage TennCare's business. The System Liaison shall also be responsible for the maintenance and management of Contractor's website, including updating. The System Liaison position is not required to be located in the Tennessee office.

m. Member Materials and Marketing Coordinator – The Contractor shall designate and maintain, subject to TennCare approval, one (1) Member Materials and Marketing Coordinator responsible for ensuring that all member materials including, but not limited to, member handbooks, provider directories, member newsletters, dental reminder notices, fact sheets, notices or any other materials necessary to provide information to enrollees as developed by the Contractor, including materials specific to adult dental benefits in the TennCare ECF CHOICES DBM Program and TennCare Adults with Intellectual or Developmental Disabilities Dental Program, are approved by TennCare and disseminated timely.

n. Fraud and Abuse Investigators – One (1) Fraud and Abuse Investigator dedicated to TennCare who shall be responsible for all fraud and abuse detection activities for the State DBM Programs, including the Fraud and Abuse Compliance Plan, and who shall be the Key Staff person handling day-to-day provider investigation-related inquiries from TennCare. This Fraud and Abuse Investigator shall be assisted, on an as-needed basis, with up to two (2) other designated Fraud and Abuse Investigators and one (1) staff person, all of whom may be located in the Contractor's corporate offices, but who have full knowledge of provider investigations related to the State DBM Programs and shall work with the TennCare Office of Program Integrity (OPI).

o. MCO and DBM Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, a full-time MCO Coordinator, physically located in Tennessee. The MCO Coordinator shall develop, prior to program implementation and maintain thereafter through the duration of this Contract, a system for data exchange with the MCOs and the Contractor, including, but not limited to, functionality to exchange the following information: referrals; treatment plans; stratification of proposed treatment plan procedures; authorizations; and other information as determined necessary by TennCare. Additionally, the MCO and DBM Coordinator shall be responsible for the requirements set forth in Section A.49.

p. The Contractor shall identify in writing the name and contact information for the Key Staff persons within thirty (30) days of Contract award. Any changes in Key Staff persons listed in this section during the term of this Contract shall be made within ten (10) business days after receipt of any required approvals from TennCare. The identity of each of the Key Staff persons listed above shall be disclosed on the Contractor's web site.

2. Contract Section A.20 is deleted in its entirety and replaced with the following:

A.20. Access to Care

The Contractor shall maintain a network of State DBM Program dental providers with a sufficient number of providers who accept new enrollees in accordance with the geo access standards required under this Contract so that appointment waiting times do not exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care. The Contractor will maintain the general dentist network, so that there is a member to dentist ratio of no greater than two thousand (2,000) to one (1) at program go-live for Medicaid enrollees and no greater than one thousand eight

hundred (1,800) to one (1) by year three (3) for Medicaid enrollees. TennCare reserves the right to reevaluate one (1) year post go-live and in subsequent years to determine if these network ratios are adequate to meet the needs of the members and make adjustments if changes are needed. This will ensure that there is network capacity that will enable all members to have their unmet dental needs addressed, through adequate appointment availability. The Contractor has entered a full risk-based contract for the adult dental benefit and is required to negotiate fee schedule rates with dental providers as needed, in order to ensure an adequate provider network to serve this new member population. Built into the capitation rates are funds, expressly for this purpose. The Contractor shall ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. Services must be available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. Performance on access to care shall be monitored by the Contractor. Additional monitoring of these standards may be conducted by TennCare and/or the External Quality Review Organization (EQRO). The Contractor shall consider the following when establishing its networks:

a. The anticipated Medicaid and CoverKids enrollment;

b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid and CoverKids populations represented in the DBM;

c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid and CoverKids services;

d. The numbers of network providers who are not accepting new Medicaid and CoverKids patients;

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

f. Mobile dental clinics shall not be considered in determining sufficient network access.

3. **Contract Section A.115 is deleted in its entirety and replaced with the following:**

A.115. Contractor's Outreach Activities

The Contractor shall conduct regularly scheduled outreach activities designed to educate enrollees about the availability of EPSDT services and to increase the number of children receiving services.

a. Within forty-five (45) days of TennCare Programs Start Date, the Contractor shall submit a proposed outreach plan.

1. The Contractor's plan shall identify the target populations, service areas, specific outreach activities, including numbers of screens to be conducted, schedule for completion and include copies of any material to be released to enrollees.

2. The proposed plan and any related material shall require approval by TennCare. TennCare shall have thirty (30) days to review material and provide notice of approval or notice to make changes.

3. A minimum of seventy-five (75) in-person outreach events per year shall be conducted with no less than fifteen (15) per quarter, equally distributed across all three regions. At least twenty-five (25) of the member related activities and/or

events must be conducted in rural areas each year. Results of the Contractor's CMS 416 dental screening rates as well as county demographics must be utilized in determining counties for targeted activities and in developing strategies for specific populations.

4. The Contractor shall contact a minimum of twenty-five (25) state agencies or community-based organizations per quarter, to either educate them on services available through the Contractor or to develop outreach and educational activities. Collaborative activities should include those designed to reach enrollees with limited English proficiency, special health care needs, or those who are pregnant.

5. The Annual Outreach Plan shall be updated annually and submitted no later than August 15 in a format specified by TennCare. The Annual Outreach Plan will be effective for the Federal Fiscal Year, which is October 1-September 30. An annual Year-End Update of the Plan shall be due no later than sixty (60) days following the end of a Federal Fiscal Year in a format specified by TennCare. The Year-End Update shall include, but is not limited to, an assessment of the events that were conducted in the previous Federal Fiscal Year.

6. The Contractor shall be responsible for distributing annual notices to enrollees of their dental benefit encouraging them to schedule a dental appointment.

b. The Contractor is required to participate in the Managed Care Contractor (MCC) and Tennessee Department of Health Collaborative, and is required to submit quarterly a dental article for publication in the MCO teen newsletter or other member newsletter as required by TennCare according to a timeframe prescribed by TennCare.

c. The Contractor shall submit quarterly reports of outreach activities in a format specified by TennCare thirty (30) days after the end of each Federal Fiscal Year quarter.

d. If the Contractor's CMS 416 dental screening rate is below eighty percent (80%), the Contractor shall conduct a new initiative, approved by TennCare, to increase participation of all children who have not received screenings.

e. The Contractor may provide member incentives that have received prior written approval by TennCare in promoting compliance with dental visits.

Failure to comply with the requirements of this Section may result in the application of liquidated damages as provided in Section E.10 and Attachment B of this Contract.

4. Contract Section A.148 is deleted in its entirety and replaced with the following:

A.148. Reports

a. The Contractor shall provide the following reports every month:

1. PI TIPs
2. Encounter data report (837D)
3. Provider Enrollment File

b. The Contractor shall provide the following reports every quarter:

1. TennCare/EPSDT Report

2. Non-Traditional FI Varnish Program Report
3. "Insure Kids Now" (IKN) File
4. DBM Quarterly TennCare Kids Report
5. Quarterly Utilization by Std Dev
6. Quarterly Disclosure Rate Report
7. Enrollee cost-sharing liabilities
8. Adult Dental Program Report
   (a) Number of Unique Members 21 years of age and older who received a dental service
   (b) Number of Paid and Denied Dental Claims for members 21 years of age and older
   (c) Number of Dental Services provided for members 21 years of age and older, differentiated by service category
   (d) Dental Expenditures for members 21 years of age and older, differentiated by service category
   (e) Number of General Dentists contracted in the TennCare Adult Dental network
   (f) Number of Actively Participating General Dentists in the TennCare Adult Dental network (treating at least 25 patients and billing a minimum of $2,500 per quarter)
9. Outreach Attempts Report - Number of outreach attempts (telephonic, text, mailers, etc) to eligible pregnant members age 21 and older to connect to dental services
10. Quarterly Dental Provider Extrapolation Report
11. Encounter/MLR Reconciliation Report
12. Quarterly Provider Remediation, CAP, and Reassignments Report

c. The Contractor shall provide the following reports once a year:

1. Annual Outreach Plan
2. Annual Access Report
3. DBM Community Outreach Plan Annual Evaluation
4. Annual Disclosure Form
5. Annual Opioid Dental Prescriptions Report (number of prescriptions provided to child and adult members written by participating dentists)
6. Annual Dental Provider Opioid Outlier Report
7. Systems Refresh Plan
8. HEDIS Measures Report by June 15

d. The Contractor shall provide ad hoc reports, as requested by TennCare. The time intervals/schedule of such reports shall be determined by TennCare.

5. Contract Section C.3 is deleted in its entirety and replaced with the following:

C.3. Payment Methodology. The Contractor shall be compensated based on the payment methodology for goods or services authorized by the State in a total amount as set forth in Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in Section A.

b. The Contractor shall be compensated based upon the following payment methodology:

(1) For the transition period of September 1, 2018 – April 30, 2019, there shall be no cost to the State.

(2) For TennCare Children's DBM Program, TennCare ECF CHOICES DBM Program, and TPPOHP DBM Program services performed from May 1, 2019 through the end of the contract, the following rates shall apply:

Cost Item Description	Amount (per compensable increment)
May 1, 2019 – April 30, 2023 **TennCare Children's DBM Program** Administrative Fee Per Child (Under Age 21) Eligible for Full Dental Benefit Package (per member per month) AND **TPPOHP DBM Program** Administrative Fee per TennCare Enrollee who is a Pregnant Woman (21 Years of Age and Older) Eligible for TPPOHP DBM Program Limited Benefits (per member per month)	$ 0.50 per member per month
TennCare ECF CHOICES DBM Program May 1, 2019 – April 30, 2023 Administrative Fee Per Eligible Adult Enrolled in the TennCare ECF CHOICES DBM Program (per member per month)	$ 0.01 per member per month

(3) For CoverKids DBM Program services performed from July 1, 2020 (Go Live Date) through the end of the contract, the following rates shall apply. There shall be no cost to the State for CoverKids DBM Program services prior to Go Live Date of July 1, 2020.

Cost Item Description	Amount (per compensable increment)
CoverKids DBM Program July 1, 2020 – April 30, 2023 Group One Child [1]	$ 14.70

(Monthly)	Monthly Premium Rate / Per Member
CoverKids DBM Program **July 1, 2020 – April 30, 2023** Group Two Child [2] (Monthly)	$ 20.67 Monthly Premium Rate / Per Member
CoverKids DBM Program **July 1, 2020 – April 30, 2023** AI / AN Child [3] (Monthly)	$ 18.19 Monthly Premium Rate / Per Member

[1] ***Group One Child*** *is defined as a covered child who is in a family with an income between 150 percent and 250 percent of FPL.*

[2] ***Group Two Child*** *is defined as a covered child who is in a family with an income below 150 percent of FPL and therefore subject to reduced copayments.*

[3] ***AI / AN Child*** *is defined as a covered child who is (a) certified American Indian/Alaskan Native (AI/AN) and (b) a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Eligibility Determination Contractor to the Contractor for the coverage period.*

(4) For the TennCare Adult Dental DBM Program services performed from 01-01-2023 (Go Live Date) through the end of the Contract, the Contractor will be paid a base capitation rate for each enrollee based on the enrollee's rate category. Rate categories are based on various factors, category of aid, age/sex combination and the Grand Region served by the Contractor under this Contract. TennCare shall take Third Party Liability (TPL) into account in the development of capitation rates consistent with this Contract. This recognizes that it is the Contractor that is primarily responsible for TPL recoveries and that medical claims experience used for rate setting is net of any TPL recoveries of subrogation activities. There shall be no cost to the State for TennCare Adult Dental DBM Program services prior to Go Live Date of 01-01-2023. The rate categories and the specific rates associated with each rate category are specified below.

Cost Item Description	**East Region** **Capitation Payment Rate**
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 21-44 Female (Monthly)	$ 8.07 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 21-44 Male (Monthly)	$ 6.58 Per Member/Per Month

TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 45-64 Male/Female (Monthly)	$ 8.83 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 65+ Male/Female (Monthly)	$ 3.97 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Disabled 21+ (Monthly)	$ 7.68 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/Medicare Duals (Monthly)	$ 6.89 Per Member/Per Month

Cost Item Description	**Middle Region Capitation Payment Rate**
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 21-44 Female (Monthly)	$ 8.02 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 21-44 Male (Monthly)	$ 6.67 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 45-64 Male/Female (Monthly)	$ 8.86 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 65+ Male/Female (Monthly)	$ 3.98 Per Member/Per Month

TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Disabled 21+ (Monthly)	$ 7.70 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/Medicare Duals (Monthly)	$ 6.91 Per Member/Per Month

Cost Item Description	West Region Capitation Payment Rate
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 21-44 Female (Monthly)	$ 6.51 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 21-44 Male (Monthly)	$ 4.88 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 45-64 Male/Female (Monthly)	$ 6.88 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/TANF 65+ Male/Female (Monthly)	$ 3.09 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Disabled 21+ (Monthly)	$ 5.98 Per Member/Per Month
TennCare Adult Dental DBM Program **January 1, 2023 – December 31, 2023** Medicaid/Medicare Duals (Monthly)	$ 5.36 Per Member/Per Month

(a) The Contractor shall ensure that no payment is made to a network provider other than the services covered under the Contract between the State and the Contractor, except when these payments are specifically required to be made by the state in Title XIX of the Social Security Act, in 42 CFR 438.60, or when the state agency makes direct payments to network providers for graduate medical education costs approved under the state plan.

(b) In accordance with TCA 71-5-188, the State will retain a qualified actuary to conduct an annual actuarial study of the TennCare program. The CONTRACTOR shall provide any information requested and cooperate in any manner necessary as requested by TENNCARE in order to assist the State's actuary with completion of the annual actuarial study.

(c) The Contractor and State agree that the capitation rates described in Section C.3.b(4) of this Contract may be adjusted periodically.

(d) The Contractor and State further agree that adjustments to capitation rates shall occur only by written notice from TennCare to the Contractor and followed up with Contract amendment. The notice will be given at least thirty (30) calendar days before the new rates are paid. Should the Contractor refuse to continue this Contract under the new rates, the Contractor then may activate the Termination provisions contained in this Contract. During the six (6) month Termination Notice period the Contractor will continue to be paid under the new rates. In the event the Contractor indicates that it is refusing to accept the new rates, but does not choose to institute Termination proceedings under this Contract then the State may at its option:

i. Declare that a public exigency exists under this Contract. If the State makes this declaration the Contractor will continue to be paid under the new rates,

ii. Declare that the Contract is Terminated for Convenience under the provisions of this Contract. If the State makes this declaration the Contractor will continue to be paid under the new rates for the period of time until the Termination date.

(e) In addition to other adjustments specified in Section C.3.b(4) of this Contract, the capitation rates shall be adjusted annually for inflation in accordance with the recommendation of the State's actuary.

(f) If (i) changes are required pursuant to federal or state statute, federal regulations, the action of a federal agency, a state or federal court, or rules and regulations of a State of Tennessee agency other than the Division of TennCare and (ii) the changes are likely to impact the actuarial soundness of the capitation rate(s) described in Section C.3.b(4), as determined by TennCare, TennCare shall have its independent actuary review the required change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TennCare's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

(g) In the event TennCare amends TennCare rules or regulations or initiates a policy change not addressed elsewhere in this Contract that is likely to impact the capitation rate(s) described in Section C.3.b(4), as determined by TennCare, TennCare shall have its independent actuary review the proposed change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TennCare's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

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

(i) Any rate adjustments shall be subject to the availability of state appropriations.

(j) TennCare shall make payment by the fifth (5th) business day of each month to the Contractor for the Contractor's satisfactory performance of its duties and responsibilities as set forth in this Contract.

i. TennCare shall generate a X12 compliant 820 which contains detail PMPM new payments, voids and adjustments transactions for each monthly capitation payments to the Contractor. The Contractor must accept, load, maintain and reconcile each 820 file to the Contractor's eligibility data. No 820 reconciliation reporting is required from the Contractor to TennCare.

(k) CAPITATION PAYMENT CALCULATION

i When eligibility has been established by the State for enrollees, the amount owed to the Contractor shall be calculated as described herein.

ii Each month, payment to the Contractor shall be equal to the number of enrollees enrolled in the Contractor's plan based on an eligibility snapshot each month prior to the capitation payment multiplied by the appropriate capitation rate(s) for the enrollee.

iii The capitation rates stated above in this Section C.3.b(4) will be the amounts used to determine the amount of the monthly capitation payment.

iv The actual amount owed the Contractor for each member shall be determined by dividing the appropriate monthly capitation rate(s) by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the member was enrolled in the Contractor's plan.

v The amount paid to the Contractor shall equal the total of the amount owed for all enrollees determined pursuant to Section C.3.b(4) less capitation payment adjustments made pursuant to this Section C.3.b(4), and any other adjustments, which may include, damages, liquidated damages, or adjustments based upon a change of enrollee status.

(l) CAPITATION PAYMENT ADJUSTMENTS

i The State has the discretion to retroactively adjust the capitation payment for any enrollee if TennCare determines an incorrect payment was made to the Contractor; provided, however:

(1) For determining the capitation rate(s) only, each Grand Region under this Contract will be used to determine payment. The capitation payment shall not be retroactively adjusted to reflect a different Grand Region of residence.

(2) For individuals enrolled with a retroactive effective date on the date of enrollment, the capitation payment rate shall begin up to one (1) month before the current capitation cycle date and shall be the capitation rate(s) for the applicable rate category and the Grand Region as specified in C.3.b(4).

(A) The Contractor will not receive a capitation payment for periods of retroactive eligibility greater than one (1) month prior to the member's date of enrollment with the Contractor. The Contractor agrees to process claims and reimburse providers for services incurred during a period of retroactive eligibility more than one (1) month prior to the member's date of enrollment with the Contractor; however, the Contractor will not be at risk for these services. The Contractor shall reimburse providers in accordance with this Contract and shall submit to TennCare on a monthly basis a claims invoice file for the provision of covered services incurred during an enrollee's period of retroactive eligibility greater than one (1) month prior to the member's date of enrollment with the Contractor. TennCare shall remit payment to the Contractor in an amount equal to the amount to be paid to providers within ten (10) business days of receipt of notice; however, TennCare reserves the right to further review such claims and to recover any overpayments subsequently identified. The Contractor shall release payments to providers within two (2) business days of the receipt of funds from the State. Based on the provisions herein, TennCare shall not make any further retroactive adjustments, other than those described herein.

(3) If a provider seeks reimbursement for a service provided during a retroactive period of eligibility, the Contractor shall assess cost sharing responsibilities in accordance with the cost sharing schedules in effect on the date of service for which reimbursement is sought.

(4) Should TennCare determine after the capitation payment is made that an enrollee's capitation rate category had changed, the enrollee is subject to retroactive disenrollment, including but not limited to, the enrollee was deceased, TennCare shall retroactively adjust the payment to the Contractor as follows:

(A) If an enrollee is deceased, TennCare shall recoup any and all capitation payments made after the enrollee's date of death, including any pro-rated share of a capitation payment intended to cover dates of service after the enrollee's date of death.

(B) If an enrollee's capitation rate category has changed, or the member has been retroactively disenrolled for reasons described in this Contract, TennCare shall retroactively adjust the payment to the Contractor to accurately reflect the enrollee's capitation rate category or disenrollment for the period for which payment has been made. Based on the provisions herein, TennCare shall not make any further retroactive adjustments, other than those described herein.

(C) TennCare and the Contractor agree that the retro-active capitation payment limitation described in Section C.3.b(4) is applicable only to retroactive capitation rate payment adjustments described in those paragraphs and shall in no way be construed as limiting the effective date of eligibility or enrollment in the Contractor's plan.

(5) Payment adjustments resulting in a reduction or increase of the capitation rate shall be accomplished through the monthly capitation reconciliation process, or pursuant to other processes as established by TennCare.

(m) Pursuant to 42 CFR 438.6, any incentive arrangements shall comply with the following:

i The total of all payments made to the Contractor for a measurement year shall not exceed one hundred and five percent (105%) of capitation payments made to the Contractor.

ii Are for a fixed period of time and performance is measured during the rating period under the Contract in which the incentive arrangement is applied;

iii Are not renewed automatically;

iv Are made available to both public and private contractors under the same terms of performance;

v Do not condition Contractor's participation in the incentive arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.

(n) Effect of Disenrollment on Capitation Payments

i Payment of capitation payments shall cease effective the date of the member's disenrollment from the Contractor's MCO, and the Contractor shall have no further responsibility for the care of the enrollee. Disenrollment from TennCare shall not be made retroactively with the exception of the following situations:

(A) Fraudulent applications;

(B) Fraudulent Enrollment

(i) In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the Contractor, at its discretion, may refund to TennCare all capitation payments made on behalf of persons who obtained enrollment in TennCare through such means and the Contractor may pursue full restitution for all payments made on behalf of the individual while the person was inappropriately enrolled in the Contractor's plan.

(ii) In the event of enrollment obtained by fraud, misrepresentation or deception by the Contractor's staff, officers, employees, providers, volunteers, subcontractors, or anyone acting for or on behalf of the Contractor, TennCare may retroactively recover capitation amounts plus interest, as allowed by TCA 47-14-103, and any other monies paid to the Contractor for the enrollment of that individual. The refund of capitation payments plus interest will not preclude the State from exercising its right to criminal prosecution, civil penalties, trebled damages and/or other remedial measures.

(C) Member's death;

(D) TennCare and/or OIG determines the member moved out of state and failed to inform TennCare within a timely manner; and

(E) An appeal by the member to disenroll with a retroactive effective date is decided by TennCare in favor of the member.

(o) Medical Loss Ratio

i. The Contractor shall submit a *Medical Loss Ratio Report* monthly (on the 20th day of each month) with cumulative year to date calculation and shall comply with the following:

(A) The Contractor shall report all capitated dental expenses, costs related to the provision of support coordination, and complete the supporting claims lag tables. Expenses shall be reported in accordance with the following:

(i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense shall be prorated between types of expenses.

(ii) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on pro rata basis.

(iii) Expense allocation shall be based on a generally accepted accounting method that is expected to yield the most accurate results.

(iv) Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense.

Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to the other entities.

(v) The Contractor shall use an MLR template that is provided by TennCare.

ii. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

(A) The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the state.

(B) The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

(C) If a Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

iii. The MLR calculation in a MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

iv. The Contractor shall aggregate data for all Medicaid eligibility groups covered under the Contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

v. The Contractor shall submit an annual MLR report to TennCare, due by the end of the ninth (9^{th}) month following the rating period. This MLR report shall include the following for the most recent MLR reporting year:

(A) Total incurred claims.

(B) Expenditures on quality improving activities.

(C) Expenditures related to activities compliant with program integrity requirements.

(D) Non-claims costs.

(E) Premium revenue.

(F) Taxes.

(G) Licensing fees.

(H) Regulatory fees.

(I) Methodology(ies) for allocation of expenditures.

(J) Any credibility adjustment applied.

(K) The calculated MLR.

(L) Any remittance owed to the state, if applicable.

(M) A comparison of the information reported with the audited financial report.

(N) A description of the aggregation method used to calculate total incurred claims.

(O) The number of member months.

vi. The Contractor shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within One Hundred Eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

vii. In any instance where TennCare makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the Contractor shall:

(A) Re-calculate the MLR for all MLR reporting years affected by the change.

(B) Submit a new MLR report meeting the applicable requirements.

viii. This report shall be accompanied by a letter from an actuary, who may be an employee of the Contractor, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy.

ix. The Contractor shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

x. The Contractor shall also file this report with its NAIC filings due in March and August of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary.

(A) This report shall reconcile to NAIC filings including the supplemental TennCare income statement.

xi. The Contractor shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the Contractor's encounter file submission as specified in Sections A.148 and A.151.b.

(p) Risk Corridor

i. In each capitation year, TennCare has the option to, but is not required to, implement a risk corridor in the rates.

ii. For purposes of risk corridor calculations, the MLR shall be calculated as follows:

(A) The numerator shall include claim costs net of any third party liabilities (TPL) incurred during the measurement period, along with incurred but not reported (IBNR) reserve amounts to be calculated by the State or its actuaries.

(B) The denominator shall include State revenues net of any taxes and fees.

ii. Directed payment amounts made by the State to the Contractor or by the Contractor to providers outside of claims data will not be included in the MLR calculation. Additionally, expenses related to Fraud, Waste, and Abuse; initiatives that improve health care quality; and any other administrative / non-benefit activities shall also be excluded.

iii. The target MLR shall be calculated by the State's actuaries, and shall be defined as one (1) less the administrative/non-benefit load on the gross premium capitation rates prior to the inclusion of external directed payments. However, pursuant to 42 CFR 438.8(c), the target MLR may not be lower than 85%.

iv. A remittance of capitation payments related to the TennCare MLR from the DBM to the State shall occur in accordance with a methodology that will be specified by the State and communicated in writing to the DBM.

v. For each MLR reporting year, the Contractor must provide a rebate to the State if the Contractor meets the MLR remittance requirements outlined in this Contract.

vi. For each MLR reporting year, the State must provide a rebate to the Contractor if the Contractor meets the MLR remittance requirements outlined in this Contract.

vii. The Contractor rebate amounts will be assessed by the State using the MLR calculations provided within the CY MLR Report submitted to the State by the Contractor. The MLR rebate, if any, is due to the State in full sixty (60) calendar days after the State notifies the Contractor in writing of any MLR rebate amount due.

viii. If the Contractor determines that payment of the MLR rebate by the Contractor will cause the Contractor's risk-based capital to fall below the level required by the State, the Contractor's responsible official must notify the State in writing as soon as administratively possible and prior to making any MLR rebate payments to the State.

(5) Should Term Extension Option (Section B.2) be utilized, the following rates shall apply for services performed during extension periods:

Cost Item Description	**Amount** (per compensable increment)
TennCare Children's DBM Program	$ .50

Administrative Fee Per Child (Under Age 21) Eligible for Full Dental Benefit Package (per member per month) AND **TPPOHP DBM Program** Administrative Fee per TennCare Enrollee who is a Pregnant Woman (21 Years of Age and Older) Eligible for TPPOHP DBM Program Limited Benefits (per member per month)	per member per month
TennCare ECF CHOICES DBM Program Administrative Fee Per Eligible Adult Enrolled in the ECF CHOICES Program (per member per month)	$ .01 per member per month
CoverKids DBM Program Group One Child (Monthly)	$ 14.70 Monthly Premium Rate / Per Member
CoverKids DBM Program Group Two Child (Monthly)	$ 20.67 Monthly Premium Rate / Per Member
CoverKids DBM Program AI / AN Child [3] (Monthly)	$ 18.19 Monthly Premium Rate / Per Member

c. The Contractor shall assume risk levels for the TennCare Children's DBM Program only of at least 20% based on levels submitted in Cost Proposal (Contract Section A.164).

Risk Levels	
DBM Assumes _50% of Loss	DBM Share: _50% of any Savings

6. Contract Attachment C is deleted in its entirety and replaced with the new Attachment C attached hereto.

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

Amendment Effective Date. The revisions set forth herein shall be effective December 31, 2022. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

DENTAQUEST USA INSURANCE COMPANY, INC.:

Brett Bostrack
Brett Bostrack (Nov 18, 2022 15:30 CST)

Nov 18, 2022

SIGNATURE **DATE**

Brett Bostrack EVP

PRINTED NAME AND TITLE OF SIGNATORY (above)

STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF TENNCARE

Jim Bryson /jz

12/01/2022

JIM BRYSON, COMISSIONER **DATE**

DBM Deliverables Requirement

DBM Dental Deliverables	Scheduled Due Dates
Monthly Reports: • Batch Claims operation	**Thirty (30) calendar days after the end of each calendar month unless otherwise noted.**
• Program Integrity (PI) Exception List Report	**20th of the month – submit to OPI**
• Bi-monthly PI TIPs Report	**20th of the month for tips received between the 1st and 15th and the 5th of the month for tips received between the 16th and end of the month.**
• PI Involuntary Termination Report	**20th of the month – submit to OPI**
• Claims Lag Triangle	
• Claims Activity	
• Subrogation recoveries collected outside claims processing system (received ad hoc)	Forty-eight (48) hours after weekly payment cycle
• Encounter Data Report (837D)	By fifth business day each month
• Provider Enrollment File☼	
• Systems Availability and Performance Report	
Quarterly Reports: • PI EOB Report	**Thirty (30) days after the end of each Federal Fiscal Year quarter (unless noted)**
• Enrollee Cost Sharing	
• Customer Service Report o Referral time by county o Phone response time o Request for assistance	
• Non-Discrimination Compliance Reports	
• Quarterly Financials/ Income Statements	
• Encounter/MLR Reconciliation Report	
• DBM Quarterly TennCare Kids Report	

• Quarterly Provider Remediation, CAP, and Reassignments Report	
• QMP Committee Meeting Minutes	**PI referrals should be submitted as soon as the FWA is suspected or confirmed**
• Quality Indicator	
• PI Referral ¥	Ten (10) days after the end of each federal quarter
• Quarterly FWA Activities Report	
• Non-Traditional FI Varnish Program Report	
• "Insure Kids Now" (IKN) File☼	
• PI Disclosure Rate Report	Submit to TC OPI
• Quarterly Member Newsletter	
• PI Utilization by Standard Deviation	Submit to TC OPI
• PI Cost Savings Report	Submit to TC OPI
Annual Reports/ Plans/Studies:	**Ninety (90) days after end of Federal Year (unless noted)**
• Annual Outreach Plan	By August 15 each year
• Audited Financial Statements	By March 30 each year
• Member Satisfaction Surveys*	By March 30 each year
• Provider Satisfaction Surveys*	By March 30 each year
• Non-Discrimination Compliance Plan & Assurance of Non-Discrimination	By August 15 each year
• Annual Outreach Plan Year-End Update	By November 30 each year
• Two (2) PIPs Dental Studies†	By June 30 each year
• QMP Report‡ (QMP, work plan, and evaluation)	By March 30 each year
• Licensure Documentation	By September 15 each year
• Systems Refresh Plan	By December 1 each year
• Fraud, Waste And Abuse Compliance Plan	By July 1 each year
• Annual Disclosure Form	By March 30 each year
• Annual policies for employees, contractors, and agents that comply with 1902(a)(68) SSA (Deficit Reduction)	By July 1 each year

• Annual Recoveries Report	**By February 15 each year**
• HEDIS Measures Report	By June 15 each year
Ad Hoc Reports:	Within ten (10) business days from the date of the request when reasonable unless otherwise specified by TennCare.
Progress Reports	As Requested
On Request Reports (ORRs)	Within three (3) business days from the date of request when reasonable unless otherwise specified by TennCare.
Requests for Information (RFIs)	As Requested

¥ PI TIPs Report and PI Referrals should be submitted via the Secured File Transport (SFTP) server and in format specifications designated by TennCare.

☼ File format shall comply with specifications as outlined by TennCare.

DBM Cover Kids Dental Deliverables	Scheduled Due Dates
Quarterly Reports:	Thirty (30) days after the end of each Federal Fiscal Year quarter (unless noted)
• Claims Payment Reports	Within 5 days of end of each quarter
• Member/Provider Service Lines	
• Network Changes Update Report	Within 5 days of end of each quarter
• Network Quarterly Payment	
• Member Newsletter	
• Member Handbook ID, and Provider Network Directories Distributed	
• PI Report-Fraud and Abuse	

• External Quality Review Organization (EQRO) Provider Data • Non-Discrimination Compliance Report • CoverKids Member Complaint Log • CoverKids Provider Complaint Log • CoverKids Dental Benefit Savings and Payments Report • Enrollment Summary Plan • FQHC/RHC Report	
Annual Reports/ Plans/Studies: • Enrollee Satisfaction Survey • Provider Satisfaction Survey • Non-Discrimination Policy • Non-Discrimination Policy Compliance Plan	**Ninety (90) days after end of Federal Year (unless noted)** By March 30 each year By March 30 each year By August 16 each year By August 16 each year
Ad Hoc Reports: **Progress Reports** **On Request Reports (ORRs)** **Requests for Information (RFIs)**	Within ten (10) business days from the date of the request when reasonable unless otherwise specified by TennCare. As Requested Within three (3) business days from the date of request when reasonable unless otherwise specified by TennCare. As Requested

Management Reporting Requirements

Contract Management Reports by which the State can assess the CoverKids Dental program costs and usage. Reports shall be submitted in an electronic format as referenced in Section A.151.a (Management Reports). Management Reports shall include:

1) Performance Guarantee Reports, as detailed at Contract Attachment C (each component to be submitted at the frequency indicated), shall include:

- Status report narrative
- Detail report on each performance measure by appropriate time period

2) **Quarterly CoverKids Dental Benefit Savings and Payments Report,** must be submitted as follows distinguishing between in-network and out-of-network:

GROUP ONE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

GROUP TWO CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						

Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

AMERICAN INDIAN/ ALASKAN NATIVE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

3) **Quarterly Provider and Out-of-Network Claims Utilization by:**
   - Submitted charges
   - Benefits paid
   - Member Utilization
4) **Quarterly Enrollment Summary Plan Report:**

Premium Category	Subscribers	Premium	Total Claims
Group One Child			
Group Two Child			
American Indian/ Alaskan Native Child			
Total			

5) Quarterly Network Changes Update Report, displaying the following:

- Present Network of Participating Providers by Specialty
- Additions to the Network by Name, Specialty and Location
- Terminations to the Network by Name, Specialty and Location
- Targeted areas for recruitment

Signature: Brett Bostrack
Brett Bostrack (Nov 18, 2022 15:30 CST)

Email: brett.bostrack@dentaquest.com

Title: EVP

Company: DentaQuest

4_AMD#5_31865-00490_59802

Final Audit Report 2022-11-18

Created:	2022-11-18
By:	DentaQuest Compliance & Legal (EchoSignLegalCompliance@dentaquest.com)
Status:	Signed
Transaction ID:	CBJCHBCAABAAunYcett_YcxcKySLBDb-ySkgtsqcJXY8

"4_AMD#5_31865-00490_59802" History

Document created by DentaQuest Compliance & Legal (EchoSignLegalCompliance@dentaquest.com)
2022-11-18 - 3:10:46 PM GMT- IP address: 54.186.59.220

Document emailed to Brett Bostrack (brett.bostrack@dentaquest.com) for signature
2022-11-18 - 3:12:24 PM GMT

Email viewed by Brett Bostrack (brett.bostrack@dentaquest.com)
2022-11-18 - 3:12:59 PM GMT- IP address: 52.14.141.67

Document e-signed by Brett Bostrack (brett.bostrack@dentaquest.com)
Signature Date: 2022-11-18 - 9:30:24 PM GMT - Time Source: server- IP address: 52.14.90.44

Agreement completed.
2022-11-18 - 9:30:24 PM GMT

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00490		59802	4

Contractor Legal Entity Name	Edison Vendor ID
DentaQuest USA Insurance Company, Inc.	222275

Amendment Purpose & Effect(s)

Scope Updates, Exercising Renewal Option, Maximum Liability Increase

Amendment Changes Contract End Date: ☐ YES ☒ NO **End Date:** April 30, 2024

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): $164,000,800.00

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2019	$475,027.00	$475,027.00			$950,054.00
2020	$2,850,162.00	$2,850,162.00			$5,700,324.00
2021	$7,853,137.00	$17,859,086.00			$25,712,223.00
2022	$7,853,137.00	$17,859,086.00			$25,712,223.00
2023	$30,664,228.00	$62,049,598.00			$92,713,826.00
2024	$30,664,228.00	$62,049,598.00			$92,713,826.00
TOTAL:	**$80,359,919.00**	**$163,142,557.00**			**$243,502,476.00**

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

Crystal G. Allen

Digitally signed by: Crystal G. Allen
DN: CN = Crystal G. Allen email = Crystal.G.Allen@tn.gov C = US O = TennCare OU = TennCare/Budget
Date: 2022.09.23 12:52:30 -06'00'

CPO USE

Speed Chart (optional)

Account Code (optional)

AMENDMENT #4
OF CONTRACT 59802
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF TENNCARE
AND
DENTAQUEST USA INSURANCE COMPANY, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Division of TennCare, hereinafter referred to as the "State" or "TennCare" and DentaQuest USA Insurance Company, Inc., hereinafter referred to as the "Contractor". For good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

1. Contract Section A.2 is deleted in its entirety and replaced with the following:

A.2. General Requirements

The State administers five (5) separate TennCare health benefit programs identified below in Sections A.2.a(1) through A.2.a(5) which include certain managed dental benefit (DBM) services, collectively referred to herein as the "TennCare DBM Programs". The State also administers the federal Children's Health Insurance Program (CHIP) program known in Tennessee as the "CoverKids" program, which offers certain DBM services and is identified in Section A.2.b below. Each of these six (6) DBM programs (collectively referred to as the "State DBM Programs") operates on a statewide basis in Tennessee and provides benefits for its enrollees, hereinafter variously referred to as "enrollees", "members", "recipients" or "participants". The Contractor shall provide DBM services for all of the State DBM Programs as indicated below:

a. The federal Medicaid program, known as "TennCare" in Tennessee, is operated by the State pursuant to a waiver from the Centers for Medicare and Medicaid Services (CMS). Nothing in this Contract shall be deemed to be a delegation to the Contractor of the State's non-delegable duties relating to TennCare, as administered by the single state agency designated by the State and CMS, pursuant to Title XIX of the Social Security Act (42 U.S.C § 1396 *et seq.*) ,Section 1115 research and demonstration waiver granted to the State and any successor programs, and the State's Section 1915(c) Home and Community Based Services Waivers. The TennCare DBM Programs are categorized into the following five (5) programs based upon each program's eligible enrollees:

1. TennCare Children's DBM Program. The Contractor shall, pursuant to requirements set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols, administer covered dental benefits to approximately nine hundred thousand (900,000) eligible enrollees under age twenty-one (21) in the TennCare Program.

2. TennCare ECF CHOICES DBM Program. The Contractor shall, pursuant to requirements set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols, administer covered adult dental benefits to approximately two thousand seven hundred (2,700) eligible adults age twenty-one (21) and older who have an intellectual or developmental disability and are enrolled in the TennCare Employment and Community First (ECF) CHOICES Program.

3. TPPOHP DBM Program. Upon approval by TennCare for the new TennCare Perinatal and Postpartum Oral Health Program (TPPOHP) as set forth in Section A.3 below, the Contractor shall administer the TPPOHP DBM Program, providing outreach and limited dental benefits to approximately fifty thousand (50,000) TennCare enrollees who are pregnant women twenty-one (21) years of age and older who are eligible for enrollment in TPPOHP. The TPPOHP DBM Program is intended to raise awareness of the consequences associated with oral disease by teaching eligible enrollees:

   (a) the importance of good oral health during pregnancy;

   (b) the value of establishing good oral health habits for their babies; and

   (c) how to access covered dental services during pregnancy.

4. TennCare Adults with Intellectual or Developmental Disabilities Dental Program. The Contractor shall, pursuant to the requirements set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols, be responsible for managing the dental benefits for adults with Intellectual or Developmental Disabilities (IDD) that are enrolled in the Section 1915(c) Home and Community Based Services (HCBS) Waiver (TennCare 1915(c) Dental Program) as set forth in Contract Section A.200.

5. TennCare Adult Dental DBM Program. The Contractor shall, pursuant to the requirements set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols, administer covered adult dental benefits to all eligible adults aged twenty-one (21) and older who are TennCare members.

b. CoverKids DBM Program. The federal Social Security Act Title XXI Children's Health Insurance Program (CHIP), known as "CoverKids" in Tennessee, provides self-funded health plan services, including certain dental benefits, to eligible enrollees. CoverKids DBM Program eligible enrollees include approximately seventy thousand (70,000) children under age nineteen (19) enrolled in CoverKids medical coverage, hereafter to be collectively referred to as "CoverKids", with the exception of those CoverKids enrollees who are participating in HealthyTNBabies due to their pregnancy and who are not eligible for CoverKids DBM Program benefits under this Contract. The Contractor shall comply with all applicable administrative rules and CoverKids written policies and procedures, as may be amended from time to time. TennCare shall provide the Contractor with copies of such rules and policies. The State shall be the Contract holder, and the persons covered through the CoverKids program shall be enrollees, who receive the benefits set forth in a CoverKids Member Handbook (MH). When used in this Contract, the term "member" shall have the same meaning as the term "enrollee." CoverKids Enrollees are defined as:

1. Group One Child: Enrollees who are a member of a family with an income between one hundred fifty percent (150%) and two hundred fifty percent (250%) of the Federal Poverty Level (FPL) as reported by the State to the Contractor for the coverage period.

2. Group Two Child: Enrollees who are a member of a family with an income below one hundred fifty percent (150%) of FPL as reported by the State to the Contractor for the coverage period.

3. American Indian and Alaskan Native Child (AI/AN): American Indian and Alaska Native individuals (individually or collectively, "AI/AN"), as defined by the Indian Health Care Improvement Act of 1976 and certified by the State, will be exempt from all cost sharing to the extent that such children are covered by Children's Health Insurance Plan (CHIP) as required by Federal law. This group includes enrollees who are (a) certified AI/AN, and (b) members of families with incomes less than or equal to two hundred fifty percent (250%) of the FPL, as reported by the State to the Contractor for the coverage period.

The estimated number of eligible enrollees in each of the State DBM Programs indicated above is based on current and projected enrollment numbers and shall not, for any of the State DBM Programs, be deemed by the Contractor to represent the maximum number of enrollees for whom it shall be required to provide services.

The services Contractor will be required to provide for the State DBM Programs shall include, but are not limited to, establishment and management of dental provider network(s), credentialing and contracting with providers, utilization management and utilization review, provider profiling, identification, investigation and referral of suspected fraud cases, ensuring effective dental care within a predictable budget, claims processing adjudication and payment, management of third party liability, enrollee outreach, customer service and interface, all as more particularly set forth in this Contract for each of the State DBM Programs. To the extent they do not conflict with any Contract requirements, the Contractor shall adhere to its standard administrative policies and procedures, including without limitation dental policies, claims administration procedures, provider reimbursement practices and grievance procedures, in administering its fully insured coverage. The Contractor shall use its network of dental providers (Contractor's DBM Provider Network) to meet the requirements set forth herein to provide required services to the State DBM Programs. All requirements set forth in this Contract shall apply to all four (4) of the State DBM Programs, unless specifically stated otherwise.

2. Contract Section A.3 is deleted in its entirety and replaced with the following:

A.3. State DBM Programs Implementation

a. General Requirements

The Contractor shall complete all tasks, obligations, and requirements of this Contract for each phase of the State DBM Program implementation, in a timely and satisfactory manner, by the dates identified in the approved project plan (Project Plan) which shall be created by the Contractor and submitted to TennCare for review and approval as specified below in Section A.3.b.1. Implementation of the State DBM Programs shall be conducted according to the approved Project Plan as a series of defined phases for each of the State DBM Programs. TennCare's current timeline for implementation of the State DBM Programs is as follows:

1. For the TennCare Children's DBM Program, the TennCare ECF CHOICES DBM Program, and TPPOHP DBM Program the Contract Start Date will be September 1, 2018 (TennCare Programs Start Date). The Contractor shall have an eight (8) month implementation period. Therefore, Contractor's services shall be fully implemented and operable on the Go-Live date for these programs, which is currently scheduled for May 1, 2019 (TennCare Programs Go-Live Date), or such later date as TennCare may specify in writing to the Contractor.

2. Contractor's implementation of services relating to the TPPOHP DBM Program shall only commence and be implemented upon approval of the TPPOHP DBM

Program by TennCare. If TennCare provides written notice to the Contractor of the State's approval of the TPPOHP DBM Program within two (2) months from the TennCare Programs Start Date, then these services shall be fully implemented and operable on the TennCare Programs Go-Live Date. However, if TennCare does not provide written notice to Contractor of the State's approval of the TPPOHP DBM Program within two (2) months from the TennCare Programs Start Date, then the start of Contractor's services relating to the TPPOHP DBM Program shall be delayed and only begin upon receipt of written notice from TennCare that it has approved the TPPOHP DBM Program. In that case, Contractor's services shall be fully implemented and operable no later than six (6) months from Contractor's receipt of written notification from TennCare (Alternative TPPOHP Program Go-Live Date) that the TPPOHP DBM Program have been approved.

3. For the CoverKids DBM Program, the Contractor shall start the implementation period on January 1, 2020 (CoverKids Program Start Date). The Contractor shall have six (6) months to implementation period for the CoverKids DBM Program. Therefore, the Contractor's services shall be fully implemented and operable on the Go-Live date for this program (CoverKids Program Go-Live), which is currently scheduled for July 1, 2020, or such later date as TennCare may specify in writing to the Contractor.

4. For the TennCare Adult Dental DBM Program, the Contractor shall start the readiness and implementation period on July 1, 2022. The Contractor shall have a six (6) month readiness period for the TennCare Adult Dental DBM Program. Therefore, the Contractor's services shall be fully implemented and operable on the Go-Live date for this program, which is currently scheduled for January 1, 2023, unless otherwise directed by TennCare through a Control Memorandum.

b. <u>Project Initiation and Requirements Definition Phase</u>

TennCare shall conduct a series of project kick-off meetings to begin the Project Initiation and Requirements Definition Phase of this Contract. All key Contractor project staff shall attend these meeting which shall be conducted on site at TennCare offices located in Nashville, Tennessee. During these meetings, TennCare project staff shall provide access and orientation to the State DBM Programs and system documentation and TennCare technical staff shall provide an overview of the Tennessee TennCare Management Information System (MMIS) emphasizing dental claims processing and adjudication, reference files, and payment processes. In addition, other pertinent information will be provided to the Contractor and the Contractor shall develop the following documentation, for review and approval by TennCare:

1. Project Plan. The Project Plan shall be created by the Contractor and submitted to TennCare for approval within 15 calendar days after the TennCare Start Programs Date. It shall include a detailed timeline and description of all work to be performed by the Contractor and TennCare. It shall also include a proposed description of the participants in the DBM transition team and their roles and schedules of meetings between the DBM transition team and TennCare. The Project Plan may be amended from time to time by TennCare to reflect adjustments to the detailed timelines and required services as implementation of the State DBM Programs progresses.

2. Functional and Informational Requirements (FIR) Document. This document shall include detailed requirements for both internal and external interfaces and all State DBM Programs' functionalities required by the RFP for this Contract and/or contained in the Contractor's RFP proposal and/or this Contract. Eligibility interfaces with TennCare are critical and the Contractor must be in sync with the MMIS eligibility data and the CoverKids Eligibility Contractor Children's Health Administration System (CHAS). All outbound 834 files from TennCare must be loaded to the Contractor's data base within twenty-four (24) hours of receipt from TennCare and the Eligibility contractor, including any 834 transactions that must be handled manually by the Contractor. Failure to meet this performance standard may result in Liquidated Damages.
3. Upon implementation of the new Tennessee Eligibility Determination System (TEDS), the Contractor shall be required to sync to TEDS in order to receive CoverKids eligibility. The Contractor shall sync with TEDS within sixty (60) calendar days from receipt of written notification from TennCare to do so. All outbound 834 files from the State shall be loaded to the Contractor's database within twenty-four (24) hours of receipt of these files, including any 834 transactions that are required to be handled manually by the Contractor. Failure to meet this performance standard may result in Liquidated Damages.
4. Data Dictionary. For each data field this shall indicate content, size, values, structure, edit criteria and purpose.
5. Data Mapping. This shall consist of a cross-reference map of required MMIS data and TennCare and CoverKids data elements and data structures. A separate data structure map shall be required for each transaction and interface. A data conversion plan, that includes both automated and manual activities, shall be provided for each data structure map. TennCare shall make any necessary data formats available to the Contractor.
6. The Contractor shall recommend any design modifications to the TennCare MMIS and CoverKids CHAS systems that it feels are necessary for acceptable operations of these systems. Determination of whether the recommended modifications will be made and performing any maintenance and design modifications or enhancements to MMIS and the CHAS systems shall be at the sole discretion of TennCare and TennCare shall be responsible for making any such modifications or enhancements.

c. System Analysis/General Design Phase. After approval by TennCare of all Contractor services and deliverables required in the Project Initiation and Requirements Definition Phase, the Contractor shall develop the General System Design Document, which shall, at a minimum include the following:

1. An Operational Impact Analysis that details the procedures and infrastructure required to enable MMIS and the Contractor's system used by dental providers to work effectively together.
2. A Detailed Conversion Plan that specifies plans for conversion of fifteen (15) months of MMIS and the previous DBM contractor/processor's claims history, prior authorization and reference data.
3. A Software Release Plan that sets forth the project's implementation into production. This document shall explain procedures for coordinating system changes that shall have an operational or information impact on TennCare Programs and CoverKids Programs operations. It shall detail how TennCare, CoverKids and/or MMIS software releases are tested and coordinated

d. Technical Design Phase. During this phase, detailed specifications shall be developed for conversion and for the interface(s) between the MMIS and the Contractor's system. The Contractor shall develop detailed plans that address, but are not limited to, back-up and recovery, information security and system testing. The Contractor shall develop the System Interface Design Overview Document, which shall be completed after the Contractor has conducted a review of all previous design documents. In addition to the System Interface Design Overview Document, the Contractor shall provide the following system plan documents which shall include all applicable services and deliverables required in this Contract:

1. Unit Test Plan that includes test data, testing process, and expected results;
2. Back-up and Recovery Plan that includes processes for daily backup and recovery of system information;
3. Final Disaster Recovery Plan;
4. Information Security Plan that includes how the Contractor shall maintain confidentiality of TennCare and CoverKids data. This document shall include a comprehensive Risk Analysis; and
5. System, Integration, and Load and Test Plan

e. Development Phase. This phase includes activities that shall lead to implementation of the State DBM Programs. The Contractor shall` develop interface and conversion programs, develop system documentation, and develop Unit Test Plans. Where manual data entry screens are required, the Contractor shall develop these screens. Testing shall be performed on all phases and programs shall be documented. System testing shall require reports to substantiate and document the testing. These reports shall include but are not limited to number of tests run, number of requirements tested, number of tests passed, number of tests failed, and number of tests retested after initial failure. The Contractor must maintain an issues log which details any testing failures and includes the resolution for those issues. During final User Acceptance Testing (UAT) with TennCare, only TennCare can approve the Contractor's issue resolutions. The Contractor shall perform testing activities that shall include the following:

1. System test to validate the appropriate adjudication of a claim which shall include a description of the test procedure, expected results, and actual results;
2. Integration testing shall test external system impacts, downstream MMIS applications, and all interfaces. It shall include a description of the test procedure, expected results, and actual results; and
3. Load and Stress testing shall include volume and efficiency to ensure that the system is able to process the volume of TennCare and CoverKids dental claims. It shall include a description of the test procedure, expected results, and actual results.

f. Implementation/Operations Phase. During this phase the Contractor and TennCare shall assess the operational readiness of all required system components. This shall result in the establishment of the operational production environment in which all TennCare and CoverKids dental claims shall be accurately and reliably processed, adjudicated and paid. TennCare shall have final approval for the elements of the operational production environment. The Contractor's Implementation/Operations Phase services shall include, but are not limited to, the following:

1. The Contractor shall develop and prepare the operations documentation of all procedures of the Contractor's performance. This shall include, but may not be limited to: automated

operations, data entry operations, prior authorization operations/interfaces, check and remittance fulfillment and member notifications.

2. With the approval of TennCare, the Contractor shall develop production and report distribution schedules.
3. The Contractor shall update the operations training plan for TennCare approval. The Contractor shall schedule and conduct training and develop the training materials for TennCare and CoverKids staff, dental providers, and other identified stakeholders.
4. The Contractor and TennCare shall prepare a final conversion plan and perform final conversion activities that include procedures for testing the conversion data. The conversion plan shall include loading fifteen (15) months of claims history from the current system. The plan shall also include migrating current prior authorizations overrides with their end dates into the Contractor's system, running other conversion programs, performing manual functions, performing quality control, reporting on outcomes, and converting files in preparation for system operation.

g. Readiness Review. The State may conduct an on-site review to assess the readiness of the Contractor to effectively administer and provide the services as defined in this Contract. The Contractor shall complete all implementation actions prior to the TennCare Programs Go-Live date and the CoverKids Program Go-Live date, respectively, the Alternative TPPOHP Program Go-Live Date, and the TennCare Adult Dental DBM Program Go-Live date, if applicable, and according to the implementation timeline provided by the Contractor and approved by TennCare. The Contractor shall receive TennCare's sign-off that each action has been completed successfully. Implementation action steps shall include, at a minimum, the following items:

1. Benefit plan designs loaded, operable, and tested;
2. Comprehensive systems testing (including interface testing with all third parties) and quality assurance audits, with results reported to the TennCare prior to the TennCare Programs Go-Live and the CoverKids Program Go-Live dates, respectively, the Alternative TPPOHP Program Go-Live Date, and the TennCare Adult Dental DBM Program Go-Live date, if applicable;
3. Eligibility feed formats loaded and tested end-to-end;
4. Operable and tested toll-free numbers;
5. Account management, Help Desk, and Prior Authorization staff hired and trained;
6. Established billing/banking requirements;
7. Complete notifications to the outgoing State DBM contractor's dental providers regarding the upcoming change of State DBM contractor;
8. Each component shall be completed by an agreed upon deadline, in an implementation timeline provided by Contractor and approved by TennCare. Implementation action requirements may include other items necessary to meet the claims processing commencement date of May 1, 2019 for the TennCare DBM Programs and July 1, 2020 for the CoverKids DBM Program;
9. Claims history and existing prior authorizations and overrides from the outgoing State DBM contractor shall be successfully migrated into the Contractor's system.
10. Satisfactory Completion of the requirements of Contract Section A.100.
11. No less than sixty (60) days prior to the TennCare Programs Go-Live, as defined in Contract Section A.3.a, the Contractor must be prepared to receive and load a mass 834 file for the base TennCare member population with future eligibility begin dates.

12. After delivery from the State of the base line TennCare member population, the Contractor must be prepared to receive and load daily 834 files which will contain new members and changes as applicable for the base line population with future eligibility begin dates.
13. No less than thirty (30) days prior to the TennCare Programs Go-Live date, the Contractor must be prepared to submit HIPAA complaint X12 837D encounter files to TennCare.

h. TennCare ECF CHOICES DBM Program Readiness Review. The Contractor shall participate in a readiness review prior to the implementation of the Contractor's management of dental benefits in the TennCare ECF CHOICES DBM Program, in addition to any other readiness requirements under Section A.3.g of this Contract. This readiness review specific to the TennCare ECF CHOICES DBM Program will be conducted during a timeframe determined by TennCare, and will include, at a minimum, development of the Contractor's TennCare ECF CHOICES DBM Program Participating Dental Provider network, requirements to develop and amend policies, procedures, and other documents related to this Contract for TennCare review and approval and demonstration of systems readiness to meet the requirements of this Contract for TennCare's review and approval.

i. TennCare Adult Dental DBM Program Readiness Review. The Contractor shall participate in a readiness review prior to the implementation of the Contractor's management of dental benefits in the TennCare Adult Dental DBM Program, in addition to any other readiness requirements under Section A.3.g of this Contract. This readiness review specific to the TennCare Adult Dental DBM Program will be conducted from July 1, 2022 until January 1, 2023 or later as determined by TennCare, and will include, at a minimum, development of the Contractor's TennCare Adult Dental DBM Program Participating Dental Provider network, requirements to develop and amend policies, procedures, and other documents related to this Contract for TennCare review and approval and demonstration of systems readiness to meet the requirements of this Contract for TennCare's review and approval.

3. Contract Section A.4 is deleted in its entirety and replaced with the following:

A.4. Services

The Contractor shall administer the dental benefit for the TennCare Children's DBM Program, TennCare ECF Choices DBM Program, TPPOHP DBM Program, TennCare Adults with Intellectual or Developmental Disabilities Dental Program, TennCare Adult Dental DBM Program, and CoverKids DBM Program as specified in this Contract. The Contractor shall make maximum efforts to ensure minimum disruption in service to enrollees and a smooth interface of any claims processing or system changes to transfer necessary information without material disruption during implementation of the Contract requirements and shall manage the State DBM Programs in a manner that ensures an adequate network(s) of qualified dental providers for whom the Contractor is responsible. These providers shall render high quality, medically necessary, cost effective dental care. Furthermore, the Contractor shall exercise every available means, including but not limited to, its provider agreements, office reference manuals and Contractor's policies and procedures, to ensure that the State DBM Programs are managed in this manner.

4. Contract Section A.5 is deleted in its entirety and replaced with the following:

A.5. State DBM Programs Benefit Packages

The Contractor shall be responsible for ensuring that benefits are provided to eligible enrollees in accordance with TennCare rules, court orders and other applicable law for each of the State DBM Programs covered by this Contract.

a. TennCare Children's DBM Program.

The Contractor shall be responsible for ensuring that the following benefits are provided to eligible enrollees in the TennCare Children's DBM Program in accordance with federal requirements, TennCare rules, court orders and other applicable law:

1. Preventive, diagnostic and treatment services conferred on behalf of children under age twenty-one (21) - Any limitations described in this Contract shall be exceeded to the extent necessary to ensure compliance with applicable court orders relating to Early, Periodic Screening, Diagnostic and Treatment (EPSDT) requirements. By amendment to this Contract, TennCare may at any time alter the covered benefits for the TennCare Standard enrollees under age twenty-one (21).

2. Orthodontics – In order for orthodontic services to be covered, all orthodontic services must be prior authorized by the Contractor and must be determined to be medically necessary in accordance with TennCare rules. Orthodontic services are only covered for individuals under age twenty-one (21) as medically necessary to treat a handicapping malocclusion. The Contractor's dental providers shall furnish all records required by then current TennCare Rules to validate a handicapping malocclusion, which may include but are not limited to: dental records from the treating dentist, orthodontic records and treatment plan, radiographs of impacted teeth, OrthoCAD, or study casts or photographs of study models and/or photographs of intraoral tissue lacerations, the orthodontic readiness form, and medical records from the primary care physician. Pediatrics growth data or similar information required by then current TennCare Rules shall be required for orthodontic appeals related to nutritional deficiency and speech/language records shall be provided for orthodontic appeals related to speech pathology. TennCare reimbursement for orthodontic services begun before age twenty-one (21) will end on the individual's 21st birthday. Orthodontic treatment shall not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for TennCare and the services are determined to be medically necessary in accordance with TennCare Rules.

3. Age twenty-one (21) and Older - When the Contractor denies a claim or prior authorization request submitted by or on behalf of an individual over age twenty-one (21), despite the fact that the individual's age may render him/her ineligible for TennCare benefits, the Contractor nonetheless agrees to render such denial in writing and in accordance with the appeals process set forth in Grievances and Appeals, Sections A.116 – A.132 of this Contract.

4. Non-Traditional Fluoride Varnish and Dental Screening Program - The Contractor shall implement a program that would allow non-traditional providers (such as Primary Care Physicians, Pediatricians, Physician Assistants, Nurse Practitioners and Public Health Nurses) to conduct dental screenings and apply fluoride varnish to the teeth of TennCare enrollees six (6) months through five (5) years of age. Non-traditional providers will be reimbursed for such services within the age range of six (6) months through five (5) years only if fluoride varnish application and dental screening are also conducted at the same visit. The Contractor shall be

responsible for non-traditional provider network development, including provider credentialing, provider billing, provider reimbursement, provider training and applicable reporting to TennCare. Non-traditional providers shall submit current dental terminology (CDT) procedure codes D1206 (for fluoride varnish) and D0190 (for a dental screening) directly to the Contractor utilizing a standard ADA claim form. Non-traditional providers will be reimbursed using maximum allowable rates of $20.50 per fluoride varnish application and $12.00 for a dental screening. Each enrollee is permitted two (2) such visits per year. The Contractor shall have this program operational within three (3) months of TennCare Programs Go-Live date but no later than May 1, 2019, or be subjected to damages under the liquidated damages provisions in Attachment B. The Contractor shall manage the encounter data files for TennCare enrollees receiving fluoride varnish and dental screenings by non-traditional providers in accordance with the specifications, format and timeframes outlined by the TennCare.

b TennCare ECF Choices DBM Program

1. The Contractor shall, pursuant to requirements set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols, administer covered adult dental benefits to eligible adults age twenty-one (21) and older who have an intellectual or developmental disability and are enrolled in the TennCare ECF CHOICES DBM Program. This includes all applicable requirements set forth in this Contract unless specifically identified as non-applicable to the TennCare ECF CHOICES PBM Program in Section A.5.b.13. ECF CHOICES Members enrolled in the TennCare ECF CHOICES DBM Program shall also receive all covered benefit services that are provided in the TennCare Adult DBM Program, as specified in Section A.5.d.

2. A Member enrolled in TennCare ECF CHOICES DBM Program shall receive covered dental services only as specified in the Member's approved Person Centered Support Plan ("PCSP"). The Contractor shall provide only the following covered dental benefits in the TennCare ECF CHOICES DBM Program:

   (a) Adult dental services as provided under the State's Section 1915(c) waivers for individuals with intellectual disabilities, which include specific preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments as medically necessary to relieve pain and infection, as well as adjunctive sedation services, which may include medically necessary and appropriate deep sedation or general anesthesia, provided in the dentist's office by and billed by the dentist.

   (b) Such services will be reimbursed in accordance with the maximum reimbursement rate listed in the TennCare ECF CHOICES DBM Program Dental Fee Schedule which shall be provided by TennCare. Orthodontic services are excluded from coverage in the TennCare ECF CHOICES DBM Program.

3. All Covered Services for children under age 21 enrolled in the TennCare ECF CHOICES DBM Program are provided through the TennCare EPSDT program as

provided in Contract Sections A.4 and A.5. Therefore, dental services shall not be covered under the TennCare ECF CHOICES DBM Program for children under age 21 years, since it would duplicate TennCare EPSDT benefits.

4. Covered Services for eligible adults age 21 and older in the TennCare ECF CHOICES DBM Program shall be limited to a maximum of $5,000 per member per calendar year, and a maximum of $7,500 per member across three (3) consecutive calendar years. Covered Services that are received on or after Adult Dental go-live shall apply to the maximum amount allowable only if the service is not covered as part of the TennCare Adult DBM Program. Any adult dental services received prior to the Adult Dental go-live date, shall apply to the maximum amount allowable for the qualifying time period. A Member's Managed Care Organization (MCO) may elect, at its sole discretion, to exceed these limits as a Cost-Effective Alternative Service, when the provision of such additional dental services would be medically appropriate and offer a more Cost-Effective Alternative Service to other covered services the Member would otherwise require.

5. Adult dental services in the TennCare ECF CHOICES DBM Program shall be provided only as specified in the member's PCSP. The MCO shall be responsible for ensuring that the amount approved for dental services in the PCSP does not exceed the limitations specified in Contract Section A.5.b.4, except when the MCO elects to exceed such limit as a Cost-Effective Alternative Service. Upon inclusion of dental services in an ECF CHOICES member's PCSP, the Contractor shall work with the Member's MCO support coordinator to assist the Member in selecting a contracted TennCare ECF CHOICES DBM Program Participating Dental Provider. A copy of the PCSP or relevant portions of the PCSP, as determined by TennCare, shall be provided to the TennCare ECF CHOICES DBM Program Participating Dental Provider by the Member's MCO pursuant to a process approved by TennCare.

6. Coordination of TennCare ECF CHOICES DBM Program dental benefits between the Contractor and members' MCOs shall be conducted in accordance with this Contract and any protocols and procedures developed by TennCare.

7. Upon selection of an TennCare ECF CHOICES DBM Program Participating Dental Provider and subject to the amount approved for dental services in the member's PCSP, each TennCare ECF CHOICES DBM Program member shall undergo a thorough dental evaluation prior to receiving Covered Services, unless the Member has had such an evaluation in the ninety (90) days prior to such service request. The results of that evaluation will be a proposed treatment plan that will include both short-term dental needs (i.e. cavities detected during the exam to be filled) and long-term dental services (i.e. cleaning every six months), which shall be incorporated into the Member's PCSP, as determined by the Member or his/her authorized representative. Notwithstanding the proposed treatment plan developed by the TennCare ECF CHOICES DBM Program Participating Dental Provider, the total cost of dental services that may be authorized are subject to the amount approved for dental services in the member's PCSP.

8. TennCare ECF CHOICES DBM Program Participating Dental Providers may perform any Medically Necessary Covered Services determined to be needed after

the dental evaluation referenced in Section A.5.b.7 above (or if an evaluation is not required, refer to A.5.b.7.) even if the treatment plan has not yet been incorporated into the PCSP, unless such service is of a type that requires prior authorization under this Contract, subject to the amount authorized for dental services in the member's PCSP. If the total cost of services proposed in the treatment plan exceed the amount authorized for dental services in the member's PCSP, the Participating Dental Provider shall not proceed to perform such services, except as specifically approved by the member or his/her authorized representative, and with full disclosure that other services proposed in the treatment plan will not be provided based on the current amount approved for dental services in the member's PCSP.

9. The Contractor shall not authorize nor reimburse dental services for ECF CHOICES members that are not covered under the TennCare ECF CHOICES DBM Program, except for dental services approved by a Member's MCO as a Cost-Effective Alternative Service. The Contractor shall track dental expenditures for each ECF CHOICES member and shall not authorize nor reimburse dental services for an ECF CHOICES member that exceed the amount approved for such services in the member's PCSP. Upon request, the Contractor shall also make available to TennCare ECF CHOICES DBM Program Participating Dental Providers the total dental expenditures that have been authorized and reimbursed for each ECF CHOICES Member served by any other TennCare ECF CHOICES DBM Program Participating Dental Providers in order to ensure that dental services are not provided to the member in excess of the amount approved for such services in the member's PCSP. Any authorization and reimbursement of dental services for TennCare ECF CHOICES DBM Program members that exceed the amount approved for such services in a Member's PCSP may subject the Contractor to liquidated damages pursuant to Attachment B.

10. The Contractor shall be responsible for the submission of encounter data to TennCare regarding Covered Services provided under the Contract and the TennCare ECF CHOICES DBM Program, including Covered Services authorized by a member's MCO as a Cost-Effective Alternative Service.

11. The Contractor shall only contract with dentists and dental providers who have completed TennCare's electronic provider registration process, have been issued a current valid Medicaid Provider number, and been placed in an eligible pool of providers which the Contractor can select from. All decisions regarding the Contractor's provider network, including but not limited to, which providers are permitted to participate in the Contractor's provider network, are the sole responsibility of the Contractor and made by the Contractor in its sole discretion.

12. TennCare shall deliver the most current version of the TennCare ECF CHOICES DBM Program Dental Fee Schedule referenced in section A.5.b.2(b) to the Contractor in writing promptly upon (and in no event more than three (3) business days following) its approval for use. This fee schedule is updated annually to reflect any additions, deletions and modifications made to the Code on Dental Procedures and Nomenclature /Current Dental Terminology (CDT) as published by the American Dental Association. The revised fee schedule becomes effective each January.

13. Requirements set forth in this Contract pertaining to TennCare dental benefits for children under age twenty one (21) that are not applicable to the Contractor's administration of dental benefits in the TennCare ECF CHOICES DBM Program are set forth in Contract Sections A.9, A.10.d, A.44, A.45, A.47, A.50, A.51, A.60, A.61, A.106, A.110, A.113, A.114, A.115, and A.164.

c. TPPOHP DBM Program Benefits

1. The Contractor shall provide enrollees in the TPPOHP DBM Program the following benefits from the date it receives notification of the TPPOHP DBM Program member's diagnosis of pregnancy until two (2) months postpartum. Covered benefits include the following services:

(a) Diagnostic

(b) Preventive – Fluoride treatments, Silver Diamine Fluoride (SDF), and teeth cleaning

(c) Restorative – Fillings

(d) Periodontal – Scaling and Deep Cleaning

(e) Oral Surgery – Extractions (simple, surgical, and soft tissue impacted), as well as

(f) Adjunctive General Services – Emergency relief of pain and nitrous oxide analgesia.

2. Applicable current dental terminology codes for the TPPOHP DBM Program include:

D0000's Codes Diagnostic	D1000's Codes Preventive	D2000's Codes Restorative	D4000's Codes Periodontal	D7000's Codes Oral Surgery	D9000's Codes Adjunctive General Services
D0120	D1110	D2140	D4341	D7140	D9110
D0140	D1206	D2150	D4342	D7210	D9230
D0150	D1208	D2160	D4355	D7220	
D0160	D1354	D2161		D7250	
D0220		D2330			
D0230		D2331			
D0270		D2332			

D0272		D2335			
D0273		D2391			
D0274		D2392			
D0330		D2393			
		D2394			
		D2920			
		D2931			

3. Once the Contractor is notified of the pregnancy status of a TPPOHP DBM Program enrollee, it shall establish a dental home for the enrollee and notify the enrollee in writing about their dental home. The Contractor shall send dental home contact information to the enrollee and information regarding how to access benefits and the resources available in the TPPOHP DBM Program. The Contractor shall also facilitate setting up dental appointments between the enrollee and their dental home dentist(s), including but not limited to scheduling appointments and contacting the dentist on behalf of the enrollee.

4. The Contractor shall provide education and outreach to TPPOHP DBM Program enrollees, including but not limited to, mailings that include the following two brochures, as approved by the State: *A Pregnant Women's Guide to Healthy Gums* and *A Guide to Your Young Child's Oral Health*. The Contractor shall also send enrollees a reminder notice to schedule an appointment with their dental home, as well as provide additional call and digital strategies as options for supplemental outreach to increase access and utilization.

5. The Contractor shall mail letters, as approved by the State, to participating TennCare dentists and physicians that describe the TPPOHP DBM Program objectives and the importance of screening pregnant women for oral health. The dentist packets shall include research links to articles on the oral health of mothers in relationship with babies, as well as a copy of the TPPOHP DBM Program welcome materials for new TPPOHP DBM Program members.

d. <u>TennCare Adult Dental DBM Program Benefits</u>

1. The Contractor shall provide enrollees in the TennCare Adult Dental DBM Program some of the following covered benefit services:

(a) Diagnostic;

(b) Preventive – Fluoride treatments, Silver Diamine Fluoride (SDF), and teeth cleaning;

(c) Restorative – Fillings;

(d) Endodontics – Root canals;

(e) Periodontal – Scaling and Deep Cleaning;

(f) Prosthodontics – crowns and dentures;

(g) Oral Surgery – Extractions (simple, surgical, and soft tissue impacted); and

(h) Adjunctive General Services – Emergency relief of pain and nitrous oxide inhalation analgesia.

2. Applicable current dental terminology codes for the TennCare Adult Dental DBM Program are listed in Attachment J.

3. Once the TennCare Adult Dental DBM Program is implemented, it will subsume the TPPOHP DBM Program and, although there will not be a dental home for adult TennCare members in general, there will continue to be a dental home for adult members who are pregnant and postpartum.

e. CoverKids DBM Program Benefits.

The Contractor shall be responsible for ensuring that the benefits itemized below in the CoverKids DBM Program Dental Service Category table are provided for CoverKids enrollees under age nineteen (19).

CoverKids DBM Program Dental Service Category

DENTAL BENEFITS	GROUP ONE CHILD	GROUP TWO CHILD	AMERICAN INDIAN/ ALASKAN NATIVE (AI/AN) CHILD
Preventive -- Fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a calendar year up to age 14 -- Dental sealants for permanent molars, no limit -- 2 cleanings per calendar year -- Silver Diamine Fluoride (SDF) four applications per tooth per lifetime	No copayment	No copayment	No copayment
Diagnostic Services -- 2 oral exams per calendar year	No copayment	No copayment	No copayment

Emergency Services -- 2 visits per calendar year during office hours -- 2 visits per calendar year after office hours	$15 copayment	$5 copayment	No copayment
Restorative Services -- Stainless steel crowns -- Routine fillings (silver or tooth colored)	$15 copayment	$5 copayment	No copayment
Extractions	$15 copayment	$5 copayment	No copayment
Radiographs -- Bitewing x-rays no more frequently than once per calendar year (2 years of age and older -- Full mouth x-rays no more frequently than once every three calendar years	No copayment	No copayment	No copayment
Therapeutic Pulpotomy	$15 copayment	$5 copayment	No copayment
Anesthesia	$15 copayment	$5 copayment	No copayment
Other Dental Services	$15 copayment	$5 copayment	No copayment
Orthodontics Services • **12-month waiting period***	$15 copayment	$5 copayment	No copayment
Deductibles	None	None	None
Annual Benefit Maximum per child	$1,000	$1,000	$1,000
Lifetime Orthodontics Maximum amount person**	$1250	$1250	$1250
Annual Out of Pocket Maximum as a Percentage (%) of Family Income per calendar year	5%	5%	Not applicable

Note: The copayments indicated above are the maximum amounts allowable per visit. No more than one (1) copayment shall be charged for a single visit.

** The Lifetime Orthodontics Maximum limit is not applicable to the family's five percent (5%) cost sharing.

1. The benefit shall not exceed one thousand dollars ($1,000) per child per calendar year. For the purpose of the annual maximum, the time period shall be the twelve (12) months of the calendar year beginning with the child's original effective date of coverage (beginning of a month). Calendar year 2020 will begin no later than January 1, 2020 and extend to December 31, 2020.

2. Notwithstanding the benefit cap of one thousand dollars ($1,000) per child, the Contractor shall, at a minimum, provide to each enrollee the services required by the CoverKids DBM Program basic dental package detailed below.

COVERKIDS DBM PROGRAM DENTAL SERVICE CATEGORY **Provided during a calendar year without consideration of the benefit cap of $1,000**		
Type of Dental Service	**Frequency during a calendar year**	**Service by Dental Code**
Preventive	No less than one (1) service	D1120
Diagnostic Services	No less than one (1) service	D0120 D0150
Emergency Services	No less than two (2) services	D9110 D9440
Restorative Services	No less than two (2)services	D2140 D2150 D2160 D2330 D2331
Extractions	No less than two (2) services	D7140 D7210 D7250
Radiographs	No less than one (1) service	D0210 D0220 D0230 D0270 D0272
Anesthesia	Whenever medically indicated	D9230 D9248
Orthodontics		D8020 D8030 D8080 D8210 D8220 D8660

COVERKIDS DBM PROGRAM DENTAL SERVICE CATEGORY Provided during a calendar year without consideration of the benefit cap of $1,000		
Type of Dental Service	**Frequency during a calendar year**	**Service by Dental Code**
		D8670 D8680 D8999

3. The complete list of CoverKids DBM Program dental service categories by CDT Codes, subject to medical necessity determination by the Contractor, is located in Contract Attachment D, Dental Service Categories by Dental CDT Codes.

4. The Contractor shall maintain a year to date calculation of all copayments required from CoverKids enrollees. The Contractor shall also maintain, in its enrollment database, an indicator which identifies enrollees that are subject to the application of the five percent (5%) out of pocket cap during any specific calendar year. This five percent (5%) out of pocket maximum is accumulated across all benefits (medical, vision, and dental). The Contractor shall coordinate with the MCO in order to calculate the accumulated out of pocket maximum.

5. In instances where an enrollee is no longer required to pay a copayment for a service because the enrollee has met the five percent (5%) out of pocket cap through medical, dental or a combination of these, the Contractor shall pay the provider the full allowable amount. In these cases, the Contractor shall apply the allowable amount less the applicable copayment to the $1,000 payment cap.

5. Contract Section A.6 is deleted in its entirety and replaced with the following:

A.6. TennCare DBM Programs Enrollee Cost Share Responsibilities

The Contractor and its providers and subcontractors shall not require any cost sharing responsibilities of enrollees for covered services, except to the extent that cost sharing responsibilities are required for those services in the various TennCare DBM Programs and in accordance with applicable rules and regulations or approved policies and procedures. The Contractor and its providers and subcontractors shall not charge enrollees for missed appointments. Enrollees shall not be held liable for payments in the event of the Contractor's insolvency, or in the event the State does not pay the Contractor, or the Contractor does not pay its provider.

a. TennCare Children's DBM Program

1. Enrollee Cost Share Responsibilities. The Contractor and its providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TennCare in accordance with TennCare rules and regulations or TennCare approved policies and procedures for TennCare enrollees, nor may the

Contractor and its providers and subcontractors charge enrollees for missed appointments. Enrollees may not be held liable for payments in the event of the Contractor's insolvency- or in the event the State does not pay the Contractor, or the Contractor does not pay its provider.

Cost sharing responsibilities shall apply to services for children under age twenty one (21) years of age enrolled in TennCare Standard per TennCare Rule 1200-13-14-.05 other than the preventive services described in Section A.4 and specified in the table below. Co-payments shall be applied on a sliding scale according to the enrollee's income. The procedure code listing for preventive services is as follows:

TennCare Standard Preventive Dental Services for Children Under 21 Years of Age

D1110	Prophylaxis –adult (when billed for children over age 13 and under age 21)
D1120	Prophylaxis child
D1206	Topical Fluoride Varnish
D1208	Topical Application of Fluoride
D1310	Nutritional Counseling for Control of Dental Disease
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease
D1330	Oral Hygiene Instructions
D1351	Sealant per tooth
D1352	Preventive Resin Restoration
D1353	Sealant Repair – Per Tooth
D1354	Interim Caries Arresting Medicament Application/ Silver Diamine Fluoride

2. The current sliding scale schedule to be used in determining applicable cost sharing responsibilities for TennCare Standard enrollees under age twenty one (21) years of age is described in the following chart:

Co-Pay	0 to 100% of Poverty	101-199% of Poverty	200% and Above Poverty
Dental visits	0	$5 per visit	$20 per visit

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

(b) The Contractor shall be expressly prohibited from waiving or using any alternative cost sharing schedules, unless required and approved in writing by TennCare. Further, the Contractor shall not discourage enrollees from paying applicable co-payment obligations. If, and at such time as changes occur to the cost sharing rules, the Contractor will be notified of new co-payment rates.

(c) The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service. A provider or a collection agency acting on the provider's behalf shall not bill the enrollee for more than the allowable copay. If the Contractor discovers that the enrollee is being inappropriately billed, it shall notify the provider or collection agency to cease and desist billing immediately. After notification by the Contractor, if a provider continues to bill an enrollee, the Contractor shall refer the provider to the Tennessee Bureau of Investigations (TBI).

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

(a) If the services are not covered by TennCare and the provider informed the enrollee the services were not covered prior to providing the service. This shall include any services provided to a member who is an ECF CHOICES member ("ECF CHOICES Member") that exceed the amount approved in the ECF CHOICES Member's PCSP. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service; or

(b) If the person'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; or

(c) If the person's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable cost share amounts shall be refunded when a claim is submitted to the Contractor if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. In this case, the monies collected shall be refunded by the provider as soon as a claim is submitted and shall not be held conditionally upon payment of the claim.

4. Dental services in the TennCare ECF CHOICES DBM Program shall be reimbursed only when the TennCare ECF CHOICES DBM Program member was enrolled in the TennCare ECF CHOICES DBM Program at the time the service was delivered, and subject to the amount approved for such services in the ECF CHOICES Member's PCSP. The procedure codes listing for TennCare ECF CHOICES DBM Program preventive services are as follows:

Preventive Services – TennCare ECF CHOICES DBM Program

D1110	Prophylaxis –adult
D1206	Topical Fluoride Varnish
D1208	Topical Application of Fluoride
D1352	Preventive Resin Restoration
D1354	Interim Caries Arresting Medicament Application/ Silver Diamine Fluoride

a. TennCare ECF CHOICES DBM Program Cost Sharing

The Contractor is not responsible for administering any cost share responsibilities for dental services in the TennCare ECF CHOICES DBM Program. Collection of any Patient Liability amounts due from an ECF CHOICES Member pursuant to federal post-eligibility provisions shall be the responsibility of the member's MCO.

b. TennCare Adults with Intellectual or Developmental Disabilities Dental Program Cost Sharing

The Contractor is not responsible for administering any cost share responsibilities for dental services in the TennCare Adults with Intellectual or Developmental Disabilities Dental Program. Collection of any Patient Liability amounts due from an Adults with Intellectual or Developmental Disabilities Dental Program member pursuant to federal post-eligibility provisions shall be the responsibility of the member's MCO.

c. TPPOHP DBM Program Cost Sharing

The Contractor is not responsible for administering any cost share responsibilities for the TPPOHP DBM Program. Collection of any Patient Liability amounts due from a TPPOHP DBM Program member pursuant to federal post-eligibility provisions shall be the responsibility of the member's MCO.

d. Adult Dental DBM Program Cost Sharing

The Contractor is not responsible for administering any cost share responsibilities for the Adult Dental DBM Program. Collection of any Patient Liability amounts due from an Adult Dental DBM Program member pursuant to federal post-eligibility provisions shall be the responsibility of the member's MCO.

e. CoverKids DBM Program Cost Sharing.

1. Contract Sections A.6.d.1 through A.6.d.4 shall only apply to enrollees in the CoverKids DBM Program. The Contractor shall report cost sharing requirements, based upon claims filed by providers, to the Medical Plan Administrator on a daily basis. The Medical Plan Administrator provides comprehensive health coverage to CoverKids members. The information, which shall include patient name, date of service and patient copayment/coinsurance, shall be transmitted to the Medical Plan Administrator in an encrypted, secure electronic file via that data transfer method specified in advance by the State. The Medical Plan Administrator shall report to the Contractor on a daily basis the information on CoverKids enrollees who have met or exceeded the five percent (5%) out of pocket maximum. The Medical Plan Administrator and the Contractor shall enter into a business associates agreement, as required by the federal Health Insurance Portability and Accountability Act.

2. When advised by the Medical Plan Administrator that the CoverKids enrollee has reached or exceeded the out of pocket maximum, the Contractor shall provide information through written correspondence to the CoverKids enrollee advising him/her that for the balance of the plan year he/she will no longer be required to pay copayments/coinsurance for covered CoverKids DBM Program dental expenses. The Contractor shall not have responsibility for the reimbursement to the family when the five percent (5%) out of pocket maximum has been met. In situations where the CoverKids enrollee's family has exceeded the five percent (5%) out of pocket maximum, the Medical Plan Administrator and the Contractor shall be responsible for notifying the providers of the provider's responsibility to reimburse the family.

3. The Contractor shall maintain a process, through a service center, that enables providers to verify that the CoverKids DBM Program enrollee has reached or exceeded their annual out of pocket maximum.

4. Network providers and collection agencies acting on the provider's behalf may not bill enrollees for any amounts other than the applicable cost sharing responsibilities applicable to the CoverKids DBM Program. Providers may seek payment from an enrollee in the following situation: If the service(s) is not covered by the CoverKids DBM Program, the provider shall inform the enrollee that the service(s) is not covered prior to providing the service. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge receipt of this information. If the enrollee still requests the non-covered service, the provider shall obtain such acknowledgment in writing prior to rendering the non-covered service. The provider may bill the enrollee the total amount specified in the provider participation agreement. Non-covered services will not apply to any service or benefit

maximum accumulators. Where the enrollee is a minor, the provider shall not provide any non-covered service without first advising the enrollee's parent or guardian in writing that the service is not covered and obtaining a written acknowledgement signed by the enrollee's parent or guardian.

6. Contract Section A.10 is deleted in its entirety and replaced with the following:

A.10. Enrollee Materials Requirements

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

a. Member Handbook

1. The Contractor shall develop a member handbook based on a template provided by TennCare and update its member handbook when major changes occur within the State DBM Programs, with the Contractor or upon request by TennCare. The member handbooks shall contain the actual date it was printed either on the handbook or on the first page within the handbook. Member handbooks must be distributed to enrollee within thirty (30) days of receipt of notice of enrollment in a State DBM Program. In situations where there is more than one (1) enrollee in a TennCare case, it shall be acceptable for the Contractor to mail one (1) member handbook to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to the enrollee. If an individual is enrolled and added into an existing case, a new or updated member handbook must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to another enrollee in the existing case.

2. Upon notice by TennCare of State DBM Program benefit changes, the Contractor shall make the appropriate revisions to the member handbook. Since TennCare Medicaid children and TennCare Standard children receive the same dental benefits, only one Member Handbook will be required for both populations. The Contractor shall also draft separate Member Handbooks for each of the other TennCare DBM Programs. The Contractor shall not disseminate the member handbook until all revisions are approved by TennCare prior to dissemination.

3. Once materials are approved by TennCare, the Contractor shall submit an electronic version (pdf) of the final product, unless otherwise specified by TennCare, within thirty (30) calendar days from the print date. If the print date exceeds thirty (30) calendar days from the date of approval, the Contractor shall submit a written notification to the TennCare Member Materials Coordinator to

specify a print date. Should TennCare request original prints be submitted in hard copy, photocopies may not be submitted as a final product. Upon request, the Contractor shall provide additional original prints of the final product to TennCare. When large distributions of the member handbook occur, the Contractor must submit to TennCare the date the information was mailed to the enrollees along with an invoice or a specific document to indicate the date and volume of handbooks mailed. Each member handbook shall, at a minimum, be in accordance with the following guidelines:

(a) Must be in accordance with all applicable requirements as described in this contract.

(b) Shall include a table of contents;

(c) Shall include an explanation on how enrollees will be notified of member specific information such as effective date of enrollment.

(d) Shall include a description of services provided including limitations, exclusions and out-of-plan use;

(e) Shall include a description of applicable cost share responsibilities for eligible individuals including an explanation that providers and/or the DBM may utilize whatever legal actions that are available to collect these amounts;

(f) Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to providers outside of the plan. The handbook should advise enrollees 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;

(g) Shall explain that prior authorization is required for some services, including non-emergency services provided by a non-contract provider, that such services will be covered and reimbursed only if such prior authorization/service authorization is received before the service is provided; that all prior authorizations/service authorizations are null and void upon expiration of a member's TennCare eligibility; and that the member shall be responsible for payment for any services provided after the member's eligibility has expired;

(h) Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the Contractor's service area;

(i) Shall include grievance/appeal procedures as described in Sections A.116 through A.132 of the Contract;

(j) Shall include written policies on enrollee rights and responsibilities as described in Section A.144;

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

(l) Shall include notice to the member that it is the member's responsibility to notify the Contractor, TennCare, and DHS (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify DHS (or for SSI eligibles, SSA) could result in the member not receiving important eligibility and/or benefit information;

(m) Shall include the toll free telephone number for TennCare with a statement that the enrollee may contact the plan or TennCare regarding questions about TennCare. The TennCare Family Assistance Service Center number is 1-866-311-4287. Shall also include the toll free telephone number for CoverKids with a statement that the enrollee may contact the plan or CoverKids regarding questions about CoverKids. The CoverKids Call Center number is 1-866-620-8864;

(n) Shall include information that the enrollee has a right to receive services without being treated in a different way because of race, color, national origin, language, sex, age, religion, or disability or other protected statuses and that they have a right to file a complaint. Information shall also be provided on how to obtain free language and communication assistance services, such as, auxiliary aids or services and how to access language interpretation and written translation services as well as a statement that these services are free;

(o) Shall include information educating enrollees of their rights and necessary steps to amend their data in accordance with HIPAA regulations;

(p) Shall include other information on requirements for accessing services to which they are entitled under the contract including, but not limited to, factors such as physical access and non-English languages spoken as required in 42 § CFR 438.10;

(q) Shall include a copy of TennCare's discrimination complaint forms;

(r) Shall include information about preventive services; and

(s) Shall include information about the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and how to access component services.

b. Member Newsletter

The Contractor shall, at a minimum, distribute on a quarterly basis a newsletter to all State DBM Program enrollees which is intended to educate the enrollee about the managed care system, proper utilization of services, and encourage utilization of preventive care services.

1 The Contractor shall include the following information, in each newsletter:

(a) Specific articles or other specific information as described when requested by TennCare. Such requests by TennCare shall be limited to two hundred (200) words and shall include sufficient notification of information to be included;

(b) The TennCare taglines and nondiscrimination notice, which includes the procedures on how to obtain free language and communication assistance services like language interpretation and written translation services and auxiliary aids or services, how to file discrimination complaints, and any other TennCare information on how individuals with disabilities can request assistance with accessing services or other program benefits. Electronic versions of the quarterly member newsletters do not need to contain this information as it is readily available to members on the DBM's website. This information shall comply with the Contract requirements set forth in A.13 and at a minimum be available in the English and Spanish newsletters; and

(c) The TennCare taglines, nondiscrimination notice, and any other TennCare information on how individuals with disabilities can request assistance with accessing services or other program benefits. This information shall comply with the Contract requirements set forth in A.13 and at a minimum be available in the English and Spanish newsletters.

2. The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the Contractor shall also submit to TennCare, five (5) final printed originals, unless otherwise specified by TennCare, of the newsletters and documentation from the DBM's mail room or outside vendor indicating the quantity and date mailed to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in this Contract.

3. The Contractor shall also include in the newsletter notice to the enrollee 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 and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, and 42 U.S.C.A. § 18116 and a Contractor contact phone number for doing so. The notice shall be in the English and Spanish newsletters.

c. <u>Provider Directory</u>

The Contractor shall be responsible for providing information on how to access the provider directory, including the right to request a hard copy, how to contact member services, and how to access the searchable version of the provider directory on the Contractor's website to new enrollees within thirty (30) calendar days of receipt of notification of enrollment in the plan. The Contractor shall also be responsible for redistribution of updated provider

information on a regular basis and shall make available a complete and updated provider directory at least on an annual basis.

1. The provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken and cultural and linguistic capabilities including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, whether offices/facilities have accommodations for people with physical disabilities including offices, exam room(s) and equipment, specialties as appropriate by current network providers, and identification of providers accepting new patients.

2. Enrollee provider directories, and any revisions thereto, shall be submitted to TennCare for approval prior to distribution to enrollees. The text of the directory shall be in Microsoft Word or Adobe (pdf) format. In addition, the provider information used to populate the enrollee provider directory shall be submitted as a TXT file or such format as otherwise approved by TennCare and be produced using the same extract process as the actual enrollee provider directory.

3. In situations where there is more than one (1) enrollee in a TennCare case, it shall be acceptable for the Contractor to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.

4 The Contractor shall provide a Provider Listing specific to each TennCare DBM Program, which shall include a breakdown by specialist. However, all provider directories shall be approved by TennCare prior to the Contractor's distribution.

d. Dental Notices. The Contractor shall be responsible for distributing dental appointment notices annually to the head of household for all TennCare child enrollees who have not had a dental service within the past year.

7. Contract Section A.13 is deleted in its entirety and replaced with the following:

A.13. Written Material Guidelines

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

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

c. All written materials shall be printed with the notice of non-discrimination and taglines as required by TennCare and set forth in TennCare's tagline template. In addition to any other requirements specified in the member materials requirement sections, the Contractor may also provide required member materials/information electronically or on its website pursuant to the specifications set forth in the A.165 the nondiscrimination section of this Contract, TennCare's tagline template, and the following requirements: (1) the material/information must be placed on the Contractor's website in a location that is prominent and readily accessible for applicants and members to link to from Contractor's

home page; (2) the material/information must be provided in a format that can be electronically saved and printed; and (3) if a member or applicant requests that the Contractor mail them a copy of the material/information, the Contractor must mail free of charge the material/information to them within five (5) days of that request. To the extent that the Contractor and its providers and/or subcontractors are using electronic and information technology to fulfill its obligations under this Contract, the entities shall comply with requirements set forth in Section A.165 the nondiscrimination section of this Contract.

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

1. The Seal of the State of Tennessee;

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

3. The CoverKids[sm] name unless the initials "SM" denoting a service mark, are superscripted to the right of the name;

4. The word "free" can only be used if the service is no cost to all enrollees; and

5. Any of the Program names and logos, unless permission is given by the State.

e. Within ninety (90) calendar days of notification from TennCare, all vital Contractor documents related to this Contract shall be translated and available to each Limited English Proficiency ("LEP") group identified by TennCare in accordance with the applicable standards set forth below:

1. If a LEP group constitutes five percent (5%) or 1,000, whichever is less, of the population targeted under this Contract, vital documents shall be translated into that LEP language. Translation of other documents, if needed, can be provided orally; or

2. If there are fewer than fifty (50) individuals in a language group that is part the population targeted under this Contract that reaches the five percent (5%) trigger in (a), the Contractor shall inform those individuals that it does not provide written translation of vital documents but provides written notice in that group's primary language of the right to receive competent oral interpretation of those written materials, free of cost.
3. At a minimum, all vital Contractor documents shall be translated and available in Spanish.

f. All written member materials shall notify enrollees that free language and communication assistance services like auxiliary aids or services, language interpretation, and written translation services are available at no expense to the member and how to access those services.

g. All written member materials shall ensure effective communication with individuals who need language and communication assistance services, like individuals who are LEP or individuals with disabilities at no expense to the enrollee and/or the enrollee's representative. Effective Communication may be achieved by providing interpreters and auxiliary aids or services, including, but may not be limited to: Braille, large print, and audio and shall be based on the needs of the individual enrollee. The Contractor and its providers and direct service subcontractors shall be required to comply with the applicable federal and state nondiscrimination laws. These laws require Title III of the Americans with Disabilities Act of 1990 in the provision of language and communication assistance auxiliary

aids and services to enrollees to achieve effective communication. In the event that the enrollee's requested language or communication assistance provision of auxiliary aids and services to an enrollee is not readily achievable by the Contractor's providers or direct service subcontractors, the Contractor shall provide the enrollee with a language or communication assistance the auxiliary aid or service that would result in effective communication with the enrollee.

h. The Contractor shall provide written notice of any changes in policies or procedures described in written materials previously sent to enrollees at least thirty (30) days before the effective date of the change to provide TennCare an opportunity to review prior to the changes taking effect.

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

j. The Contractor shall use the TennCare approved glossary of required Spanish terms in the Spanish translation of all member materials.

8. Contract Section A.17 is deleted in its entirety and replaced with the following:

A.17. Key Staff

The Contractor shall maintain sufficient levels of staff, including supervisory and support staff, with appropriate training, work experience, and expertise to perform all contract requirements on an ongoing basis and be available to attend meetings as requested by TennCare. Key Staff personnel shall be assigned solely to work on matters arising under this Contract unless specific permission to the contrary is given by TennCare. The Contractor shall request approval from the State for all Key Staff candidates prior to assigning them to work on this Contract. The State may, in its sole discretion, require the Contractor's proposed Key Staff candidates to interview with the State. The State shall have the discretion to approve or disapprove of the Contractor's and any of its subcontractor's Key Staff, or to require the removal or reassignment of any Contractor's employee or subcontractor personnel found unacceptable to the State for work under this Contract only. Unless otherwise approved in advance in writing by the State, all of Contractor's Key Staff shall be full time staff who are one hundred percent (100%) dedicated to working on this Contract and may not hold more than one (1) Key Staff position at the same time. Unless specifically stated to the contrary in Section A.17, key staff are required to be physically located in the Davidson County Tennessee office. Key Staff shall include but are not limited to the following positions:

a. DBM Project Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Project Director one hundred percent (100%) dedicated to this Contract who has day-to-day authority to manage the total project. The Project Director shall be readily available to TennCare staff during regular working hours. The Project Director shall be physically located in the Contractor's Tennessee location as specified in Contract Section A.15.

b. DBM Dental Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Dental Director one hundred percent (100%) dedicated to this Contract who has day-to-day authority to manage the clinical aspects of the project. A dentist who is licensed by the Tennessee Board of Dentistry, in good standing, and physically located in the State of Tennessee shall serve as full-time DBM Dental Director to oversee and be responsible for the proper provision of medically necessary covered services for enrollees. The DBM Dental Director shall be closely involved in the monitoring of program integrity, quality, utilization management and utilization review, provider corrective action, site visits, credentialing processes, and Performance Improvement Projects (PIPs). The DBM Dental Director shall serve on the Peer Review Committee as chairperson, and on the Quality

Monitoring Program (QMP) Committee and Credentialing Committee. The DBM Dental Director shall attend all TennCare Dental Advisory Committee (TDAC) meetings and be on the quarterly meeting agenda when needed to present recommendations regarding changes to clinical guidelines.

c. Staff Dentist for the TennCare ECF CHOICES DBM Program - The Contractor shall designate and maintain, subject to TennCare approval, a full-time staff dentist reporting to the DBM Dental Director. The Staff Dentist shall be primarily focused on benefits provided under the TennCare ECF CHOICES DBM Program but may also support the CoverKids DBM Program and the TPPOHP DBM Program as time permits. The Staff Dentist shall be licensed by the Tennessee Board of Dentistry, be in good standing, and physically located in the State of Tennessee. The Staff Dentist shall have at least five (5) years of experience directing dental services for people with I/DD or have completed a residency or certification program specific to the provision of dental services for people with I/DD and at least two (2) years of experience providing dental services for people with I/DD and demonstrate to TennCare the ability to lead and direct adult dental services for the TennCare ECF CHOICES DBM Program. The Staff Dentist shall be responsible for the clinical oversight of TennCare ECF CHOICES DBM Program adult dental benefits, including, but not limited to, quality, utilization management and utilization review, site visits and credentialing of providers for the TennCare ECF CHOICES DBM Program dental network, development of clinical practice standards and clinical policies and procedures, PIPs pertaining to the TennCare ECF CHOICES DBM Program, provider corrective actions, leadership in training and development of the TennCare ECF CHOICES DBM Program dental provider network, and development of statewide capacity to provide dental services to individuals with I/DD broadly, including children with I/DD receiving dental services pursuant to EPSDT or the CoverKids DBM Program, and participation in meetings as requested by TennCare. The Staff Dentist shall be hired no later than sixty (60) calendar days prior to TennCare Programs Go-Live Date.

d. EPSDT Outreach Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, a full-time EPSDT Outreach Coordinator, physically located in Tennessee, whose primary duties include development and implementation of the Contractor's strategy to increase enrollee utilization of dental services by TennCare enrollees under the age of twenty-one (21) years of age.

e. PCDH and Member Outreach Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Patient Centered Dental Home (PCDH) and Member Outreach Coordinator physically located in Tennessee whose primary duties will support key areas of the TennCare and Contractor's Dental Strategy and increased utilization of high-value preventative dental services. At a minimum, the Coordinator will support outreach, coaching, and education to TennCare Patient Centered Dental Homes; and the coordinator will support member outreach and engagement, particularly focusing on hard-to-reach patient populations and underutilizing TennCare enrollees. TennCare and the Contractor will jointly design the scope of responsibilities and high-value activities that the Coordinator will conduct in alignment with the TennCare and Contractor's Dental strategy. TennCare and the Contractor will mutually agree upon start date for this position but no later than six (6) months after go-live.

f. Client-Partner Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, one full-time (1 FTE) person physically located in Tennessee to

coordinate dental services between the DBM and MCO specific to the TennCare Adult Dental DBM Program. The Client-Partner Coordinator position shall not be filled with any person concurrently employed by the Contractor as the MCO-DBM Coordinator. Prior to program implementation and thereafter through the duration of this Contract, the Client-Partner Coordinator shall develop and maintain, a system for data exchange with the MCOs and the Contractor, which shall include, at minimum, functionality to exchange the following information: referrals; treatment plans; stratification of proposed treatment plan procedures; authorizations; and other information as determined necessary by TennCare for the TennCare Adult Dental DBM Program.

g. Regulatory Compliance Manager – The Contractor shall designate and maintain, subject to TennCare approval, a full-time Regulatory Compliance Manager, physically located in Tennessee. The Regulatory Compliance Manager shall possess a thorough knowledge regarding investigations related to provider fraud and abuse in the TennCare program and will be the key staff handling day-to-day provider investigation related to inquiries from TennCare and TBI MFCU.

h. Provider Network Director – The Contractor shall designate and maintain, subject to TennCare approval, a Provider Network Director, physically located in Tennessee, responsible for network development and management to ensure that there is a statewide dental network adequate to make services, service locations and service sites available and accessible in accordance with the terms and conditions for access and availability outlined in the Contract, The Provider Network Director shall coordinate with other areas of the Contractor's organization that may impact provider recruitment, retention or termination. The Provider Network Director will also ensure that the provider enrollment file and the Insure Kids Now (IKN) files are accurate and delivered to TennCare timely. The Provider Network Director shall have a provider service line staffed adequately to respond to providers' questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in this Contract.

i. Adult Dental Program Provider Network Director – The Contractor shall designate and maintain, subject to TennCare approval, a full-time Adult Dental Program Provider Network Director, physically located in Tennessee, responsible for network development and management to ensure that there is a statewide Adult Dental network adequate to make services, service locations and service sites available and accessible in accordance with the terms and conditions for access and availability outlined in the Contract, and a TennCare ECF CHOICES DBM Program and TennCare Adults with Intellectual or Developmental Disabilities Dental Program network of participating Dental Providers, including both traditional and preventative dental services and specialists such as oral surgeons who have experience and/or expertise in serving individuals with intellectual and developmental disabilities with preferred contracting standards as defined in Section A.21 of this Contract. The Adult Dental Program Provider Network Director shall coordinate with other areas of the Contractor's organization that may impact provider recruitment, retention or termination, including for the TennCare ECF CHOICES DBM Program, TennCare Adults with Intellectual or Developmental Disabilities Dental Program, the TennCare Staff Dentist for the ECF CHOICES DBM Program, TennCare Adults with Intellectual or Developmental Disabilities Dental Program, and TennCare Adult Dental DBM Program. The Adult Dental Program Provider Network Director will also ensure that the provider enrollment file and

the Insure Kids Now (IKN) files are accurate and delivered to TennCare timely, and that TennCare ECF CHOICES DBM Program and TennCare Adults with Intellectual or Developmental Disabilities Dental Program Participating Dental Providers are clearly identified. The Adult Dental Program Provider Network Director shall have a provider service line staffed adequately to respond to providers' questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in this Contract.

j. Provider Representatives – The Contractor shall designate and maintain, subject to TennCare approval, a minimum of five (5) full-time Provider Representatives physically located in Tennessee to educate and assist participating dental providers in working with all State DBM Programs, including, but not limited to, management of TennCare ECF CHOICES DBM Program dental benefits and benefit limits, TennCare Adults with Intellectual or Developmental Disabilities Dental Program benefits and benefit limits, CoverKids DBM Program benefits and benefit limits, TPPOHP DBM Program benefits and benefit limits, and TennCare Adult Dental DBM Program . Each of the five (5) full-time Provider Representatives shall be assigned to work in one Grand Region within the state of Tennessee and shall be completely familiar with the operation of all of the applicable State DBM Programs in their respective region. For the TennCare ECF CHOICES DBM Program and TennCare Adults with Intellectual or Developmental Disabilities Dental Program, Provider Representatives shall educate and assist TennCare ECF CHOICES DBM Program and TennCare Adults with Intellectual or Developmental Disabilities Dental Program participating dental providers in working with utilization management programs specific to TennCare ECF CHOICES DBM Program adult dental benefits, including, but not limited to, management of adult dental benefits and benefit limits, prior authorizations requests (including initial evaluation and treatment plan approval), electronic billing, compliance initiatives, or other program requirements as specified by TennCare.

k. Data Research Analyst – The Contractor shall designate and maintain, subject to TennCare approval, one (1) Data Research Analyst responsible for generating daily, weekly, monthly, quarterly and yearly reports required by the Contract, in addition to all ad hoc requests made by TennCare, in formats requested by TennCare. The Data Research Analyst shall be expert in data that is warehoused by Contractor on behalf of TennCare and shall be available to assist TennCare staff with Contractor's decision support systems. The Data Research Analyst shall provide expertise and assistance in provider post utilization review, establishing benchmarks for procedures prone to provider fraud and abuse that don't require prior authorization, evaluation of provider's treatment patterns, identification of provider outliers, and drawing statistically valid random sample (SVRS) of dental records, utilizing a ninety five percent (95%) confidence interval, specific to the procedure(s) where the provider is an outlier. The Data Research Analyst position is not required to be located in Tennessee office.

l. System Liaison- The Contractor shall designate and maintain, subject to TennCare approval, one (1) system liaison responsible for, but not limited to, the planning and timely coding of edits to the Contractor's system when requested by TennCare, and the quality control of such edits to ensure proper functioning within the system, and to ensure that newly entered system changes and edits do not affect existing edits within Contractor's system causing unanticipated adverse system events affecting TennCare's claims, enrollees and providers. The System Liaison shall be responsible for all testing of new

programs or modules to be used by Contractor to manage TennCare's business. The System Liaison shall also be responsible for the maintenance and management of Contractor's website, including updating. The System Liaison position is not required to be located in the Tennessee office.

m. Member Materials and Marketing Coordinator – The Contractor shall designate and maintain, subject to TennCare approval, one (1) Member Materials and Marketing Coordinator responsible for ensuring that all member materials including, but not limited to, member handbooks, provider directories, member newsletters, dental reminder notices, fact sheets, notices or any other materials necessary to provide information to enrollees as developed by the Contractor, including materials specific to adult dental benefits in the TennCare ECF CHOICES DBM Program and TennCare Adults with Intellectual or Developmental Disabilities Dental Program, are approved by TennCare and disseminated timely.

n. Fraud and Abuse Investigators – One (1) Fraud and Abuse Investigator dedicated to TennCare who shall be responsible for all fraud and abuse detection activities for the State DBM Programs, including the Fraud and Abuse Compliance Plan, and who shall be the Key Staff person handling day-to-day provider investigation-related inquiries from TennCare. This Fraud and Abuse Investigator shall be assisted, on an as-needed basis, with up to two (2) other designated Fraud and Abuse Investigators and one (1) staff person, all of whom may be located in the Contractor's corporate offices, but who have full knowledge of provider investigations related to the State DBM Programs and shall work with the TennCare Office of Program Integrity (OPI).

o. MCO and DBM Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, a full-time MCO Coordinator, physically located in Tennessee. The MCO Coordinator shall develop, prior to program implementation and maintain thereafter through the duration of this Contract, a system for data exchange with the MCOs and the Contractor, including, but not limited to, functionality to exchange the following information: referrals; treatment plans; stratification of proposed treatment plan procedures; authorizations; and other information as determined necessary by TennCare. Additionally, the MCO and DBM Coordinator shall be responsible for the requirements set forth in Section A.49.

p. The Contractor shall identify in writing the name and contact information for the Key Staff persons within thirty (30) days of Contract award. Any changes in Key Staff persons listed in this section during the term of this Contract shall be made within ten (10) business days after receipt of any required approvals from TennCare. The identity of each of the Key Staff persons listed above shall be disclosed on the Contractor's web site.

9. **Contract Section A.19 is deleted in its entirety and replaced with the following**:

A.19. General Requirements

The Contractor shall maintain and administer dental provider network(s) covering the entire State of Tennessee service area to serve eligible enrollees, in accordance with this Contract, with coverage to be effective on the respective TennCare Programs Go-Live and CoverKids Program Go-Live dates, TennCare Adult Dental DBM Program Go-Live date, and the Alternative TPPOHP Program Go-Live Date, if applicable. The Contractor shall arrange for the provision of all covered services described in this Contract. The Contractor shall maintain under contract, a state-wide

provider network, including General Dentists and Dental Specialists, adequate to make services, service locations, and service sites available and accessible in accordance with the terms and conditions for access and availability outlined for each of the respective State DBM Programs in Contract Section A.20. Each State DBM Programs enrollee shall be required to obtain covered services from any general or pediatric dentist in the Contractor's network(s) accepting new patients. Nothing in this Contract shall be construed to preclude the Contractor from closing portions of the network(s) to new providers when all conditions of access and availability are met.

10. Contract Section A.20 is deleted in its entirety and replaced with the following:

A.20. Access to Care

The Contractor shall maintain a network of State DBM Program dental providers with a sufficient number of providers who accept new enrollees in accordance with the geo access standards required under this Contract so that appointment waiting times do not exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care. The Contractor will maintain the general dentist network, so that there is a member to dentist ratio of no greater than two thousand (2,000) to one (1) at program go-live for Medicaid enrollees and no greater than one thousand eight hundred (1,800) to one (1) by year three (3) for Medicaid enrollees. TennCare reserves the right to reevaluate one (1) year post go-live and in subsequent years to determine if these network ratios are adequate to meet the needs of the members and make adjustments if changes are needed. This will ensure that there is network capacity that will enable all members to have their unmet dental needs addressed, through adequate appointment availability. The Contractor shall ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. Services must be available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. Performance on access to care shall be monitored by the Contractor. Additional monitoring of these standards may be conducted by TennCare and/or the External Quality Review Organization (EQRO). The Contractor shall consider the following when establishing its networks:

a. The anticipated Medicaid and CoverKids enrollment;

b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid and CoverKids populations represented in the DBM;

c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid and CoverKids services;

d. The numbers of network providers who are not accepting new Medicaid and CoverKids patients;

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

f. Mobile dental clinics shall not be considered in determining sufficient network access.

11. **Contract Section A.23 is deleted in its entirety and replaced with the following:**

A.23. Transport Distance and Time

The Contractor shall maintain under contract a statewide network of dental providers to provide the covered services specified in Sections A.4 and A.5, Obligations of the Contractor, including adult dental benefits provided through the TennCare ECF CHOICES DBM Program, TennCare Adults

with Intellectual or Developmental Disabilities Dental Program, and TennCare Adult Dental DBM Program. The Contractor shall make services, service locations and service sites available and accessible so that transport distance and time to general dental and dental specialty providers shall not exceed an average of thirty (30) miles or forty-five (45) minutes for general dental services; sixty (60) miles or sixty (60) minutes for oral surgery services; sixty (60) miles or sixty (60) minutes for orthodontic services; and, seventy (70) miles or seventy (70) minutes for pediatric dental services, as measured by geographic access software. The Contractor shall not refuse to credential a qualified provider, on the sole basis of the network already meeting the contractual distance accessibility standard, if there is a subset of enrollees in the proposed service area that must travel beyond the average standard to access dental care. The Contractor shall maintain under contract a network of TennCare ECF CHOICES DBM Program and TennCare Adults with Intellectual or Developmental Disabilities Dental Program Participating Dental Providers who have experience and/or expertise in serving individuals with intellectual and developmental disabilities with preferred contracting standards as defined in Section A.21 of this Contract, with seventy-five percent (75%) of such services, service locations, and service sites available and accessible so that transport distance to these providers shall not exceed an average of thirty (30) miles or forty-five (45) minutes, as measured by geographic access software, and one hundred percent (100%) of such services, service locations, and service sites shall be available and accessible so that transport distance to these providers shall not exceed an average of sixty (60) miles or sixty (60) minutes, as measured by geographic access software.

12. Contract Section A.27 is deleted in its entirety and replaced with the following:

A.27. Cultural Competency

The Contractor and its providers and subcontractors shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency, disabilities, and diverse cultural and ethnic backgrounds regardless of an enrollee's sex. This includes the Contractor emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities and diverse cultural and ethnic backgrounds.

13. Contract Section A.31 is deleted in its entirety and replaced with the following:

A.31. TRS/TDY

The Contractor shall make free of charge Telecommunications Relay Services ("TRS") to enrollees, which allow persons who are deaf, hard of hearing, deafblind, or have speech disabilities to communicate by telephone in a manner that is functionally equivalent to telephone services used by persons without such disabilities.

14. Contract Section A.62 is deleted in its entirety and replaced with the following:

A.62. General Requirements

The Contractor shall assure that medically necessary, covered services as specified in this Contract are provided. The Contractor shall enter into agreements with providers and/or provider subcontracting entities or organizations which will provide medically necessary services to the enrollees in exchange for payment from the Contractor for services rendered. The Contractor shall ensure that the Provider Agreement remains up-to-date and reflects applicable law or revisions to TennCare rules and Contractor policy. The initial provider template and revisions thereto must be submitted to TennCare and the TDCI for review and approval prior to distribution. Participating providers shall be apprised of revisions to the Provider Agreement by the Contractor through written notice thirty (30) days in advance of the implementation of the new template.

The Contractor is neither required to contract with providers beyond the number necessary to meet the needs of the enrollees, nor precluded from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollees. No provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the Contractor to TennCare to assure that all activities under this Contract are carried out.

There is no requirement that the Contractor enter into an agreement with a provider merely because the provider was a TennCare provider prior to the contract start date. The Contractor shall make every effort to enter into provider agreements with those entities whose practices exhibit a substantive balance between Medicaid and commercial patients. The Contractor shall enter into provider agreements that require a Patient-Centered Dental Home as defined in Contract Section A.63 for enrollees in the TennCare Children's DBM Program, CoverKids DBM Program, the TPPOHP DBM Program, and TennCare Adult Dental DBM Program. Mobile clinic providers should only be utilized in areas underserved by community providers willing to provide a dental home for members enrolled in the above DBM Programs. There will be granted an exception to this policy discouraging use of mobile providers in the case of state or local governmental programs designed to reach specific underserved populations, i.e. school children. Nothing in this Contract requires the Contractor to enter into agreements with dental providers if the Contractor believes such agreements might adversely affect the dental provider network.

15. Contract Section A.63 is deleted in its entirety and replaced with the following:

A.63. Patient-Centered Dental Home (PCDH)

The Contractor shall establish a Patient-Centered Dental Home (PCDH), which is defined as a place where an enrollee in the TennCare Children's DBM Program, CoverKids DBM Program, the TPPOHP DBM Program and TennCare Adult Dental DBM Program has oral health care delivered in a comprehensive, continuously accessible, coordinated and family centered way by a dentist participating in the above identified DBM programs.

One of the primary reasons for establishing the PCDH is to ensure that enrollees in the TennCare Children's DBM Program, CoverKids DBM Program, the TPPOHP DBM Program, and the TennCare Adult Dental DBM Program have access to a participating primary care dentist who is identified through member assignment. Provider acceptance and involvement is essential to success of the PCDH for beneficiaries. Members can either choose their dental home dentist or be assigned a dentist for care.

Individual primary care dentists must be able to access their roster of dental home assignments through their provider web portal established by the Contractor.

The dental home model is key component of TennCare's overall vision to transform the existing TennCare and CoverKids dental programs from dental restorative programs to more balanced programs that emphasize prevention and control of oral diseases through engagement of the DBM Contractor and its network of participating providers, to improve the health and quality of life for members.

The Contractor shall establish a robust oral disease prevention strategy. This strategy must, at a minimum, include prevention of early childhood caries through the "routine" use of topical fluorides such as fluoride varnish, as well as Silver Diamine Fluoride (SDF) for arresting the caries process,

as well as for Operating Room (OR) diversion by offering parents or guardians of child members a minimally invasive in-office dental treatment alternative to treatment under general anesthesia in a medical facility.

The oral disease prevention strategy must also include routine provider application of dental sealants for pit and fissure surfaces of first and second permanent molar teeth, as soon as these teeth have fully erupted into the oral cavity.

The Contractor shall also develop an individual confidential provider performance report (PPR) for the TennCare program that is sent to participating primary care dentists on a quarterly basis. The PPR is a provider educational tool to afford providers in the network the opportunity to see how their practice compares with their peers and the overall network average in cost, access, and preventive care. The preventive component of the PPR must include network benchmark averages for dental sealants for the 6-9 year old age group and 11-15 year old age group. The preventive component of PPR must also include comparisons to the SDF network benchmark and topical fluoride network benchmark. It is anticipated that sharing confidential feedback with providers through the PPR will result in a shift by those performing under the network benchmark average to modify their practice pattern to meet or exceed network benchmarks. In order to encourage quality and cost improvement, additional member assignments as well as reassignment of existing members to a dental home will be based upon the PPR or other pertinent reports. Section A.8, as well as Sections A.42.a and A.43.b., describe in detail the written corrective action plans that must be issued to providers for not complying with their dental provider agreement, ORM, or adhering to TennCare's medical necessity criteria or Contractor criteria in the provision of a procedure(s) including specific preventive procedure(s) such as SDF and Dental Sealants. This will ensure that TennCare members have access to dental home providers demonstrating a commitment to providing the highest quality care.

In order to effectively communicate the expectations of the new Patient Centered Dental Home initiatives to providers, a PCDH Provider Manual must be developed by the DBM and approved by TennCare and shared with the provider network. The PCDH Provider Manual must include criteria that discuss the reasons for assignment of new members and reassignment of existing members as well as corrective action plans, for quality of care purposes. Provider incentives must be awarded by the DBM in those contract years that the DBM receives a bonus from TennCare.

The PCDH Provider Manual must be updated as necessary, but at least annually.
The DBM must submit quarterly reports (in a format approved by TennCare) to TennCare that track assignment of new members and reassignment of existing members, as well as outreach and corrective action plans to providers.

16. Contract Section A.66.pp is deleted in its entirety and replaced with the following:

pp. The provider agreements shall include the following nondiscrimination provisions: Specify that the provider agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the provider on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal and, State laws and regulations;

1. Specify that the provider have written procedures and policies that demonstrate nondiscrimination in the provision of services, benefits, and/or activities concerning

TennCare enrollees like providing reasonable accommodations and language and communication assistance services for the provision of free language interpretation and translation services including auxiliary aids and services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;

2. Require the provider to agree to cooperate with TennCare and the Contractor during discrimination complaint investigations and to assist enrollees with obtaining discrimination complaint forms and contact information for MCO's Nondiscrimination Office. The Provider may direct individuals to TennCare's real-time complaint form at https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html; and

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

4. Ethical and Religious Directives. Should the Provider not provide certain services covered under this Agreement due to their sincerely held ethical/moral beliefs and/or religious directives the Provider will comply with the following requirements:

   a. The Provider will provide a list of the services it does not deliver due to the Ethical/Moral and Religious Directives to the Contractor. The Contractor will furnish this list to the State, notating those services that are TennCare covered services. This list will be used by the Contractor and the State to provide information to TennCare enrollees about where and how enrollees can obtain the services that are not being delivered by the Provider due to their sincerely held ethical/moral beliefs and/or religious directives.

   b. Should an issue arise at the time of service, the Provider will inform TennCare enrollees that the Contractor has additional information on providers and procedures that are covered by TENNCARE. The Provider is not required to make specific recommendations or referrals.

5. Electronic and Information Technology Accessibility Requirements. To the extent that the Provider is using electronic and information technology to interact with TennCare members, the Provider agrees to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508"), the Americans with Disabilities Act, and 45 C.F.R. pt. 92 (or any subsequent standard adopted by an oversight administrative body, including the Federal Accessibility Board). To comply with the accessibility requirements for Web content and non-Web electronic documents and software, the Provider will use the most current W3C's Web Content Accessibility Guidelines ("WCAG") level AA or higher with a goal to transition to WCAG 3 level silver (For the W3C's guidelines see: https://www.w3.org/WAI/standards-guidelines/; and for Section 508 standards see: https://www.access-board.gov/ict/).

6. Social Risk Factors of Health. The Contractor will partner with TennCare on initiatives aimed to address Social Risk Factors of Health as requested by

TennCare. This may include partnering with dentists to improve members' access to community resources.

17. **Contract Section A.67 is deleted in its entirety and replaced with the following**:

A.67. Provider Discrimination Prohibited

The Contractor shall have in place written policies and procedures for the selection and/or retention of providers and policies and procedures must not discriminate against particular provider that specialize in conditions that require costly treatment. The Contractor shall not discriminate in the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. The Contractor's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination.

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

18. Contract Section A.77 is deleted in its entirety and replaced with the following:

A.77. Subcontractor Nondiscrimination Provisions

If the Contractor delegates its responsibilities under this Agreement to subcontractors, the Contractor shall require the direct service subcontractors to comply with the following nondiscrimination requirements set forth in Section A.66. pp Provider Nondiscrimination Requirements:

a. Specify that the subcontractor agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of the delegated responsibilities pertaining to this Contract or in the employment practices of the subcontractor on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal and State laws and regulations;

b. Specify that the subcontractor have written procedures and policies for the provision of free language interpretation and translation services including auxiliary aids and services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;

c. Require the subcontractor to agree to cooperate with TennCare and the Contractor during discrimination complaint investigations, and

d. Require the subcontractor to assist TennCare enrollees in obtaining discrimination complaint forms and contact information for the Contractor's Nondiscrimination Office.

19. Contract Section A.116 is deleted in its entirety and replaced with the following:

A.116. TennCare Children's DBM Program, TennCare ECF CHOICES DBM Program, TennCare Adults with Intellectual or Developmental Disabilities Dental Program, Adult Dental DDBM Program and TPPOHP DBM Program

Contract Sections A.116 through A.132 shall only apply to the TennCare Children's DBM Program, TennCare ECF CHOICES DBM Program, TennCare Adults with Intellectual or Developmental Disabilities Dental Program, Adult Dental DBM Program, and TPPOHP DBM Program.

20. **Contract Section A.118.e is deleted in its entirety and replaced with the following**:

e. Reasonable Assistance with Grievance and Request for SFH.

1. In accordance with 42 CFR §438.406(a) and 42 CFR §438.228(a), Contractor shall give enrollees any reasonable assistance in completing grievance and SFH request forms and other procedural steps related to a grievance or SFH request. This includes, but is not limited to, upon enrollee request providing language and communication assistance services like auxiliary aids and services, upon request, such as providing interpreter services and toll-free numbers for TRS Teletypewriter/Telephone/ Telecommunication Device for the Deaf (TTY/TDD) and interpreter capability.

2. In accordance with 42 CFR §438.406(b) and 42 CFR §438.228(a), Contractor shall acknowledge receipt of an enrollee grievance. If Contractor receives an enrollee appeal or SFH request, Contractor must, within one business day, submit the appeal or SFH request to TennCare. TennCare will send enrollee an acknowledgement letter and inform enrollee that matter will be treated as a request for a SFH.

21. Contract Section A.134 is deleted in its entirety and replaced with the following:

A.134. Committee Meeting Requirements

The Contractor shall provide the TennCare Dental Director with ten (10) days advance notice of all regularly scheduled meetings of the Quality Monitoring Program Committee and Peer Review Committee. To the extent allowed by law, the Dental Director of TennCare, or his/her designee, may attend the committee meetings at his/her option. The Contractor shall provide the State a copy of the written minutes for each meeting shall be forwarded to TennCare per Sections A.135.f and A.136.e of this Contract.

22. Contract Section A.136 is deleted in its entirety and replaced with the following:

A.136. Provider Peer Review Committee

The Contractor shall establish a Provider Peer Review Committee composed of dentists currently licensed in Tennessee and in good standing with the Tennessee Board of Dentistry. This Committee shall meet regularly (no less than quarterly) as necessary to review the processes, outcomes and appropriateness of dental care provided to enrollees by participating providers. The Contractor shall submit the names of proposed committee members to TennCare within thirty (30) days of the TennCare Programs Start Date. The Contractor's Dental Director shall be the Provider Peer Review Committee chairperson. The Committee shall include at least five (5) Participating Dentists who file at least thirty-five (35) TennCare claims per year and not otherwise employed by the current Contractor. This requirement will be waived for the first three (3) months of the contract period if the Contractor can prove an equivalent mechanism for provider peer review during that period.

a. The Committee shall review and provide detailed written findings, recommendations and appropriate corrective action for any participating dental provider who has provided inappropriate care.

b. The Contractor shall manage the network and inform TennCare's Office of Program Integrity regarding imposition of sanctions and any other corrective actions including termination of a Participating Dental Provider who has provided inappropriate care. The Contractor should also notify the Tennessee Board of Dentistry when indicated.

c. Suspected cases of fraud or abuse shall be referred to TennCare OPI and the TBI as appropriate.

d. The Committee shall review and recommend appropriate action on appeals or inquiries provided by Enrollees, Participating Dental Providers, TennCare or other persons regarding quality of care, access or other issues related to the State DBM Programs.

e. The Committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review

23. Contract Section A.138 is deleted in its entirety and replaced with the following:

A.138. Credentialing and Re-credentialing

The Contractor is responsible for ensuring that the Dental Specialists and other oral health professionals, who are under contract to the organization, are qualified to perform their duties. The Contractor is responsible for provider selection policies and procedures that cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Since the Board of Dentistry requires that dental professionals renew licensure every two (2) years, it is the responsibility of the Contractor to ensure that a copy of the current, valid license is maintained on file at the Contractor's location for every dental professional in the network(s).

a. Timely Credentialing - It is the Contractor's responsibility to completely process a credentialing/recredentialing application within sixty (60) calendar days after the receipt of the following from the provider: a fully completed clean application, including all necessary documentation and attachments, a Medicaid ID number and signed provider agreement/contract.

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

c. Oversight by Governing Body - The Governing Body, or the group or individual, to which the Governing Body has formally delegated the credentialing function, and TennCare shall review and approve the credentialing policies and procedures.

d. Credentialing Entity - The Contractor's credentialing policies and procedures shall designate a Credentialing Committee or other peer review body which makes recommendations regarding credentialing decisions.

e. Process - The Contractor's initial credentialing process shall obtain and review verification of the following information, at a minimum:

1. Primary Verification:

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

(b) valid DEA certificate, as applicable;

(c) confirmation of highest level of education and training received;

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

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

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

(g) any revocation or suspension of a state license or DEA number.

2. Secondary Verification (self reported)

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

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

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

(d) the application process includes a statement by the applicant and an investigation of said statement regarding:

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

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

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

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

(5) current malpractice coverage and limits;

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

(7) current or former listing on the national sex offender registry; and

(8) current or former listing on the Tennessee Sex Offender Registry.

3. The Contractor must verify licensure and valid DEA certificate, as applicable, within one hundred eighty (180) calendar days prior to the credentialing date.

4. Any information obtained shall be evaluated to determine whether any or all of said information would impact a practitioner's ability to conform to the standards

established by the Contractor in accordance with the requirements placed on the Contractor by this Contract. The Contractor may decide, based on information obtained in the credentialing process, not to contract with a provider. If credentialing is denied the provider must be notified in writing and the reasons for the denial must be specified.

5. A site review shall be required by the Contractor for a dentist's office for which the Contractor receives a grievance from an enrollee.

f. Recredentialing - A process for the periodic reverification of clinical credentials (recredentialing, reappointment, or recertification) shall be described in the Contractor's policies and procedures.

1. There is evidence that the procedure is implemented at least every three (3) years.

2. There is verification of State licensure at least every three (3) years,

3. The Contractor shall conduct periodic review of information from the National Practitioner Data Bank, along with performance data, on all dentists to decide whether to renew the participating dentist agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing on items listed in subsections '"f 1" through "f-2" above.

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

(a) enrollee grievances;

(b) results of quality reviews;

(c) utilization management;

(d) member satisfaction surveys; and

(e) reverification of hospital privileges and current licensure.

g. Reporting Requirement – The Contractor shall have a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.

h. Appeals Process – The Contractor shall have a provider appellate process for instances where the Contractor chooses to reduce, suspend or terminate a practitioner's privileges with the organization.

i. If credentialing is denied, the provider must be notified in writing by the Contractor and the reason for the denial must be specified.

j. Credentialing of providers with multiple service locations - Except for public health or accredited schools of dentistry in Tennessee, no entity owning or operating multiple practice locations nor any individual provider nor group of providers operating multiple practice locations, may be credentialed by the Contractor at more than one location at the time of the initial credentialing by the Contractor. All requests for satellite office

credentialing will be based upon proven delivery of good quality dental care at the initial location and subject to careful individual review of the new location's dentist, dental associates and entire dental staff. The requirement of one initial location may be waived, at the sole discretion of the Contractor, only for providers in good standing who are current TennCare providers, with a proven record of delivery of quality dental care, at the time of the Contract start date. Prior to credentialing satellite offices, the Contractor must conduct a thorough and documented site visit which takes into account the impact of the satellite on existing TennCare dental provider network in that community. Such documentation must be made available to TennCare on request.

24. **Contract Section A.147 is deleted in its entirety and replaced with the following**:

A.147. Reporting Requirements

At a minimum, the Contractor shall provide to TennCare the deliverables related to reports, plans, studies or files including timeframes as outlined in Attachment C.

a. All deliverables must be presented in a format/record layout approved by TennCare. The Contractor shall also provide such additional reports, or make revisions in the data elements or format of the reports upon request of TennCare without additional charge to TennCare. TennCare shall provide written notice of such requested revisions of format changes in a Notice of Required Report Revisions.

b. The Contractor shall furnish to TennCare an electronic Decision Support System (DSS) described as a data gathering and storage system sufficient to meet the requirements of this Contract.

c. The Contractor shall also furnish TennCare staff with access to the Contractor's DSS allowing TennCare to retrieve paid claims data, along with a user interface that shall allow user defined queries to address managerial concerns that would normally be requested in an ORR. The capability shall not diminish the Contractors responsibility for responding to requests for ORRs.

d. Additional reporting requirements as established by TennCare in collaboration with the Contractor for Covered Services provided pursuant to the ECF CHOICES DBM Program, TennCare Adults with Intellectual or Developmental Disabilities Dental Program, TPPOHP DBM Program, Adult Dental DBM Program and CoverKids DBM Program, including, but not limited to, ECF CHOICES dental service utilization and a separate report for utilization of adjunctive dental sedation, an accounting of Member utilization as compared to authorized amounts for dental services in Members' PCSPs, network adequacy and capacity for ECF CHOICES, and ECF CHOICES network training and development.

e. The Contractor shall be responsible to offer assistance to TennCare associates using the Contractor's DSS as needed, including both dental staff and other departmental staff's users.

TennCare may impose liquidated damages under Section E.10 and Attachment B of the Contract based upon Contractor's failure to timely submit Standard Reports in the required format and medium.

25. Contract Section A.148 is deleted in its entirety and replaced with the following:

A.148. Reports

a. The Contractor shall provide the following reports every month:

1. PI TIPs
2. Encounter data report (837D)
3. Provider Enrollment File

b. The Contractor shall provide the following reports every quarter:

1. TennCare/EPSDT Report
2. Non-Traditional FI Varnish Program Report
3. "Insure Kids Now" (IKN) File
4. DBM Quarterly TennCare Kids Report
5. Quarterly Utilization by Std Dev
6. Quarterly Disclosure Rate Report
7. Enrollee cost-sharing liabilities
8. Adult Dental Program Report
   (a) Number of Unique Members 21 years of age and older who received a dental service
   (b) Number of Paid and Denied Dental Claims for members 21 years of age and older
   (c) Number of Dental Services provided for members 21 years of age and older, differentiated by service category
   (d) Dental Expenditures for members 21 years of age and older, differentiated by service category
   (e) Number of General Dentists contracted in the TennCare Adult Dental network
   (f) Number of Actively Participating General Dentists in the TennCare Adult Dental network (treating at least 25 patients and billing a minimum of $2,500 per quarter)
9. Outreach Attempts Report - Number of outreach attempts (telephonic, text, mailers, etc) to eligible pregnant members age 21 and older to connect to dental services
10. Quarterly Dental Provider Extrapolation Report
11. Encounter/MLR Reconciliation Report

c. The Contractor shall provide the following reports once a year:

1. Annual Outreach Plan
2. Annual Access Report
3. DBM Community Outreach Plan Annual Evaluation
4. Annual Disclosure Form
5. Annual Opioid Dental Prescriptions Report (number of prescriptions provided to child and adult members written by participating dentists)
6. Annual Dental Provider Opioid Outlier Report
7. Systems Refresh Plan

d. The Contractor shall provide ad hoc reports, as requested by TennCare. The time intervals/schedule of such reports shall be determined by TennCare.

26. Contract Section A.151 is deleted in its entirety and replaced with the following:

A.151. Management and Information Systems Reports

a. Management Reports. The Contractor shall submit Management Reports by which the State can assess the State DBM Programs costs and usage, in a mutually agreeable electronic format (MSWord, MSExcel, etc.), of the type, at the frequency, and containing the detail in Attachment C. Reporting shall continue for the twelve (12) month period following termination of the Contract. The Contractor shall also generate and submit to the State, within five (5) working days of the end of each Contract quarter a Quarterly Network Changes Report, also in electronic format.

b. Information Systems Reports.

1. The Contractor shall submit an annual *Systems Refresh Plan* on December 1 for the upcoming year that outlines how Systems within the Contractor's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The systems refresh plan shall also indicate how the Contractor will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

2. The Contractor shall submit *Encounter Data* Report in a standardized format as specified by TennCare (see Section A.102) and transmitted electronically to TennCare on a weekly basis.

3. The Contractor shall provide an electronic version of a reconciliation between the amount paid as captured on the Contractor's encounter file submissions and the amount paid as reported by the Contractor in the 'CMS 1450 Claims Triangle' and 'CMS 1500 Claims Triangle' that accompanies the monthly Medical Loss Ratio report (see Section C.3.b.4.p). In the event of any variances, the Contractor shall submit a written explanation accompanied by a 'CMS 1450 Claims Triangle' by category of service and a 'CMS 1500 Claims Triangle' by category of service, as applicable, to substantiate the explanation of the variance and identify the categories of services to which the variance is attributable. In the event that TennCare requires further detail of the variances listed, the Contractor shall provide any other data as requested by TennCare. This information shall be submitted with the MLR report.

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

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

(b) The reconciliation report shall include an overall assessment of reporting integrities between the two Claim Triangle reports in terms

of counts and amount based on the common delineations. When the two reports are not reconciling under the common delineations, the Contractor shall address the root causes of the gaps with proposed corrective action plans.

5. The Contractor shall provide any information and/or data requested in a format to be specified by TennCare as required to support the validation, testing or auditing of the completeness and accuracy of encounter data submitted by the Contractor.

6. The Contractor shall submit a monthly *Systems Availability and Performance Report* that provides information on availability and unavailability by major system as well as response times for the Contractor's Confirmation of MCO Enrollment and Electronic Claims Management functions, as measured within the Contractor's span of control.

7. The Contractor shall submit a baseline *Business Continuity and Disaster Recovery (BC-DR)* plan for review and written approval as specified by TennCare. Thereafter, the Contractor shall submit, at a minimum, an annual update to their BC-DR. The Contractor shall communicate proposed modifications to the BC-DR plan at least fifteen (15) calendar days prior to their proposed incorporation. Such updates and/or modifications shall be subject to review and written approval by TennCare.

27. Contract Section A.163 is deleted in its entirety and replaced with the following:

A.163. Allowable Rates

TennCare has established and maintained the TennCare Dental Fee Schedules for this Contract by which all claims are paid for the TennCare DBM Programs. The TennCare Dental Fee Schedules for TennCare DBM Programs shall be provided by TennCare. All dentists and dental specialists providing services to enrollees in the TennCare DBM Programs shall be reimbursed on a fee-for-service basis where one maximum allowable dental fee schedule per TennCare DBM Program for all providers is used. The provider will be reimbursed at the lesser of billed charges or the maximum allowable fee listed in the approved TennCare Dental Fee Schedule. The Contractor shall not deviate from the approved reimbursement rates, unless TennCare provides written permission to do so. The TennCare Dental Fee Schedules are not applicable to the CoverKids DBM Program or the Adult Dental DBM Program, and the Fee Schedule for the CoverKids Program and the Adult Dental DBM Program shall be developed and provided by the Contractor.

28. Contract Section A.165 is deleted in its entirety and replaced with the following:

A.165. Non-Discrimination Compliance Requirements

The Contractor agrees that the following requirements apply to the Contractor's administration of the TennCare DBM programs.

a. General Requirements. The Contractor shall comply with all applicable federal and state civil rights laws, regulations, rules, and policies and protocols, as well as Contract Section D.9 of this Contract.

1. *Nondiscrimination Compliance Coordinator.* In order to demonstrate compliance with the applicable federal and State civil rights laws and regulations, which may include, but are not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and 42 U.S.C. § 18116 (codified at 45 C.F.R. pt. 92), the Contractor shall designate a Nondiscrimination Compliance Coordinator ("NCC") who shall be responsible for

compliance with the nondiscrimination requirements set forth in this Contract. Contractor agrees that its civil rights compliance staff member will work directly with TennCare's Director of Civil Rights Compliance ("DCRC") in order to implement and coordinate nondiscrimination compliance activities.

2. *Readiness Review*. Prior to implementation of this Contract, the NCC shall participate in a nondiscrimination/civil rights readiness review phase. The DCRC shall provide the NCC with the nondiscrimination/civil rights protocols and readiness review expectations for this Contract and provide technical assistance to the NCC.

3. *Complaint Forms.* The Contractor shall use and have available TennCare's discrimination complaint forms to provide to individuals who want to file a complaint and the Contractor may direct the individual to TennCare's real-time complaint form at https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html. Upon request, the Contractor shall mail the individual a copy of the TennCare Complaint form and post the forms on the Contractor's website that is specific to the TennCare program. TennCare's discrimination complaint forms are vital documents and must be available at a minimum in the English, Spanish, Arabic languages. The above link to TennCare's discrimination complaint forms may be placed on the Contractor's website, which will direct individuals to TennCare's complaint forms. The Contractor shall provide assistance to individuals that request that the Contractor assist them with filing discrimination complaints with the TennCare program(s) covered under this contract. The Contractor shall inform its employees and its providers and subcontractors that are considered to be recipients of federal financial assistance under this contract about how to assist individuals with obtaining discrimination complaint forms and assistance with submitting the forms to the DCRC.

4. *Nondiscrimination Notice and Taglines.* Should the Contractor create TennCare materials, the Contractor shall ensure that significant publications and significant communications, including small sized publications and communications that are targeted to beneficiaries, participants, enrollees, applicants, and members of the public shall be printed with the notice of nondiscrimination and LEP taglines as required by TennCare and set forth in TennCare tagline templates and the applicable federal civil rights laws, including 45 C.F.R. pt. 92 and 68 Fed. Reg. 47311-02. Written materials specific to TennCare program members shall be prior approved in writing by TennCare prior to the materials being sent to these individuals and at a minimum vital documents shall be translated and available in Spanish.

b. Nondiscrimination Compliance Reports. The Contractor shall submit the following nondiscrimination compliance deliverables to TennCare as follows:

1. *Annual Compliance Questionnaire.* Annually, the DCRC shall provide the NCC with a Nondiscrimination Compliance Questionnaire. The NCC shall answer the questions contained in the Compliance Questionnaire and submit the completed Questionnaire to DCRC within sixty (60) days of receipt of the Questionnaire with any requested documentation, which shall include, the Contractor's Assurance of Nondiscrimination. The Nondiscrimination Compliance Questionnaire deliverables shall be in a format specified by TennCare and will gather date on the Contractor's annual compliance activities like the provision of language and communication assistance services and completing the annual civil rights and cultural compliance training requirements.

2. *Quarterly Compliance Reports.* The NCC shall submit a quarterly Non-discrimination Compliance Report which shall include the following:

(i) A summary listing that captures the total number of the Contractor's new hires that have completed civil rights/nondiscrimination training and cultural competency training and the dates the trainings were completed for that quarter;

(ii) The NCC shall provide a listing of all discrimination claims that are reported to the Contractor that are claimed to be related to the provision of and/or access to TennCare's covered services provided by the Contractor.

(iii) The language and communication assistance report shall capture a summary listing of language and communication assistance services that were requested by members and/or participants (i.e. Arabic; Braille) and the methods used to provide those services.

c. *Discrimination Complaint Investigations*. All discrimination complaints against the Contractor and its employees and its subcontractors that are considered to be recipients of federal financial assistance under this contract shall be resolved according to the provisions of this Section and TennCare's policies and protocols. When complaints concerning alleged acts of discrimination committed by the Contractor and/or its employees and subcontractors related to the provision of and/or access to one of TennCare's programs are reported to the Contractor, the NCC shall send such complaints within two (2) business days of receipt to the DCRC. The DCRC shall investigate and resolve all alleged acts of discrimination committed by the Contractor and/or its employees and subcontractors. The Contractor and/or its employees and subcontractors shall cooperate with TennCare during the investigation and resolution of such complaints. During the complaint investigation, the NCC shall have the opportunity to provide the DCRC with any information that is relevant to the complaint investigation. The Contractor shall take reasonable methods to keep such documentation and materials confidential and shall not disclose the documentation or materials related to such investigation, to any third party unless otherwise required by law.

d. *Electronic and Information Technology Accessibility Requirements*.

1. The Contractor shall comply with the civil rights requirements set forth in 42 C.F.R. § 433.112 regarding the design, development, installation or enhancement of mechanized processing and information retrieval systems. In addition, the Contractor shall participate in the State's effort to comply with the nondiscrimination requirements for acquiring automatic data and processing equipment and services set forth in 45 C.F.R. § 95.633.

2. To the extent that the Contractor is using electronic and information technology to fulfill its obligations under this Contract, the Contractor agrees to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508"), the Americans with Disabilities Act, and 45 C.F.R. pt. 92 (or any subsequent standard adopted by an oversight administrative body, including the Federal Accessibility Board). To comply with the accessibility requirements for Web content and non-Web electronic documents and software, the Contractor shall use the most current W3C's Web Content Accessibility Guidelines ("WCAG") level AA or higher with a goal to transition to WCAG 3 level silver (For the W3C's guidelines see: https://www.w3.org/WAI/standards-guidelines/; and for Section 508 standards see: https://www.access-board.gov/ict/).

3. Additionally, the Contractor agrees to comply with Title VI of the Civil Rights Act of 1964. As part of achieving Title VI compliance, the Contractor should add a system function that allows users to translate the content into a language other than English. This requirement may be satisfied by the provision of a link to Google translate or other machine translate tool or translating the page into non-English languages as directed by TennCare.

e. *Ethical/Moral/Religious Directives*. Should the Contractor or it's subcontractor not perform services or activities pursuant to its obligations under this Contract because of moral/ethical or religious reasons, the Contractor shall provide a list of these services to TennCare. This list shall be used by TennCare to provide information to TennCare applicants and members about where and how the individuals can obtain the services that are not being delivered due to Ethical and Religious Directives.

f. *Health Care Disparities*. The Contractor shall collaborate with TennCare and other entities designated by TennCare to develop and implement projects that identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability statuses.

29. The following is added as a new Contract Section A.177, and the subsequent section shall be renumbered Contract Section A.178 as follows:

A.177. Program Integrity Requirements for Extrapolation of Provider Claims.

a. When extrapolating provider claims, as defined in TennCare rules and regulations, the Contractor shall utilize the following process:

1. The Contractor shall initiate a provider review based on findings from data mining, medical records review results, or any other source of information utilized in preventing fraud or abuse. Upon initiating a review, the Contractor shall pull a statistically valid random sample (SVRS) of records as determined by a software tool such as RAT-STATS.

2. Upon conclusion of the review, the Contractor shall inform the Provider of the review's factual findings and give the Provider an opportunity to present new documents or make other arguments as to why the findings might be in error. After the reconsideration requested by the Provider is completed, Contractor shall calculate an error rate for each specific DBM code evaluated and establish the total number of instances where the provider billed the relevant DBM codes for the review period.

3. The Contractor shall determine a calculated dollars at risk amount by multiplying the error rate by the total universe of relevant claims during the time period and the dollars paid for that service.

(i) If upcoding is suspected, the provider shall be given credit for the amount paid for the service actually rendered. As such, the actual dollars at risk amount shall be calculated by subtracting the payment for services from the calculated dollars at risk amount.

4. If the calculated dollars at risk or actual dollars at risk amount exceeds $10,000.00 in total, the Contractor shall report this information to the TennCare Office of Program Integrity in accordance with guidelines or instructions supplied by the TennCare Office

of Program Integrity or at the applicable monthly or quarterly meetings when review findings are presented.

5. After receipt of approval from TennCare to use extrapolation in this review, the Contractor will issue a final findings letter to the Provider laying out the factual findings of the review and the estimated amount of the recovery based upon the extrapolation calculation above. If there is no approval by TennCare, the overpayment recovery amount will be limited to the amount paid for the actual claims reviewed.

6. The final findings letter will offer the provider a chance for the findings to be reviewed by the Contractor's peer review committee and/ or for the Provider to file an administrative appeal with TennCare OGC if the Provider chooses to contest the findings.

7. If the provider chooses to utilize the peer review process, the Contractor will make any necessary adjustments to the error rate and estimated overpayment amount totals necessitated by the conclusions of the peer review committee (for example if one of the basis for an initial finding was deemed by the peer review committee to be erroneous such that the claims should have been paid, the error rate and dollar amounts would be adjusted accordingly).

8. The Contractor will report the final overpayment amounts to be recouped to TennCare OPI either

   (i) after the final findings letter is issued to the Provider and the Provider has not elected to use the Peer review process; or
   (ii) after the Peer review process has been completed and any necessary adjustments to the overpayment amounts have been made.

9. The TennCare Office of General Counsel shall issue a payment demand letter and handle any provider appeals resulting from the overpayment collection. The Contractor shall provide litigation support (i.e., affidavits, expert witness, etc.) as needed.

b. The provisions of A.177.a shall not apply to the adult dental benefit program until a time to be determined by TennCare after consultation with the Contractor. This determination shall not be made for at least a period of one year from the effective date of this Amendment.

A.178. Records Availability

The Contractor and providers shall, upon request and as required by this Contract or state and/or federal law, make available to the TennCare Office of Program Integrity, TBI MFCU, and/or 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 TennCare Office of Program Integrity, TBI MFCU, and/or OIG shall be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TennCare Office of Program Integrity, TBI MFCU, and/or OIG. The Contractor shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section.

30. Contract Section A.188 is deleted in its entirety and replaced with the following:

A.188. General Requirements

The Contractor shall have available an up-to-date website dedicated to TennCare that shall aid providers and enrollees in all aspects of the State DBM Programs. The website shall be available

for TennCare approval at least one (1) month prior to the commencement of claims processing and be available on the internet two (2) weeks prior to the commencement of claims processing. The website shall contain a home page with general dental information with links to dedicated areas for providers and enrollees. Each of these sections shall contain information that shall answer, in an interactive format, the majority of questions that each group would ask. This shall include, but is not limited to:

a. Home Page, which includes:

1. General information related to dental benefit, and recent changes occurring within the State DBM Programs, including pertinent fact sheets, and

2. Navigation tool bar that links to enrollee information, provider information, finding a dentist, policy and guidelines.

b. Provider Page, which includes:

1. Applying to become a participating provider;

2. Provider credentialing and recredentialing;

3. Provider Office Reference Manual;

4. Current TennCare Dental Fee Schedules;

5. Program policies and procedures;

6. Procedures for obtaining Prior Authorizations (PA's);

7. Printable provider education material;

8. Provider newsletters;

9. Procedures for electronic billing;

10. Fluoride varnish program;

11. Information about Peer Review Committee, and

12. Call Center hours of operation and contact numbers.

13. Contact information for assigned Dental Provider Representative

c. Enrollee Page, which includes:

1. A description of services provided including limitations, exclusions and out-of-network use;

2. Member Handbook including provider directory;

3. Call Center hours of operation and contact numbers;

4. Copay information;

5. Transportation assistance;

6. Language assistance service;

7. Printable education material specific to enrollees, and

8. On-line search, by address or zip code, to locate the network dentists nearest to the enrollee.

9. Privacy and Security information regarding enrollee records;

10. Privacy Assistance for individuals with disabilities, and

11. Discrimination complaint forms and the Civil Rights Notice.

31. Contract Section A.200.l is deleted in its entirety and replaced with the following:

l. Covered Services and Limitations.

1. The Contractor shall ensure all TennCare 1915(c) Dental Program participating providers render high quality, Medically Necessary, cost effective dental care for members. Section 1915(c) HCBS Waiver members enrolled in the TennCare 1915(c) Dental Program shall also receive all covered benefit services that are provided in the TennCare Adult DBM Program, as specified in Section A.5.d The Contractor shall exercise every available means through this Contract, provider agreements, office reference manual, policies and procedures, and educational programs to ensure that dental benefits in the TennCare 1915(c) Dental Program are managed in this manner.

2. The Contractor shall ensure TennCare 1915(c) Dental Program benefits are properly coordinated with the members' MCOs in accordance with this Contract and any protocols and procedures developed by TennCare.

3. Covered Services for eligible adults age 21 and older in the TennCare 1915(c) Dental Program shall be limited to a maximum of $5,000 per member per calendar year, and a maximum of $7,500 per member across three (3) consecutive calendar years. Covered Services that are received on or after Adult Dental go-live shall apply to the maximum amount allowable only if the service is not covered as part of the TennCare Adult DBM Program. Any adult dental services received prior to the Adult Dental go-live date, shall apply to the maximum amount allowable for the qualifying time period. A member's MCO may elect, at its sole discretion, to exceed these limits as a Cost-Effective Alternative Service, when the provision of such additional dental services would be medically appropriate and offer a more Cost-Effective Alternative Service to other covered services the member would otherwise require.

4. Adult dental services in the TennCare 1915(c) Dental Program shall be provided only as specified in the member's PCSP. Upon inclusion of dental services in a TennCare 1915(c) Dental Program member's PCSP, the Contractor shall work with the 6 member's MCO support coordinator or the member's Independent Support Coordinator or DIDD Case Manager, as applicable, to assist the member in selecting a contracted TennCare 1915(c) Dental Program participating provider. A copy of the PCSP or relevant portions of the PCSP, as determined by TennCare, shall be provided to the TennCare 1915(c) Dental Program participating provider by the member's MCO pursuant to a process approved by TennCare in writing. The covered services as described above are the same services for members of the TennCare ECF CHOICES Dental Program.

5. Upon selection of a TennCare 1915(c) Dental Program participating provider and subject to the amount approved for dental services in the member's PCSP, each TennCare 1915(c) Dental Program member shall undergo a thorough dental evaluation prior to receiving Covered Services, unless the member has had such an evaluation in the ninety (90) calendar days prior to such service request. The results of that evaluation will be a proposed treatment plan that will include both short-term dental needs (e.g., cavities detected during the exam to be filled) and long-term dental services

(e.g., cleaning every six months), which shall be incorporated into the member's PCSP, as determined by the member or his/her authorized representative. Notwithstanding the proposed treatment plan developed by the TennCare 1915(c) Dental Program participating provider, the total cost of dental services that may be authorized by the Contractor are subject to the amount approved for dental services in the member's PCSP. If the total cost of services proposed in the treatment plan exceed the amount authorized for dental services in the member's PCSP, the Participating Dental Provider shall not proceed to perform such services, except as specifically approved by the member or his/her authorized representative, and with full disclosure that other services proposed in the treatment plan will not be provided based on the current amount approved for dental services in the member's PCSP.

6. The Contractor shall not authorize nor reimburse dental services for TennCare 1915(c) Dental Program members that are not covered by TennCare, except for dental services approved by a member's MCO as a Cost-Effective Alternative Service. The Contractor shall track dental expenditures for each TennCare 1915(c) Dental Program member and shall not authorize nor reimburse dental services for a TennCare 1915(c) Dental Program member that exceed the amount approved for such services in the member's PCSP. Upon request, the Contractor shall also make available to TennCare 1915(c) Dental Program participating providers the total dental expenditures that have been authorized and reimbursed for each TennCare 1915(c) Dental Program member served by any other TennCare 1915(c) Dental Program participating providers in order to ensure that dental services are not provided to the member in excess of the amount approved for such services in the member's PCSP. Any authorization and reimbursement of dental services for TennCare 1915(c) Dental Program members that exceed the amount approved for such services in a member's PCSP may subject the Contractor to liquidated damages.

7. The Contractor shall be responsible for the submission of encounter data to TennCare regarding Covered Services provided under the Contract and the TennCare 1915(c) Dental Program, including Covered Services authorized by a member's MCO as a Cost-Effective Alternative Service.

8. The Contractor shall not authorize coverage of orthodontic services for members of the TennCare 1915(c) Dental Program.

32. Contract Section B.1 is deleted in its entirety and replaced with the following:

B.1. This Contract shall be effective for the period beginning September 1, 2018 ("Effective Date") and ending on April 29, 2024 ("Term"). The State shall have no obligation for goods delivered or services provided by the Contractor prior to the Effective Date.

33. Contract Section C.1 is deleted in its entirety and replaced with the following:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Two Hundred Forty-Three Million Five Hundred Two Thousand Four Hundred Seventy-Six Dollars and Zero cents ($243,502,476.00) ("Maximum Liability"). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract.

34. Contract Section C.3 is deleted in its entirety and replaced with the following:

C.3. Payment Methodology. The Contractor shall be compensated based on the payment methodology for goods or services authorized by the State in a total amount as set forth in Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in Section A.

b. The Contractor shall be compensated based upon the following payment methodology:

(1) For the transition period of September 1, 2018 – April 30, 2019, there shall be no cost to the State.

(2) For TennCare Children's DBM Program, TennCare ECF CHOICES DBM Program, and TPPOHP DBM Program services performed from May 1, 2019 through the end of the contract, the following rates shall apply:

Cost Item Description	**Amount** (per compensable increment)
May 1, 2019 – April 30, 2023 **TennCare Children's DBM Program** Administrative Fee Per Child (Under Age 21) Eligible for Full Dental Benefit Package (per member per month) AND **TPPOHP DBM Program** Administrative Fee per TennCare Enrollee who is a Pregnant Woman (21 Years of Age and Older) Eligible for TPPOHP DBM Program Limited Benefits (per member per month)	$ 0.50 per member per month
TennCare ECF CHOICES DBM Program May 1, 2019 – April 30, 2023 Administrative Fee Per Eligible Adult Enrolled in the TennCare ECF CHOICES DBM Program (per member per month)	$ 0.01 per member per month

(3) For CoverKids DBM Program services performed from July 1, 2020 (Go Live Date) through the end of the contract, the following rates shall apply. There shall be no cost to the State for CoverKids DBM Program services prior to Go Live Date of July1, 2020.

Cost Item Description	**Amount** (per compensable increment)
CoverKids DBM Program July 1, 2020 – April 30, 2023 Group One Child [1]	$ 14.70

(Monthly)	Monthly Premium Rate / Per Member
CoverKids DBM Program **July 1, 2020 – April 30, 2023** Group Two Child [2] (Monthly)	$ 20.67 Monthly Premium Rate / Per Member
CoverKids DBM Program **July 1, 2020 – April 30, 2023** AI / AN Child [3] (Monthly)	$ 18.19 Monthly Premium Rate / Per Member

[1] ***Group One Child*** *is defined as a covered child who is in a family with an income between 150 percent and 250 percent of FPL.*

[2] ***Group Two Child*** *is defined as a covered child who is in a family with an income below 150 percent of FPL and therefore subject to reduced copayments.*

[3] ***AI / AN Child*** *is defined as a covered child who is (a) certified American Indian/Alaskan Native (AI/AN) and (b) a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Eligibility Determination Contractor to the Contractor for the coverage period.*

(4) Unless otherwise specified in writing to the Contractor, the TennCare Adult Dental DBM Program services shall have a Go-Live date in the first quarter of 2023. For the TennCare Adult Dental DBM Program services performed from the Go-Live Date through the end of the Term of the Contract, the Contractor shall be paid a base capitation rate for each enrollee based on the enrollee's rate category. Rate categories are based on various factors, category of aid, age/sex combination, and the Grand Region served by the Contractor under this Contract. TennCare shall take Third Party Liability (TPL) into account in the development of capitation rates consistent with this Contract. This recognizes that it is the Contractor that is primarily responsible for TPL recoveries and that medical claims experience used for rate setting is net of any TPL recoveries of subrogation activities. There shall be no cost to the State for TennCare Adult Dental DBM Program services prior to the Go-Live Date for these specific services. The rate categories and the specific rates associated with each rate category are to be determined by actuaries at a later date and followed up with a Contract amendment.

(a) The Contractor shall ensure that no payment is made to a network provider other than the services covered under the Contract between the State and the Contractor, except when these payments are specifically required to be made by the state in Title XIX of the Social Security Act, in 42 CFR 438.60, or when the state agency makes direct payments to network providers for graduate medical education costs approved under the state plan.

(b) In accordance with TCA 71-5-188, the State will retain a qualified actuary to conduct an annual actuarial study of the TennCare program. The CONTRACTOR shall provide any information requested and cooperate in any manner necessary as requested by TENNCARE in order to assist the State's actuary with completion of the annual actuarial study.

(The Contractor and State agree that the capitation rates this section may be adjusted periodically.

(d) The Contractor and State further agree that adjustments to capitation rates shall occur only by written notice from TennCare to the Contractor and followed up with Contract amendment. The notice will be given at least thirty (30) calendar days before the new rates are paid. Should the Contractor refuse to continue this Contract under the new rates, the Contractor then may activate the Termination provisions contained in this Contract. During the six (6) month Termination Notice period the Contractor will continue to be paid under the new rates. In the event the Contractor indicates that it is refusing to accept the new rates, but does not choose to institute Termination proceedings under this Contract then the State may at its option:

i. Declare that a public exigency exists under this Contract. If the State makes this declaration the Contractor will continue to be paid under the new rates,

ii. Declare that the Contract is Terminated for Convenience under the provisions of this Contract. If the State makes this declaration the Contractor will continue to be paid under the new rates for the period of time until the Termination date.

(e) The capitation rates shall be adjusted annually for inflation in accordance with the recommendation of the State's actuary.

(f) If (i) changes are required pursuant to federal or state statute, federal regulations, the action of a federal agency, a state or federal court, or rules and regulations of a State of Tennessee agency other than the Division of TennCare and (ii) the changes are likely to impact the actuarial soundness of the capitation rate(s), as determined by TennCare, TennCare shall have its independent actuary review the required change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TennCare's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

(g) In the event TennCare amends TennCare rules or regulations or initiates a policy change not addressed elsewhere in this Contract, as determined by TennCare, TennCare shall have its independent actuary review the proposed change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TennCare's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

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

(i) Any rate adjustments shall be subject to the availability of state appropriations.

(j) TennCare shall make payment by the fifth (5th) business day of each month to the Contractor for the Contractor's satisfactory performance of its duties and responsibilities as set forth in this Contract.

i. TennCare shall generate a X12 compliant 820 which contains detail PMPM new payments, voids and adjustments transactions for each monthly capitation payments to the Contractor. The Contractor must accept, load, maintain and reconcile each 820 file to the Contractor's eligibility data. No 820 reconciliation reporting is required from the Contractor to TennCare.

(k) CAPITATION PAYMENT CALCULATION

i When eligibility has been established by the State for enrollees, the amount owed to the Contractor shall be calculated as described herein.

ii Each month, payment to the Contractor shall be equal to the number of enrollees enrolled in the Contractor's plan based on an eligibility snapshot each month prior to the capitation payment multiplied by the appropriate capitation rate(s) for the enrollee.

The capitation rates will be the amounts used to determine the amount of the monthly capitation payment.

iv The actual amount owed the Contractor for each member shall be determined by dividing the appropriate monthly capitation rate(s) by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the member was enrolled in the Contractor's plan.

v The amount paid to the Contractor shall equal the total of the amount owed for all enrollees less capitation payment adjustments, and any other adjustments, which may include, damages, liquidated damages, or adjustments based upon a change of enrollee status.

(l) CAPITATION PAYMENT ADJUSTMENTS

i The State has the discretion to retroactively adjust the capitation payment for any enrollee if TennCare determines an incorrect payment was made to the Contractor; provided, however:

(1) For determining the capitation rate(s) only, each Grand Region under this Contract will be used to determine payment. The capitation payment shall not be retroactively adjusted to reflect a different Grand Region of residence.

(2) For individuals enrolled with a retroactive effective date on the date of enrollment, the capitation payment rate shall begin up to one (1) month before the current capitation cycle date and shall be the capitation rate(s) for the applicable rate category and the Grand Region.

(A) The Contractor will not receive a capitation payment for periods of retroactive eligibility greater than one (1) month prior to the member's date

of enrollment with the Contractor. The Contractor agrees to process claims and reimburse providers for services incurred during a period of retroactive eligibility more than one (1) month prior to the member's date of enrollment with the Contractor; however, the Contractor will not be at risk for these services. The Contractor shall reimburse providers in accordance with this Contract and shall submit to TennCare on a monthly basis a claims invoice file for the provision of covered services incurred during an enrollee's period of retroactive eligibility greater than one (1) month prior to the member's date of enrollment with the Contractor. TennCare shall remit payment to the Contractor in an amount equal to the amount to be paid to providers within ten (10) business days of receipt of notice; however, TennCare reserves the right to further review such claims and to recover any overpayments subsequently identified. The Contractor shall release payments to providers within two (2) business days of the receipt of funds from the State. Based on the provisions herein, TennCare shall not make any further retroactive adjustments, other than those described herein.

(3) If a provider seeks reimbursement for a service provided during a retroactive period of eligibility, the Contractor shall assess cost sharing responsibilities in accordance with the cost sharing schedules in effect on the date of service for which reimbursement is sought.

(4) Should TennCare determine after the capitation payment is made that an enrollee's capitation rate category had changed, the enrollee is subject to retroactive disenrollment, including but not limited to, the enrollee was deceased, TennCare shall retroactively adjust the payment to the Contractor as follows:

(A) If an enrollee is deceased, TennCare shall recoup any and all capitation payments made after the enrollee's date of death, including any pro-rated share of a capitation payment intended to cover dates of service after the enrollee's date of death.

(B) If an enrollee's capitation rate category has changed, or the member has been retroactively disenrolled for reasons described in this Contract, TennCare shall retroactively adjust the payment to the Contractor to accurately reflect the enrollee's capitation rate category or disenrollment for the period for which payment has been made. Based on the provisions herein, TennCare shall not make any further retroactive adjustments, other than those described herein.

(C) TennCare and the Contractor agree that the retro-active capitation payment limitation is applicable only to retroactive capitation rate payment adjustments described in those paragraphs and shall in no way be construed as limiting the effective date of eligibility or enrollment in the Contractor's plan.

(5) Payment adjustments resulting in a reduction or increase of the capitation rate shall be accomplished through the monthly capitation reconciliation process, or pursuant to other processes as established by TennCare.

(m) Pursuant to 42 CFR 438.6, any incentive arrangements shall comply with the following:

i The total of all payments made to the Contractor for a measurement year shall not exceed one hundred and five percent (105%) of capitation payments made to the Contractor.

ii Are for a fixed period of time and performance is measured during the rating period under the Contract in which the incentive arrangement is applied;

iii Are not renewed automatically;

iv Are made available to both public and private contractors under the same terms of performance;

v Do not condition Contractor's participation in the incentive arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.

(n) Effect of Disenrollment on Capitation Payments

i Payment of capitation payments shall cease effective the date of the member's disenrollment from the Contractor's MCO, and the Contractor shall have no further responsibility for the care of the enrollee. Disenrollment from TennCare shall not be made retroactively with the exception of the following situations:

(A) Fraudulent applications;

(B) Fraudulent Enrollment

(i) In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the Contractor, at its discretion, may refund to TennCare all capitation payments made on behalf of persons who obtained enrollment in TennCare through such means and the Contractor may pursue full restitution for all payments made on behalf of the individual while the person was inappropriately enrolled in the Contractor's plan.

(ii) In the event of enrollment obtained by fraud, misrepresentation or deception by the Contractor's staff, officers, employees, providers, volunteers, subcontractors, or anyone acting for or on behalf of the Contractor, TennCare may retroactively recover capitation amounts plus interest, as allowed by TCA 47-14-103, and any other monies paid to the Contractor for the enrollment of that individual. The refund of capitation payments plus interest will not preclude the State from exercising its right to criminal prosecution, civil penalties, trebled damages and/or other remedial measures.

(C) Member's death;

(D) TennCare and/or OIG determines the member moved out of state and failed to inform TennCare within a timely manner; and

(E) An appeal by the member to disenroll with a retroactive effective date is decided by TennCare in favor of the member.

(o) Medical Loss Ratio

i. The Contractor shall submit a *Medical Loss Ratio Report* monthly (on the 20th day of each month) with cumulative year to date calculation and shall comply with the following:

(A) The Contractor shall report all capitated dental expenses, costs related to the provision of support coordination, and complete the supporting claims lag tables. Expenses shall be reported in accordance with the following:

(i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense shall be prorated between types of expenses.

(ii) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on pro rata basis.

(iii) Expense allocation shall be based on a generally accepted accounting method that is expected to yield the most accurate results.

(iv) Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense.

(v) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to the other entities.

(vi) The Contractor shall use an MLR template that is provided by TennCare.

ii. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

(A) The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the state.

(B) The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

(C) If a Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

iii. The MLR calculation in a MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

iv. The Contractor shall aggregate data for all Medicaid eligibility groups covered under the Contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

v. The Contractor shall submit an annual MLR report to TennCare, due by the end of the ninth (9th) month following the rating period. This MLR report shall include the following for the most recent MLR reporting year:

(A) Total incurred claims.

(B) Expenditures on quality improving activities.

(C) Expenditures related to activities compliant with program integrity requirements.

(D) Non-claims costs.

(E) Premium revenue.

(F) Taxes.

(G) Licensing fees.

(H) Regulatory fees.

(I) Methodology(ies) for allocation of expenditures.

(J) Any credibility adjustment applied.

(K) The calculated MLR.

(L) Any remittance owed to the state, if applicable.

(M) A comparison of the information reported with the audited financial report.

(N) A description of the aggregation method used to calculate total incurred claims.

(O) The number of member months.

vi. The Contractor shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within One Hundred Eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

vii. In any instance where TennCare makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the Contractor shall:

(A) Re-calculate the MLR for all MLR reporting years affected by the change.

(B) Submit a new MLR report meeting the applicable requirements.

viii. This report shall be accompanied by a letter from an actuary, who may be an employee of the Contractor, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy.

ix. The Contractor shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

x. The Contractor shall also file this report with its NAIC filings due in March and August of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary.

(A) This report shall reconcile to NAIC filings including the supplemental TennCare income statement.

xi. The Contractor shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the Contractor's encounter file submission as specified in Sections A.148 and A.151.b.

(p) Risk Corridor

i. In each capitation year, TennCare has the option to, but is not required to, implement a risk corridor in the rates.

ii. For purposes of risk corridor calculations, the MLR shall be calculated as follows:

(A) The numerator shall include claim costs net of any third party liabilities (TPL) incurred during the measurement period, along with incurred but not reported (IBNR) reserve amounts to be calculated by the State or its actuaries.

(B) The denominator shall include State revenues net of any taxes and fees.

ii. Directed payment amounts made by the State to the Contractor or by the Contractor to providers outside of claims data will not be included in the MLR calculation. Additionally, expenses related to Fraud, Waste, and Abuse; initiatives that improve health care quality; and any other administrative / non-benefit activities shall also be excluded.

iii. The target MLR shall be calculated by the State's actuaries, and shall be defined as one (1) less the administrative/non-benefit load on the gross premium capitation rates prior to the inclusion of external directed payments. However, pursuant to 42 CFR 438.8(c), the target MLR may not be lower than 85%.

iv. A remittance of capitation payments related to the TennCare MLR from the DBM to the State shall occur in accordance with a methodology that will be specified by the State and communicated in writing to the DBM.

v. For each MLR reporting year, the Contractor must provide a rebate to the State if the Contractor meets the MLR remittance requirements outlined in this Contract.

vi. For each MLR reporting year, the State must provide a rebate to the Contractor if the Contractor meets the MLR remittance requirements outlined in this Contract.

vii. The Contractor rebate amounts will be assessed by the State using the MLR calculations provided within the CY MLR Report submitted to the State by the Contractor. The MLR rebate, if any, is due to the State in full sixty (60) calendar days after the State notifies the Contractor in writing of any MLR rebate amount due.

viii. If the Contractor determines that payment of the MLR rebate by the Contractor will cause the Contractor's risk-based capital to fall below the level required by the State, the Contractor's responsible official must notify the State in writing as soon as administratively possible and prior to making any MLR rebate payments to the State.

(5) Should Term Extension Option (Section B.2) be utilized, the following rates shall apply for services performed during extension periods:

Cost Item Description	**Amount** (per compensable increment)
TennCare Children's DBM Program Administrative Fee Per Child (Under Age 21) Eligible for Full Dental Benefit Package (per member per month) AND **TPPOHP DBM Program** Administrative Fee per TennCare Enrollee who is a Pregnant Woman (21 Years of Age and Older) Eligible for TPPOHP DBM Program Limited Benefits (per member per month)	$ .50 per member per month
TennCare ECF CHOICES DBM Program Administrative Fee Per Eligible Adult Enrolled in the ECF CHOICES Program (per member per month)	$ .01 per member per month
CoverKids DBM Program Group One Child (Monthly)	$ 14.70 Monthly Premium Rate / Per Member
CoverKids DBM Program Group Two Child (Monthly)	$ 20.67

	Monthly Premium Rate / Per Member
CoverKids DBM Program AI / AN Child [3] (Monthly)	$ 18.19 Monthly Premium Rate / Per Member

c. The Contractor shall assume risk levels for the TennCare Children's DBM Program only of at least 20% based on levels submitted in Cost Proposal (Contract Section A.164).

Risk Levels	
DBM Assumes 50% of Loss	DBM Share: 50% of any Savings

35. Contract Section C.9 is deleted in its entirety and replaced with the following:

C.9. Service Dates
Except where required by this Contract or by applicable federal or state law, the Contractor shall not make payment for the cost of any services provided prior to the effective date of eligibility in the Contractor's plan. The Contractor shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the Contractor's plan.

36. The following are added as new Contract Sections C.10 and C.11:

C.10. State Expenditures Consistent With Federal Legal Requirements

Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the state paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

C.11. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following, properly completed documentation.

a. The Contractor shall complete, sign, and present to the State the "Authorization Agreement for Automatic Deposit Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once this form is received by the State, payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee, may be made by ACH; and

b. The Contractor shall complete, sign, and return to the State the State-provided W-9 form. The taxpayer identification number on the W-9 form must be the same as the Contractor's Federal Employer Identification Number or Social Security Number referenced in the Contractor's Edison registration information.

37. Contract section D.30.b. is deleted in its entirety and replaced with the following:

D.30. Incorporation of Additional Documents. Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below:

b. this Contract with any attachments or exhibits (excluding the items listed at subsections c. through f., below), which includes Attachment A, Terms and Definitions; Attachment B, Liquidated Damages; Attachment C, DBM Deliverable Requirements; Attachment D, Dental Service Categories by Dental CDT Codes; Attachment E, Annual Dental Participation Ratio; Attachment F, Dental Screening Percentage, Attachment G, Attestation RE: Personnel Used in Contract Performance, Attachment H, Multiple PEAR Corresponding PMPM Targets and PEAR Credits, Attachment I, Silver Diamine Fluoride (SDT) Percentage and Dental Percentage, and Attachment J, dental terminology codes for the TPPOHP DBM Program, Attachment K, Business Associate Agreement

38. Contract Attachment A is deleted in its entirety and replaced with the new Attachment A attached hereto.

39. Contract Attachment B is deleted in its entirety and replaced with the new Attachment B attached hereto.

40. Contract Attachment C is deleted in its entirety and replaced with the new Attachment C attached hereto.

41. Contract Attachment J is deleted in its entirety and replaced with the new Attachment J attached hereto.

42. Contract Attachment K attached hereto is added as a new attachment.

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

Amendment Effective Date. The revisions set forth herein shall be effective once all required approvals are obtained. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

DENTAQUEST USA INSURANCE COMPANY, INC.:

Brett Bostrack
Brett Bostrack (Sep 14, 2022 16:33 CDT)

Sep 14, 2022

SIGNATURE **DATE**

Brett Bostrack

PRINTED NAME AND TITLE OF SIGNATORY (above)

STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF TENNCARE

Jim Bryson

Digitally signed by Jim Bryson
Date: 2022.09.25 21:23:13 -05'00'

JIM BRYSON, COMISSIONER **DATE**

Terms and Definitions

1. Administrative Cost – All costs to the Contractor related to 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 TennCare under the terms of this Contract (including, but not limited to, claims processing, marketing, postage, personnel, rent) are considered to be an "administrative cost".

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

3. AI/AN Child - a child covered by CoverKids who is a certified American Indian/Alaskan Native and a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Plan Administrator to the Dental Benefits Manager for the coverage period.

4. Benefits - A schedule of health care services to be delivered to enrollees covered by the Contractor

5. Auxiliary Aids and Services - include, but are not limited to:

    a. Qualified interpreters on-site or through video remote interpreting (VRI) services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;

    b. Qualified readers; taped texts; audio recordings; Brailled materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;

    c. Acquisition or modification of equipment or devices; and

    d. Other similar services and actions as defined in 28 CFR § 36.303.

6. CFR - Code of Federal Regulations

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

8. CMS - Centers for Medicare and Medicaid Services (formerly HCFA).

9. Community Service Area - Community Service Area (CSA) shall mean one (1) or more counties in a defined geographical area in which the Contractor is authorized to enroll providers and serve TennCare enrollees.

The following geographical areas shall constitute the twelve (12) Community Service Areas in Tennessee:

Northwest CSA	-	Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll and Benton
Southwest CSA	-	Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester and McNairy
Shelby CSA	-	Shelby County
Mid-Cumberland CSA	-	Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson and Rutherford
Davidson CSA	-	Davidson County
South Central CSA	-	Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore
Upper Cumberland CSA	-	Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, DeKalb, Putnam, Cumberland, White, Cannon, Warren and Van Buren
Southeast CSA	-	Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley and Marion
Hamilton CSA	-	Hamilton County
East Tennessee CSA	-	Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon and Roane
Knox CSA	-	Knox County
First Tennessee CSA	-	Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter and Johnson

10. Cost-effective Alternative Service – A service that is not a Covered Service but that is approved by TennCare and CMS and provided at an MCO's discretion. TennCare enrollees are not entitled to receive these services. Cost-effective alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in the MCO's judgment, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the MCO's judgment, would require more costly treatment in the future.

11. Covered Service - See Benefits at Contract Sections A.4, A.5, and A.105.

12. Cultural Competence - The level of knowledge-based skills required to provide effective clinical care to enrollees of particular ethnic or racial groups.

13. DBM – Dental Benefits Manager.

14. Department of Intellectual and Developmental Disabilities (DIDD) – The State agency having the statutory authority to plan, promote, provide and support the delivery of services for persons with intellectual and developmental disabilities, and which serves as the contracted operating agency for the State's 1915(c) home and community-based services waivers and is responsible for the performance of contracted functions for ECF CHOICES as specified in interagency agreement.

15. 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 TennCare to the Contractor.

16. ECF CHOICES Participating Dental Provider –A Participating Dental Provider contracted to serve Members age 21 and older enrolled in the ECF CHOICES program.

17. Effective Communication – means taking the appropriate steps to ensure that communications with disabled applicants, participants, members of the public, and their companions are as effective as communications with others by providing alternative formats such as auxiliary aids as defined in USCA.

18. Eligible Person - Any person certified by TennCare as eligible to receive services and benefits under the TennCare Program.

19. Emergency Services – Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act and that are needed to evaluate or stabilize an emergency medical condition.

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

21. Enrollee - Synonymous with "Member". A Medicaid recipient, Medicaid Waiver recipient, or CoverKids recipient who is currently assigned to a Managed Care Organization (MCO), Pre-paid Inpatient Health Plan (PIHP), Pre-paid Ambulatory Health Plan (PAHP) or Primary Case Care Management Program (PCCM) in a given managed care program. For purposes of the Appeal System-related provisions herein, "Enrollee" means enrollee, enrollee-authorized representative, or someone with written consent to act on enrollee's behalf.

22. Enrollee Month – A month of health care coverage for the TennCare eligible enrolled in a Dental Plan.

23 Enrollment - The process by which a person becomes a member of the Contractor's plan through TennCare.

24. EPSDT - The Early, Periodic Screening, Diagnosis, and Treatment services mandated by 42 U.S.C. § 1396d(e) and amended by OBRA 1989. EPSDT services shall mean:

    (a) Screening in accordance with professional standards, interperiodic screenings, and diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare enrollees under age twenty-one (21) and

(b) Health care, treatment, and other measures, described in 42 U.S.C. § 1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.

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

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

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

28. Grand Region – A defined geographical region that includes specified Community Service Areas in which a Contractor is authorized to enroll providers and serve TennCare enrollees. The following Community Service Areas constitute the three (3) Grand Regions in Tennessee:

East Grand Region	Middle Grand Region	West Grand Region
First Tennessee	Upper Cumberland	Northwest
East Tennessee	Mid Cumberland	Southwest
Knox	Davidson	Shelby
Southeast Tennessee	South Central	
Hamilton		

29. Handicapping Malocclusion – for the purposes of determining eligibility for orthodontia shall mean the presence of abnormal dental development that has at least one of the following:

(a) A medical condition and/or a nutritional deficiency with medical physiological impact, that is documented in the physician progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to medical treatment without orthodontic treatment.

(b) The presence of a speech pathology, that is documented in speech therapy progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to speech therapy without orthodontic treatment.

(c) Palatal tissue laceration from a deep impinging overbite where lower incisor teeth contact palatal mucosa. This does not include occasional biting of the cheek.

Anecdotal information is insufficient to document the presence of a handicapping malocclusion. Anecdotal information is represented by statements that are not supported by professional progress notes that the patient has difficulty with eating, chewing, or speaking. These conditions may be caused by other medical conditions in addition to the malalignment of the teeth.

30. Health Maintenance Organization (HMO) - An entity certified by the Department of Commerce and Insurance under applicable provisions of TCA Title 56, Chapter 32.

31. Immediate Eligibility – Temporary eligibility granted to a child upon entering into DCS Custody in order to give children in DCS adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility.

32. Limited English Proficient (LEP) – As defined at 42 CFR §438.10(a).

33. Managed Care Contractor (MCC) – shall mean: (a) A Managed Care Organization, Pharmacy Benefits Manager and/or a Dental Benefits Manager which has signed a TennCare Contractor Risk Agreement with the State and operates a provider network and provides covered health services to TennCare enrollees; or (b) A Pharmacy Benefits Manager, Behavioral Health Organization or Dental Benefits Manager which subcontracts with a Managed Care Organization to provide services; or (c) A State government agency (i.e., Department of Children's Services and Division of Intellectual Disabilities Services) that contracts with TennCare for the provision of services.

34. Managed Care Organization ("MCO") - An HMO which participates in the TennCare Program.

35. Medical Record - A single complete record kept at the site of the enrollee's treatment(s), which documents all of the treatment plans developed, medical services ordered for the enrollee and medical services received by the enrollee.

36. Medically Necessary - Is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in these rules, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in the Medical Necessity rule chapter at 1200-13-16.

37. NAIC – National Association of Insurance Commissioners.

38. Non-TennCare Provider – A provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.

39. Office of the Inspector General - A Unit established to help prevent, identify and investigate fraud and abuse within the healthcare system, most notably the TennCare system.

40. Out-of-Plan Services - Services provided by a non-TennCare provider.

41. Participating Dental Provider – A TennCare provider, as defined herein and in the TennCare Rules, who has entered into a contract with the Contractor to provide Covered Services. A Participating Dental Provider may be contracted to serve children under age 21, adults age 21 and older in ECF CHOICES, individuals enrolled in TPPOHP DBM Program, TennCare Adult Dental DBM Program and CoverKids enrollees or to provide dental services to individuals in all populations.

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

43. Person-Centered Support Plan (PCSP) – As it pertains to ECF CHOICES, the PCSP is a written plan developed by the MCO support coordinator using a person-centered planning process that accurately documents the member's strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the member to help them achieve their preferred lifestyle and goals, and to meet their identified unmet needs (after considering the availability and role of unpaid supports provided by family members and other natural supports) through paid services provided by the MCO and other payor sources).

44. Potential Enrollee – A Medicaid recipient or Medicaid Waiver recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, and PCCM.

45. Prepaid Ambulatory Health Plan (PAHP) – As defined at 42 CFR §438.2. Contractor is classified as a Prepaid Ambulatory Health Plan pursuant to the TennCare II Demonstration Project approved by CMS. Prepaid ambulatory health plan (PAHP) means an entity that—

    (a) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
    (b) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
    (c) Does not have a comprehensive risk contract.

    For example, a dental PAHP is a managed care entity that provides only dental services.

46. Presumptive Eligible - Temporary eligibility granted to a pregnant woman whose family income is at or below a specified percentage of the federal poverty level in order for the woman to receive prenatal care services.

47. Primary Care Physician - A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

48. Primary Care Provider - A primary care physician or registered professional nurse or physician assistant practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

49. Prior Authorization (PA) - The act of authorizing specific services or activities before they are rendered or activities before they occur.

50. Privacy/Security Incidents - Any use or disclosure that is not permitted under the Privacy and Security Rules (Privacy/Security Incident) that compromises the protected health information (PHI) that poses a potential for significant risk of financial, reputational, or other harm to the enrollee as determined by TennCare.

51. Program Integrity - The Program Integrity unit is responsible for assisting with the prevention, identification and investigation of fraud and abuse within the health care system.

52. Provider - An appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services. Providers are categorized as either TennCare Providers or Non-TennCare Providers. TennCare Providers may be further categorized as being one of the following: (a) Participating Providers or In-Network Providers; (b) Non-Participating Providers or Out-of-Network Providers; (c) Out-of-State Emergency Providers. Definitions of each of these terms are contained in this Attachment.

53. Provider Agreement - An agreement between an MCO or DBM and a provider or an MCO's or DBM's subcontractors and a provider of oral health care services which describes the conditions under which the provider agrees to furnish covered services to the MCO's or DBM's enrollees.

54. 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.

55. 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.

56. Service Location - Any location at which an enrollee obtains any oral health care service covered by the Contractor pursuant to the terms of this Contract.

57. Service Site - The locations designated by the Contractor at which enrollees shall receive oral health treatment and preventive services.

58. Services - The benefits described in this Contract, including but not limited to, Section A.3.

59. Shall - Indicates a mandatory requirement or a condition to be met.

60. Specialty Services – Includes Endodontics, Oral Surgery, Orthodontics, Pediatric Dentistry, Periodontics, Prosthodontics.

61. State - State of Tennessee.

62. Subcontract - An agreement that complies with all applicable requirements of this Contract entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract, (e.g., claims processing, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Contract. Agreements to provide covered services as described in Section A.4 of this Contract shall be considered Provider Agreements and governed by Sections A.62 – A.74 of this Contract. If a subcontractor will also be a Provider the requirements for Provider Agreements must also be met.

63. Subcontractor - Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract.

64. Targeted Service Expenditure Baseline – The amount of expenditure, adjusted for factors such as increased provider fees and increased enrollment, against which the actual service expenditures for the period are to be measured to ascertain any savings/loss for purposes of making the risk sharing calculation.

65. TennCare - The Single State Agency designated by the State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the Single State Agency in administering and/or enforcing the TennCare and CoverKids Programs and the terms of this Contract. Such entities include, but are not limited to, the Department of Finance and Administration, Division of TennCare (TennCare), the Department of Health (DOH), the Department of Children's Services (DCS), the Department of Intellectual and Developmental Disabilities (DIDD) the Department of Finance and Administration (F&A), the Department of Mental Health and Substance Abuse Services (DMH/SAS), the TennCare Oversight Division within the Tennessee Department of Commerce and Insurance (C&I) and the Tennessee Bureau of Investigation (TBI), Medicaid Fraud Control Unit (MFCU).

66. TennCare Provider - A provider who accepts as payment in full for furnishing benefits to an enrollee, the amounts paid pursuant to an approved agreement with an MCO or TennCare. Such payment may include copayments from the enrollee or the enrollee's responsible party. Except in the case of Out-of-State Emergency Providers, as defined in the TennCare Rules, a TennCare provider must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including the rules regarding provider billing of patients as found in Rule 1200-13-13-.08.

TennCare Providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in Medicare or Medicaid.

67. 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".

68. Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The State agency responsible for the investigation of provider fraud and abuse in the State Medicaid Program.

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

70. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party payor.

71. Urgent Care - Services for urgent dental and oral conditions or injuries on the basis of the professional judgment of the enrollee's treating dentist, other dental professional, primary care provider or a triage nurse who is trained in dental care and oral health care.

72. Utilization Rate – An adjusted proportion of enrollees in the TennCare Children's DBM Program, ages 2-20, or enrollees in the CoverKids DBM Program, ages 2-18, with a minimum of ninety (90) days eligibility who have received any dental service during the past federal fiscal year.

73. Vital Documents – Consent and grievance forms, intake and application forms with the potential for important consequences, and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents shall be at a minimum available in Spanish.

LIQUIDATED DAMAGES

In the event of a Contract performance or compliance failure by Contractor and such Contract performance or compliance failure is not included in the following table with an associated Liquidated Damage amount, the parties hereby agree that the State may choose one of the following courses of action in order to obtain redressability for such Contract performance or compliance failure: (1) the State may assess actual damages resulting from the Contract performance or compliance failure against the Contractor in the event that such actual damages are known or are reasonably ascertainable at the time of discovery of such Contract performance or compliance failure or (2) if such actual damages are unknown or are not reasonably ascertainable at the time of discovery of the Contract performance or compliance failure, the State may (a) require the Contractor to submit a corrective action plan to address any such Contract performance or compliance failure and (b) assess liquidated damages against Contractor for an amount that is reasonable in relation to the Contract performance or compliance failure as measured at the time of discovery of the Contract performance or compliance failure. In the event that the State chooses to assess a Liquidated Damage for a Contract performance or compliance failure according to the immediately preceding sentence, in no event shall such Liquidated Damage be in excess of $1,000 for any single Contract performance or compliance failure.

TennCare may elect to apply the following liquidated damages remedies in the event the Contractor fails to perform its obligations under this Contract in a proper and/or timely manner. Upon determination by TennCare that the Contractor has failed to meet any of the requirements of this Contract in a proper and/or timely manner, TennCare will notify the Contractor in writing of the performance or compliance failure and of the potential liquidated damages to be assessed. Should the performance or compliance failure remain uncorrected for more than thirty (30) calendar days from the date of the original notification of the performance or compliance failure by TennCare, TennCare may impose an additional liquidated damage of Five Hundred Dollars ($500) per day from the date of the original notification to Contractor until said performance or compliance failure is resolved.

All liquidated damages remedies set forth in the following table may, at TennCare's election, be retroactive to the date of the initial occurrence of the failure to comply with the terms of the Contract as set forth in the notice of performance or compliance failure from TennCare and may continue until such time as the TennCare Deputy Commissioner, or the Deputy Commissioner's representative, determines the performance or compliance failure has been cured.

If liquidated damages are assessed, TennCare shall reduce the amount of any payment due to the Contractor in the next invoice by the amount of damages. In the event that damages due exceed the amount TennCare is to pay to Contractor in a given payment, TennCare shall invoice Contractor for the amount exceeding the amount payable to Contractor, and such excess amount shall be paid by Contractor within thirty (30) calendar days of the invoice date. In situations where the Contractor wishes to dispute any liquidated damages assessed by TennCare, the Contractor must submit a written notice of dispute, including the reasons for disputing the liquidated damages, to the TennCare Deputy Commissioner or the Deputy Commissioner's representative within thirty (30) calendar days of receipt of the notice from TennCare containing the total amount of damages assessed against the Contractor. If the Contractor fails to timely dispute a liquidated damages assessment as set forth herein, such failure shall constitute a bar to the Contractor seeking to have the assessment amount overturned in a forum or court of competent jurisdiction.

Liquidated damages will apply to the Contract performance or compliance failures listed below. Contractor acknowledges that the actual damages likely to result from Contract performance or compliance failures are difficult to estimate and may be difficult for the State to prove. The parties intend that the Contractor's payment of assessed liquidated damages will compensate the State for breach of the Contractor obligations under this Contract. Liquidated damages do not serve as punishment for any breach by the Contractor.

	PROGRAM ISSUES		DAMAGE
1.	Failure by the Contractor to meet the standards for privacy, security, and confidentiality of individual data as evidenced by a breach of the security per Section E. 2. and E.18 and Contractor's failure to timely and reasonably comply with its obligation to appropriately respond to any such breach		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member . For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter.
2.	Failure by the Contractor to execute the appropriate agreements to effectuate transfer and exchange of enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party. (See E.17. and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member . For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter.
3.	Failure by the Contractor to seek express written approval from TennCare prior to the use or disclosure of enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States. (See E.13 and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member . For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter.

4.	Failure by the Contractor to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of suspected breach per Sections (See E.18 and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member . For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter.
5.	Failure to implement Non-Traditional Fluoride Varnish and Dental Screening Program within six months of contract start as referenced in Section A.5.a.4.		The damage that may be assessed shall be five hundred dollars ($500) per calendar day past expected implementation date.
6.	In the event the Contractor provides authorization and reimbursement of dental services for ECF CHOICES members that exceed the amount approved for such services in a member's PCSP as required by Contract Section A.5.b.9.		The damage that may be assessed shall be five hundred dollars ($500) per occurrence.
7.	Failure to obtain approval of member materials as required by Sections A.10 - A.13 of this Contract.		The damage that may be assessed shall be five hundred dollars ($500) per day for each calendar day that TennCare determines the Contractor has provided enrollee material that has not been approved by TennCare.
8.	Failure to comply with licensure requirements in Section A.16 of this Contract.		The damage that may be assessed shall be five thousand dollars ($5,000) per calendar day that staff/provider/agent/ subcontractor is not licensed as required by applicable state law, plus, the amount paid to the staff/provider/agent/ subcontractor during that period.
9.	Failure to comply in any way with staffing requirements described in Sections A.14 - A.18 of this Contract.		The damage that may be assessed shall be two hundred and fifty dollars ($250) per calendar day for each day that staffing requirements described in

			Sections A.14 - A.18 of this Contract are not met.
10.	Provider network includes insufficient numbers and geographical disbursement of providers in order to satisfy the requirements outlined in the Access and Availability to Care section of this contract, Sections A.19 – A.28.		A maximum of twenty-five thousand dollars ($25,000) for failure to meet each of the listed standards, either individually or in combination on a monthly basis. The liquidated damage may be lowered to five thousand dollars ($5,000) in the event that the Contractor timely provides a corrective action plan that is accepted by TennCare
11.	TennCare-related Enrollee Appeals. Failure to confer a timely response to a request for Prior Authorization in accordance with 42 CFR §438.210 and Section A.41 of this contract.		TennCare may assess damages amounting to $500 for each day DBM is in default for each occurrence.
12.	Failure to maintain provider agreements in accordance with Sections A.62 – A.74 of this Contract.		TennCare may assess $5,000 per each occurrence of a provider agreement found to be non-compliant.
13.	Failure to comply with claims processing requirements described by Sections A.84–A.89 of this Contract and the performance requirements in Section A.191.		The damage that may be assessed shall be ten thousand dollars ($10,000) per month, for each month that TennCare determines that the Contractor is not in compliance with any of the requirements of Sections A.84–A.89 and A.191.
14.	Maintain an average daily abandonment rate of 5% or less for each queue on each day the Service Center is open for business excluding calls abandoned before thirty seconds as specified in Sections A.29 and A.95.		A maximum of five hundred dollars ($500) per queue per day for a daily abandonment rate of 6% - 10%. A maximum of one thousand five hundred dollars ($1,500) per day for a daily abandonment rate over 10%.
15.	Maintain an Average Speed of Answer (ASA) per queue per day of 60 seconds or less as specified in Sections A.29. and A.95. ASA is to be calculated from the time that a call comes into the queue from the IVR and when it is answered.		A maximum of five hundred dollars ($500) per queue per day for an ASA of 61 seconds – 180 seconds. A maximum of one thousand five hundred dollars ($1,500) per queue per operating day for an ASA of 181 seconds or more.
16.	Maintain a daily blocked call rate of 1% or less as specified in Sections A.29 and A.95.		A maximum of one thousand dollars ($1,000) for each percentage point above 1%.

17.	The Contractor's shall answer 100% of calls each day within 300 seconds as specified in Section A.29 and A.95.		A maximum of five hundred dollars ($500) for each instance of each call answered within 301 seconds to 600 seconds during each operating day; provided, however total liquidated damages under this section shall not exceed twenty-five thousand dollars ($25,000) per operating day. A maximum of one thousand dollars ($1,000) for each instance of each call answered in 601 seconds or more during each operating day; provided, however total liquidated damages under this section shall not exceed fifty thousand dollars ($50,000) per operating day.
18.	Failure to maintain an appeal system as required by TennCare Rules, the provisions contained in the contract, and applicable provisions of 42 CFR 438 Subpart F in accordance with Sections A.116 – A.132 of this contract. Such failure may be evidenced by Contractor's failure to meet compliance requirements for any aspect of the appeal system.		TennCare may assess damages amounting to $1,500 for each day DBM is in default until a TennCare-approved corrective action plan is fully implemented by the DBM.
19.	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 Section A.152 of this Contract.		The damage that may be assessed shall be the actual amount paid by DCS and/or TennCare for necessary services or one thousand dollars ($1000) per occurrence, whichever is greater, to be deducted from monthly fixed administrative fee payments.
20.	Failure to comply with the program integrity provisions as described in Section A.166 through A.187 of this Contract		The damage that may be assessed is $500 per calendar day for each day that the Contractor does not comply with the program integrity provisions
21.	Maintain a Dental Screening Percentage (DSP) (Refer to Attachment F) greater than or equal to 80% as required in Section A.192.		Liquidated Damages of up to $100,000.00 may be assessed for every 1.0% decrease in DSP below 80%.
22.	Failure by the Contractor to have the PEAR for the CoverKids Program above 50 percent (50%) on an annual		A maximum of up to one hundred thousand dollars ($100,000) in liquidated damages for failure to have the PEAR for the CoverKids Program

	basis as required by Contract Section A.193.		above 50 percent (50%) on an annual basis.
23.	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized by the TennCare Chief Medical Officer.		The damage that may be assessed shall be one thousand dollars ($1000) per occurrence.
24.	Failure to comply with distribution timeframes for providing Member Handbooks, Provider Directories, and Newsletters, as required by Contract Section A.10.		The damage that may be assessed shall be five thousand dollars ($5000) for each occurrence.
25.	Failure to complete or comply with Corrective Action Plans as required by TennCare in Contract A.8.		The damage that may be assessed shall be five hundred dollars ($500) per calendar day for each day the corrective action is not completed or complied with as required.
26.	Failure to completely process a clean credentialing application within sixty (60) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement/contract as required by Contract Section A.138.		$5,000 per application that has not been approved and loaded into the Contractor's system or denied within (30) calendar days of receipt of a completed credentialing application and a signed provider agreement/contract if applicable. $1,000 per application per calendar day for each day beyond thirty (30) calendar days that a completed credentialing application has not been processed.
27.	Failure to report provider notice of termination of participation in the Contractor's Plan as required by Contract Section A.58.		The damage that may be assessed shall be two hundred dollars ($200) per calendar day for each day that Contractor fails to report provider notice of termination of participation.
28.	Failure to submit a Provider Enrollment File that meets TennCare's specifications as required by Contract Sections A.22 and A.148.		$500 per day after the due date that the Provider Enrollment File fails to meet TennCare's specifications.
29.	The level of overall customer satisfaction, as measured annually by a State approved Enrollee Satisfaction survey(s), shall be equal to or greater than 85% in the first year of the Contract, and 90% in all subsequent		$3000.00 per Enrollee Satisfaction survey(s), less than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the Contract term.

	year(s) within the Contract term as required by Contract Section A.36.		
30.	Failure to disclose Lobbying Activities as specified in Section E.8.		The damage that may be assessed shall be one thousand dollars ($1000) per calendar day that disclosure is late.

DBM Deliverables Requirement

DBM Dental Deliverables	Scheduled Due Dates
Monthly Reports: • Batch Claims operation	**Thirty (30) calendar days after the end of each calendar month unless otherwise noted.**
• Program Integrity (PI) Exception List Report	**20th of the month – submit to OPI**
• Bi-monthly PI TIPs Report	**20th of the month for tips received between the 1st and 15th and the 5th of the month for tips received between the 16th and end of the month.**
• PI Involuntary Termination Report	**20th of the month – submit to OPI**
• Claims Lag Triangle	
• Claims Activity	
• Subrogation recoveries collected outside claims processing system (received ad hoc)	Forty-eight (48) hours after weekly payment cycle
• Encounter Data Report (837D)	By fifth business day <u>each month</u>
• Provider Enrollment File☼	
• Systems Availability and Performance Report	
Quarterly Reports: • PI EOB Report	**Thirty (30) days after the end of each Federal Fiscal Year quarter (unless noted)**
• Enrollee Cost Sharing	

• Customer Service Report
  ○ Referral time by county
  ○ Phone response time
  ○ Request for assistance	

• Non-Discrimination Compliance Reports	
• Quarterly Financials/ Income Statements	
• Encounter/MLR Reconciliation Report	
• DBM Quarterly TennCare Kids Report	

• QMP Committee Meeting Minutes • Quality Indicator • PI Referral ¥ • Quarterly FWA Activities Report • Non-Traditional FI Varnish Program Report • "Insure Kids Now" (IKN) File☼ • PI Disclosure Rate Report • Quarterly Member Newsletter • PI Utilization by Standard Deviation • PI Cost Savings Report	**PI referrals should be submitted as soon as the FWA is suspected or confirmed** Ten (10) days after the end of each federal quarter Submit to TC OPI Submit to TC OPI Submit to TC OPI
Annual Reports/ Plans/Studies: • Annual Outreach Plan • Audited Financial Statements • Member Satisfaction Surveys* • Provider Satisfaction Surveys* • Non-Discrimination Compliance Plan & Assurance of Non-Discrimination • Annual Outreach Plan Year-End Update • Two (2) PIPs Dental Studies† • QMP Report‡ (QMP, work plan, and evaluation) • Licensure Documentation • Systems Refresh Plan • Fraud, Waste And Abuse Compliance Plan • Annual Disclosure Form • Annual policies for employees, contractors, and agents that comply with 1902(a)(68) SSA (Deficit Reduction) • Annual Recoveries Report	**Ninety (90) days after end of Federal Year (unless noted)** By August 15 each year By March 30 each year By March 30 each year By March 30 each year By August 15 each year By November 30 each year By June 30 each year By March 30 each year By September 15 each year By December 1 each year By July 1 each year By March 30 each year By July 1 each year **By February 15 each year**

Ad Hoc Reports:	Within ten (10) business days from the date of the request when reasonable unless otherwise specified by TennCare.
Progress Reports	As Requested
On Request Reports (ORRs)	Within three (3) business days from the date of request when reasonable unless otherwise specified by TennCare.
Requests for Information (RFIs)	As Requested

¥ PI TIPs Report and PI Referrals should be submitted via the Secured File Transport (SFTP) server and in format specifications designated by TennCare.

☼ File format shall comply with specifications as outlined by TennCare.

DBM Cover Kids Dental Deliverables	Scheduled Due Dates
Quarterly Reports: • Claims Payment Reports • Member/Provider Service Lines • Network Changes Update Report • Network Quarterly Payment • Member Newsletter • Member Handbook ID, and Provider Network Directories Distributed • PI Report-Fraud and Abuse • External Quality Review Organization (EQRO) Provider Data	Thirty (30) days after the end of each Federal Fiscal Year quarter (unless noted) Within 5 days of end of each quarter Within 5 days of end of each quarter

• Non-Discrimination Compliance Report • CoverKids Member Complaint Log • CoverKids Provider Complaint Log • CoverKids Dental Benefit Savings and Payments Report • Enrollment Summary Plan • FQHC/RHC Report	
Annual Reports/ Plans/Studies: • Enrollee Satisfaction Survey • Provider Satisfaction Survey • Non-Discrimination Policy • Non-Discrimination Policy Compliance Plan	**Ninety (90) days after end of Federal Year (unless noted)** By March 30 each year By March 30 each year By August 16 each year By August 16 each year
Ad Hoc Reports: **Progress Reports** **On Request Reports (ORRs)** **Requests for Information (RFIs)**	Within ten (10) business days from the date of the request when reasonable unless otherwise specified by TennCare. As Requested Within three (3) business days from the date of request when reasonable unless otherwise specified by TennCare. As Requested

Management Reporting Requirements
Contract Management Reports by which the State can assess the CoverKids Dental program costs and usage. Reports shall be submitted in an electronic format as referenced in Section A.151.a (Management Reports). Management Reports shall include:

1) Performance Guarantee Reports, as detailed at Contract Attachment C (each component to be submitted at the frequency indicated), shall include:

- Status report narrative
- Detail report on each performance measure by appropriate time period

2) **Quarterly CoverKids Dental Benefit Savings and Payments Report,** must be submitted as follows distinguishing between in-network and out-of-network:

GROUP ONE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

GROUP TWO CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						

Therapeutic Pulpotomy						
Total						

AMERICAN INDIAN/ ALASKAN NATIVE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

3) **Quarterly Provider and Out-of-Network Claims Utilization by:**
   - Submitted charges
   - Benefits paid
   - Member Utilization

4) **Quarterly Enrollment Summary Plan Report:**

Premium Category	Subscribers	Premium	Total Claims
Group One Child			
Group Two Child			
American Indian/ Alaskan Native Child			
Total			

5) **Quarterly Network Changes Update Report, displaying the following:**

- Present Network of Participating Providers by Specialty
- Additions to the Network by Name, Specialty and Location
- Terminations to the Network by Name, Specialty and Location
- Targeted areas for recruitment

D0000's Codes Diagnostic	D1000's Codes Preventive	D2000's Codes Restorative	D3000's Codes Endodontics	D4000's Codes Periodontal	D5000's Codes Prosthodontics	D7000's Codes Oral Surgery	D9000's Codes Adjunctive General Services
D0120	D1110	D2140	D3310	D4341	D5110	D7140	D9110
D0140	D1206	D2150	D3320	D4342	D5120	D7210	D9230
D0150	D1208	D2160	D3330	D4355	D5130	D7220	
D0160	D1354	D2161			D5140	D7250	
D0210		D2330			D5211	D7310	
D0220		D2331			D5212	D7311	
D0230		D2332			D5213	D7320	
D0270		D2335			D5214	D7321	
D0272		D2391			D5282	D7471	
D0273		D2392			D5283	D7472	
D0274		D2393			D5284	D7473	
D0330		D2394			D5286	D7485	
D0367		D2721			D5730		
		D2722			D5731		
		D2740			D5750		
		D2750			D5751		
		D2751					
		D2752					
		D2753					
		D2781					
		D2782					
		D2783					
		D2791					
		D2792					
		D2920					
		D2931					

TN Division of TennCare

HIPAA Business Associate Agreement

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT ("Agreement") is between The State of Tennessee, Division of TennCare ("TennCare" or "Covered Entity"), located at 310 Great Circle Road, Nashville, TN 37243 and DentaQuest USA Insurance Company, Inc. ("Business Associate"), located at 11100 W Liberty Drive Milwaukee, WI 53224, including all office locations and other business locations at which Business Associate data may be used or maintained. Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

The Parties acknowledge that they are subject to the Privacy and Security Rules (45 C.F.R. Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, and as amended by the final rule modifying the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act (HITECH). If Business Associate provides services to Covered Entity pursuant to one or more contractual relationships, said Agreements are detailed below and hereinafter referred to as "Service Agreements."

LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT:

In the course of performing services under a Service Agreement, Business Associate may come into contact with, use, or disclose Protected Health Information ("PHI"). Said Service Agreements are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security rules and regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, D and E, which require Covered Entity to have a written memorandum with each of its Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard PHI that Business Associate may receive (if any) from or on behalf of Covered Entity, and, therefore, execute this Agreement.

1. DEFINITIONS

All capitalized terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms defined in 45 C.F.R. Parts 160 through 164 or other applicable law or regulation. A reference in this Agreement to a section in the Privacy or Security Rule means the section as in effect or as amended.

1.1 "Commercial Use" means obtaining PHI with the intent to sell, transfer or use it for commercial, or personal gain, or malicious harm; sale to third party for consumption, resale, or processing for resale; application or conversion of data to make a profit or obtain a benefit contrary to the spirit of this Agreement, including but not

limited to presentation of data or examples of data in a conference or meeting setting where the ultimate goal is to obtain or gain new business.

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

1.3 "Electronic Signature" means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

1.4 "Marketing" shall have the meaning under 45 C.F.R. § 164.501 and the act or process of promoting, selling, leasing or licensing any TennCare information or data for profit without the express written permission of TennCare.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Compliance with the Privacy Rule. Business Associate shall fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose PHI other than as permitted or required by this Agreement, the Service Agreements, or as required by law. In case of any conflict between this Agreement and the Service Agreements, this Agreement shall govern.

2.2 HITECH Act Compliance. The Health Information Technology for Economic and Clinical Health Act (HITECH) was adopted as part of the American Recovery and Reinvestment Act of 2009. HITECH and its implementing regulations impose new requirements on Business Associates with respect to privacy, security, and Breach notification. Business Associate hereby acknowledges and agrees that to the extent it is functioning as a Business Associate of Covered Entity, Business Associate shall comply with any applicable provisions of HITECH. Business Associate and the Covered Entity further agree that the provisions of HIPAA and HITECH that apply to business associates and that are required to be incorporated by reference in a business associate agreement have been incorporated into this Agreement between Business Associate and Covered Entity. Should any provision not be set forth specifically, it is as if set forth in this Agreement in its entirety and is effective as of the Applicable Effective Date, and as amended.

2.3 Business Management. Business Associate may use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of Business Associate. Business Associate may provide data aggregation services relating to the Health Care Operations of TennCare, or as required by law. Business Associate is expressly prohibited from using or disclosing PHI other than as permitted by this Agreement, any associated Service Agreements, or as otherwise permitted or required by law, and is prohibited from uses or disclosures of PHI that would not be permitted if done by the Covered Entity.

2.4 Privacy Safeguards and Policies. Business Associate shall use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the Service Agreement(s), this Agreement or as required by law. This includes the implementation of Administrative, Physical, and Technical Safeguards to reasonably and appropriately protect the Covered Entity's PHI against any reasonably anticipated threats or hazards, utilizing the technology commercially available to the Business Associate (See also Section 3.2). The Business Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, and procedures, records of training and sanctions of members of its Workforce.

2.5 Business Associate Contracts. Business Associate shall require any agent, including a Subcontractor, to whom it provides PHI received from, maintained, created or received by Business Associate on behalf of Covered Entity, or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI or other confidential TennCare information, to agree, by written agreement with Business Associate, to substantially similar, but not less stringent restrictions and conditions that apply through this Agreement to Business Associate with respect to such information except for the provision at section 4.6, which shall only apply to the Business Associate notwithstanding the requirements in this section 2.5.

2.6 Mitigation of Harmful Effect of Violations. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.7 Reporting of Violations in Use and Disclosure of PHI. Business Associate shall require its employees, agents, and Subcontractors to promptly report to Business Associate immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement and to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. The Business Associate shall report such violation to Covered Entity immediately upon becoming aware of, and in no case later than 48 hours after discovery.

2.8 Breach of Unsecured Protected Health Information. As required by the Breach Notification Rule, Business Associate shall, and shall require its Subcontractor(s) to, maintain systems to monitor and detect a Breach of Unsecured PHI, whether in paper or electronic form.

2.8.1 Business Associate shall provide to Covered Entity notice of a Breach of Unsecured PHI immediately upon becoming aware of the Breach, and in no case later than 48 hours after discovery.

2.8.2 Business Associate shall cooperate with Covered Entity in timely providing the appropriate and necessary information to Covered Entity.

2.8.3 Covered Entity shall make the final determination whether the Breach requires notification to affected individuals and whether the notification shall be made by Covered Entity or Business Associate.

2.9 Access of Individual to PHI and other Requests to Business Associate. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity in order to meet its requirements under 45 C.F.R. § 164.524. If Business Associate receives a request from an Individual for a copy of the Individual's PHI, and the PHI is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the Individual in a timely manner. If Business Associate receives a request for PHI not in its possession and in the possession of the Covered Entity, or receives a request to exercise other Individual rights as set forth in the Privacy Rule, Business Associate shall promptly forward the request to Covered Entity. Business Associate shall then assist Covered Entity as necessary in responding to the request in a timely manner. If a Business Associate provides copies of PHI to the Individual, it may charge a reasonable fee for the copies as the regulations shall permit.

2.10 Requests to Covered Entity for Access to PHI. The Covered Entity shall forward to the Business Associate in a timely manner any Individual's request for access to or a copy (in any form they choose, provided the PHI is readily producible in that format) of their PHI that shall require Business Associate's participation, after which the Business Associate shall provide access to or deliver such information as follows:

(a) The Parties understand that if either Party receives a request for access to or copies of PHI from an Individual which the Party may complete with only its own onsite information, the time for such response shall be thirty (30) days, with notification to the Covered Entity upon completion.

(b) If the Covered Entity receives a request and requires information from the Business Associate in addition to the Covered Entity's onsite information to fulfill the request, the Business Associate shall have fifteen (15) days from date of Covered Entity's notice to provide access or deliver such information to the Covered Entity so that the Covered Entity may timely respond to the Individual within the thirty (30) day requirement of 45 C.F.R. § 164.524.

(c) If the Party designated above as responding to the Individual's request is unable to complete the response to the request in the time provided, that Party shall provide the Individual, or Individual's designee, with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Party may extend the response time once for no more than thirty (30) additional days.

(d) Business Associate is permitted to send an Individual or Individual's designee unencrypted emails including Electronic PHI if the Individual requests it, provided the Business Associate has advised the Individual of the risk and the Individual still prefers to receive the message by unencrypted email.

2.11 Individuals' Request to Amend PHI. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526, regarding an Individual's request to amend PHI. The Business Associate shall make the amendment promptly in the time and manner designated by Covered Entity, but shall have thirty (30) days' notice from Covered Entity to complete the amendment to the Individual's PHI and to notify the Covered Entity upon completion.

2.12 Recording of Designated Disclosures of PHI. Business Associate shall document any and all disclosures of PHI by Business Associate or its agents, including information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

2.13 Accounting for Disclosures of PHI. The Business Associate agrees to provide to Covered Entity or to an Individual, or Individual's designee, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. The Covered Entity shall forward the Individual's request requiring the participation of the Business Associate to the Business Associate in a timely manner, after which the Business Associate shall provide such information as follows:

(a) If Covered Entity directs Business Associate to provide an accounting of disclosures of the Individual's PHI directly to the Individual, the Business Associate shall have sixty (60) days from the date of the Individual's request to provide access to or deliver such information to the Individual or Individual's designee. The Covered Entity shall provide notice to the Business Associate in time to allow the Business Associate a minimum of thirty (30) days to timely complete the Individual's request.

(b) If the Covered Entity elects to provide the accounting to the Individual, the Business Associate shall have thirty (30) days from date of Covered Entity's notice of request to provide information for the Accounting to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day period.

(c) If either of the Parties is unable to complete the response to the request in the times provided above, that Party shall notify the Individual with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Parties may extend the response time once for no more than thirty (30) additional days.

(d) The accounting of disclosures shall include at least the following information:

(1) date of the disclosure;

(2) name of the third party to whom the PHI was disclosed,

(3) if known, the address of the third party;

(4) brief description of the disclosed information; and

(5) brief explanation of the purpose and basis for such disclosure.

(e) The Parties shall provide one (1) accounting in any twelve (12) months to the Individual without charge. The Parties may charge a reasonable, cost-based fee, for each subsequent request for an accounting by the same Individual if he/she is provided notice and the opportunity to modify his/her request. Such charges shall not exceed any applicable State statutes or rules.

2.14 Minimum Necessary. Business Associate shall use reasonable efforts to limit any use, disclosure, or request for use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.14.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, PHI shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.14.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.14.3 Business Associate shall adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity.

2.15 Privacy Compliance Review upon Request. Business Associate agrees to make its internal practices, books and records, including policies, procedures, and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of Covered Entity available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.16 Cooperation in Privacy Compliance. Business Associate agrees to fully cooperate in good faith and to assist Covered Entity in complying with the requirements of the Privacy Rule.

3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Compliance with Security Rule. Business Associate shall fully comply with the requirements under the Security Rule applicable to "Business Associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Security Safeguards and Policies. Business Associate shall implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule. This includes specifically, but is not limited to, the utilization of technology commercially available at the time to the Business Associate to protect the Covered Entity's PHI against any reasonably anticipated threats or hazards. The Business Associate understands that it has an affirmative duty to perform a regular review or assessment of security risks, conduct active risk management and supply best efforts to assure that only authorized persons and devices access its computing systems and information storage, and that only authorized transactions are allowed. The Business Associate will maintain appropriate documentation of its compliance with the Security Rule.

3.3 Security Provisions in Business Associate Contracts. Business Associate shall ensure that any agent to whom it provides Electronic PHI received from, maintained, or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI supplied by Covered Entity, shall execute a bilateral contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, incorporating substantially similar, but not less stringent restrictions and conditions in this

Agreement with Business Associate regarding PHI except for the provision in Section 4.6.

3.4 Reporting of Security Incidents. The Business Associate shall track all Security Incidents as defined and as required by HIPAA and shall periodically report such Security Incidents in summary fashion as may be requested by the Covered Entity. The Covered Entity shall not consider as Security Incidents, for the purpose of reporting, external activities (port enumeration, etc.) typically associated with the "footprinting" of a computing environment as long as such activities have only identified but not compromised the logical network perimeter, including but not limited to externally facing firewalls and web servers. The Business Associate shall reasonably use its own vulnerability assessment of damage potential and monitoring to define levels of Security Incidents and responses for Business Associate's operations. However, the Business Associate shall expediently notify the Covered Entity's Privacy Officer of any related Security Incident, immediately upon becoming aware of any unauthorized acquisition including but not limited to use, disclosure, modification, or destruction of PHI by an employee or otherwise authorized user of its system of which it becomes aware.

3.4.1 Business Associate identifies the following key contact persons for all matters relating to this Agreement:

Sarah Shannon

Business Associate shall notify Covered Entity of any change in these key contacts during the term of this Agreement in writing within ten (10) business days.

3.5 Contact for Security Incident Notice. Notification for the purposes of Sections 2.8and 3.4 shall be in writing made by email/fax, certified mail or overnight parcel immediately upon becoming aware of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

TennCare Privacy Officer
310 Great Circle Rd.
Nashville Tennessee 37243
Phone: (615) 507-6697
Facsimile: (615) 734-5289
Email: Privacy.Tenncare@tn.gov

3.6 Security Compliance Review upon Request. Business Associate shall make its internal practices, books, and records, including policies and procedures relating to the security of Electronic PHI received from, created by or received by Business Associate on behalf of Covered Entity, available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's, Business Associate's compliance with the Security Rule.

3.7 Cooperation in Security Compliance. Business Associate shall fully cooperate in good faith to assist Covered Entity in complying with the requirements of the Security Rule.

3.8 Refraining from intimidation or retaliation. A Covered Entity or Business Associate may not threaten, intimidate, coerce, harass, discriminate against, or take any other retaliatory action against any Individual or other person for-- (a) Filing of a complaint under 45 C.F.R. § 160.306; (b) testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or (c) opposing any act or practice made unlawful,

provided the Individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of PHI in violation of HIPAA.

4. USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Use and Disclosure of PHI for Operations on Behalf of Covered Entity. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform Treatment, Payment or Health Care Operations for, or on behalf of, Covered Entity as specified in Service Agreements, provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity.

4.2 Other Uses of PHI. Except as otherwise limited in this Agreement, Business Associate may use PHI within its Workforce as required for Business Associate's proper management and administration, not to include Marketing or Commercial Use, or to carry out the legal responsibilities of the Business Associate.

4.3 Third Party Disclosure Confidentiality. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are required by law, or, if permitted by law, this Agreement, and the Service Agreement, provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as required by law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is Breached immediately upon becoming aware.

4.4 Other Uses Strictly Limited. Nothing in this Agreement shall permit the Business Associate to share PHI with Business Associate's affiliates or contractors except for the purposes of the Service Agreement(s) between the Covered Entity and Business Associate(s) identified in the "LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT" on page one (1) of this Agreement.

4.5 Covered Entity Authorization for Additional Uses. Any use of PHI or other confidential TennCare information by Business Associate, its Subcontractors, its affiliate or Contractor, other than those purposes of this Agreement, shall require express written authorization by the Covered Entity, and a Business Associate agreement or amendment as necessary. Activities which are prohibited include, but not are not limited to, Marketing or the sharing for Commercial Use or any purpose construed by Covered Entity as Marketing or Commercial use of TennCare enrollee personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws.

4.6 Prohibition of Offshore Disclosure. Nothing in this Agreement shall permit the Business Associate to share, use or disclose PHI in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without express written authorization from the Covered Entity.

4.7 Prohibition of Other Uses and Disclosures. Business Associate shall not use or disclose PHI that is Genetic Information for underwriting purposes. Moreover, the sale, marketing or the sharing for commercial use or any purpose construed by Covered Entity as the sale, marketing or commercial use of TennCare enrollee personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws, is prohibited.

4.8 Data Use Agreement - Use and Disclosure of Limited Data Set. Business Associate may use and disclose a Limited Data Set that Business Associate creates for Research, public health activity, or Health Care Operations, provided that Business Associate complies with the obligations below. Business Associate may not make such use and disclosure of the Limited Data Set after any cancellation, termination, expiration, or other conclusion of this Agreement.

4.9 Limitation on Permitted Uses and Disclosures. Business Associate will limit the uses and disclosures it makes of the Limited Data Set to the following: Research, public health activity, or Health Care Operations, to the extent such activities are related to covered functions**,** including business planning and development such as conducting cost-management and planning-related analysis related to managing and operating Business Associates functions, formulary development and administration, development and improvement of methods of payment or coverage policies, customer service, including the provision of data analysis for policy holders, plan sponsors, or other customers, to the extent such activities are related to covered functions, provided that PHI is not disclosed and disclosure is not prohibited pursuant to any other provisions in this Agreement related to Marketing or Commercial use.

4.10 Business Associate shall enter into written agreements that are substantially similar to this Business Associate Agreements with any Subcontractor or agent which Business Associate provides access to Protected Health Information.

4.11 Business Associates shall implement and maintain information security policies that comply with the HIPAA Security Rule.

5. OBLIGATIONS OF COVERED ENTITY

5.1 Notice of Privacy Practices. Covered Entity shall provide Business Associate with the notice of Privacy Practices produced by Covered Entity in accordance with 45 C.F.R. § 164.520, as well as any changes to such notice.

5.2 Notice of Changes in Individual's Access or PHI. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses.

5.3 Notice of Restriction in Individual's Access or PHI. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use of PHI.

5.4 Reciprocity for Requests Received by Business Associate. The Parties agree that this Section (Section 5) is reciprocal to the extent Business Associate is notified or receives an inquiry from any Individual within Covered Entity's covered population.

6. TERM AND TERMINATION

6.1 Term. This Agreement shall be effective as of the date on which it has been signed by both parties and shall terminate when all PHI which has been provided, regardless of form, by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if the Parties agree that it is unfeasible to return or destroy PHI, subsection 6.3.5 below shall apply.

6.2 Termination for Cause. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to terminate this Agreement and Service Agreement in the event Business Associate fails to comply with, or violates a material provision of this Agreement and any provision of the Privacy and Security Rules.

6.2.1 Upon Covered Entity's knowledge of a Breach by Business Associate, Covered Entity shall either:

(a) Provide notice of breach and an opportunity for Business Associate to reasonably and promptly cure the breach or end the violation, and terminate this BAA if Business Associate does not cure the breach or end the violation within the reasonable time specified by Covered Entity; or

(b) Immediately terminate this BAA if Business Associate has breached a material term of this BAA and cure is not possible.

6.3 Effect of Termination. Upon termination of this Agreement for any reason, except as provided in subsections 6.3.2 and 6.3.5 below, Business Associate shall at its own expense either return and/or destroy all PHI and other confidential information received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision applies to all confidential information regardless of form, including but not limited to electronic or paper format. This provision shall also apply to PHI and other confidential information in the possession of sub-contractors or agents of Business Associate.

6.3.1 The Business Associate shall consult with the Covered Entity as necessary to assure an appropriate means of return and/or destruction and shall notify the Covered Entity in writing when such destruction is complete. If information is to be returned, the Parties shall document when all information has been received by the Covered Entity.

6.3.2 This provision (Section 6.3 and its subsections) shall not prohibit the retention of a single separate, archived file of the PHI and other confidential TennCare information by the Business Associate if the method of such archiving reasonably protects the continued privacy and security of such information and the Business Associate obtains written approval at such time from the Covered Entity. Otherwise, neither the Business Associate nor its Subcontractors and agents shall retain copies of TennCare confidential information, including enrollee PHI, except as provided herein in subsection 6.3.5.

6.3.3 The Parties agree to anticipate the return and/or the destruction of PHI and other TennCare confidential information, and understand that removal of the confidential information from Business Associate's information system(s) and premises will be expected in almost all circumstances. The Business Associate shall notify the Covered Entity whether it intends to return and/or destroy the confidential with such additional detail as requested. In the event Business Associate determines that returning or destroying the PHI and other confidential information received by or created for the Covered Entity at the end or other termination of the Service Agreement is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible.

6.3.4 Except for Business Associate Agreements in effect prior to April 21, 2005 when the Security Rule became effective, for the renewal or amendment of those same Agreements, or for other unavoidable circumstances, the Parties contemplate that PHI and other confidential information of the Covered Entity shall not be merged or aggregated with data from sources unrelated to that Agreement, or Business Associate's other business data, including for purposes of data backup and disaster recovery, until the parties identify the means of return or destruction of the TennCare data or other confidential information of the Covered Entity at the conclusion of the Service Agreement, or otherwise make an express alternate agreement consistent with the provisions of Section 6.3 and its subsections.

6.3.5 Upon written mutual agreement of the Parties that return or destruction of PHI is unfeasible and upon express agreement as to the means of continued protection of the data, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

7. MISCELLANEOUS

7.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and/or Security Rule means the section as in effect or as amended.

7.2 Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended, including, but not limited to, changes required by the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

7.3 Survival. The respective rights and obligations of Business Associate under Confidentiality and Section6.3 of this Agreement shall survive the termination or expiration of this Agreement.

7.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

7.5 Headings. Paragraph Headings used in this Agreement are for the convenience of the Parties and shall have no legal meaning in the interpretation of the Agreement.

7.6 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by electronic mail, hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice. (For purposes of this section, effective notice to "Respective Party" is not dependent on whether the person named below remains employed by such Party.) The Parties agree to use their best efforts to immediately notify the other Party of changes in address, telephone number, and fax numbers and to promptly supplement this Agreement as necessary with corrected information.

Notifications relative to Sections 2.8 and 3.4 of this Agreement must also be reported to the Privacy Officer pursuant to Section 3.5.

COVERED ENTITY:
Stephen Smith, Director
Division of TennCare
310 Great Circle Rd.
Nashville, TN 37243
Fax: (615) 253-5607

BUSINESS ASSOCIATE:
Courtney Barnes Ransom
Courtney Barnes Ransom (Sep 15, 2022 08:44 EDT)
Courtney Barnes Ransom
SVP, Risk Management, Chief Ethics & Compliance Officer

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

7.7 Transmission of PHI or Other Confidential Information. Regardless of the transmittal methods permitted above, Covered Entity and Business Associate agree that all deliverables set forth in this Agreement that are required to be in the form of data transfers shall be transmitted between Covered Entity and Business Associate via the data transfer method specified in advance by Covered Entity. This may include, but shall not be limited to, transfer through Covered Entity's SFTP system. Failure by the Business Associate to transmit such deliverables in the manner specified by Covered Entity may, at the option of the Covered Entity, result in liquidated damages if and as set forth in one (1) or more of the Service Agreements between Covered Entity and Business Associate listed above. All such deliverables shall be considered effectively submitted upon receipt or recipient confirmation as may be required.

7.8 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

7.9 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

7.10 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA and HITECH and without giving effect to principles of conflicts of law. Jurisdiction shall be Davidson County, Nashville, Tennessee, for purposes of any litigation resulting from disagreements of the parties for purpose of this Agreement and the Service Agreement (s).

7.11 Compensation. There shall be no remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative requirements of Tennessee State government and Services Agreement(s) referenced herein.

7.12 Validity of Execution. Unless otherwise agreed, the parties may conduct the execution of this Business Associate Agreement transaction by electronic means. The parties may agree that an electronic record of the Agreement containing an Electronic Signature is valid as an executed Agreement.

IN WITNESS WHEREOF, the Parties execute this Agreement to be valid and enforceable from the last date set out below:

DIVISION OF TENNCARE

By: Stephen M. Smith Digitally signed by Stephen M. Smith Date: 2022.09.30 16:30:50 -05'00'

Stephen Smith, Director

Date: _____

Division of TennCare
310 Great Circle Road
Nashville, TN 37243
Fax: (615) 253-5607

BUSINESS ASSOCIATE

By: Courtney Barnes Ransom
Courtney Barnes Ransom (Sep 15, 2022 08:44 EDT)

Date: Sep 15, 2022

Signature: Brett Bostrack
Brett Bostrack (Sep 14, 2022 16:33 CDT)
Email: brett.bostrack@dentaquest.com
Title: EVP
Company: DentaQuest

Signature: Courtney Barnes Ransom
Courtney Barnes Ransom (Sep 15, 2022 08:44 EDT)
Email: courtney.ransom@greatdentalplans.com
Title: SVP, Risk Management, Chief Ethics & Compliance
Company: DentaQuest

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00490		59802	3

Contractor Legal Entity Name	Edison Vendor ID
DentaQuest USA Insurance Company, Inc.	222275

Amendment Purpose & Effect(s)
Scope Updates Addition of IDD

Amendment Changes Contract End Date: ☐ YES ☒ NO **End Date:** April 30, 2023

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A)**:** **$ 0.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2019	$475,027.00	$475,027.00			$950,054.00
2020	$2,850,162.00	$2,850,162.00			$5,700,324.00
2021	$7,853,137.00	$17,859,086.00			$25,712,223.00
2022	$7,853,137.00	$17,859,086.00			$25,712,223.00
2023	$6,544,280.00	$14,882,572.00			$21,426,852.00
TOTAL:	**$25,575,743.00**	**$53,925,933.00**			**$79,501,676.00**

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

Zane Seals

CPO USE

Speed Chart (optional)	Account Code (optional)

AMENDMENT #3
OF CONTRACT 59802
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF TENNCARE
AND
DENTAQUEST USA INSURANCE COMPANY, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Division of TennCare, hereinafter referred to as the "State" and DentaQuest USA Insurance Company, Inc., hereinafter referred to as the "Contractor." For good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

1. Contract section A.39 is deleted in its entirety and replaced with the following:

A.39. Utilization Management for the TennCare ECF CHOICES DBM Program

The Contractor shall conduct utilization management and prior authorization for Covered Services under the TennCare ECF CHOICES DBM Program as may be required for the specific services included in members' PCSPs, including any dental services approved by the MCO as a Cost-Effective Alternative Service, subject to the amount approved for such services in the member's PCSP. This information shall be communicated to the Contractor by the member's applicable MCO. As further specified in writing by TennCare, the Contractor shall utilize robust evidence-based Utilization Management (UM) processes and electronic edits to improve efficiencies, prevent fraud and abuse, as well as to triage treatment plans/PCSPs to identify complex cases that shall require greater professional review and evaluation by DBM dentist reviewers. The Contractor shall utilize the same UM processes to identify less medically complex treatment plans that will require less intensive review, to allow for greater automation, and enable more expeditious approval.

2. The following is added as Contract section A.200:

A.200. TennCare Adults with Intellectual or Developmental Disabilities Dental Program. The Contractor shall be responsible for managing the dental benefits for adults with Intellectual or Developmental Disabilities (IDD) that are enrolled in the Section 1915(c) Home and Community Based Services (HCBS) Waiver (TennCare 1915(c) Dental Program) pursuant to the following requirements:

a. *Consolidation of Programs*. The Contractor shall coordinate with TennCare to gradually integrate the TennCare 1915(c) Dental Program and the TennCare ECF CHOICES Dental Program into one consolidated TennCare IDD Dental Program. Said consolidation shall be completed by the Contractor pursuant to expectations and timeframes to be provided by TennCare in a separate written schedule.

b. *Readiness Review and Implementation*. Prior to "go-live" of the TennCare 1915(c) Dental Program, the Contractor shall participate in a readiness review in coordination with TennCare. This readiness review shall be specific to the TennCare 1915(c) Dental Program and shall be conducted pursuant to TennCare expectations and timeframes. The Contractor shall develop or revise, as applicable, all documentation necessary to ensure adults with IDD receive services under the TennCare 1915(c) Dental Program. At minimum, the Contractor shall update all related policies and procedures, the IDD Dental Provider Office Reference Manual, the IDD Member Handbook, and all Contractor web content pages. Updates to said materials shall include both member and provider resources. The Contractor shall submit all items to TennCare for review and approval. The Contractor shall also conduct a demonstration of systems readiness and provider network adequacy to meet the requirements of this Contract for TennCare's review and approval.

c. *"Go-Live" Date*. The Contractor shall "go-live" with the IDD Dental Program on September 1, 2021, unless otherwise directed by TennCare. If the Contractor fails to demonstrate its readiness to "go-live", TennCare may, at its sole discretion, postpone or cancel the "go-live" date.

d. *Provider Network Requirements*.

1. Prior to "go-live", the Contractor shall demonstrate its network adequacy for providers treating members of the TennCare 1915(c) Dental Program, as well as compliance with continuity of care requirements.

2. The Contractor shall utilize its existing ECF CHOICES provider network as an initial resource for development of a TennCare 1915(c) Dental Program provider network. Although dental providers in the ECF CHOICES Program provider network cannot be required to join the TennCare 1915(c) Dental Program provider network, the Contractor shall provide education to ECF CHOICES providers regarding the TennCare 1915(c) Dental Program and further assist any provider that is interested in joining the TennCare 1915(c) Dental Program provider network.

3. The Contractor shall develop and maintain a TennCare 1915(c) Dental Program provider network that meets the following Access to Care and Transport Distance requirements:

(i) All services, service locations, and service sites are available and accessible to the extent that transport distance and time to all network providers do not exceed an average of thirty (30) miles or forty-five (45) minutes for general dental services; sixty (60) miles or sixty (60) minutes for oral surgery services; sixty (60) miles or sixty (60) minutes for orthodontic services; and, seventy (70) miles or seventy (70) minutes for pediatric dental services, as measured by GeoAccess Software.

(ii) The Contractor shall not refuse to credential a qualified provider on the sole basis of the network already meeting the contractual distance accessibility standard, if there is a subset of enrollees in the proposed service area that must travel beyond the average standard to access dental care.

(iii) The Contractor shall maintain under contract a network of TennCare 1915(c) Dental Program participating dental providers who have experience and/or expertise in serving individuals with IDD with preferred contracting standards, with seventy-five percent (75%) of such services, service locations, and service sites available and accessible so that transport distance to these providers shall not exceed an average of thirty (30) miles or forty-five (45) minutes, as measured by GeoAccess Software, and one hundred percent (100%) of such services, service locations, and service sites shall be available and accessible so that transport distance to these providers shall not exceed an average of sixty (60) miles or sixty (60) minutes, as measured by GeoAccess software.

(iv) If the Contractor is unable to meet the Access to Care and Transport Distance requirements provided above, the Contractor may submit to TennCare a request for temporary waiver of said requirements. Such waiver shall provide a justification for the Contractor's request, including a report of dental providers in the Contractor's TennCare 1915(c) Dental Program provider network that do meet TennCare's provider requirements. TennCare shall have sole discretion to approve or reject such waiver request and shall state a specific term for each granted waiver (i.e. length of time before the Contractor must comply with Access to Care and Transport Distance requirements).

4. The Contractor shall ensure continuity of care for individuals already receiving adult dental services through a CHOICES Waiver for a period of up to six (6) months following the integration of adult dental benefits for adults enrolled in a Section 1915(c) HCBS Waiver into the TennCare 1915(c) Dental Program. If continuity of care for the individual is impacted after the six (6) months resulting from the development of the TennCare 1915(c) Dental Program provider network, the Contractor shall coordinate with the Independent Support Coordinator or DIDD Case Manager, as applicable, to facilitate the member's seamless transition to a contracted TennCare 1915(c) Dental Program Participating Provider of the individual's choice.

5. All decisions regarding the Contractor's TennCare 1915(c) Dental Program provider network, including which providers are permitted to participate in the Contractor's provider network and best practices for management of the provider network, are the sole responsibility of the Contractor and made by the Contractor in its sole discretion.

e. *Minimum Provider Requirements*. Prior to the effective date of the Contractor's TennCare 1915(c) Dental Program provider agreement with a dental provider, the Contractor shall ensure said dental provider meets the following requirements:

1. Provider must be a currently licensed dentist in the State of Tennessee;

2. Provider must complete the TennCare electronic provider registration process;

3. Provider must provide proof of a current and valid Medicaid Provider number; and

4. Provider must meet such other standards developed by TennCare that are provided to the Contractor in writing.

f. *Enhanced Provider Qualifications Thresholds*. In developing a provider network for the TennCare 1915(c) Dental Program, TennCare encourages the Contractor to include dental providers that meet specific qualifications thresholds above the minimum provider requirements, including the following:

1. Provider has a minimum of two (2) years of experience providing dental services to individuals with IDD, including successful treatment of at least twenty (20) individuals with IDD;

2. Provider has completed a residency, internship, certification of continuing education, or other training specific to providing dental services to individuals with IDD, including training regarding alternative adjunctive techniques and modalities that may be used to facilitate the delivery of dental services and reduce the inappropriate use of sedation;

3. Provider can demonstrate its regular use of modalities to reduce the use of sedation services, including a demonstration of best practices for alternative approaches to reduce the rate of dental sedation in serving individuals with IDD; and

4. Any other qualifications threshold identified by the Parties as critical to providing quality services to individuals with IDD.

g. *Enhanced Provider Qualifications Report*. The Contractor shall submit a quarterly report to TennCare detailing the Contractor's efforts to identify dental providers that meet the Enhanced Provider Qualifications Thresholds. The Contractor shall submit said report in a narrative format until TennCare provides written guidance further detailing any additional required data elements to be included.

h. *Credentialing Providers*. To satisfy credentialing and recredentialing processes, the Contractor shall conduct a site visit for all TennCare 1915(c) Dental Program providers

and assess the provider pursuant to the following criteria:

1. Determine whether said provider's dental office meets accessibility requirements;

2. Determine whether provider's treatment approach for serving individuals with IDD meets TennCare standards, including the provider's use of sedation services for individuals with IDD, as well as the provider's use of alternative adjunctive techniques and modalities to reduce the use of sedation services, as applicable; and

3. Determine provider's existing efforts and proposed action steps for seeking education and training opportunities to further develop capacity and expertise to provide dental services to individuals with IDD.

i. *Provider Agreement*.

1. The Contractor shall prepare a draft TennCare 1915(c) Dental Program provider agreement and submit said draft to TennCare and the State of Tennessee Department of Commerce and Insurance TennCare Oversight Division for review and approval prior to contracting with any providers interested in joining the TennCare 1915(c) Dental Program provider network.

2. The Contractor shall enter separate provider agreements for dental providers treating members of the TennCare 1915(c) Dental Program. Provider agreements between the Contractor and TennCare ECF CHOICES Dental Program providers will not be sufficient for purposes of the TennCare 1915(c) Dental Program. However, as part of the program consolidation efforts further described above (see Section A.200.a), the Parties shall collectively work toward combining the TennCare ECF CHOICES Dental Program provider agreement and the TennCare 1915(c) Dental Program provider agreement into one consolidated agreement template, which shall not be utilized by the Contractor until this Contract is amended to reflect the proper effective date for said template.

j. *Provider Manual*. The Contractor shall produce and distribute a TennCare 1915(c) Dental Program provider manual to assist participating dental providers. The provider manual shall clearly define covered services, limitations, exclusions, and Utilization Management procedures. Utilization Management procedures shall include details for prior authorization requirements, medical necessity guidelines for dental procedures, and special documentation requirements (e.g., hospital readiness form, orthodontic readiness form, documentation of nutritional deficiencies or general pediatric records including growth data), and speech/hearing evaluations (may include school records) for treatment of enrollees. The provider manual shall also include a detailed description of billing requirements for participating dental providers and shall contain a copy of the Contractor's paper billing form and electronic billing format. The Contractor shall ensure that the provider manual remains up-to-date and reflects changes in applicable law or revisions to TennCare or Contractor policy. The initial version of the provider manual and any subsequent revisions thereto shall be submitted to TennCare and the State of Tennessee Department of Commerce and Insurance TennCare Oversight Division for review and approval prior to distribution to providers. Participating dental providers shall be apprised of revisions to the provider manual by the Contractor, by means of written or electronic notice, to be sent thirty (30) days in advance of the implementation of the new policy or procedure. The required details outlined above shall be delivered to dental providers in the form of a supplement or internal component to the Contractor's existing provider manual, so long as said supplement or component is conspicuously labeled as applying to the TennCare 1915(c) Dental Program.

k. *Minimum Staffing Requirements*. The Contractor shall meet minimum staffing requirements for the TennCare 1915(c) Dental Program, including the following:

1. **IDD Staff Dentist** - The Contractor shall designate and maintain, subject to TennCare approval, one full-time (1 FTE) IDD Staff Dentist, which shall report to the Contractor's DBM Dental Director. The IDD Staff Dentist position shall not be filled with any person concurrently employed by the Contractor as the ECF CHOICES Staff Dentist. The IDD Staff Dentist shall be dedicated solely to the TennCare 1915(c) Dental Program. The IDD Staff Dentist shall be licensed by the Tennessee Board of Dentistry, remain in good standing, be physically located in the State of Tennessee, have at least four (4) years of experience with people with IDD, or alternatively, have completed a residency or certification program specific to the provision of dental services for people with IDD. The IDD Staff Dentist shall be responsible for the clinical oversight of adult dental benefits applicable to the TennCare 1915(c) Dental Program, including quality improvement, utilization management, utilization review, site visits and credentialing of providers, development of clinical practice standards, clinical policies and procedures, performance improvement plans, provider corrective actions, leadership in training and development of the provider network, and development of statewide capacity to provide dental services to individuals with IDD broadly, including children with IDD receiving dental services pursuant to EPSDT or the CoverKids DBM Program, and participation in meetings as requested by TennCare. The IDD Staff Dentist shall be hired no later than sixty (60) calendar days prior to September 1, 2021.

2. **Client-Partner Coordinator** - The Contractor shall designate and maintain, subject to TennCare approval, one full-time (1 FTE) person physically located in Tennessee to coordinate dental services between the DBM and MCO specific to the TennCare 1915(c) Dental Program. The Client-Partner Coordinator position shall not be filled with any person concurrently employed by the Contractor as the MCO-DBM Coordinator. Prior to program implementation and thereafter through the duration of this Contract, the Client-Partner Coordinator shall develop and maintain, a system for data exchange with the MCOs and the Contractor, which shall include, at minimum, functionality to exchange the following information: referrals; treatment plans; stratification of proposed treatment plan procedures; authorizations; and other information as determined necessary by TennCare for the TennCare 1915(c) Dental Program.

l. *Covered Services and Limitations*.

1. The Contractor shall ensure all TennCare 1915(c) Dental Program participating providers render high quality, Medically Necessary, cost effective dental care for members. The Contractor shall exercise every available means through this Contract, provider agreements, office reference manual, policies and procedures, and educational programs to ensure that dental benefits in the TennCare 1915(c) Dental Program are managed in this manner.

2. The Contractor shall ensure TennCare 1915(c) Dental Program benefits are properly coordinated with the members' MCOs in accordance with this Contract and any protocols and procedures developed by TennCare.

3. Covered Services for eligible adults age 21 and older in the TennCare 1915(c) Dental Program shall be limited to a maximum of $5,000 per member per calendar year, and a maximum of $7,500 per member across three (3) consecutive calendar years. A member's MCO may elect, at its sole discretion, to exceed these limits as a Cost-Effective Alternative Service, when the provision of such additional dental services would be medically appropriate and offer a more Cost-Effective Alternative Service to other covered services the member would otherwise require.

4. Adult dental services in the TennCare 1915(c) Dental Program shall be provided only as specified in the member's PCSP. Upon inclusion of dental services in a TennCare 1915(c) Dental Program member's PCSP, the Contractor shall work with the

member's MCO support coordinator or the member's Independent Support Coordinator or DIDD Case Manager, as applicable, to assist the member in selecting a contracted TennCare 1915(c) Dental Program participating provider. A copy of the PCSP or relevant portions of the PCSP, as determined by TennCare, shall be provided to the TennCare 1915(c) Dental Program participating provider by the member's MCO pursuant to a process approved by TennCare in writing. The covered services as described above are the same services for members of the TennCare ECF CHOICES Dental Program.

5. Upon selection of a TennCare 1915(c) Dental Program participating provider and subject to the amount approved for dental services in the member's PCSP, each TennCare 1915(c) Dental Program member shall undergo a thorough dental evaluation prior to receiving Covered Services, unless the member has had such an evaluation in the ninety (90) calendar days prior to such service request. The results of that evaluation will be a proposed treatment plan that will include both short-term dental needs (e.g., cavities detected during the exam to be filled) and long-term dental services (e.g., cleaning every six months), which shall be incorporated into the member's PCSP, as determined by the member or his/her authorized representative. Notwithstanding the proposed treatment plan developed by the TennCare 1915(c) Dental Program participating provider, the total cost of dental services that may be authorized by the Contractor are subject to the amount approved for dental services in the member's PCSP. If the total cost of services proposed in the treatment plan exceed the amount authorized for dental services in the member's PCSP, the Participating Dental Provider shall not proceed to perform such services, except as specifically approved by the member or his/her authorized representative, and with full disclosure that other services proposed in the treatment plan will not be provided based on the current amount approved for dental services in the member's PCSP.

6. The Contractor shall not authorize nor reimburse dental services for TennCare 1915(c) Dental Program members that are not covered by TennCare, except for dental services approved by a member's MCO as a Cost-Effective Alternative Service. The Contractor shall track dental expenditures for each TennCare 1915(c) Dental Program member and shall not authorize nor reimburse dental services for a TennCare 1915(c) Dental Program member that exceed the amount approved for such services in the member's PCSP. Upon request, the Contractor shall also make available to TennCare 1915(c) Dental Program participating providers the total dental expenditures that have been authorized and reimbursed for each TennCare 1915(c) Dental Program member served by any other TennCare 1915(c) Dental Program participating providers in order to ensure that dental services are not provided to the member in excess of the amount approved for such services in the member's PCSP. Any authorization and reimbursement of dental services for TennCare 1915(c) Dental Program members that exceed the amount approved for such services in a member's PCSP may subject the Contractor to liquidated damages.

7. The Contractor shall be responsible for the submission of encounter data to TennCare regarding Covered Services provided under the Contract and the TennCare 1915(c) Dental Program, including Covered Services authorized by a member's MCO as a Cost-Effective Alternative Service.

8. The Contractor shall not authorize coverage of orthodontic services for members of the TennCare 1915(c) Dental Program.

m. *Utilization Management and Prior Authorization Requirements*. The Contractor shall conduct Utilization Management (UM) and prior authorization for medically necessary Covered Services under the TennCare 1915(c) Dental Program as may be required for the specific services included in a member's PCSP. The Contractor will also review non-covered dental services prior to approval by the MCO as a Cost-Effective Alternative Service, subject to the amount approved for such services in the member's PCSP. This

information will be communicated to the Contractor by the member's MCO. The Contractor shall utilize evidence-based UM processes and electronic edits to improve efficiencies, prevent fraud and abuse, and triage treatment plans / PCSPs to identify medically complex cases that requiring greater professional review and evaluation by DBM dentist reviewers. The Contractor will utilize the same UM processes to identify less medically complex treatment plans that will require less case management, to allow for greater automation, and enable more expeditious approval.

n. *Medical Necessity Guidelines for Treating Members in a Medical Facility*. The Contractor shall establish medical necessity guidelines for covered dental procedures for individuals with IDD. If a TennCare 1915(c) Dental Program participating provider is requesting to treat an IDD member in a medical facility due to an inability to treat the member in a dental office, then said provider must seek authorization from the Contractor by completing a dental specific inpatient and outpatient hospital readiness pre-admission form.

o. *Fee Schedule*. TennCare shall deliver the most current version of the TennCare 1915(c) Dental Program fee schedule to the Contractor in writing promptly upon (and in no event more than three (3) business days following) its approval for use. This fee schedule is updated annually to reflect any additions, deletions and modifications made to the *Code on Dental Procedures and Nomenclature / Current Dental Terminology* (CDT) as published by the American Dental Association. The revised fee schedule becomes effective each January 1st.

p. *CDT Codes*. The Contractor shall apply the Current Dental Terminology (CDT) codes listed in the table below to TennCare 1915(c) Dental Program services:

CATEGORY	CODES				
Diagnostic (D0000)	D0120	D0210	D0251	D0277	D0460
	D0140	D0220	D0270	D0322	D0470
	D0150	D0230	D0272	D0330	
	D0160	D0240	D0273	D0340	
	D0170	D0250	D0274	D0367	
Preventive (D1000)	D1110	D1206	D1208	D1354	
Restorative (D2000)	D2140	D2390	D2740	D2791	D2951
	D2150	D2391	D2750	D2792	D2952
	D2160	D2392	D2751	D2920	D2953
	D2161	D2393	D2752	D2931	D2954
	D2330	D2394	D2753	D2932	D2955
	D2331	D2710	D2781	D2933	D2957
	D2332	D2721	D2782	D2940	D2980
	D2335	D2722	D2783	D2950	
Endodontics (D3000)	D3220	D3330	D3346	D3352	D3425
	D3221	D3331	D3347	D3353	D3426
	D3310	D3332	D3348	D3410	D3430
	D3320	D3333	D3351	D3421	D3450
Periodontal (D4000)	D4210	D4240	D4341	D4346	D4910
	D4211	D4241	D4342	D4355	
Prosthodontics (D5000) (D6000)	D5110	D5422	D5721	D5864	D6740
	D5120	D5511	D5730	D5865	D6751
	D5130	D5512	D5731	D5866	D6752

CATEGORY	CODES				
	D5140	D5520	D5740	D5867	D6753
	D5211	D5611	D5741	D5876	D6781
	D5212	D5612	D5750	D6211	D6782
	D5213	D5621	D5751	D6212	D6783
	D5214	D5622	D5760	D6241	D6784
	D5225	D5630	D5761	D6242	D6791
	D5226	D5640	D5810	D6243	D6792
	D5282	D5650	D5811	D6245	D6920
	D5283	D5660	D5820	D6251	D6930
	D5284	D5670	D5821	D6252	D6940
	D5286	D5671	D5850	D6545	D6950
	D5410	D5710	D5851	D6548	D6980
	D5411	D5711	D5862	D6721	
	D5421	D5720	D5863	D6722	
Oral Surgery (D7000)	D7140	D7260	D7310	D7465	D7530
	D7210	D7270	D7320	D7471	D7540
	D7220	D7272	D7410	D7472	D7880
	D7230	D7280	D7413	D7473	D7970
	D7240	D7282	D7440	D7485	D7971
	D7241	D7285	D7450	D7510	D7972
	D7250	D7286	D7460	D7511	D7997
Adjunctive General Services (D9000)	D9110	D9215	D9239	D9630	D9945
	D9210	D9222	D9243	D9910	D9946
	D9211	D9223	D9248	D9911	D9971
	D9212	D9230	D9610	D9944	

CDT codes are subject to change based on any additions, deletions, and modifications made to the *Code on Dental Procedures and Nomenclature* as published by the American Dental Association.

3. Contract Section C.3 shall be deleted in its entirety and replaced with the following:

C.3. Payment Methodology. The Contractor shall be compensated based on the payment methodology for goods or services authorized by the State in a total amount as set forth in Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in Section A.

b. The Contractor shall be compensated based upon the following payment methodology:

(1) For the transition period of September 1, 2018 – April 30, 2019, there shall be no cost to the State.

(2) For TennCare Children's DBM Program, TennCare ECF CHOICES Dental Program, and TPPOHP DBM Program services performed from May 1, 2019 through April 30, 2023, the following rates shall apply:

Cost Item Description	Amount (per compensable increment)

Cost Item Description	Amount (per compensable increment)
May 1, 2019 – April 30, 2023 **TennCare Children's DBM Program** Administrative Fee Per Child (Under Age 21) Eligible for Full Dental Benefit Package (per member per month) AND **TPPOHP DBM Program** Administrative Fee per TennCare Enrollee who is a Pregnant Woman (21 Years of Age and Older) Eligible for TPPOHP DBM Program Limited Benefits (per member per month)	$0.50 per member per month
TennCare ECF CHOICES Dental Program **May 1, 2019 – April 30, 2023** Administrative Fee Per Eligible Adult Enrolled in the TennCare ECF CHOICES Dental Program (per member per month)	$0.01 per member per month

(3) For CoverKids DBM Program services performed from July 1, 2020 (Go Live Date) through April 30, 2023, the following rates shall apply. There shall be no cost to the State for CoverKids DBM Program services prior to Go Live Date of July1, 2020.

Cost Item Description	Amount (per compensable increment)
CoverKids DBM Program **July 1, 2020 – April 30, 2023** Group One Child [1] (Monthly)	$14.70 Monthly Premium Rate Per Member
CoverKids DBM Program **July 1, 2020 – April 30, 2023** Group One Child [2] (Monthly)	$20.67 Monthly Premium Rate Per Member
CoverKids DBM Program **July 1, 2020 – April 30, 2023** AI / AN Child [3] (Monthly)	$18.19 Monthly Premium Rate Per Member

[1] ***Group One Child*** *is defined as a covered child who is in a family with an income between 150 percent and 250 percent of FPL.*

[2] ***Group Two Child*** *is defined as a covered child who is in a family with an income below 150 percent of FPL and therefore subject to reduced copayments.*

[3] ***AI / AN Child*** *is defined as a covered child who is (a) certified American Indian/Alaskan Native (AI/AN) and (b) a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Eligibility Determination Contractor to the Contractor for the coverage period.*

(4) Should Term Extension Option (Section B.2) be utilized, the following rates shall apply for services performed during extension periods:

Cost Item Description	**Amount** (per compensable increment)
TennCare Children's DBM Program Administrative Fee Per Child (Under Age 21) Eligible for Full Dental Benefit Package (per member per month) AND **TPPOHP DBM Program** Administrative Fee per TennCare Enrollee who is a Pregnant Woman (21 Years of Age and Older) Eligible for TPPOHP DBM Program Limited Benefits (per member per month)	$0.50 Per Member Per Month
TennCare ECF CHOICES Dental Program Administrative Fee Per Eligible Adult Enrolled in the ECF CHOICES Program (per member per month)	$0.01 Per Member Per Month
CoverKids DBM Program Group One Child (Monthly)	$14.70 Monthly Premium Rate Per Member
CoverKids DBM Program Group Two Child (Monthly)	$20.67 Monthly Premium Rate Per Member
CoverKids DBM Program AI / AN Child [3] (Monthly)	$18.19 Monthly Premium Rate Per Member

[3] ***AI / AN Child*** *is defined as a covered child who is (a) certified American Indian/Alaskan Native (AI/AN) and (b) a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Eligibility Determination Contractor to the Contractor for the coverage period.*

c. The Contractor shall assume risk levels for the TennCare Children's DBM Program only of at least 20% based on levels submitted in Cost Proposal (Contract Section A.164).

Risk Levels	
DBM Assumes 50% of Loss	DBM Share: 50% of any Savings

d. The Contractor shall assume "no" risk for the TennCare 1915(c) Dental Program.

e. The Contractor shall be compensated for the TennCare 1915(c) Dental Program based upon the following compensation methodology:

(1) For the transition period of March 1, 2021 – September 1, 2021, there shall be no cost to the State.

(2) The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in section A.

(3) For TennCare IDD Dental services performed from September 1, 2021 through April 30, 2023, the following rates shall apply:

Cost Item Description	Amount (per compensable increment)
TennCare 1915(c) Dental Program September 1, 2021 – April 30, 2023 Administrative Fee Per Eligible Adult Enrolled in the TennCare 1915(c) Home and Community Based Services (HCBS) Waiver (Per Member Per Month)	$5.15 per member per month

(4) For the TennCare IDD Dental Program the rates are based upon seven thousand (7,000) members enrolled in a Section 1915(c) Home and Community Based Services (HCBS) Waiver. If at any time the number of members drops below five thousand (5,000), the Contractor will be reimbursed based on a membership of five thousand (5,000).

(5) Should Term Extension Option (Section B.2) be utilized, the following rates shall apply for services performed during extension periods:

Cost Item Description	Amount (per compensable increment)
TennCare IDD Dental Program Administrative Fee Per Eligible Adult Enrolled in the 1915(c) Home and Community Based Services (HCBS) Waiver (per member per month)	$5.15 Per Member Per Month

4. Contract Attachment A is deleted in its entirety and replaced with the new Attachment A attached hereto.

5. Contract Attachment B is deleted in its entirety and replaced with the new Attachment B attached hereto.

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

Comptroller of the Treasury).

Amendment Effective Date. The revisions set forth herein shall be effective once all required approvals are obtained. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

DENTAQUEST USA INSURANCE COMPANY, INC.:

Brett Bostrack
Brett Bostrack (Mar 24, 2021 11:20 CDT)

Mar 24, 2021

SIGNATURE **DATE**

Brett Bostrack Senior Vice President

PRINTED NAME AND TITLE OF SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION, DIVISION OF TENNCARE:

Butch Eley
Digitally signed by Butch Eley
Date: 2021.03.30 15:50:40 -05'00'

BUTCH ELEY, COMMISSIONER **DATE**

Terms and Definitions

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

2. Administrative Cost – All costs to the Contractor related to 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 TennCare under the terms of this Contract (including, but not limited to, claims processing, marketing, postage, personnel, rent) are considered to be an "administrative cost".

3. Administrative Services Fee – The per member per month amount that the Contractor will charge for provision of the services outlined in this Contract.

4. AI/AN Child - a child covered by CoverKids who is a certified American Indian/Alaskan Native and a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Plan Administrator to the Dental Benefits Manager for the coverage period.

5. Benefits - A schedule of health care services to be delivered to enrollees covered by the Contractor

6. Auxiliary Aids and Services - include, but are not limited to:

    a. Qualified interpreters on-site or through video remote interpreting (VRI) services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;

    b. Qualified readers; taped texts; audio recordings; Brailled materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;

    c. Acquisition or modification of equipment or devices; and

    d. Other similar services and actions as defined in 28 CFR § 36.303.

7. CFR - Code of Federal Regulations

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

9. CMS - Centers for Medicare and Medicaid Services (formerly HCFA).

10. Community Service Area - Community Service Area (CSA) shall mean one (1) or more counties in

a defined geographical area in which the Contractor is authorized to enroll providers and serve TennCare enrollees. The following geographical areas shall constitute the twelve (12) Community Service Areas in Tennessee:

1.	Northwest CSA	Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll, and Benton Counties
2.	Southwest CSA	Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester, and McNairy Counties
3.	Shelby CSA	Shelby County
4.	Mid-Cumberland CSA	Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson, and Rutherford Counties
5.	Davidson CSA	Davidson County
6.	South Central CSA	Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln, and Moore Counties
7.	Upper Cumberland CSA	Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, DeKalb, Putnam, Cumberland, White, Cannon, Warren, and Van Buren Counties
8.	Southeast CSA	Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley, and Marion Counties
9.	Hamilton CSA	Hamilton County
10.	East Tennessee CSA	Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon, and Roane Counties
11.	Knox CSA	Knox County
12.	First Tennessee CSA	Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter, and Johnson Counties

11. Cost-effective Alternative Service – A service that is not a Covered Service but that is approved by TennCare and CMS and provided at an MCO's discretion. TennCare enrollees are not entitled to receive these services. Cost-effective alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in the MCO's judgment, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the MCO's judgment, would require more costly treatment in the future.

12. Covered Service - See Benefits at Contract Sections A.4, A.5, and A.105.

13. Cultural Competence - The level of knowledge-based skills required to provide effective clinical care to enrollees of particular ethnic or racial groups.

14. DBM – Dental Benefits Manager.

15. Department of Intellectual and Developmental Disabilities (DIDD) – The State agency having the statutory authority to plan, promote, provide and support the delivery of services for persons with intellectual and developmental disabilities, and which serves as the contracted operating agency for the State's 1915(c) home and community-based services waivers and is responsible for the performance of contracted functions for ECF CHOICES as specified in interagency agreement.

16. 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 TennCare to the Contractor.

17. ECF CHOICES Participating Dental Provider –A Participating Dental Provider contracted to serve Members age 21 and older enrolled in the TennCare ECF CHOICES Dental Program.

18. Effective Communication – means taking the appropriate steps to ensure that communications with disabled applicants, participants, members of the public, and their companions are as effective as communications with others by providing alternative formats such as auxiliary aids as defined in USCA.

19. Eligible Person - Any person certified by TennCare as eligible to receive services and benefits under the TennCare Program.

20. Emergency Services – Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act and that are needed to evaluate or stabilize an emergency medical condition.

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

22. Enrollee - Synonymous with "Member". A Medicaid recipient, Medicaid Waiver recipient, or CoverKids recipient who is currently assigned to a Managed Care Organization (MCO), Pre-paid Inpatient Health Plan (PIHP), Pre-paid Ambulatory Health Plan (PAHP) or Primary Case Care Management Program (PCCM) in a given managed care program. For purposes of the Appeal System-related provisions herein, "Enrollee" means enrollee, enrollee-authorized representative, or someone with written consent to act on enrollee's behalf.

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

24. Enrollee Month – A month of health care coverage for the TennCare eligible enrolled in a Dental Plan.

25. Enrollment - The process by which a person becomes a member of the Contractor's plan through TennCare.

26. EPSDT - The Early, Periodic Screening, Diagnosis, and Treatment services mandated by 42 U.S.C. § 1396d(e) and amended by OBRA 1989. EPSDT services shall mean:

    a. Screening in accordance with professional standards, inter-periodic screenings, and diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare enrollees under age twenty-one (21) and Health care, treatment, and other measures, described in 42 U.S.C. § 1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.

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

28. Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to this Contract; or (b) maintained by a

subcontractor or provider to provide services on behalf of the Contractor.

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

30. 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 (42 CFR 455.2).

31. Full-Time – shall mean: (1) the number of hours worked per week by each Key Staff member shall be a minimum of thirty-seven and one-half (37.5) hours, and (2) each Key Staff position set forth in Contract Section A.17 shall be a Full Time position, with the exception of the Assistant Fraud and Abuse Investigators and the Fraud and Abuse staff person, each of whom work on an as-needed basis.

32. Grand Region – A defined geographical region that includes specified Community Service Areas in which a Contractor is authorized to enroll providers and serve TennCare enrollees. The following Community Service Areas constitute the three (3) Grand Regions in Tennessee:

East Grand Region	Middle Grand Region	West Grand Region
First Tennessee	Upper Cumberland	Northwest
East Tennessee	Mid Cumberland	Southwest
Knox	Davidson	Shelby
Southeast Tennessee	South Central	
Hamilton		

33. Handicapping Malocclusion – shall mean, for the purposes of determining eligibility for orthodontia, the presence of abnormal dental development that has at least one of the following:

    1. A medical condition and/or a nutritional deficiency with medical physiological impact, that is documented in the physician progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to medical treatment without orthodontic treatment.
    2. The presence of a speech pathology, that is documented in speech therapy progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to speech therapy without orthodontic treatment.
    3. Palatal tissue laceration from a deep impinging overbite where lower incisor teeth contact palatal mucosa. This does not include occasional biting of the cheek.

    Anecdotal information is insufficient to document the presence of a handicapping malocclusion. Anecdotal information is represented by statements that are not supported by professional progress notes that the patient has difficulty with eating, chewing, or speaking. These conditions may be caused by other medical conditions in addition to the malalignment of the teeth.

34. Health Maintenance Organization (HMO) - An entity certified by the Department of Commerce and Insurance under applicable provisions of TCA Title 56, Chapter 32.

35. Hire Date and Start Date – “Hire Date” and “Start Date” shall be deemed synonymous for purposes of the Contract, and all Key Staff are to begin work on the same date they are hired so they can become familiar with the TennCare Program prior to Go-Live Date, or so they can immediately begin to familiarize themselves with the TennCare Program if they are hired after the Go-Live Date.

36. Immediate Eligibility – Temporary eligibility granted to a child upon entering into DCS Custody in order to give children in DCS adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility.

37. Limited English Proficient (LEP) – As defined at 42 CFR §438.10(a).

38. Managed Care Contractor (MCC) – shall mean: (a) A Managed Care Organization, Pharmacy Benefits Manager and/or a Dental Benefits Manager which has signed a TennCare Contractor Risk Agreement with the State and operates a provider network and provides covered health services to TennCare enrollees; or (b) A Pharmacy Benefits Manager, Behavioral Health Organization or Dental Benefits Manager which subcontracts with a Managed Care Organization to provide services; or (c) A State government agency (i.e., Department of Children's Services and Division of Intellectual Disabilities Services) that contracts with TennCare for the provision of services.

39. Managed Care Organization ("MCO") **-** An HMO which participates in the TennCare Program.

40. Medical Record - A single complete record kept at the site of the enrollee's treatment(s), which documents all of the treatment plans developed, medical services ordered for the enrollee and medical services received by the enrollee.

41. Medically Necessary - Is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in these rules, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in the Medical Necessity rule chapter at 1200-13-16.

42. NAIC – National Association of Insurance Commissioners.

43. Non-TennCare Provider – A provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.

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

45. Out-of-Plan Services - Services provided by a non-TennCare provider.

46. Office Reference Manual – A dental program criteria manual specific to each separate dental benefit program, to assist participating dental providers.

47. Participating Dental Provider – A TennCare provider, as defined herein and in the TennCare Rules, who has entered into a contract with the Contractor to provide Covered Services. A Participating Dental Provider may be contracted to serve children under age 21, adults age 21 and older in ECF CHOICES and the 1915(c) HCBS Waiver, individuals enrolled in TPPOHP DBM Program, and CoverKids enrollees or to provide dental services to individuals in all populations.

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

49. Person-Centered Support Plan (PCSP) – As it pertains to ECF CHOICES, the PCSP is a written plan developed by the MCO support coordinator using a person-centered planning process that accurately documents the member's strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the member to help them achieve their preferred lifestyle and goals, and to meet their identified unmet needs (after

considering the availability and role of unpaid supports provided by family members and other natural supports) through paid services provided by the MCO and other payor sources).

50. Potential Enrollee – A Medicaid recipient or Medicaid Waiver recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program but is not yet an enrollee of a specific MCO, PIHP, PAHP, and PCCM.

51. Prepaid Ambulatory Health Plan (PAHP) – As defined at 42 CFR §438.2. Contractor is classified as a Prepaid Ambulatory Health Plan pursuant to the TennCare II Demonstration Project approved by CMS. Prepaid ambulatory health plan (PAHP) means an entity that—

    1. Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
    2. Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
    3. Does not have a comprehensive risk contract.

    For example, a dental PAHP is a managed care entity that provides only dental services.

52. Presumptive Eligible - Temporary eligibility granted to a pregnant woman whose family income is at or below a specified percentage of the federal poverty level in order for the woman to receive prenatal care services.

53. Primary Care Physician - A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

54. Primary Care Provider - A primary care physician or registered professional nurse or physician assistant practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

55. Prior Authorization (PA) - The act of authorizing specific services or activities before they are rendered or activities before they occur.

56. Privacy/Security Incidents - Any use or disclosure that is not permitted under the Privacy and Security Rules (Privacy/Security Incident) that compromises the protected health information (PHI) that poses a potential for significant risk of financial, reputational, or other harm to the enrollee as determined by TennCare.

57. Program Integrity - The TennCare Office of Program Integrity (OPI) is responsible for the prevention, detection and investigation of alleged provider fraud, waste and/or abuse. OPI collaborates with the Managed Care Contractors (MCCs), law enforcement, and various state and federal agencies to ensure regulatory compliance and accountability and protects the financial and health care service integrity of the TennCare program.

58. Provider -An appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services. Providers are categorized as either TennCare Providers or Non-TennCare Providers. TennCare Providers may be further categorized as being one of the following: (a) Participating Providers or In-Network Providers; (b) Non-Participating Providers or Out-of-Network Providers; (c) Out-of-State Emergency Providers. Definitions of each of these terms are contained in this Attachment.

59. Provider Agreement - An agreement between an MCO or DBM and a provider or an MCO's or

DBM's subcontractors and a provider of oral health care services which describes the conditions under which the provider agrees to furnish covered services to the MCO's or DBM's enrollees.

60. 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.

61. 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.

62. Service Location - Any location at which an enrollee obtains any oral health care service covered by the Contractor pursuant to the terms of this Contract.

63. Service Site - The locations designated by the Contractor at which enrollees shall receive oral health treatment and preventive services.

64. Services - The benefits described in this Contract, including but not limited to, Section A.3.

65. Shall - Indicates a mandatory requirement or a condition to be met.

66. Specialty Services – Includes Endodontics, Oral Surgery, Orthodontics, Pediatric Dentistry, Periodontics, Prosthodontics.

67. State - State of Tennessee.

68. Subcontract - An agreement that complies with all applicable requirements of this Contract entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract, (e.g., claims processing, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Contract. Agreements to provide covered services as described in Section A.4 of this Contract shall be considered Provider Agreements and governed by Sections A.62 – A.74 of this Contract. If a subcontractor will also be a Provider the requirements for Provider Agreements must also be met.

69. Subcontractor - Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract.

70. Targeted Service Expenditure Baseline – The amount of expenditure, adjusted for factors such as increased provider fees and increased enrollment, against which the actual service expenditures for the period are to be measured to ascertain any savings/loss for purposes of making the risk sharing calculation.

71. TennCare - The Single State Agency designated by the State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the Single State Agency in administering and/or enforcing the TennCare and CoverKids Programs and the terms of this Contract. Such entities include, but are not limited to, the Department of Finance and Administration, Division of TennCare (TennCare), the Department of Health (DOH), the Department of Children's Services (DCS), the Department of Intellectual and Developmental Disabilities (DIDD) the Department of Finance and Administration (F&A), the Department of Mental Health and Substance Abuse Services (DMH/SAS), the TennCare Oversight Division within the Tennessee Department of Commerce and Insurance (C&I) and the Tennessee Bureau of Investigation Medicaid Fraud Control Division (MFCD).

72. TennCare 1915(c) Dental Program – Adult dental services as provided under the State's Section 1915(c) waivers for individuals with intellectual disabilities, which include specific preventive dental services (as listed in A.200), fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments as medically necessary to relieve pain and infection, as well as adjunctive sedation services, which may include medically necessary and appropriate deep sedation or general anesthesia, provided in the dentist's office by and billed by the contracted treating dentist. TennCare 1915(c) Dental Program benefits are identical to the dental benefits, procedure codes, and dental fee schedule for the ECF CHOICES Dental Program.

73. TennCare Employment and Community First CHOICES (ECF CHOICES) Dental Program - Adult dental services as provided under the State's ECF CHOICES program, which include specific preventive dental services (as listed in A.200), fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments as medically necessary to relieve pain and infection, as well as adjunctive sedation services, which may include medically necessary and appropriate deep sedation or general anesthesia, provided in the dentist's office by and billed by the contracted treating dentist. TennCare ECF CHOICES Dental Program benefits are identical to the dental benefits, procedure codes, and dental fee schedule for the TennCare 1915(c) Dental Program.

74. TennCare Provider - A provider who accepts as payment in full for furnishing benefits to an enrollee, the amounts paid pursuant to an approved agreement with an MCO or TennCare. Such payment may include copayments from the enrollee or the enrollee's responsible party. Except in the case of Out-of-State Emergency Providers, as defined in the TennCare Rules, a TennCare provider must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including the rules regarding provider billing of patients as found in Rule 1200-13-13-.08. TennCare Providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in Medicare or Medicaid.

75. 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".

76. Tennessee Bureau of Investigation, Medicaid Fraud Control Division (TBI MFCD) – TBI MFCD 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 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.

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

78. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party payor.

79. Urgent Care - Services for urgent dental and oral conditions or injuries on the basis of the professional judgment of the enrollee's treating dentist, other dental professional, primary care provider or a triage nurse who is trained in dental care and oral health care.

80. Utilization Rate – An adjusted proportion of enrollees in the TennCare Children's DBM Program, ages 2-20, or enrollees in the CoverKids DBM Program, ages 2-18, with a minimum of ninety (90) days eligibility who have received any dental service during the past federal fiscal year.

81. Vital Documents – Consent and grievance forms, intake and application forms with the potential for important consequences, and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents shall be at a minimum available in Spanish.

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

.

LIQUIDATED DAMAGES

In the event of a Contract performance or compliance failure by Contractor and such Contract performance or compliance failure is not included in the following table with an associated Liquidated Damage amount, the parties hereby agree that the State may choose one of the following courses of action in order to obtain redressability for such Contract performance or compliance failure: (1) the State may assess actual damages resulting from the Contract performance or compliance failure against the Contractor in the event that such actual damages are known or are reasonably ascertainable at the time of discovery of such Contract performance or compliance failure or (2) if such actual damages are unknown or are not reasonably ascertainable at the time of discovery of the Contract performance or compliance failure, the State may (a) require the Contractor to submit a corrective action plan to address any such Contract performance or compliance failure and (b) assess liquidated damages against Contractor for an amount that is reasonable in relation to the Contract performance or compliance failure as measured at the time of discovery of the Contract performance or compliance failure. In the event that the State chooses to assess a Liquidated Damage for a Contract performance or compliance failure according to the immediately preceding sentence, in no event shall such Liquidated Damage be in excess of $1,000 for any single Contract performance or compliance failure.

TennCare may elect to apply the following liquidated damages remedies in the event the Contractor fails to perform its obligations under this Contract in a proper and/or timely manner. Upon determination by TennCare that the Contractor has failed to meet any of the requirements of this Contract in a proper and/or timely manner, TennCare will notify the Contractor in writing of the performance or compliance failure and of the potential liquidated damages to be assessed. Should the performance or compliance failure remain uncorrected for more than thirty (30) calendar days from the date of the original notification of the performance or compliance failure by TennCare, TennCare may impose an additional liquidated damage of Five Hundred Dollars ($500) per day from the date of the original notification to Contractor until said performance or compliance failure is resolved.

All liquidated damages remedies set forth in the following table may, at TennCare's election, be retroactive to the date of the initial occurrence of the failure to comply with the terms of the Contract as set forth in the notice of performance or compliance failure from TennCare and may continue until such time as the TennCare Deputy Commissioner, or the Deputy Commissioner's representative, determines the performance or compliance failure has been cured.

If liquidated damages are assessed, TennCare shall reduce the amount of any payment due to the Contractor in the next invoice by the amount of damages. In the event that damages due exceed the amount TennCare is to pay to Contractor in a given payment, TennCare shall invoice Contractor for the amount exceeding the amount payable to Contractor, and such excess amount shall be paid by Contractor within thirty (30) calendar days of the invoice date. In situations where the Contractor wishes to dispute any liquidated damages assessed by TennCare, the Contractor must submit a written notice of dispute, including the reasons for disputing the liquidated damages, to the TennCare Deputy Commissioner or the Deputy Commissioner's representative within thirty (30) calendar days of receipt of the notice from TennCare containing the total amount of damages assessed against the Contractor. If the Contractor fails to timely dispute a liquidated damages assessment as set forth herein, such failure shall constitute a bar to the Contractor seeking to have the assessment amount overturned in a forum or court of competent jurisdiction.

Liquidated damages will apply to the Contract performance or compliance failures listed below. Contractor acknowledges that the actual damages likely to result from Contract performance or compliance failures are difficult to estimate and may be difficult for the State to prove. The parties intend that the Contractor's payment of assessed liquidated damages will compensate the State for breach of the Contractor obligations under this Contract. Liquidated damages do not serve as punishment for any breach by the Contractor.

	PROGRAM ISSUE		DAMAGE
1.	Failure by the Contractor to meet the standards for privacy, security, and confidentiality of individual data as evidenced by a breach of the security per Section E. 2. and E.18 and Contractor's failure to timely and reasonably comply with its obligation to		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be

	PROGRAM ISSUE		DAMAGE
	appropriately respond to any such breach		assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
2.	Failure by the Contractor to execute the appropriate agreements to effectuate transfer and exchange of enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party. (See E.17. and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
3.	Failure by the Contractor to seek express written approval from TennCare prior to the use or disclosure of enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States. (See E.13 and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
4.	Failure by the Contractor to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of suspected breach per Sections (See E.18 and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter.
5.	Failure to implement Non-Traditional Fluoride Varnish and Dental Screening Program within six months of contract start as referenced in Section A.5.a.4.		The damage that may be assessed shall be five hundred dollars ($500) per calendar day past expected implementation date.
6.	In the event the Contractor provides authorization and reimbursement of dental services for ECF CHOICES members that exceed the amount approved for such services in a member's PCSP as required by Contract Section A.5.b.9.		The damage that may be assessed shall be five hundred dollars ($500) per occurrence.
7.	Failure to obtain approval of member materials as required by this Contract.		The damage that may be assessed shall be five hundred dollars ($500) per day for each calendar day that TennCare determines the Contractor has provided enrollee material that has not been approved by TennCare.
8.	Failure to comply with the licensure requirements of this Contract.		The damage that may be assessed shall be five thousand dollars ($5,000) per calendar day that staff/provider/agent/ subcontractor is not licensed as required by applicable state

	PROGRAM ISSUE		DAMAGE
			law, plus, the amount paid to the staff/provider/agent/ subcontractor during that period.
9.	Failure to comply in any way with staffing requirements described in this Contract.		The damage that may be assessed shall be two hundred and fifty dollars ($250) per calendar day for each day that staffing requirements are not met.
10.	Provider network includes insufficient numbers and geographical disbursement of providers in order to satisfy the requirements outlined in the Access and Availability to Care sections of this Contract.		A maximum of twenty-five thousand dollars ($25,000) for failure to meet each of the listed standards, either individually or in combination on a monthly basis. The liquidated damage may be lowered to five thousand dollars ($5,000) in the event that the Contractor timely provides a corrective action plan that is accepted by TennCare
11.	TennCare-related Enrollee Appeals. Failure to confer a timely response to a request for Prior Authorization in accordance with 42 CFR §438.210 and Section A.118 of this Contract.		TennCare may assess damages amounting to $500 for each day DBM is in default for each occurrence.
12.	TennCare-related Enrollee Appeals. Failure to confer a timely and content compliant Notice of Adverse Benefit Determination in accordance with 42 CFR 438 Subpart F and Sections A.118, A.119, and A.120.		TennCare may assess damages amounting to $500 for each day DBM is in default for each occurrence.
13.	Failure to provide a timely and complete response to a TennCare request for the Contractor's internal Appeal file or for Appeal-related documentation, such as notices issued to enrollee, dental records, and prior authorization requests and decisions.		$500 per calendar day CONTRACTOR is in default.
14.	Failure to confer a timely and complete response to an On Request Report (ORR) instructing Contractor to determine whether a request for SFH warrants expedited resolution.		$500 per calendar day Contractor is in default.
15.	Enrollee Benefit Appeals. Failure to submit a standard appeal/SFH request to TennCare within five (5) business days of receipt by Contractor.		$500 per calendar day Contractor is in default.
16.	Enrollee Benefit Appeals. Failure to submit an expedited appeal/SFH request to TennCare within twenty-four (24) hours of receipt by Contractor.		$500 per calendar day Contractor is in default.
17.	Failure to maintain provider agreements in accordance with this Contract.		TennCare may assess $5,000 per each occurrence of a provider agreement found to be non-compliant.
18.	Failure to comply with claims processing requirements described by Sections A.84 – A.89 of this Contract and the performance requirements in Section A.191.		The damage that may be assessed shall be ten thousand dollars ($10,000) per month, for each month that TennCare determines that the Contractor is not in compliance with any of the requirements of Sections A.84–A.89 and A.191.
19.	Maintain an average daily abandonment rate of 5% or less for each queue on each day the Service Center is open for business excluding calls abandoned before thirty seconds as specified in Sections A.29 and A.95.		A maximum of five hundred dollars ($500) per queue per day for a daily abandonment rate of 6% - 10%. A maximum of one thousand five hundred dollars ($1,500) per day for a daily

	PROGRAM ISSUE		DAMAGE
			abandonment rate over 10%.
20.	Maintain an Average Speed of Answer (ASA) per queue per day of 60 seconds or less as specified in Sections A.29. and A.95. ASA is to be calculated from the time that a call comes into the queue from the IVR and when it is answered.		A maximum of five hundred dollars ($500) per queue per day for an ASA of 61 seconds – 180 seconds. A maximum of one thousand five hundred dollars ($1,500) per queue per operating day for an ASA of 181 seconds or more.
21.	Maintain a daily blocked call rate of 1% or less as specified in Sections A.29 and A.95.		A maximum of one thousand dollars ($1,000) for each percentage point above 1%.
22.	The Contractor's shall answer 100% of calls each day within 300 seconds as specified in Section A.29 and A.95.		A maximum of five hundred dollars ($500) for each instance of each call answered within 301 seconds to 600 seconds during each operating day; provided, however total liquidated damages under this section shall not exceed twenty-five thousand dollars ($25,000) per operating day. A maximum of one thousand dollars ($1,000) for each instance of each call answered in 601 seconds or more during each operating day; provided, however total liquidated damages under this section shall not exceed fifty thousand dollars ($50,000) per operating day.
23.	Failure to maintain an appeal system as required by TennCare Rules, the provisions contained in the contract, and applicable provisions of 42 CFR 438 Subpart F in accordance with Sections A.116 – A.132 of this contract. Such failure may be evidenced by Contractor's failure to meet compliance requirements for any aspect of the appeal system.		TennCare may assess damages amounting to $1,500 for each day DBM is in default until a TennCare-approved corrective action plan is fully implemented by the DBM.
24.	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 Section A.152 of this Contract.		The damage that may be assessed shall be the actual amount paid by DCS and/or TennCare for necessary services or one thousand dollars ($1000) per occurrence, whichever is greater, to be deducted from monthly fixed administrative fee payments.
25.	Failure to comply with the program integrity provisions as described in Section A.166 through A.187. of this Contract		The damage that may be assessed is $500 per calendar day for each day that the Contractor does not comply with the program integrity provisions
26.	Maintain a Dental Screening Percentage (DSP) (Refer to Attachment F) greater than or equal to 80% as required in Section A.192.		Liquidated Damages of up to $100,000.00 may be assessed for every 1.0% decrease in DSP below 80%.
27.	Failure by the Contractor to have the PEAR for the CoverKids Program above 50 percent (50%) on an annual basis as required by Contract Section A.193.		A maximum of up to one hundred thousand dollars ($100,000) in liquidated damages for failure to have the PEAR for the CoverKids Program above 50 percent (50%) on an annual basis.
28.	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized		The damage that may be assessed shall be one thousand dollars ($1000) per occurrence.

	PROGRAM ISSUE		DAMAGE
	by the TennCare Chief Medical Officer.		
29.	Failure to comply with distribution timeframes for providing Member Handbooks, Provider Directories, and Newsletters, as required by Contract Section A.10.		The damage that may be assessed shall be five thousand dollars ($5000) for each occurrence.
30.	Failure to complete or comply with Corrective Action Plans as required by TennCare in Contract A.8.		The damage that may be assessed shall be five hundred dollars ($500) per calendar day for each day the corrective action is not completed or complied with as required.
31.	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement / contract as required by Contract Section A.138.		$5,000 per application that has not been approved and loaded into the Contractor's system or denied within (30) calendar days of receipt of a completed credentialing application and a signed provider agreement/contract if applicable. $1,000 per application per calendar day for each day beyond thirty (30) calendar days that a completed credentialing application has not been processed.
32.	Failure to report provider notice of termination of participation in the Contractor's Plan as required by Contract Section A.58.		The damage that may be assessed shall be two hundred dollars ($200) per calendar day for each day that Contractor fails to report provider notice of termination of participation.
33.	Failure to submit a Provider Enrollment File that meets TennCare's specifications as required by Contract Sections A.22 and A.148.		$250 per day after the due date that the Provider Enrollment File fails to meet TennCare's specifications.
34.	The level of overall customer satisfaction, as measured annually by a State approved Enrollee Satisfaction survey(s), shall be equal to or greater than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the Contract term as required by Contract Section A.36.		$3000.00 per Enrollee Satisfaction survey(s), less than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the Contract term.
35.	Failure to disclose Lobbying Activities as specified in Section E.8.		The damage that may be assessed shall be one thousand dollars ($1000) per calendar day that disclosure is late.
36.	Failure to timely comply with overpayment reporting as outlined in A.170.		The damage that may be assessed shall be one thousand dollars ($1000) per calendar day that disclosure is late.
37.	Failure to coordinate with TennCare for the timely and effective completion of the readiness review process and implementation relating to the TennCare 1915(c) Dental Program (see A.200.b).		$1,000 per readiness review deliverable (e.g., documents and demonstrations) that is not provided by the Contractor pursuant to TennCare expectations and timeframes.
38.	Failure to ensure each TennCare 1915(c) Dental Program members receives a timely and proper evaluation prior to receiving covered services (see A.200.j.5).		$1,000 per member that does not receive a timely and proper evaluation
39.	Failure to ensure that only covered services are rendered to TennCare 1915(c) Dental program members		$1,000 per improper authorization and/or reimbursement of dental services for TennCare 1915(c) Dental Program members
40.	Failure of the Contractor's TennCare 1915(c) Dental Program provider network to meet Access to Care and Transport Distance requirements (see A.200.d.3) without a		A maximum of twenty-five thousand dollars ($25,000) for failure to meet each of the listed standards, either individually or in combination on a monthly basis. The

	PROGRAM ISSUE		DAMAGE
	TennCare-approved waiver.		liquidated damage may be lowered to five thousand dollars ($5,000) in the event that the Contractor timely provides a corrective action plan that is accepted by TennCare

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00490		59802	2

Contractor Legal Entity Name	Edison Vendor ID
DentaQuest USA Insurance Company, Inc.	222275

Amendment Purpose & Effect(s)
Scope Updates

Amendment Changes Contract End Date: ☐ YES ☒ NO **End Date:** April 30, 2023

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A)**:** **$ 0.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2019	$475,027.00	$475,027.00			$950,054.00
2020	$2,850,162.00	$2,850,162.00			$5,700,324.00
2021	$7,853,137.00	$17,859,086.00			$25,712,223.00
2022	$7,853,137.00	$17,859,086.00			$25,712,223.00
2023	$6,544,280.00	$14,882,572.00			$21,426,852.00
TOTAL:	**$25,575,743.00**	**$53,925,933.00**			**$79,501,676.00**

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

Zane Seals

CPO USE

Speed Chart (optional)	Account Code (optional)

AMENDMENT #2
OF CONTRACT 59802
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF TENNCARE
AND
DENTAQUEST USA INSURANCE COMPANY, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Division of TennCare, hereinafter referred to as the "State" and DentaQuest USA Insurance Company, Inc., hereinafter referred to as the "Contractor." For good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

1. **Contract section A.116. is deleted in its entirety and replaced with the following:**

A.116. Paragraphs A.116 through A.132, as amended, shall be designated as the "Grievances and Appeals Section" of this contract. The provisions contained in the Grievances and Appeals Section shall apply to each of the programs listed in paragraph A.2 of this contract, as amended.

2. **Contract section A.126.a. is deleted in its entirety and replaced with the following:**

A.126. Continuation of Benefits

a. The Contractor must not accept a continuation of benefits request from anyone for a CoverKids enrollee appeal. The Contractor must not accept a continuation of benefits request from a provider for a TennCare enrollee appeal, since providers are prohibited from requesting continuation of benefits pursuant to 42 CFR §438.402(c)(1)(ii) and §438.420(b)(5). The Contractor must continue the enrollee's benefits while SFH request is in process if all of the following occur:

1. The enrollee files the request for SFH within sixty (60) calendar days following the date on the Adverse Benefit Determination notice.

2. The contested issue at the SFH involves the termination, suspension, or reduction of a previously authorized Medicaid service.

3. The enrollee's services were ordered by an authorized provider.

4. The period covered by the original authorization has not expired.

5. Enrollee files the request for continuation of benefits within ten (10) calendar days of the date on the notice of Adverse Benefit Determination, or if enrollee files the request before the intended effective date of the proposed Adverse Benefit Determination. See; 42 CFR §438.420(b)(1)-(5); 42 CFR §438.402(c)(2)(ii).

3. **Contract section A.132., first paragraph, is deleted in its entirety and replaced with the following:**

A.132. CoverKids Enrollee Grievance and Appeal System.

This Contract Section A.132 shall only apply to the CoverKids DBM Program. Contractor shall have a Grievance and Appeal System in place for CoverKids enrollees, as required by 42 CFR 457.1260. The Contractor shall use the same Grievance and Appeal System for CoverKids that it uses for TennCare enrollees set forth in Contract Sections A.116 through A.131 above, with the exception that CoverKids enrollees do not have a right to receive continuation of benefits. As permitted under federal and State law, TennCare, at

its sole discretion, may delegate back to itself and the State any portion of the appeal process that the Contractor is obligated to perform.

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

Amendment Effective Date. The revisions set forth herein shall be effective once all required approvals are obtained. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

DENTAQUEST USA INSURANCE COMPANY, INC.:

Brett Bostrack
Brett Bostrack (Jan 15, 2021 10:15 CST)

Jan 15, 2021

SIGNATURE **DATE**

Brett Bostrack Senior Vice President

PRINTED NAME AND TITLE OF SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF TENNCARE:

Butch Eley
Digitally signed by Butch Eley
DN: cn=Butch Eley, o=Finance & Administration, ou=Commissoner, email=butch.eley@tn.gov, c=US
Date: 2021.01.20 07:59:16 -06'00'

01/20/2021

BUTCH ELEY, COMMISSIONER **DATE**

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00490		59802	1

Contractor Legal Entity Name	Edison Vendor ID
DentaQuest USA Insurance Company, Inc.	222275

Amendment Purpose & Effect(s)
Scope Updates

Amendment Changes Contract End Date: ☐ YES ☒ NO **End Date:** April 30, 2023

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$ 0.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2019	$475,027.00	$475,027.00			$950,054.00
2020	$2,850,162.00	$2,850,162.00			$5,700,324.00
2021	$7,853,136.71	$17,859,086.12			$25,712,223.00
2022	$7,853,136.71	$17,859,086.12			$25,712,223.00
2023	$6,544,280.59	$14,882,571.76			$21,426,852.00
TOTAL:	**$25,575,743.00**	**$53,925,933.00**			**$79,501,676.00**

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

CPO USE

Speed Chart (optional)	Account Code (optional)

AMENDMENT #1
OF CONTRACT 59802
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF TENNCARE
AND
DENTAQUEST USA INSURANCE COMPANY, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Division of TennCare, hereinafter referred to as the "State" and DentaQuest USA Insurance Company, Inc., hereinafter referred to as the "Contractor." For good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

1. Contract section A.2. is deleted in its entirety and replaced with the following:

A.2. General Requirements

The State administers four (4) separate dental benefit programs managed by the DBM. As further described below, three (3) of the four (4) dental benefit programs are considered to be "TennCare DBM programs", and one (1) of the four (4) dental benefit programs is considered to be the "CoverKids DBM program." Together, the four (4) separate DBM programs are collectively known as the "State DBM Programs." The three (3) *TennCare* DBM programs are described below in Sections A.2.a(1) through A.2.a(3). The one (1) *CoverKids* DBM program is described below in Section A.2.b. Each of these 4 State DBM programs operates on a statewide basis in Tennessee and provides benefits for its enrollees, hereinafter variously referred to as "enrollees", "members", "recipients" or "participants". The Contractor shall provide DBM services for all the State DBM Programs as indicated below:

a. The federal Medicaid program, known as "TennCare" in Tennessee, is operated by the State pursuant to a waiver from the Centers for Medicare and Medicaid Services (CMS). Nothing in this Contract shall be deemed to be a delegation to the Contractor of the State's non-delegable duties relating to TennCare, as administered by the single state agency designated by the State and CMS, pursuant to Title XIX of the Social Security Act (42 U.S.C § 1396 *et seq*.) and the Section 1115 research and demonstration waiver granted to the State and any successor programs. The TennCare DBM Programs are categorized into the following three (3) programs based upon each program's eligible enrollees:

1. TennCare Children's DBM Program. The Contractor shall, pursuant to requirements set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols, administer covered dental benefits to approximately nine hundred thousand (900,000) eligible enrollees under age twenty-one (21) in the TennCare Program.

2. TennCare ECF CHOICES DBM Program. The Contractor shall, pursuant to requirements set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols, administer covered adult dental benefits to approximately two thousand seven hundred (2,700) eligible adults age twenty-one (21) and older who have an intellectual or developmental disability and are enrolled in the TennCare Employment and Community First (ECF) CHOICES Program.

3. TPPOHP DBM Program. Upon approval by TennCare for the new TennCare Perinatal and Postpartum Oral Health Program (TPPOHP) as set forth in Section A.3 below, the Contractor shall administer the TPPOHP DBM Program, providing outreach and limited dental benefits to approximately fifty thousand (50,000) TennCare enrollees who are pregnant women twenty-one (21) years of age and

older who are eligible for enrollment in TPPOHP. The TPPOHP DBM Program is intended to raise awareness of the consequences associated with oral disease by teaching eligible enrollees:

(a) the importance of good oral health during pregnancy;

(b) the value of establishing good oral health habits for their babies; and

(c) how to access covered dental services during pregnancy.

b. CoverKids DBM Program. The federal Social Security Act Title XXI Children's Health Insurance Program (CHIP), known as "CoverKids" in Tennessee, provides self-funded health plan services, including certain dental benefits, to eligible enrollees. CoverKids DBM Program eligible enrollees include approximately forty-five thousand (45,000) children under age nineteen (19) enrolled in CoverKids medical coverage, hereinafter to be collectively referred to as "CoverKids", with the exception of those CoverKids enrollees who are participating in HealthyTNBabies due to their pregnancy and who are not eligible for CoverKids DBM Program benefits under this Contract. The Contractor shall comply with all applicable administrative rules and CoverKids written policies and procedures, as may be amended from time to time. TennCare shall provide the Contractor with copies of such rules and policies. The State shall be the Contract holder, and the persons covered through the CoverKids program shall be enrollees, who receive the benefits set forth in a CoverKids Member Handbook (MH). When used in this Contract, the term "TennCare Member" shall have the same meaning as the term "TennCare Enrollee", and the term "CoverKids Member" shall have the same meaning as the term "CoverKids Enrollee." CoverKids Enrollees are defined as:

1. CoverKids Group One Child: a member of a family with an income between two hundred percent (200%) and two hundred fifty percent (250%) of the Federal Poverty Level (FPL) as reported by the State to the Contractor for the coverage period.

2. CoverKids Group Two Child: a member of a family with an income below two hundred percent (200%) of FPL as reported by the State to the Contractor for the coverage period.

3. American Indian and Alaskan Native Child (AI/AN): American Indian and Alaska Native individuals (individually or collectively, "AI/AN"), as defined by the Indian Health Care Improvement Act of 1976 and certified by the State, will be exempt from all cost sharing to the extent that such children are covered by Children's Health Insurance Plan (CHIP) as required by Federal law. This group includes enrollees who are (a) certified AI/AN, and (b) members of families with incomes less than or equal to two hundred fifty percent (250%) of the FPL, as reported by the State to the Contractor for the coverage period.

The estimated number of eligible enrollees in each of the State DBM Programs indicated above is based on current and projected enrollment numbers and shall not, for any of the State DBM Programs, be deemed by the Contractor to represent the maximum number of enrollees for whom it shall be required to provide services.

The services Contractor will be required to provide for the State DBM Programs shall include, but are not limited to, establishment and management of dental provider network(s), credentialing and contracting with providers, utilization management and utilization review, provider profiling, identification, investigation and referral of suspected fraud cases, ensuring effective dental care within a predictable budget, claims processing adjudication and payment, management of third party liability, enrollee outreach, customer service and interface, all as more particularly set forth in this Contract for each of the State DBM Programs. To the extent they do not conflict with any Contract requirements, the Contractor shall adhere to its standard administrative policies and procedures, including without limitation dental policies, claims administration procedures, provider

reimbursement practices and grievance procedures, in administering its fully insured coverage. The Contractor shall use its network of dental providers (Contractor's DBM Provider Network) to meet the requirements set forth herein to provide required services to the State DBM Programs. All requirements set forth in this Contract shall apply to all four (4) of the State DBM Programs, unless specifically stated otherwise.

2. Contract section A.5.c.1 is deleted in its entirety and replaced with the following:

c. TPPOHP DBM Program Benefits

1. The Contractor shall provide enrollees in the TPPOHP DBM Program the following benefits from the date it receives notification of the TPPOHP DBM Program member's diagnosis of pregnancy and through the postpartum coverage period. Covered benefits include some of each of the following services:

(a) Diagnostic

(b) Preventive – Fluoride treatments, Silver Diamine Fluoride (SDF), and teeth cleaning

(c) Restorative – Fillings

(d) Endodontics – Root canals

(e) Periodontal – Scaling and Deep Cleaning

(f) Prosthodontics – crowns and complete dentures

(g) Oral Surgery – Extractions (simple, surgical, and soft tissue impacted), as well as

(h) Adjunctive General Services – Emergency relief of pain and nitrous oxide analgesia.

3. Contract section A.5.c.2 is deleted in its entirety and replaced with the following:

2. Applicable current dental terminology codes for the TPPOHP DBM Program are listed in Attachment J.

4. Contract section A.5.c.2 (Table) is deleted in its entirety and is replaced with Contract Attachment J attached hereto as a new attachment.:

5. Contract section(s) A.5.d. (Table) and A.5.d.2. (Table) are deleted in their entirety and replaced with the following:

Table A.5.d.

CoverKids DBM Program Dental Service Category

DENTAL BENEFITS	GROUP ONE CHILD	GROUP TWO CHILD	AMERICAN INDIAN/ ALASKAN NATIVE (AI/AN) CHILD

Preventive -- Fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a calendar year up to age 14 -- Dental sealants for permanent molars1 per tooth per lifetime -- 2 cleanings per calendar year -- Silver Diamine Fluoride (SDF) four applications per tooth per lifetime	No copayment	No copayment	No copayment
Diagnostic Services -- 2 oral exams per calendar year	No copayment	No copayment	No copayment
Emergency Services -- 2 visits per calendar year during office hours -- 2 visits per calendar year after office hours	$15 copayment	$5 copayment	No copayment
Restorative Services -- Stainless steel crowns -- Routine fillings (silver or tooth colored)	$15 copayment	$5 copayment	No copayment
Extractions	$15 copayment	$5 copayment	No copayment
Radiographs -- Bitewing x-rays no more frequently than once per calendar year (2 years of age and older -- Full mouth x-rays no more frequently than once every three calendar years	No copayment	No copayment	No copayment
Therapeutic Pulpotomy	$15 copayment	$5 copayment	No copayment
Anesthesia	$15 copayment	$5 copayment	No copayment
Other Dental Services	$15 copayment	$5 copayment	No copayment
Orthodontics Services	$15 copayment	$5 copayment	No copayment
Deductibles	None	None	None
Annual Benefit Maximum per child	$1,000	$1,000	$1,000
Lifetime Orthodontics Maximum amount per member**	$1250	$1250	$1250
Annual Out of Pocket Maximum as a Percentage (%) of Family Income per calendar year	5%	5%	Not applicable

Note: The copayments indicated above are the maximum amounts allowable per visit.

No more than one (1) copayment shall be charged for a single visit.

** The Lifetime Orthodontics Maximum limit is not applicable to the family's five percent (5%) cost sharing and is separate from the $1,000 benefit cap.

Table A.5.d.2

COVERKIDS DBM PROGRAM DENTAL SERVICE CATEGORY **The following services may be provided before counting toward the benefit cap of $1,000**		
Type of Dental Service	**Number of each service allowed prior to counting toward the $1,000 benefit cap**	**Service by Dental Code**
Preventive	One (1) service	D1110 D1120
Diagnostic Services	One (1) service	D0120 D0150
Emergency Services	Two (2) services	D9110 D9440
Restorative Services	Two (2) services	D2140 D2150 D2160 D2330 D2331
Extractions	Two (2) services	D7140 D7210 D7250
Radiographs	One (1) service	D0210 D0220 D0230 D0270 D0272
Anesthesia	Whenever medically necessary	D9230 D9248
COVERKIDS DBM PROGRAM DENTAL SERVICE CATEGORY **The following services may be provided before counting toward the benefit cap of $1,000**		
Type of Dental Service	**Number of each service allowed prior to counting toward the $1,000 benefit cap**	**Service by Dental Code**

6. Contract section A.6.a.2. (Table) is deleted in its entirety and replaced with the following:

Co-Pay	0 to 99% of Poverty	100-199% of Poverty	200% and Above Poverty
Dental visits	0	$5 per visit	$20 per visit

7. All references to "TBI Medicaid Fraud Control Unit (MFCU)" throughout the contract shall be deleted and replaced with "TBI Medicaid Fraud Control Division (MFCD)."

8. Contract section A.8. is deleted in its entirety and replaced with the following:

A.8. Corrective Action Plans (CAP)

There are two types of CAPs. One is directed at remedying defective performance by the Contractor. The second is directed at remedying defective performance of the Provider.

a. Contractor CAP.

A corrective action plan (CAP) is a plan to correct Contractor's noncompliance with the Contract that the Contractor prepares at TennCare's request and submits to TennCare for review and approval. A CAP can be requested by TennCare at any time and it is a requirement of this Contract that Contractor respond timely to the CAP request and take all CAP actions that have been approved by TennCare. Failure to comply with a CAP request or an approved CAP may result in Liquidated Damages as set forth on Attachment B. The CAP process includes the following:

1. Notice of Deficiency: If TennCare determines that the Contractor or Contractor's subcontractor is not in compliance with a requirement of this Contract, TennCare will issue a notice of deficiency identifying the deficiency and request a CAP detailing how the Contactor intends to correct the deficiency. The Notice of Deficiency will also contain the deadline for the proposed CAP to be forwarded to TennCare for approval and may also contain recommendations or requirements the Contractor must include or address in the CAP.

2. Proposed CAP: Upon receipt of a Notice of Deficiency, the Contractor shall prepare a proposed CAP and submit it to TennCare for approval within the time frame specified by TennCare. The proposed CAP shall comply with all recommendations and requirements of the Notice of Deficiency and contain a proposed time by which the noncompliance will be corrected.

3. CAP Approval and Implementation: TennCare will review the proposed CAP and work with the Contactor to revise it as needed. Once approved, the Contractor shall be responsible for ensuring that all actions and documentation required by the CAP are completed in compliance with the Contract and CAP, to TennCare's satisfaction.

4. Notice of Completed CAP: Upon satisfactory completion of the implemented CAP, TennCare shall provide written notice to the Contractor. Until written approval is received by the Contractor, the approved CAP shall be deemed to not have been satisfactorily completed.

b. Provider CAP.

The Contractor shall issue CAPs to contracted provider(s) whenever such providers are materially out of compliance with their Dental Provider Agreement or the Provider Office Reference Manual (ORM). The Contractor's issuance of CAPs shall also include participating providers who fail to provide preventive procedures when indicated, including but not limited to SDF and Dental Sealants to members. Provider CAPs are tools used to manage the network, which is the Contractor's responsibility. Therefore, the Contractor shall not seek, nor shall TennCare provide guidance, on the need for or contents of a Provider CAP.

9. All references to "Fraud and abuse" throughout the contract shall be deleted and replaced with "Fraud, Waste, and Abuse."

10. Contract section A.17.e and A.17.k are deleted in their entirety and replaced with the following:

e. Regulatory Compliance Manager – The Contractor shall designate and maintain, subject to TennCare approval, a full-time Regulatory Compliance Manager, physically located in Tennessee. The Regulatory Compliance Manager shall possess a thorough knowledge regarding investigations related to provider fraud, waste, and abuse in the TennCare program and will be the key staff handling day-to-day provider investigation related to inquiries from TennCare and TBI MFCD.

k. Fraud, Waste and Abuse Investigators – One (1) Fraud, Waste, and Abuse Investigator dedicated to TennCare who shall be responsible for all fraud and abuse detection activities for the State DBM Programs, including the Fraud, Waste, and Abuse Compliance Plan, and who shall be the Key Staff person handling day-to-day provider investigation-related inquiries from TennCare. This Fraud, Waste, and Abuse Investigator shall be assisted, on an as-needed basis, with up to two (2) other designated Fraud, Waste, and Abuse Investigators and one (1) staff person, all of whom may be located in the Contractor's corporate offices, but who have full knowledge of provider investigations related to the State DBM Programs and shall work with the TennCare Office of Program Integrity (OPI). The investigator(s) shall have full knowledge of provider investigations related to the TennCare program and will be the key staff handling day-to-day provider investigation related inquiries from TENNCARE. The Investigators are required to be actively pursuing or currently have one or more of the listed credentials/degrees;

- Certified Fraud Examiner;
- NHCAA Certified Anti-Fraud Investigator;
- Degree in Statistics, Criminal Justice, Finance, Healthcare Management or any other related field that supports health care fraud investigations;
- Certified Healthcare Coder;
- Other nationally recognized healthcare certification.

11. Contract section A.36. is deleted in its entirety and replaced with the following:

A.36. Customer Satisfaction Survey

The Contractor shall perform, following review and approval of the proposed survey by the State, Participant customer satisfaction surveys. The survey shall be conducted no more frequently than once during each calendar year at a time mutually agreed upon by the State and the Contractor and reported to the State by March 30 of the following year. The survey shall involve a statistically valid random sample of parents and/or guardians of enrollees. The State reserves the right to review and mandate changes in the survey it feels are necessary to obtain valid, reliable, unbiased results. Those changes may include, but are not limited to, changes in the research design, units of analysis or observation, study dimension, sample size, sample frame, sample method, coding, or evaluation method. Based upon the results of the survey, the Contractor and the State shall jointly develop an action plan to correct problems or deficiencies identified through this activity.

a. The Participant Satisfaction shall be measured utilizing the most current National Committee on Quality Assurance (NCQA) Adult Participant Satisfaction Survey question that measures overall satisfaction.

b. The level of overall customer satisfaction, as measured annually by a State approved enrollee satisfaction survey(s), will be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and ninety percent (90%) in all subsequent year(s) within the Contract term. Failure to comply may result in monetary assessment as listed in Attachment B.

12. Contract section A.37. is deleted in its entirety and replaced with the following:

A.37. Provider Satisfaction Survey

The Contractor shall conduct a provider satisfaction survey of the participating network dentists and dental specialists, following approval by the State of the form, content and proposed administration of the survey, each October or November and report the results to the State by March 30 of each year.

13. Contract section A.52.b. is deleted in its entirety and replaced with the following:

c. The Contractor shall monitor provider compliance with TennCare coverage rules, medical necessity rules, TennCare policies and with requirements of EPSDT and clinical criteria guidelines presented in TennCare's ORM. The Contractor shall promptly address compliance deficiencies, other than fraud, waste or abuse identified through such monitoring by imposing Corrective Action Plans, including behavior management, recoupment of funds, additional training and/or termination of the Dental Provider's contract. Cases of possible fraud, waste or abuse must be reported to the TBI MFCD and TennCare's Office of Program Integrity. If the Office of Program Integrity or other appropriate authority determines that the conduct in question does not constitute fraud, waste or abuse then the Contractor may impose the corrective measure mentioned in this section.

14. Contract section A.54. is deleted in its entirety and replaced with the following:

A.54. ECF CHOICES Participating Dental Providers

ECF CHOICES Participating Dental Providers shall render high quality, Medically Necessary, cost effective dental care for ECF CHOICES members. The Contractor shall exercise every available means through this Contract, provider agreements, ECF CHOICES ORM, policies and procedures, and educational programs to ensure that dental benefits in the ECF CHOICES program are managed in this manner.

15. Contract section A.55. is deleted in its entirety and replaced with the following:

A.55. Provider Manual/Office Reference Manual (ORM).

The Contractor shall produce and distribute a dental program criteria manual, an ORM to assist Participating Dental Providers. The ORM shall be incorporated by reference in the Network Provider Agreement. The ORM shall clearly define covered services, limitations, exclusions, and utilization management procedures, including, but not limited to: prior authorization requirements, medical necessity guidelines for dental procedures, and special documentation requirements, including but not limited to Hospital readiness form, orthodontic readiness form, documentation of nutritional deficiencies (general pediatric records including growth data), and speech/hearing evaluations (may include school records) for treatment of enrollees. The ORM shall include a detailed description of billing requirements for Participating Dental Providers and shall contain a copy of Contractor's paper billing form and electronic billing format. The Contractor shall ensure that the ORM remains up-to-date and reflects changes in applicable law or revisions to TennCare or Contractor policy. The initial version of the ORM and any subsequent revisions thereto shall be submitted to TennCare and the TennCare Oversight Division, Tennessee Department of

Commerce and Insurance (TDCI) for review and approval prior to distribution. Participating Dental Providers shall be apprised of revisions to the ORM by the Contractor, by means of written or electronic notice, to be sent thirty (30) days in advance of the implementation of the new policy or procedure. The Provider Manual shall include a supplement or manual component specific to ECF CHOICES Participating Dental Providers.

16. All references to "TDCI" throughout the contract shall be deleted and replaced with "TDCI TennCare Oversight Division."

17. Contract section A.63. is deleted in its entirety and replaced with the following:

A.63. Patient-Centered Dental Home (PCDH)

The Contractor shall establish a Patient-Centered Dental Home (PCDH), which is defined as a place where an enrollee in the TennCare Children's DBM Program, CoverKids DBM Program and the TPPOHP DBM Program has oral health care delivered in a comprehensive, continuously accessible, coordinated and family centered way by a dentist participating in the above identified DBM programs.

One of the primary reasons for establishing the PCDH is to ensure that enrollees in the TennCare Children's DBM Program, CoverKids DBM Program, and the TPPOHP DBM Program have access to a participating primary care dentist who is identified through member assignment. Provider acceptance and involvement is essential to success of the PCDH for beneficiaries. Members can either choose their dental home dentist or be assigned a dentist for care.

Individual primary care dentists must be able to access their roster of dental home assignments through their provider web portal established by the Contractor.

The dental home model is key component of TennCare's overall vision to transform the existing TennCare and CoverKids dental programs from dental restorative programs to more balanced programs that emphasize prevention and control of oral diseases through engagement of the DBM Contractor and its network of participating providers, to improve the health and quality of life for members.

The Contractor shall establish a robust oral disease prevention strategy. This strategy must, at a minimum, include prevention of early childhood caries through the "routine" use of topical fluorides such as fluoride varnish, as well as Silver Diamine Fluoride (SDF) for arresting the caries process, as well as for Operating Room (OR) diversion by offering parents or guardians of child members a minimally invasive in-office dental treatment alternative to treatment under general anesthesia in a medical facility.

The oral disease prevention strategy must also include routine provider application of dental sealants for pit and fissure surfaces of first and second permanent molar teeth, as soon as these teeth have fully erupted into the oral cavity.

The Contractor shall also develop an individual confidential provider performance report (PPR) for the TennCare program that is sent to participating primary care dentists on a quarterly basis. The PPR is a provider educational tool to afford providers in the network the opportunity to see how their practice compares with their peers and the overall network average in cost, access, and preventive care. The preventive component of the PPR must include network benchmark averages for dental sealants for the 6-9 year old age group and 11-15 year old age group. The preventive component of PPR must also include comparisons to the SDF network benchmark and topical fluoride network benchmark. It is anticipated that sharing confidential feedback with providers through the PPR will result in a shift by those performing under the network benchmark average to modify their practice pattern to meet or exceed network benchmarks. In order to encourage quality and cost improvement, additional member assignments as well as reassignment of existing members to a dental home will be based upon the PPR or other pertinent reports. Sections A.8, as well as A.43.a and A.43.b, describe in detail the written corrective action plans that must be issued to providers who are not complying with their Dental

Provider Agreement, ORM, or adhering to TennCare's medical necessity criteria or Contractor criteria in the provision of a procedure(s) including specific preventive procedure(s) such as SDF and Dental Sealants. This will ensure that TennCare members have access to dental home providers demonstrating a commitment to providing the highest quality care.

In order to effectively communicate the expectations of the new PCDH initiatives to providers, a PCDH Provider Manual must be developed by the DBM and approved by TennCare and shared with the provider network. The PCDH Provider Manual must include criteria that discuss the reasons for assignment of new members and reassignment of existing members as well as corrective action plans, for quality of care purposes. Provider incentives must be awarded by the DBM in those contract years that the DBM receives a bonus from TennCare.,

The PCDH Provider Manual must be updated as necessary, but at least annually.

The DBM must submit quarterly reports (in a format approved by TennCare) to TennCare that track assignment of new members and reassignment of existing members, as well as outreach and corrective action plans to providers.

18. Contract section A.66.d/n/s/ are deleted in its entirety and replaced with the following:

d. [Reserved];

n. Enrollee Records – Access. Pursuant to 42 CFR §438.3, the State, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCD, the Tennessee Attorney General, DHHS Office of Inspector General (DHHS OIG), and DOJ CMS, the Office of the Inspector General, the Comptroller General, and their designees, may, at any time, inspect and audit any records or documents of any MCO, PIHP, PAHP (including the Contractor), PCCM or PCCM entity, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Said records will be made available at no cost to the requesting agency. At the discretion of the requesting agency "access" may include an examination of the records located in any electronic health records system as well as related information such as metadata and audit trails.

s. Require dental providers safeguard information about enrollees according to applicable state and federal laws including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, 42 CFR § 431 Subpart F, §438 Subpart E, and all applicable Tennessee statutes and TennCare rules and regulations;

19. Contract section A.75 is deleted in its entirety and replaced with the following:

A.75. Legal Responsibility

The Contractor shall be responsible for the administration and management of all aspects of this Contract and the health plan covered thereunder including all work relating to this Contract performed by Contractor's subcontractors or other entities on behalf of the Contractor. For the purposes of this Contract, the terms "subcontract" and "subcontractor" shall be distinguished from the terms "Provider" and "Provider Agreement", which are defined in Contract Section 62. A subcontract with a subcontractor shall refer to any agreement other than a Provider Agreement entered into by the Contractor and a third party for the performance of requirement in this Contract, such as but not limited to, claims processing and call center operations.

This Contract does not grant Contractor the unconditional right to subcontract the performance of any portion of this Contract. The Contractor shall include in all subcontracts a prohibition against the subcontractor entering into any subsequent agreements or subcontracts for any of the work contemplated to be performed by the subcontractors for purposes of this Contract, without prior written approval of the Contractor and TennCare. In addition, all subcontracts shall include a

provision making the subcontract subject to all applicable provisions of this Contract between TennCare and the Contractor and confirming the subcontractor's agreement to be bound by, and comply with, all provisions and requirements of this Contract.

No subcontract or other agreement relating to Contractor's duties and/or the requirements of this Contract shall terminate or reduce the Contractor's legal responsibility to TennCare to satisfactorily perform all requirements under this Contract.

The Contractor must evaluate each prospective subcontractor's ability to perform the activities specified in the subcontract. Contractor must include in each subcontract, appropriate provisions for terminating the subcontract and/or imposing other remedies or sanctions if the subcontractor's performance is inadequate. The Contractor's written agreement with the subcontractors must address the methodology for identifying deficiencies in subcontractor performance and providing corrective action plans to address such deficiencies.

20. Contract section A.104 is deleted in its entirety and replaced with the following:

A.104. Tennessee Eligibility Determination System (TEDS)

The Contractor shall continue the eligibility interface with TennCare and the Contractor must be in sync with the State's Tennessee Eligibility and Determination System (TEDS). All outbound 834 files from the state shall be loaded to the Contractor's database within twenty-four (24) hours of receipt from the State. This requirement includes any 834 transactions that must be handled manually by the Contractor. Additionally, should TennCare require, the Contractor's DBM system shall receive a second eligibility file for the CoverKids population as well have the ability to capture new data made available in the 834 file.

21. Contract section(s) A.118.c. and A.118.e.2. are deleted in their entirety and replaced with the following:

c. Prior Authorization (PA) Determination Timeframes. In accordance with 42 CFR § 438.210(d)(1), Contractor shall respond to the requesting provider within 14 days of receiving the PA request. If the Contractor determines that following the 14-day timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited service authorization decision and provide notice as expeditiously as the enrollee's health condition requires.

2. In accordance with 42 CFR §438.406(b) and 42 CFR §438.228(a), Contractor shall acknowledge receipt of an enrollee grievance. If Contractor receives an enrollee expedited appeal request or SFH request, Contractor must submit the appeal or SFH request to TennCare within one business day. If Contractor receives an enrollee standard appeal request or SFH request, Contractor must submit the appeal or SFH request to TennCare within 5 business days. TennCare will send enrollee an acknowledgement letter and inform enrollee that matter will be treated as a request for a SFH.

22. Contract sections A.120.g/h/k are deleted in its entirety and replaced with the following:

g. The Contractor may extend the 14 calendar day notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional calendar days if the Contractor justifies to the TennCare agency a need for additional information and shows how the extension is in the enrollee's best interest. See 42 CFR §438.210(d)(1)(ii); 42 CFR §438.404(c)(4). Contractor requests to extend the 14-calendar day Adverse Benefit Determination timeframe must be submitted to TennCare in writing and are subject to TennCare review and approval.

h. If the Contractor extends the 14 calendar day notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services, the Contractor

must provide the enrollee written notice of the reason for extending the timeframe and inform the enrollee of the right to file a Grievance if the enrollee disagrees with the decision. See 42 CFR §438.210(d)(1)(ii); 42 CFR §438.404(c)(4)(i).

k. The Contractor may extend the seventy-two (72) hour expedited service authorization decision time period by up to fourteen (14) calendar days if the enrollee requests an extension, or if the Contractor justifies to the TennCare agency the need for additional information and how the extension is in the enrollee's interest. See 42 CFR §438.210(d)(2)(ii); 42 CFR §438.404(c)(6). If Contractor wants to extend the fourteen (14) calendar day Adverse Benefit Determination timeframe, a request must be submitted to TennCare in writing and shall be subject to TennCare review and approval.

23. Contract section A.121.b is deleted in its entirety and replaced with the following:

b. Appeal requests filed with Contractor instead of with TennCare. Contractor shall, within twenty-four (24) hours or sooner, forward to TennCare any expedited enrollee appeal requests that are filed with Contractor. Contractor shall, within five business days or sooner, forward to TennCare any standard enrollee appeal requests that are filed with Contractor. TennCare will acknowledge receipt and treat the appeal request as a request for a SFH. [42 CFR §438.402(c)(1); 42 CFR §438.408]

24. Contract section A.148. is deleted in its entirety and replaced with the following:

A.148. Reports

a. The Contractor shall provide the following reports every month:

1. Bi-Monthly Program Integrity TIPs
2. Encounter data report (837D)
3. Provider Enrollment File
4. Program Integrity Involuntary Termination
5. Program Integrity Exclusion List

b. The Contractor shall provide the following reports every quarter:

1. TennCare/EPSDT Report
2. Non-Traditional FI Varnish Program Report
3. "Insure Kids Now" (IKN) File
4. DBM Quarterly TennCare Kids Report
5. Program Integrity Quarterly Utilization by Std Dev
6. Program Integrity Quarterly Disclosure Rate Report
7. Enrollee cost-sharing liabilities
8. Program Integrity EOB
9. Program Integrity Fraud, Waste, and Abuse Activities
10. Program Integrity Cost Savings Report

c. The Contractor shall provide the following reports once a year:

1. Annual Outreach Plan
2. DBM Community Outreach Plan Annual Evaluation
3. Annual Disclosure Form
4. Annual Compliance Plan for Program Integrity
5. Annual policies for employees, contractors, and agents that comply with 1902(a)(68) SSA (Deficit Reduction Act) for Program Integrity
6. Program Integrity Annual Recoveries

25. Contract section A.157. is deleted in its entirety and replaced with the following:

A.157. TPL Data

The Contractor shall provide Third Party Resource (TPR) data to any provider having a claim denied by the Contractor based upon a TPR. TPR shall include subrogation recoveries. The amount of any subrogation recoveries collected by the Contractor outside of the claims processing system shall be the property of the State. On an as needed basis, the Contractor shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request subsequent to this report shall be reduced by the value of the subrogation recoveries reported.

26. Contract section A.160. is deleted in its entirety and replaced with the following:

A.160. Subrogation Recoveries

The amount of provider payments shall be the net of third-party recoveries captured on the Contractor's claims processing system prior to notification of TennCare of the amount to be paid. The amount of any subrogation recoveries collected by the Contractor outside of the claims processing system shall be the property of the State. On an as needed basis, the Contractor shall report to the State the amount of any subrogation recoveries collected outside the claims processing system during the previous month. The next remittance request subsequent to this report shall be reduced by the value of the subrogation recoveries reported.

27. Contract section A.164. is deleted in its entirety and replaced with the following:

A.164. Risk Sharing Requirements

The Risk Sharing Requirements in this Section A.164 shall only apply to the TennCare Children's DBM Program. The Contractor shall operate as a partial risk-bearing entity for dental services with shared savings and losses as described below. The Contractor must notify the State of any person or corporation that has 5% or more ownership or controlling interest in the entity and such person or corporation must submit financial statements. The Contractor, unless a Federally Qualified HMO, must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the debts if the entity becomes insolvent.

a. Risk sharing calculations are influenced by three variables: annual service expenditures, annual dental participation ratio termed Partial Enrollment Adjusted Ratio (PEAR) (See Attachment E for a description and calculation of PEAR), and percentage risk level accepted by the DBM. The saving or loss amount is the difference between the target service expenditure (target PMPM) achieved by the Contractor and the actual service expenditure (actual PMPM) for the period. The Contractor risk share bonus or loss is calculated by multiplying the saving or loss amount by the 55% risk level percentage accepted by the Contractor. There is an upper and lower limit of eight (8) million dollars per year in the amount of savings bonuses earned or loss payments made by the Contractor. TennCare will not make adjustments to savings bonuses earned or loss payments made by the Contractor.

b. Multiple PEAR targets and corresponding PMPM targets will be established by TennCare and updated periodically in a table format that will be shared with the Contactor (See Attachment H). PEAR targets will be graduated in 0.5 % increments to maximize member engagement. The annual PEAR value achieved

by the Contractor will not be rounded upward. TennCare will set a minimum PEAR threshold of fifty-five (55.0)% with no profit sharing below the threshold value.

c. Annual PEAR credits for prevention can be earned by the Contractor based upon achieving defined preventive care targets for Dental Sealants and Silver Diamine Fluoride or SDF (See Attachment H). Preventive care targets will initially be established from a baseline percentage of TennCare members who received these services May 1, 2018 through April 30, 2019. Please see Attachment I for specifications on how SDF and Dental Sealant percentages are calculated. The baseline SDF value is 0.3%. The baseline Dental Sealant value is 15.1%. It is envisioned that over time, if the Contractor makes significant progress in increasing utilization of these procedures, the preventive targets in the table may need to be revised downward in amounts determined by TennCare. Additionally, in any year during the term of the contract where the Contractor achieves an SDF value of ≥ 10% or a Dental Sealant value of ≥ 30%, a PEAR credit minimum of 0.5 will be added to the annual PEAR achieved.

d. There can only be profit sharing if: a) there is a savings based on the annual target PMPM achieved by the Contractor and, b) a minimum PEAR threshold of 55.0% is met. Calculations for risk sharing will be for the period of May 1 through April 30 each year.

e. In cases where TennCare establishes additional PEAR targets and corresponding PMPM targets, these will be released to the Contractor no later than thirty (30) days before commencement of the new cycle May 1 through April 30.

The Contractor will not be penalized for budget overruns, due to exceeding established PEAR targets if the PMPM associated with such a PEAR increase is not exceeded. Nevertheless, because this scenario does not meet the goal of budget predictability by TennCare, there will be no additional bonus sharing above the highest PEAR value listed in the table in Attachment H.

f. Supplemental risk sharing as described above in paragraph c. whereby the DBM can earn PEAR credits for achieving preventive targets is solely at the discretion of the Contractor. This supplemental risk sharing allows for the Contractor to achieve extra PEAR credits when the risk calculation described in paragraph a. is being made. Should the Contractor elect supplemental risk sharing, said election shall be made in writing (email is acceptable) at the beginning of the contract year and sent to the TennCare Dental program.

g. SHARED SAVINGS WITH PROVIDERS. Contractor shall be required to share risk-based bonus payments with the providers who helped provide the preventive care services in those contract years where the Contractor receives an annual risk share bonus from TennCare.

1. The amount of the total savings shared with the providers shall be no less than five (5)% of any risk sharing bonus received by the Contractor

2. Within 30 days of the notice of election to use the supplemental preventive PEAR measures, the Contractor shall provide to TennCare, for approval, general parameters to be used in calculating shared payments for Providers. Once approved by TennCare, the Contractor shall share the approved general parameters with their general dental (including pediatric) providers. The Contractor shall

provide the specific methodology 60 days prior to making the bonus payments to Providers, to TennCare for approval, to include the following components:

(i) a Method for calculating payment amount to individual providers;

(ii) timelines for making the payment to Providers; and

3. NETWORK MANAGEMENT TOOLS. To aid the Contractor in increasing the quality of preventive services provided to Members. TennCare specifically shall allow the Contractor to use at its complete discretion the following measures to increase the delivery of sealant and SDF preventive services by Network Providers:

i. Contractor may choose not to refer new TennCare members to the provider until such time as the delivery of both these preventive services reaches a level predetermined by the Contractor, unless claims history shows that the member has already received the needed services.

ii. Contractor may remove the Provider from the network as long as network adequacy can be maintained.

iii. Contractor may choose not to contract with providers who do not routinely use SDF or sealants in their practice.

Contractor will provide a quarterly report, in a form and manner specified by TennCare, detailing the application of these Network Management Tools.

h. The Contractor must meet one of the following licensure requirements to operate as a risk bearing entity.

1. Dental Service Plan – licensed pursuant to TCA Title 56, Chapter 30;

2. Prepaid Limited Health Service Organization – licensed pursuant to TCA Title 56, Chapter 51;

3. Insurance Company – licensed pursuant to TCA Title 56, Chapter 2;

4. Hospital and Medical Service Corporation – licensed pursuant to TCA Title 56, Chapter 29, or

5. Health Maintenance Organization – licensed pursuant to TCA Title 56, Chapter 32.

28. Contract section A.164.d. (Table1 – Risk Level Scenario Calculations) is deleted in its entirety and is replaced with Contract Attachment H attached hereto as a new attachment.:

29. Contract section A.168. is deleted in its entirety and replaced with the following:

A.168. OIG Statement

The following statement shall be clearly posted in all facilities performing services to TennCare enrollees: “To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html

and click on 'Report Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCD), call toll-free 1-800-433-5454 or email TBI.MedicaidFraudTips@tn.gov."

30. Contract section A.172. is deleted in its entirety and replaced with the following:

A.172. Fraud, Waste, and Abuse Requirements

a. The Tennessee Bureau of Investigation, Medicaid Fraud Control Division (TBI MFCD) is the state agency responsible for the investigation of provider fraud, waste, and abuse (FWA) in the TennCare program.

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

c. The Attorney General's **Medicaid Fraud and Integrity Division** works with TennCare, the Tennessee Bureau of Investigation, and the Office of Inspector General in combating medical provider fraud in the TennCare/Medicaid program.

d. The Division of TennCare, Managed Care Operations, Office of Program Integrity (OPI) is the State Medicaid Agency unit responsible for the prevention, detection, and investigation of alleged provider fraud, waste, and abuse of the TennCare program. OPI is responsible for providing the Managed Care Program Integrity Guidelines for Fraud, Waste, and Abuse. These guidelines are incorporated by reference and shall be utilized.

e. The Contractor, and any subcontractors delegated responsibility for coverage of services or payment of claims under this Contract, shall implement and maintain a compliance program, as described 42 CFR 438.608

f. The Contractor, as well as its subcontractors shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request.

g. The Contractor's providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty five (35) days after any change in ownership of the disclosing entity, at least once every three (3) years, and at any time upon request.

h. The Contractor shall have procedures in place for prompt reporting of all overpayments identified or recovered due to potential administrative and non-administrative fraud, waste, and abuse to the State.

i. Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.

j. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

k. The Contractor shall establish written policies and procedures for its employees, subcontractors, providers, and agents that provide detailed information about the False Claims Act and any other federal and state laws described in section 1902(a)(68) of the Act, including whistleblower protections, administrative remedies for false claims, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs. The Contractor shall include in any employee handbook a description of the laws and the rights of employees to be protected as whistleblowers.

l. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the State Medicaid Program Integrity Unit or any potential fraud directly to the State Medicaid Fraud Control Division as directed by TennCare.

m. Provision for the Contractor's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.2. This suspension must be available both at the individual provider level by provider NPI and at the practice entity level by practice NPI. Additionally, suspension needs to be available by suspending payments by specific dental procedure code.

n. The Contractor shall have in place a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.

o. The Contractor may recoup and retain overpayments made to providers within timeframes determined by the state.

p. The Contractor shall report to TennCare OPI all non-administrative overpayments, both identified and recovered, on a quarterly basis.

q. The Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:

    i. The improperly paid funds have already been recovered by the State of Tennessee, either by TENNCARE directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or

    ii. When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Tennessee or are the subject of pending Federal or State litigation or investigation,

    iii. The prohibition described in this section shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims.

r. The Contractor shall determine if the prohibition to recoup or withhold improperly paid funds is applicable utilizing methods as directed by TennCare OPI.

s. In the event the Contractor recoups or otherwise obtains funds in cases where overpayment recovery is prohibited, under this section or as otherwise directed by TennCare, the Contractor shall notify the Director of TennCare OPI and take action in accordance with written instructions from the Director of TennCare OPI.

t. The Contractor shall report quarterly on FWA cost savings information.

u. The Contractor shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.

v. The Contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. The Contractor, its subcontractors and all tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall screen their owners and employees against the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). In addition, the Contractor and its subcontractors shall screen their owners and employees against the Social Security Master Death File. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the Contractor dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

w. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud, waste, and abuse activities.

x. The Contractor shall comply with all federal and state requirements regarding fraud, waste, and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

y. The Contractor shall comply with all written direction provided by TennCare OPI regarding fraud, waste, and abuse investigations, overpayments, and any other program integrity related activities and reporting.

z. The Contractor shall report all tips, confirmed or suspected fraud, waste, and abuse to TennCare OPI and the appropriate agency as follows:

    i. All tips (any program integrity case received within the previous two (2) weeks) shall be reported to TennCare OPI and TBI MFCD;

    ii. Suspected fraud, waste, and abuse in the administration of the program shall be reported to TennCare OPI, TBI MFCD and/or OIG;

    iii. All confirmed or suspected provider fraud, waste, and abuse shall immediately be reported to TBI MFCD and TennCare OPI; and

    iv. All confirmed or suspected enrollee fraud, waste, and abuse shall be reported immediately to OIG.

aa. The Contractor shall use the Fraud Reporting Forms, or such other form as may be deemed satisfactory by the applicable agency to whom the report is to be made under the terms of this Contract.

bb. The Contractor shall immediately contact the TennCare OPI for guidance if, during the course of an audit, it is determined the provider is already under review by the State.

cc. The Contractor shall notify TennCare's Office of Program Integrity when the Contractor denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

31. Contract section A.173. is deleted in its entirety and replaced with the following:

A.173. Cooperation

The Contractor shall cooperate with all appropriate state and federal agencies, including the TennCare Office of Program Integrity and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCD), as well as the Office of the Inspector General (OIG), and the State Attorney General's Office. Additionally, the Contractor shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Contract.

32. Contract section A.174. is deleted in its entirety and replaced with the following:

A.174.

[Reserved];

33. Contract section A.176.a. is deleted in its entirety and replaced with the following:

A.176. Preliminary Investigation

a. The Contractor shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud, waste, and abuse. Unless prior written 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 included in the submitted referral of suspected provider fraud:

1. Contact the subject of the investigation about any matters related to the investigation;

2. Enter into or attempt to negotiate any recoupment, settlement or agreement regarding the incident; or

3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

34. Contract section A.178. is deleted in its entirety and replaced with the following:

A.178.

[Reserved];

35. Contract section A.179. is deleted in its entirety and replaced with the following:

A.179.

[Reserved];

36. Contract section A.180. is deleted in its entirety and replaced with the following:

A.180. Fraud, Waste, and Abuse Reporting Requirements

a. All Fraud, Waste and Abuse deliverables shall follow the guidance outlined in the Managed Care Program Integrity Guidelines provided by TennCare OPI. These guidelines are incorporated by reference and shall be utilized.

b. The CONTRACTOR shall immediately submit a referral to TennCare OPI and TBI MFCD simultaneously once the suspected fraud, waste and abuse is determined credible upon completion of an investigation.

c. The CONTRACTOR shall submit a Bi-monthly Tips Report of all tips of potential or suspected fraud, waste or abuse received during the previous two-week period, including tips that have not yet been assigned, have been screened out, and /or have been closed with no action.

d. The CONTRACTOR shall submit a monthly Program Integrity Exception List Report that identifies employees or contractors (as defined in Section A.2.21.9) that have been reported on the HHS-OIG List of Excluded Individuals/Entities, the System for Award Management, the Social Security Master Death File, and/or the listing of Monthly Disciplinary Actions issued by the Professional Health Board.

e. The CONTRACTOR shall submit a monthly List of Involuntary Terminations Report (including providers termed due to sanctions, invalid licenses, services and billing concerns, etc.) due to program integrity concerns to TENNCARE.

f. The CONTRACTOR shall submit a quarterly Fraud, Waste, and Abuse Activities Report. This report shall summarize the results of its fraud, waste, and abuse compliance and other fraud, waste, and abuse prevention, detection, reporting, and investigation measures.

g. The CONTRACTOR shall submit a quarterly Disclosure Submission Rate Report which shall provide the percentage of providers for which the CONTRACTOR has obtained a complete and current disclosure form in accordance with 42 CFR 455, TennCare policies and procedures, and this Contract. The rate shall be provided for all tax-reporting entities with billing activities during the prior quarter. The quarterly report shall include a companion listing which shall include all tax-reporting entities with reimbursement amounts received in the prior reporting quarter along with the disclosure status. For all subcontractors and providers with a signed contract and/or with billing activities, the CONTRACTOR shall maintain a minimum of ninety-five percent (95%) compliance on all entities excluding providers who bill under emergency provisions. Should the CONTRACTOR attain a disclosure rate below ninety-five percent (95%), the CONTRACTOR shall be subject to liquidated damages as specified in Attachment B and shall submit a corrective action plan that shall address the root causes of the non–compliance.

h. The CONTRACTOR shall submit a quarterly Explanation of Benefits (EOBs) Report detailing the EOBs sent to members during the previous quarter.

i. The CONTRACTOR shall submit to the TennCare Office of Program Integrity a Quarterly Utilization Outlier Report listing peer benchmarks and outliers by specialty types and by category of services.

j. The CONTRACTOR shall submit a quarterly Fraud, Waste, and Abuse Cost Savings Information Report, including where savings were identified, and the methodology used to calculate the cost avoidance.

k. The CONTRACTOR shall submit an annual Fraud, Waste, and Abuse Compliance Plan and provide a crosswalk of the detailed compliance plan requirements and the CONTRACTOR's compliance plan. These policies shall be submitted by July 1 of each year.

l. On an annual basis the CONTRACTOR shall submit its policies for employees, contractors, and agents that comply with Section 1902(a)(68) of the Social Security Act. These policies shall be submitted by July 1 of each year.

m. The CONTRACTOR shall submit an annual Recoveries Report detailing all administrative and non-administrative recovery activities conducted by the CONTRACTOR during the previous calendar year.

37. Contract section A.181. is deleted in its entirety and replaced with the following:

A.181.

[Reserved];

38. Contract section A.182. is deleted in its entirety and replaced with the following:

A.182.

[Reserved];

39. Contract section A.183. is deleted in its entirety and replaced with the following:

A.183.

[Reserved];

40. Contract section A.184. is deleted in its entirety and replaced with the following:

A.184.

[Reserved];

41. Contract section A.185. is deleted in its entirety and replaced with the following:

A.185.

[Reserved];

42. Contract section A.187. is deleted in its entirety and replaced with the following:

A.187.

[Reserved];

43. Contract section D.30.b. is deleted in its entirety and replaced with the following:

D.30. Incorporation of Additional Documents. Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below:

b. this Contract with any attachments or exhibits (excluding the items listed at subsections c. through f., below), which includes Attachment A, Terms and Definitions; Attachment B, Liquidated Damages; Attachment C, DBM Deliverable Requirements; Attachment D, Dental Service Categories by Dental CDT Codes; Attachment E, Annual Dental Participation Ratio; Attachment F, Dental Screening Percentage, Attachment G, Attestation RE: Personnel Used in Contract Performance, Attachment H, Multiple PEAR Corresponding PMPM Targets and PEAR Credits, Attachment I, Silver Diamine Fluoride (SDT) Percentage and Dental Percentage, and Attachment J, dental terminology codes for the TPPOHP DBM Program .

44. Contract section E.20. is deleted in its entirety and replaced with the following:

E.20. Social Security Administration (SSA) Required Provisions for Data Security. The Contractor shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. §3541, *et seq*.), and related National Institute of Standards and Technology guidelines. In addition, the Contractor shall have in place administrative, physical, and technical safeguards for data.

a. The Contractor shall specify in its agreements with any agent or subcontractor that will have access to data 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;

b. The Contractor shall not duplicate in a separate file or disseminate, without prior written permission from TennCare, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the TennCare program. Should the Contractor propose a redisclosure of said data, the Contractor must specify in writing to TennCare the data the Contractor proposes to redisclose, to whom, and the reasons that justify the redisclosure. TennCare will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.

c. The Contractor agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.

d. The Contractor shall maintain a current list of the employees of such contractor with access to SSA data and provide such lists to TennCare at the start of the contract, subsequently at any time there are changes or upon request.

e. The Contractor shall restrict access to the data obtained from TennCare to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Contract. The Contractor shall not further duplicate, disseminate, or disclose such data without obtaining TennCare's prior written approval.

f. The Contractor shall provide appropriate training and ensure that its employees:

(1) Properly safeguard SSA-supplied data furnished by TennCare under this Contract from loss, theft or inadvertent disclosure;
(2) Understand and acknowledge that they are responsible for safeguarding this information at all times, regardless of whether or not the Contractor employee is at his or her regular duty station;
(3) Ensure that laptops and other electronic devices/ media containing SSA-supplied data are encrypted and/or password protected;
(4) Send emails containing SSA-supplied data only if the information is encrypted or if the transmittal is secure; and,
(5) Limit disclosure of the information and details relating to a SSA-supplied data loss only to those with a need to know.

(6) Receive regular, relevant and sufficient SSA data related training, including use, access and disclosure safeguards and information regarding penalties for misuse of information

Contractor employees who access, use, or disclose TennCare or TennCare SSA-supplied data in a manner or purpose not authorized by this Contract may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

g. Loss or Suspected Loss of Data–If an employee of the Contractor becomes aware of suspected or actual loss of SSA-supplied data, the Contractor must contact TennCare immediately upon becoming aware to report the actual or suspected loss. The Contractor must provide TennCare with timely updates as any additional information about the loss of SSA-supplied data becomes available.

If the Contractor experiences a loss or breach of said data, TennCare will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the Contractor shall bear any costs associated with the notice or any mitigation.

h. TennCare may immediately and unilaterally suspend the data flow under this Contract, or terminate this Contract, if TennCare, in its sole discretion, determines that the Contractor has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Contract Section E.20.

i. This Section further carries out Section 1106(a) of the Act (42 U.S.C. 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. 3541 et seq.), and related National Institute of Standards and Technology ("NIST") guidelines as outlined in the CMPPA and IEA governing this data,, which provide the requirements that the SSA stipulates that the Contractor must follow with regard to use, treatment, and safeguarding data in the event data is exchanged with a federal information system.

j. Definitions

"SSA-supplied data" or "data" as used in this section means an individual's personally identifiable information (e.g. name, social security number, income), supplied by the Social Security Administration to TennCare to determine entitlement or eligibility for federally-funded programs pursuant to a Computer Matching and Privacy Protection Act Agreement and Information Exchange Agreement between SSA and the State of Tennessee.

9. Contract Attachment A is deleted in its entirety and replaced with the new Attachment A attached hereto.

10. Contract Attachment B is deleted in its entirety and replaced with the new Attachment B attached hereto.

11. Contract Attachment C is deleted in its entirety and replaced with the new Attachment C attached hereto.

12. Contract Attachment H attached hereto is added as a new attachment.

13. Contract Attachment I attached hereto is added as a new attachment.

Required Approvals. The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the

Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

Amendment Effective Date. The revisions set forth herein shall be effective once all required approvals are obtained. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

DENTAQUEST USA INSURANCE COMPANY, INC.:

	6-2-2020
SIGNATURE	**DATE**
Brett A Bostrack, Senior Vice President	
PRINTED NAME AND TITLE OF SIGNATORY (above)	

DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF TENNCARE:

	6/3/20
BUTCH ELEY, COMMISSIONER	**DATE**

ATTACHMENT A

Terms and Definitions

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

2. Administrative Cost – All costs to the Contractor related to 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 TennCare under the terms of this Contract (including, but not limited to, claims processing, marketing, postage, personnel, rent) are considered to be an “administrative cost”.

3. Administrative Services Fee – The per member per month amount that the Contractor will charge for provision of the services outlined in this Contract.

4. AI/AN Child - a child covered by CoverKids who is a certified American Indian/Alaskan Native and a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Plan Administrator to the Dental Benefits Manager for the coverage period.

5. Benefits - A schedule of health care services to be delivered to enrollees covered by the Contractor

6. Auxiliary Aids and Services - include, but are not limited to:

    a. Qualified interpreters on-site or through video remote interpreting (VRI) services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;

    b. Qualified readers; taped texts; audio recordings; Brailled materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;

    c. Acquisition or modification of equipment or devices; and

    d. Other similar services and actions as defined in 28 CFR § 36.303.

7. CFR - Code of Federal Regulations

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

9. CMS - Centers for Medicare and Medicaid Services (formerly HCFA).

10. Community Service Area - Community Service Area (CSA) shall mean one (1) or more counties in a defined geographical area in which the Contractor is authorized to enroll providers and serve TennCare enrollees.

    a. The following geographical areas shall constitute the twelve (12) Community Service Areas in Tennessee:

        i. Northwest CSA - Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll and Benton

        ii. Southwest CSA - Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester and McNairy

        iii. Shelby CSA - Shelby County

        iv. Mid-Cumberland CSA - Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson and Rutherford

        v. Davidson CSA - Davidson County

        vi. South Central CSA - Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore

        vii. Upper Cumberland CSA- Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, DeKalb, Putnam, Cumberland, White, Cannon, Warren and Van Buren

        viii. Southeast CSA - Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley and Marion

        ix. Hamilton CSA - Hamilton County

        x. East Tennessee CSA - Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon and Roane

        xi. Knox CSA - Knox County

        xii. First Tennessee CSA - Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter and Johnson

11. Cost-effective Alternative Service – A service that is not a Covered Service but that is approved by TennCare and CMS and provided at an MCO's discretion. TennCare enrollees are not entitled to receive these services. Cost-effective alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in the MCO's judgment, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the MCO's judgment, would require more costly treatment in the future.

12. Covered Service - See Benefits at Contract Sections A.4, A.5, and A.105.

13. Cultural Competence - The level of knowledge-based skills required to provide effective clinical care to enrollees of particular ethnic or racial groups.

14. DBM – Dental Benefits Manager.

15. Department of Intellectual and Developmental Disabilities (DIDD) – The State agency having the statutory authority to plan, promote, provide and support the delivery of services for persons with intellectual and developmental disabilities, and which serves as the contracted operating agency for the State's 1915(c) home and community-based services waivers and is responsible for the performance of contracted functions for ECF CHOICES as specified in interagency agreement.

16. 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 TennCare to the Contractor.

17. ECF CHOICES Participating Dental Provider –A Participating Dental Provider contracted to serve Members age 21 and older enrolled in the ECF CHOICES program.

18. Effective Communication – means taking the appropriate steps to ensure that communications with disabled applicants, participants, members of the public, and their companions are as effective as communications with others by providing alternative formats such as auxiliary aids as defined in USCA.

19. Eligible Person - Any person certified by TennCare as eligible to receive services and benefits under the TennCare Program.

20. Emergency Services – Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act and that are needed to evaluate or stabilize an emergency medical condition.

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

22. Enrollee - Synonymous with "Member". A Medicaid recipient, Medicaid Waiver recipient, or CoverKids recipient who is currently assigned to a Managed Care Organization (MCO), Pre-paid Inpatient Health Plan (PIHP), Pre-paid Ambulatory Health Plan (PAHP) or Primary Case Care Management Program (PCCM) in a given managed care program. For purposes of the Appeal System-related provisions herein, "Enrollee" means enrollee, enrollee-authorized representative, or someone with written consent to act on enrollee's behalf.

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

24. Enrollee Month – A month of health care coverage for the TennCare eligible enrolled in a Dental Plan.

25. Enrollment - The process by which a person becomes a member of the Contractor's plan through TennCare.

26. EPSDT - The Early, Periodic Screening, Diagnosis, and Treatment services mandated by 42 U.S.C. § 1396d(e) and amended by OBRA 1989. EPSDT services shall mean:

    a. Screening in accordance with professional standards, interperiodic screenings, and diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare enrollees under age twenty-one (21) and

b. Health care, treatment, and other measures, described in 42 U.S.C. § 1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.

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

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

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

30. 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 (42 CFR 455.2).

31. Full-Time – shall mean: (1) the number of hours worked per week by each Key Staff member shall be a minimum of thirty-seven and one-half (37.5) hours, and (2) each Key Staff position set forth in Contract Section A.17 shall be a Full Time position, with the exception of the Assistant Fraud and Abuse Investigators and the Fraud and Abuse staff person, each of whom work on an as-needed basis.

32. Grand Region – A defined geographical region that includes specified Community Service Areas in which a Contractor is authorized to enroll providers and serve TennCare enrollees. The following Community Service Areas constitute the three (3) Grand Regions in Tennessee:

	East Grand Region	Middle Grand Region	West Grand Region
i.	First Tennessee	Upper Cumberland	Northwest
ii.	East Tennessee	Mid Cumberland	Southwest
iii.	Knox	Davidson	Shelby
iv.	Southeast Tennessee	South Central	
v.	Hamilton		

33. Handicapping Malocclusion – for the purposes of determining eligibility for orthodontia shall mean the presence of abnormal dental development that has at least one of the following:

    1. A medical condition and/or a nutritional deficiency with medical physiological impact, that is documented in the physician progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to medical treatment without orthodontic treatment.

    2. The presence of a speech pathology, that is documented in speech therapy progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to speech therapy without orthodontic treatment.

    3. Palatal tissue laceration from a deep impinging overbite where lower incisor teeth contact palatal mucosa. This does not include occasional biting of the cheek.

b. Anecdotal information is insufficient to document the presence of a handicapping malocclusion. Anecdotal information is represented by statements that are not supported by professional progress notes that the patient has difficulty with eating, chewing, or

speaking. These conditions may be caused by other medical conditions in addition to the malalignment of the teeth.

34. Health Maintenance Organization (HMO) - An entity certified by the Department of Commerce and Insurance under applicable provisions of TCA Title 56, Chapter 32.

35. Hire Date and Start Date – "Hire Date" and "Start Date" shall be deemed synonymous for purposes of the Contract, and all Key Staff are to begin work on the same date they are hired so they can become familiar with the TennCare Program prior to Go-Live Date, or so they can immediately begin to familiarize themselves with the TennCare Program if they are hired after the Go-Live Date.

36. Immediate Eligibility – Temporary eligibility granted to a child upon entering into DCS Custody in order to give children in DCS adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility.

37. Limited English Proficient (LEP) – As defined at 42 CFR §438.10(a).

38. Managed Care Contractor (MCC) – shall mean: (a) A Managed Care Organization, Pharmacy Benefits Manager and/or a Dental Benefits Manager which has signed a TennCare Contractor Risk Agreement with the State and operates a provider network and provides covered health services to TennCare enrollees; or (b) A Pharmacy Benefits Manager, Behavioral Health Organization or Dental Benefits Manager which subcontracts with a Managed Care Organization to provide services; or (c) A State government agency (i.e., Department of Children's Services and Division of Intellectual Disabilities Services) that contracts with TennCare for the provision of services.

39. Managed Care Organization ("MCO") - An HMO which participates in the TennCare Program.

40. Medical Record - A single complete record kept at the site of the enrollee's treatment(s), which documents all of the treatment plans developed, medical services ordered for the enrollee and medical services received by the enrollee.

41. Medically Necessary - Is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in these rules, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in the Medical Necessity rule chapter at 1200-13-16.

42. NAIC – National Association of Insurance Commissioners.

43. Non-TennCare Provider – A provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.

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

45. Out-of-Plan Services - Services provided by a non-TennCare provider.

46. Office Reference Manual – A dental program criteria manual specific to each separate dental benefit program, to assist participating dental providers.

47. Participating Dental Provider – A TennCare provider, as defined herein and in the TennCare Rules, who has entered into a contract with the Contractor to provide Covered Services. A

Participating Dental Provider may be contracted to serve children under age 21, adults age 21 and older in ECF CHOICES, individuals enrolled in TPPOHP DBM Program, and CoverKids enrollees or to provide dental services to individuals in all populations.

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

49. Person-Centered Support Plan (PCSP) – As it pertains to ECF CHOICES, the PCSP is a written plan developed by the MCO support coordinator using a person-centered planning process that accurately documents the member's strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the member to help them achieve their preferred lifestyle and goals, and to meet their identified unmet needs (after considering the availability and role of unpaid supports provided by family members and other natural supports) through paid services provided by the MCO and other payor sources).

50. Potential Enrollee – A Medicaid recipient or Medicaid Waiver recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, and PCCM.

51. Prepaid Ambulatory Health Plan (PAHP) – As defined at 42 CFR §438.2. Contractor is classified as a Prepaid Ambulatory Health Plan pursuant to the TennCare II Demonstration Project approved by CMS. Prepaid ambulatory health plan (PAHP) means an entity that—

    1. Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
    2. Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
    3. Does not have a comprehensive risk contract.

    b. For example, a dental PAHP is a managed care entity that provides only dental services.

52. Presumptive Eligible - Temporary eligibility granted to a pregnant woman whose family income is at or below a specified percentage of the federal poverty level in order for the woman to receive prenatal care services.

53. Primary Care Physician - A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

54. Primary Care Provider - A primary care physician or registered professional nurse or physician assistant practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

55. Prior Authorization (PA) - The act of authorizing specific services or activities before they are rendered or activities before they occur.

56. Privacy/Security Incidents - Any use or disclosure that is not permitted under the Privacy and Security Rules (Privacy/Security Incident) that compromises the protected health information (PHI) that poses a potential for significant risk of financial, reputational, or other harm to the enrollee as determined by TennCare.

57. Program Integrity - The TennCare Office of Program Integrity (OPI) is responsible for the prevention, detection and investigation of alleged provider fraud, waste and/or abuse. OPI collaborates with the Managed Care Contractors (MCCs), law enforcement, and various state and

federal agencies to ensure regulatory compliance and accountability and protects the financial and health care service integrity of the TennCare program.

58. Provider -An appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services. Providers are categorized as either TennCare Providers or Non-TennCare Providers. TennCare Providers may be further categorized as being one of the following: (a) Participating Providers or In-Network Providers; (b) Non-Participating Providers or Out-of-Network Providers; (c)Out-of-State Emergency Providers. Definitions of each of these terms are contained in this Attachment.

59. Provider Agreement - An agreement between an MCO or DBM and a provider or an MCO's or DBM's subcontractors and a provider of oral health care services which describes the conditions under which the provider agrees to furnish covered services to the MCO's or DBM's enrollees.

60. 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.

61. 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.

62. Service Location - Any location at which an enrollee obtains any oral health care service covered by the Contractor pursuant to the terms of this Contract.

63. Service Site - The locations designated by the Contractor at which enrollees shall receive oral health treatment and preventive services.

64. Services - The benefits described in this Contract, including but not limited to, Section A.3.

65. Shall - Indicates a mandatory requirement or a condition to be met.

66. Specialty Services – Includes Endodontics, Oral Surgery, Orthodontics, Pediatric Dentistry, Periodontics, Prosthodontics.

67. State - State of Tennessee.

68. Subcontract - An agreement that complies with all applicable requirements of this Contract entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract, (e.g., claims processing, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Contract. Agreements to provide covered services as described in Section A.4 of this Contract shall be considered Provider Agreements and governed by Sections A.62 – A.74 of this Contract. If a subcontractor will also be a Provider the requirements for Provider Agreements must also be met.

69. Subcontractor - Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract.

70. Targeted Service Expenditure Baseline – The amount of expenditure, adjusted for factors such as increased provider fees and increased enrollment, against which the actual service expenditures for the period are to be measured to ascertain any savings/loss for purposes of making the risk sharing calculation.

71. TennCare - The Single State Agency designated by the State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the Single State Agency in administering

and/or enforcing the TennCare and CoverKids Programs and the terms of this Contract. Such entities include, but are not limited to, the Department of Finance and Administration, Division of TennCare (TennCare), the Department of Health (DOH), the Department of Children's Services (DCS), the Department of Intellectual and Developmental Disabilities (DIDD) the Department of Finance and Administration (F&A), the Department of Mental Health and Substance Abuse Services (DMH/SAS), the TennCare Oversight Division within the Tennessee Department of Commerce and Insurance (C&I) and the Tennessee Bureau of Investigation Medicaid Fraud Control Division (MFCD).

72. TennCare Provider - A provider who accepts as payment in full for furnishing benefits to an enrollee, the amounts paid pursuant to an approved agreement with an MCO or TennCare. Such payment may include copayments from the enrollee or the enrollee's responsible party. Except in the case of Out-of-State Emergency Providers, as defined in the TennCare Rules, a TennCare provider must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including the rules regarding provider billing of patients as found in Rule 1200-13-13-.08. TennCare Providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in Medicare or Medicaid.

73. 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".

74. Tennessee Bureau of Investigation, Medicaid Fraud Control Division (TBI MFCD) – TBI MFCD 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 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.

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

76. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party payor.

77. Urgent Care - Services for urgent dental and oral conditions or injuries on the basis of the professional judgment of the enrollee's treating dentist, other dental professional, primary care provider or a triage nurse who is trained in dental care and oral health care.

78. Utilization Rate – An adjusted proportion of enrollees in the TennCare Children's DBM Program, ages 2-20, or enrollees in the CoverKids DBM Program, ages 2-18, with a minimum of ninety (90) days eligibility who have received any dental service during the past federal fiscal year.

79. Vital Documents – Consent and grievance forms, intake and application forms with the potential for important consequences, and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents shall be at a minimum available in Spanish.

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

ATTACHMENT B

LIQUIDATED DAMAGES

In the event of a Contract performance or compliance failure by Contractor and such Contract performance or compliance failure is not included in the following table with an associated Liquidated Damage amount, the parties hereby agree that the State may choose one of the following courses of action in order to obtain redressability for such Contract performance or compliance failure: (1) the State may assess actual damages resulting from the Contract performance or compliance failure against the Contractor in the event that such actual damages are known or are reasonably ascertainable at the time of discovery of such Contract performance or compliance failure or (2) if such actual damages are unknown or are not reasonably ascertainable at the time of discovery of the Contract performance or compliance failure, the State may (a) require the Contractor to submit a corrective action plan to address any such Contract performance or compliance failure and (b) assess liquidated damages against Contractor for an amount that is reasonable in relation to the Contract performance or compliance failure as measured at the time of discovery of the Contract performance or compliance failure. In the event that the State chooses to assess a Liquidated Damage for a Contract performance or compliance failure according to the immediately preceding sentence, in no event shall such Liquidated Damage be in excess of $1,000 for any single Contract performance or compliance failure.

TennCare may elect to apply the following liquidated damages remedies in the event the Contractor fails to perform its obligations under this Contract in a proper and/or timely manner. Upon determination by TennCare that the Contractor has failed to meet any of the requirements of this Contract in a proper and/or timely manner, TennCare will notify the Contractor in writing of the performance or compliance failure and of the potential liquidated damages to be assessed. Should the performance or compliance failure remain uncorrected for more than thirty (30) calendar days from the date of the original notification of the performance or compliance failure by TennCare, TennCare may impose an additional liquidated damage of Five Hundred Dollars ($500) per day from the date of the original notification to Contractor until said performance or compliance failure is resolved.

All liquidated damages remedies set forth in the following table may, at TennCare's election, be retroactive to the date of the initial occurrence of the failure to comply with the terms of the Contract as set forth in the notice of performance or compliance failure from TennCare and may continue until such time as the TennCare Deputy Commissioner, or the Deputy Commissioner's representative, determines the performance or compliance failure has been cured.

If liquidated damages are assessed, TennCare shall reduce the amount of any payment due to the Contractor in the next invoice by the amount of damages. In the event that damages due exceed the amount TennCare is to pay to Contractor in a given payment, TennCare shall invoice Contractor for the amount exceeding the amount payable to Contractor, and such excess amount shall be paid by Contractor within thirty (30) calendar days of the invoice date. In situations where the Contractor wishes to dispute any liquidated damages assessed by TennCare, the Contractor must submit a written notice of dispute, including the reasons for disputing the liquidated damages, to the TennCare Deputy Commissioner or the Deputy Commissioner's representative within thirty (30) calendar days of receipt of the notice from TennCare containing the total amount of damages assessed against the Contractor. If the Contractor fails to timely dispute a liquidated damages assessment as set forth herein, such failure shall constitute a bar to the Contractor seeking to have the assessment amount overturned in a forum or court of competent jurisdiction.

Liquidated damages will apply to the Contract performance or compliance failures listed below. Contractor acknowledges that the actual damages likely to result from Contract performance or compliance failures are difficult to estimate and may be difficult for the State to prove. The parties intend that the Contractor's payment of assessed liquidated damages will compensate the State for breach of the Contractor obligations under this Contract. Liquidated damages do not serve as punishment for any breach by the Contractor.

	PROGRAM ISSUES		DAMAGE
1.	Failure by the Contractor to meet the standards for privacy, security, and confidentiality of individual data as evidenced by a breach of the security per Section E. 2. and E.18 and Contractor's failure to timely and reasonably comply with its obligation to appropriately respond to any such breach		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
2.	Failure by the Contractor to execute the appropriate agreements to effectuate transfer and exchange of enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party. (See E.17. and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
3.	Failure by the Contractor to seek express written approval from TennCare prior to the use or disclosure of enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States. (See E.13 and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
4.	Failure by the Contractor to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of suspected breach per Sections (See E.18 and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter.
5.	Failure to implement Non-Traditional Fluoride Varnish and Dental Screening Program within six months of contract start as referenced in Section A.5.a.4.		The damage that may be assessed shall be five hundred dollars ($500) per calendar day past expected implementation date.

6.	In the event the Contractor provides authorization and reimbursement of dental services for ECF CHOICES members that exceed the amount approved for such services in a member's PCSP as required by Contract Section A.5.b.9.		The damage that may be assessed shall be five hundred dollars ($500) per occurrence.
7.	Failure to obtain approval of member materials as required by Sections A.10 - A.13 of this Contract		The damage that may be assessed shall be five hundred dollars ($500) per day for each calendar day that TennCare determines the Contractor has provided enrollee material that has not been approved by TennCare.
8.	Failure to comply with licensure requirements in Section A.16 of this Contract.		The damage that may be assessed shall be five thousand dollars ($5,000) per calendar day that staff/provider/agent/ subcontractor is not licensed as required by applicable state law, plus, the amount paid to the staff/provider/agent/ subcontractor during that period.
9.	Failure to comply in any way with staffing requirements described in Sections A.14 - A.18 of this Contract.		The damage that may be assessed shall be two hundred and fifty dollars ($250) per calendar day for each day that staffing requirements described in Sections A.14 - A.18 of this Contract are not met.
10.	Provider network includes insufficient numbers and geographical disbursement of providers in order to satisfy the requirements outlined in the Access and Availability to Care section of this contract, Sections A.19 – A.28.		A maximum of twenty-five thousand dollars ($25,000) for failure to meet each of the listed standards, either individually or in combination on a monthly basis. The liquidated damage may be lowered to five thousand dollars ($5,000) in the event that the Contractor timely provides a corrective action plan that is accepted by TennCare
11.	TennCare-related Enrollee Appeals. Failure to confer a timely response to a request for Prior Authorization in accordance with 42 CFR §438.210 and Section A.118 of this contract.		TennCare may assess damages amounting to $500 for each day DBM is in default for each occurrence.
12.	TennCare-related Enrollee Appeals. Failure to confer a timely and content-compliant Notice of Adverse Benefit Determination in accordance with 42 CFR 438 Subpart F and sections 118, 119, and 120.		TennCare may assess damages amounting to $500 for each day DBM is in default for each occurrence.
13.	Failure to provide a timely and complete response to a TennCare request for the Contractor's internal Appeal file or for Appeal-related documentation, such as notices issued to enrollee, dental records, and prior authorization requests and decisions.		$500 per calendar day CONTRACTOR is in default.
14.	Failure to confer a timely and complete response to an On Request Report instructing Contractor to determine whether a request for SFH warrants		$500 per calendar day Contractor is in default.

	expedited resolution		
15.	Enrollee Benefit Appeals. Failure to submit a standard appeal/SFH request to TennCare within five (5) business days of receipt by Contractor.		$500 per calendar day Contractor is in default.
16.	Enrollee Benefit Appeals. Failure to submit an expedited appeal/SFH request to TennCare within twenty-four (24) hours of receipt by Contractor.		$500 per calendar day Contractor is in default.
17.	Failure to maintain provider agreements in accordance with Sections A.62 – A.74 of this Contract.		TennCare may assess $5,000 per each occurrence of a provider agreement found to be non-compliant.
18.	Failure to comply with claims processing requirements described by Sections A.84–A.89 of this Contract and the performance requirements in Section A.191.		The damage that may be assessed shall be ten thousand dollars ($10,000) per month, for each month that TennCare determines that the Contractor is not in compliance with any of the requirements of Sections A.84–A.89 and A.191.
19.	Maintain an average daily abandonment rate of 5% or less for each queue on each day the Service Center is open for business excluding calls abandoned before thirty seconds as specified in Sections A.29 and A.95.		A maximum of five hundred dollars ($500) per queue per day for a daily abandonment rate of 6% - 10%. A maximum of one thousand five hundred dollars ($1,500) per day for a daily abandonment rate over 10%.
20.	Maintain an Average Speed of Answer (ASA) per queue per day of 60 seconds or less as specified in Sections A.29. and A.95. ASA is to be calculated from the time that a call comes into the queue from the IVR and when it is answered.		A maximum of five hundred dollars ($500) per queue per day for an ASA of 61 seconds – 180 seconds. A maximum of one thousand five hundred dollars ($1,500) per queue per operating day for an ASA of 181 seconds or more.
21.	Maintain a daily blocked call rate of 1% or less as specified in Sections A.29 and A.95.		A maximum of one thousand dollars ($1,000) for each percentage point above 1%.
22.	The Contractor's shall answer 100% of calls each day within 300 seconds as specified in Section A.29 and A.95.		A maximum of five hundred dollars ($500) for each instance of each call answered within 301 seconds to 600 seconds during each operating day; provided, however total liquidated damages under this section shall not exceed twenty-five thousand dollars ($25,000) per operating day. A maximum of one thousand dollars ($1,000) for each instance of each call answered in 601 seconds or more during each operating day; provided, however total liquidated damages under this section shall not exceed fifty thousand dollars ($50,000) per operating day.
23.	Failure to maintain an appeal system as required by TennCare Rules, the provisions contained in the contract, and applicable provisions of 42 CFR 438 Subpart F in accordance with Sections A.116 – A.132 of this contract. Such		TennCare may assess damages amounting to $1,500 for each day DBM is in default until a TennCare-approved corrective action plan is fully implemented by the DBM.

	failure may be evidenced by Contractor's failure to meet compliance requirements for any aspect of the appeal system.		
24.	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 Section A.152 of this Contract.		The damage that may be assessed shall be the actual amount paid by DCS and/or TennCare for necessary services or one thousand dollars ($1000) per occurrence, whichever is greater, to be deducted from monthly fixed administrative fee payments.
25.	Failure to comply with the program integrity provisions as described in Section A.166 through A.187. of this Contract		The damage that may be assessed is $500 per calendar day for each day that the Contractor does not comply with the program integrity provisions
26.	Maintain a Dental Screening Percentage (DSP) (Refer to Attachment F) greater than or equal to 80% as required in Section A.192.		Liquidated Damages of up to $100,000.00 may be assessed for every 1.0% decrease in DSP below 80%.
27.	Failure by the Contractor to have the PEAR for the CoverKids Program above 50 percent (50%) on an annual basis as required by Contract Section A.193.		A maximum of up to one hundred thousand dollars ($100,000) in liquidated damages for failure to have the PEAR for the CoverKids Program above 50 percent (50%) on an annual basis.
28.	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized by the TennCare Chief Medical Officer.		The damage that may be assessed shall be one thousand dollars ($1000) per occurrence.
29.	Failure to comply with distribution timeframes for providing Member Handbooks, Provider Directories, and Newsletters, as required by Contract Section A.10.		The damage that may be assessed shall be five thousand dollars ($5000) for each occurrence.
30.	Failure to complete or comply with Corrective Action Plans as required by TennCare in Contract A.8.		The damage that may be assessed shall be five hundred dollars ($500) per calendar day for each day the corrective action is not completed or complied with as required.
31.	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement/contract as required by Contract Section A.138.		$5,000 per application that has not been approved and loaded into the Contractor's system or denied within (30) calendar days of receipt of a completed credentialing application and a signed provider agreement/contract if applicable. $1,000 per application per calendar day for each day beyond thirty (30) calendar days that a completed credentialing application has not been processed.
32.	Failure to report provider notice of termination of participation in the Contractor's Plan as required by Contract Section A.58.		The damage that may be assessed shall be two hundred dollars ($200) per calendar day for each day that Contractor fails to report provider notice of termination of participation.
33.	Failure to submit a Provider Enrollment File that meets TennCare's		$250 per day after the due date that the Provider Enrollment File fails to meet

	specifications as required by Contract Sections A.22 and A.148.		TennCare's specifications.
34.	The level of overall customer satisfaction, as measured annually by a State approved Enrollee Satisfaction survey(s), shall be equal to or greater than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the Contract term as required by Contract Section A.36.		$3000.00 per Enrollee Satisfaction survey(s), less than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the Contract term.
35.	Failure to disclose Lobbying Activities as specified in Section E.8.		The damage that may be assessed shall be one thousand dollars ($1000) per calendar day that disclosure is late.
36.	Failure to comply with overpayment reporting as outlined in A.170.		The damage that may be assessed shall be one thousand dollars ($1000) per calendar day that disclosure is late.

ATTACHMENT C

DBM Deliverables Requirement

DBM Dental Deliverables	Scheduled Due Dates
Monthly Reports: • Batch Claims operation	**Thirty (30) calendar days after the end of each calendar month unless otherwise noted.**
• Program Integrity (PI) Exception List Report	**20th of the month – submit to OPI**
• Bi-monthly PI TIPs Report	**20th of the month for tips received between the 1st and 15th and the 5th of the month for tips received between the 16th and end of the month.**
• PI Involuntary Termination Report	**20th of the month – submit to OPI**
• Claims Lag Triangle • Claims Activity • Subrogation recoveries collected outside claims processing system (received ad hoc) • Encounter Data Report (837D)	Forty-eight (48) hours after weekly payment cycle
• Provider Enrollment File☼	By fifth business day <u>each month</u>
Quarterly Reports: • PI EOB Report • Enrollee Cost Sharing • Customer Service Report o Referral time by county o Phone response time o Request for assistance • Non-Discrimination Compliance Reports • Quarterly Financials/ Income Statements • DBM Quarterly TennCare Kids ReportQMP Committee Meeting Minutes	**Thirty (30) days after the end of each Federal Fiscal Year quarter (unless noted)**
• Quality Indicator • PI Referral ¥	**<u>PI referrals should be submitted as soon as the FWA is suspected or confirmed</u>**
• Quarterly FWA Activities Report • Non-Traditional FI Varnish Program Report	Ten (10) days after the end of <u>each federal quarter</u>
• "Insure Kids Now" (IKN) File☼PI Disclosure Rate Report	<u>Submit to TC OPI</u>
• Quarterly Member Newsletter • PI Utilization by Standard Deviation • PI Cost Savings Report	Submit to TC OPI Submit to TC OPI
Annual Reports/ Plans/Studies:	**Ninety (90) days after end of Federal Year (unless noted)**
• Annual Outreach Plan	By August 15 each year
• Audited Financial Statements	By March 30 each year
• Member Satisfaction Surveys*	By March 30 each year
• Provider Satisfaction Surveys*	By March 30 each year
• Non-Discrimination Compliance Plan &	By August 15 each year

Assurance of Non-Discrimination • Annual Outreach Plan Year-End Update • Two (2) PIPs Dental Studies† • QMP Report‡ (QMP, work plan, and evaluation) • Licensure Documentation • Fraud, Waste and Abuse Compliance Plan • Annual Disclosure Form • Annual policies for employees, contractors, and agents that comply with 1902(a)(68) SSA (Deficit Reduction Act) • Annual Recoveries Report	By November 30 each year By June 30 each year By March 30 each year By September 15 each year By July 1 each year By March 30 each year By July 1 each year **By February 15 each year**
Ad Hoc Reports: **Progress Reports** **On Request Reports (ORRs)** **Requests for Information (RFIs)**	Within ten (10) business days from the date of the request when reasonable unless otherwise specified by TennCare. As Requested Within three (3) business days from the date of request when reasonable unless otherwise specified by TennCare. As Requested

¥ PI TIPs Report and PI Referrals should be submitted via the Secured File Transport (SFTP) server and in format specifications designated by TennCare.
☼ File format shall comply with specifications as outlined by TennCare.

DBM CoverKids Dental Deliverables	Scheduled Due Dates
Quarterly Reports: • Claims Payment Reports • Member/Provider Service Lines • Network Changes Update Report • Network Quarterly Payment • Member Newsletter • Member Handbook ID, and Provider Network Directories Distributed • PI Report-Fraud and Abuse • External Quality Review Organization (EQRO) Provider Data • Non-Discrimination Compliance Report • CoverKids Member Complaint Log • CoverKids Provider Complaint Log • CoverKids Dental Benefit Savings and Payments Report	Thirty (30) days after the end of each Federal Fiscal Year quarter (unless noted) Within 5 days of the end of each quarter Within 5 days of the end of each quarter

• Enrollment Summary Plan • FQHC/RHC Report	
Annual Reports/ Plans/Studies: • Enrollee Satisfaction Survey • Provider Satisfaction Survey • Non-Discrimination Policy • Non-Discrimination Policy Compliance Plan	**Ninety (90) days after end of Federal Year (unless noted)** By March 30 each year By March 30 each year By August 16 each year By August 16 each year
Ad Hoc Reports: **Progress Reports** **On Request Reports (ORRs)** **Requests for Information (RFIs)**	Within ten (10) business days from the date of the request when reasonable unless otherwise specified by TennCare. As Requested Within three (3) business days from the date of request when reasonable unless otherwise specified by TennCare. As Requested

Management Reporting Requirements
Contract Management Reports by which the State can assess the CoverKids Dental program costs and usage. Reports shall be submitted in an electronic format as referenced in Section A.151 (Management Reports). Management Reports shall include:

1) Performance Guarantee Reports, as detailed at Contract Attachment C (each component to be submitted at the frequency indicated), shall include:

- Status report narrative
- Detail report on each performance measure by appropriate time period

2) **Quarterly CoverKids Dental Benefit Savings and Payments Report,** must be submitted as follows distinguishing between in-network and out-of-network:

GROUP ONE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

GROUP TWO CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

AMERICAN INDIAN/ ALASKAN NATIVE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

3) Quarterly Provider and Out-of-Network Claims Utilization by:

- o Submitted charges
- o Benefits paid
- o Member Utilization

4) Quarterly Enrollment Summary Plan Report:

Premium Category	Subscribers	Premium	Total Claims
Group One Child			
Group Two Child			
American Indian/ Alaskan Native Child			
Total			

5) Quarterly Network Changes Update Report, displaying the following:

- Present Network of Participating Providers by Specialty
- Additions to the Network by Name, Specialty and Location
- Terminations to the Network by Name, Specialty and Location
- Targeted areas for recruitment

ATTACHMENT H

Multiple PEAR, Corresponding PMPM Targets, and PEAR Credits

PEAR Targets	Corresponding PMPMs
55.00%	$16.08
55.50%	$16.23
56.00%	$16.37
56.50%	$16.52
57.00%	$16.66
57.50%	$16.81
58.00%	$16.96
58.50%	$17.10
59.00%	$17.25
59.50%	$17.39
60.00%	$17.54
60.50%	$17.69
61.00%	$17.83
61.50%	$17.98
62.00%	$18.13
62.50%	$18.27
63.00%	$18.42

Multiple PEAR and PMPM targets have been provided to encourage and align incentives for the DBM to maximize member engagement.

Tenncare has set a minimum threshold PEAR of 55% (no profit sharing if PEAR is below 55%).

The final PEAR calculation will not be rounded for purposes of determining the target PMPM (e.g. if PEAR is 59.8%, then the target PMPM for 59.5% will be used.

The timeline for the annual risk share calculation will be May 1 – April 30 of the contract year.

Additionally, the DBM can receive PEAR credits based on achieving TennCare defined preventive targets. Preventive target categories will be provided by TennCare prior to the start of the contract year. Preventive care targets will be set by TennCare based on the previous contract year.

Preventive Service	PEAR credit for 1.5% points above the previous year's % of members treated	PEAR credit for 3% points above the previous year's % of members treated	PEAR credits for 4.5% points above the previous year's % of members treated	PEAR credits for 6% point above the previous year's % of members treated
Sealants	0.125	0.250	0.375	0.500
SDF	0.125	0.250	0.375	0.500
Max PEAR Credit	0.250	0.500	0.750	1.000

Example #1: Multiple PEAR and Corresponding PMPM Targets:

Multiple PEAR Targets	Actual PEAR achieved	Corresponding PMPM Targets	Actual PMPM	Total Savings to TennCare (based on member population of 824,440)	55% savings
57.00		16.66	15.87	$7,815,691	$4,298,630
57.50	57.75	16.81	15.87	$9,299,683	$5,114,826
58.00		16.96	15.87	$10,783,675	$5,931,021
58.50		17.10	15.87	$12,168,734	$6,692,804

Example #2: PEAR Credits for improving SDF and Sealant Usage

DBM baseline SDF rate is 0.3% and baseline sealant rate is 15.1%.

DBM achieves an SDF rate of 3.5% (representing a 3.2% increase) and a sealant rate of 21.5% (representing a 6.4% increase)

If 57.75% was the actual PEAR achieved by the DBM, then the DBM would receive a total PEAR credit of 0. 75 applied to their risk share PMPM target, bumping the PEAR to 58.50% with an increased savings as seen in the table above.

ATTACHMENT I

Silver Diamine Fluoride (SDF) Percentage and Dental Sealant Percentage

SDF Percentage

Eligible Population

Any member ages 0-20 continuously enrolled in the TennCare program for a minimum of ninety (90) days in the measurement year plus extend three months before and after of measurement year

Qualifying Service

Paid or denied claims with a qualifying service.

Codes used to identify qualifying services CDT: D1354

Measurement Year

May 1 – April 30 each year

Metric Formulation

Numerator - Count of unduplicated members receiving qualifying service in the measurement year on a primary or permanent tooth

Denominator – Count of unduplicated eligible population

Dental Sealant Percentage

Eligible Population

Any member ages 6-15 continuously enrolled in the TennCare program for a minimum of ninety (90) days in the measurement year plus extend three months before and after of measurement year

Qualifying Service

Paid or denied claims with a qualifying service

Codes used to identify qualifying services CDT: D1351, D1352, D1353,

Measurement Year

May 1 – April 30 each year

Metric Formulation

Numerator - Count of unduplicated members receiving qualifying service in the measurement year on at least one of the following teeth: 2, 3, 14, 15, 18, 19, 30, 31

Denominator – Count of unduplicated sealant eligible population

Exclude from denominator members ages 6-11 who have received any of the following procedures (codes D1351, D1352, D1353) on *all* the following teeth: 3,14,19,30 prior to May 1 of the reporting year.

Exclude from the denominator members ages 6-11 who have received any of the following procedures (codes D2000-D7999) on *all* of the following teeth: 3, 14, 19, 30 with no date limitations.

Exclude from denominator members ages 12-15 who have received any of the following procedures (codes D1351, D1352, D1353) on *all* the following teeth: 2, 3,14,15,18,19, 30, 31 prior to May 1 of the reporting year.

Exclude from denominator members ages 12-15 who have received any of the following procedures (codes D2000-D7999) on *all* the following teeth: 2, 3,14,15,18,19, 30, 31 with no date limitations

ATTACHMENT J

D0000's Codes Diagnostic	D1000's Codes Preventive	D2000's Codes Restorative	D3000's Codes Endodontics	D4000's Codes Periodontal	D5000's Codes Prosthodontics	D7000's Codes Oral Surgery	D9000's Codes Adjunctive General Services
D0120	D1110	D2140	D3310	D4341	D5110	D7140	D9110
D0140	D1206	D2150	D3320	D4342	D5120	D7210	
D0150	D1208	D2160	D3330	D4355	D5130	D7220	
D0160	D1354	D2161			D5140	D7250	
D0210		D2330			D5730	D7310	
D0220		D2331			D5731	D7311	
D0230		D2332			D5750	D7320	
D0270		D2335			D5751	D7321	
D0272		D2391				D7471	
D0273		D2392				D7472	
D0274		D2393				D7473	
D0330		D2394				D7485	
D0367		D2721					
		D2722					
		D2740					
		D2750					
		D2751					
		D2752					
		D2753					
		D2781					
		D2782					
		D2783					
		D2791					
		D2792					
		D2920					
		D2931					

CONTRACT

(fee-for-goods or services contract with an individual, business, non-profit, or governmental entity of another state)

Begin Date	End Date	Agency Tracking #	Edison Record ID
September 1st, 2018	April 30th, 2023	31865-00490	59802

Contractor Legal Entity Name	Edison Vendor ID
DentaQuest USA Insurance Company, Inc.	222275

Goods or Services Caption (one line only)

TennCare Health Benefit Programs (TennCare DBM Programs)

Contractor	CFDA #
☒ Contractor	

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2019	$475,027.00	$475,027.00			$950,054
2020	$2,850,162.00	$2,850,162.00			$5,700,324
2021	$7,853,136.71	$17,859,086.12			$25,712,223
2022	$7,853,136.71	$17,859,086.12			$25,712,223
2023	$6,544,280.59	$14,882,571.76			$21,426,852
TOTAL:	**$25,575,743.00**	**$53,925,933.00**			**$79,501,676.00**

Contractor Ownership Characteristics:

☐ Minority Business Enterprise (MBE):

☐ African American ☐ Asian American ☐ Hispanic American ☐ Native American

☐ Woman Business Enterprise (WBE)

☐ Tennessee Service Disabled Veteran Enterprise (SDVBE)

☐ Disabled Owned Business (DSBE)

☐ Tennessee Small Business Enterprise (SBE): $10,000,000.00 averaged over a three (3) year period or employs no more than ninety-nine (99) employees.

☐ Government ☒ Non-Minority/Disadvantaged ☐ Other:

Selection Method & Process Summary (mark the correct response to confirm the associated summary)

☒ Competitive Selection	RFP 31865-00600
☐ Other	Describe the selection process used and submit a Special Contract Request

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

Speed Chart (optional)	Account Code (optional)

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE
AND
DENTAQUEST USA INSURANCE COMPANY, INC.

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Division of TennCare ("State," or "TennCare") and DentaQuest USA Insurance Company, Inc. ("Contractor"), is for the provision of statewide Dental Benefits Management (DBM) services for four (4) separate State DBM Programs, as further defined in the "SCOPE." The State and the Contractor may be referred to individually as a "Party" or collectively as the "Parties" to this Contract.

The Contractor is For-Profit Corporation
Contractor Place of Incorporation or Organization: Texas
Contractor Edison Registration ID # 222275

A. SCOPE OF SERVICES:

A.1. The Contractor shall provide all goods or services and deliverables as required, described, and detailed herein and shall meet all service and delivery timelines as specified by this Contract. Terms and Definitions relative to this Contract are located in Attachment A.

A.2. General Requirements

The State administers three (3) separate TennCare health benefit programs identified below in Sections A.2.a(1) through A.2.a(3) below which include certain managed dental benefit (DBM) services, collectively referred to herein as the "TennCare DBM Programs". The State also administers the federal Children's Health Insurance Program (CHIP) program known in Tennessee as the "CoverKids" program, which offers certain DBM services and is identified in Section A.2.b below. Each of these four (4) DBM programs (collectively referred to as the "State DBM Programs") operates on a statewide basis in Tennessee and provides benefits for its enrollees, hereinafter variously referred to as "enrollees", "members", "recipients" or "participants". The Contractor shall provide DBM services for all of the State DBM Programs as indicated below:

a. The federal Medicaid program, known as "TennCare" in Tennessee, is operated by the State pursuant to a waiver from the Centers for Medicare and Medicaid Services (CMS). Nothing in this Contract shall be deemed to be a delegation to the Contractor of the State's non-delegable duties relating to TennCare, as administered by the single state agency designated by the State and CMS, pursuant to Title XIX of the Social Security Act (42 U.S.C § 1396 *et seq*.) and the Section 1115 research and demonstration waiver granted to the State and any successor programs. The TennCare DBM Programs are categorized into the following three (3) programs based upon each program's eligible enrollees:

1. TennCare Children's DBM Program. The Contractor shall, pursuant to requirements set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols, administer covered dental benefits to approximately nine hundred thousand (900,000) eligible enrollees under age twenty-one (21) in the TennCare Program.

2. TennCare ECF CHOICES DBM Program. The Contractor shall, pursuant to requirements set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols, administer covered adult dental benefits to approximately two thousand seven hundred (2,700) eligible adults age twenty-one (21) and older who have an intellectual or developmental disability and are enrolled in the TennCare Employment and Community First (ECF) CHOICES Program.

3. TPPOHP DBM Program. Upon approval by TennCare for the new TennCare Perinatal and Postpartum Oral Health Program (TPPOHP) as set forth in Section A.3 below, the Contractor shall administer the TPPOHP DBM Program, providing outreach and limited dental benefits to approximately fifty thousand (50,000) TennCare enrollees who are pregnant women twenty-one (21) years of age and older who are eligible for enrollment in TPPOHP. The TPPOHP DBM Program is intended to raise awareness of the consequences associated with oral disease by teaching eligible enrollees:

   (a) the importance of good oral health during pregnancy;

   (b) the value of establishing good oral health habits for their babies; and

   (c) how to access covered dental services during pregnancy.

b. CoverKids DBM Program. The federal Social Security Act Title XXI Children's Health Insurance Program (CHIP), known as "CoverKids" in Tennessee, provides self-funded health plan services, including certain dental benefits, to eligible enrollees. CoverKids DBM Program eligible enrollees include approximately seventy thousand (70,000) children under age nineteen (19) enrolled in CoverKids medical coverage, hereafter to be collectively referred to as "CoverKids", with the exception of those CoverKids enrollees who are participating in HealthyTNBabies due to their pregnancy and who are not eligible for CoverKids DBM Program benefits under this Contract. The Contractor shall comply with all applicable administrative rules and CoverKids written policies and procedures, as may be amended from time to time. TennCare shall provide the Contractor with copies of such rules and policies. The State shall be the Contract holder, and the persons covered through the CoverKids program shall be enrollees, who receive the benefits set forth in a CoverKids Member Handbook (MH). When used in this Contract, the term "member" shall have the same meaning as the term "enrollee." CoverKids Enrollees are defined as:

1. Group One Child: Enrollees who are a member of a family with an income between one hundred fifty percent (150%) and two hundred fifty percent (250%) of the Federal Poverty Level (FPL) as reported by the State to the Contractor for the coverage period.

2. Group Two Child: Enrollees who are a member of a family with an income below one hundred fifty percent (150%) of FPL as reported by the State to the Contractor for the coverage period.

3. American Indian and Alaskan Native Child (AI/AN): American Indian and Alaska Native individuals (individually or collectively, "AI/AN"), as defined by the Indian Health Care Improvement Act of 1976 and certified by the State, will be exempt from all cost sharing to the extent that such children are covered by Children's

Health Insurance Plan (CHIP) as required by Federal law. This group includes enrollees who are (a) certified AI/AN, and (b) members of families with incomes less than or equal to two hundred fifty percent (250%) of the FPL, as reported by the State to the Contractor for the coverage period.

The estimated number of eligible enrollees in each of the State DBM Programs indicated above is based on current and projected enrollment numbers and shall not, for any of the State DBM Programs, be deemed by the Contractor to represent the maximum number of enrollees for whom it shall be required to provide services.

The services Contractor will be required to provide for the State DBM Programs shall include, but are not limited to, establishment and management of dental provider network(s), credentialing and contracting with providers, utilization management and utilization review, provider profiling, identification, investigation and referral of suspected fraud cases, ensuring effective dental care within a predictable budget, claims processing adjudication and payment, management of third party liability, enrollee outreach, customer service and interface, all as more particularly set forth in this Contract for each of the State DBM Programs. To the extent they do not conflict with any Contract requirements, the Contractor shall adhere to its standard administrative policies and procedures, including without limitation dental policies, claims administration procedures, provider reimbursement practices and grievance procedures, in administering its fully insured coverage. The Contractor shall use its network of dental providers (Contractor's DBM Provider Network) to meet the requirements set forth herein to provide required services to the State DBM Programs. All requirements set forth in this Contract shall apply to all four (4) of the State DBM Programs, unless specifically stated otherwise.

A.3. State DBM Programs Implementation

a. General Requirements

The Contractor shall complete all tasks, obligations and requirements of this Contract for each phase of the State DBM Program implementation, in a timely and satisfactory manner, by the dates identified in the approved project plan (Project Plan) which shall be created by the Contractor and submitted to TennCare for review and approval as specified below in Section A.3.b.1. Implementation of the State DBM Programs shall be conducted according to the approved Project Plan as a series of defined phases for each of the State DBM Programs. TennCare's current timeline for implementation of the State DBM Programs is as follows:

1. For the TennCare Children's DBM Program, the TennCare ECF CHOICES DBM Program, and TPPOHP DBM Program the Contract Start Date will be September 1, 2018 (TennCare Programs Start Date). The Contractor shall have an eight (8) month implementation period. Therefore, Contractor's services shall be fully implemented and operable on the Go-Live date for these programs, which is currently scheduled for May 1, 2019 (TennCare Programs Go-Live Date), or such later date as TennCare may specify in writing to the Contractor.

2. Contractor's implementation of services relating to the TPPOHP DBM Program shall only commence and be implemented upon approval of the TPPOHP DBM Program by TennCare. If TennCare provides written notice to the Contractor of the State's approval of the TPPOHP DBM Program within two (2) months from

the TennCare Programs Start Date, then these services shall be fully implemented and operable on the TennCare Programs Go-Live Date. However, if TennCare does not provide written notice to Contractor of the State's approval of the TPPOHP DBM Program within two (2) months from the TennCare Programs Start Date, then the start of Contractor's services relating to the TPPOHP DBM Program shall be delayed and only begin upon receipt of written notice from TennCare that it has approved the TPPOHP DBM Program. In that case, Contractor's services shall be fully implemented and operable no later than six (6) months from Contractor's receipt of written notification from TennCare (Alternative TPPOHP Program Go-Live Date) that the TPPOHP DBM Program have been approved.

3. For the CoverKids DBM Program, the Contractor shall start the implementation period on January 1, 2020 (CoverKids Program Start Date). The Contractor shall have six (6) months to implementation period for the CoverKids DBM Program. Therefore, the Contractor's services shall be fully implemented and operable on the Go-Live date for this program (CoverKids Program Go-Live), which is currently scheduled for July 1, 2020 , or such later date as TennCare may specify in writing to the Contractor.

b. Project Initiation and Requirements Definition Phase

TennCare shall conduct a series of project kick-off meetings to begin the Project Initiation and Requirements Definition Phase of this Contract. All key Contractor project staff shall attend these meeting which shall be conducted on site at TennCare offices located in Nashville, Tennessee. During these meetings, TennCare project staff shall provide access and orientation to the State DBM Programs and system documentation and TennCare technical staff shall provide an overview of the Tennessee TennCare Management Information System (MMIS) emphasizing dental claims processing and adjudication, reference files, and payment processes. In addition, other pertinent information will be provided to the Contractor and the Contractor shall develop the following documentation, for review and approval by TennCare:

1. Project Plan. The Project Plan shall be created by the Contractor and submitted to TennCare for approval within 15 calendar days after the TennCare Start Programs Date. It shall include a detailed timeline and description of all work to be performed by the Contractor and TennCare. It shall also include a proposed description of the participants in the DBM transition team and their roles and schedules of meetings between the DBM transition team and TennCare. The Project Plan may be amended from time to time by TennCare to reflect adjustments to the detailed timelines and required services as implementation of the State DBM Programs progresses.

2. Functional and Informational Requirements (FIR) Document. This document shall include detailed requirements for both internal and external interfaces and all State DBM Programs' functionalities required by the RFP for this Contract and/or contained in the Contractor's RFP proposal and/or this Contract. Eligibility interfaces with TennCare are critical and the Contractor must be in sync with the MMIS eligibility data and the CoverKids Eligibility Contractor Children's Health Administration System (CHAS). All outbound 834 files from TennCare must be

loaded to the Contractor's data base within twenty-four (24) hours of receipt from TennCare and the Eligibility contractor, including any 834 transactions that must be handled manually by the Contractor. Failure to meet this performance standard may result in Liquidated Damages.

3. Upon implementation of the new Tennessee Eligibility Determination System (TEDS), the Contractor shall be required to sync to TEDS in order to receive CoverKids eligibility. The Contractor shall sync with TEDS within sixty (60) calendar days from receipt of written notification from TennCare to do so. All outbound 834 files from the State shall be loaded to the Contractor's database within twenty-four (24) hours of receipt of these files, including any 834 transactions that are required to be handled manually by the Contractor. Failure to meet this performance standard may result in Liquidated Damages.

4. Data Dictionary. For each data field this shall indicate content, size, values, structure, edit criteria and purpose.

5. Data Mapping. This shall consist of a cross-reference map of required MMIS data and TennCare and CoverKids data elements and data structures. A separate data structure map shall be required for each transaction and interface. A data conversion plan, that includes both automated and manual activities, shall be provided for each data structure map. TennCare shall make any necessary data formats available to the Contractor.

6. The Contractor shall recommend any design modifications to the TennCare MMIS and CoverKids CHAS systems that it feels are necessary for acceptable operations of these systems. Determination of whether the recommended modifications will be made and performing any maintenance and design modifications or enhancements to MMIS and the CHAS systems shall be at the sole discretion of TennCare and TennCare shall be responsible for making any such modifications or enhancements.

c. <u>System Analysis/General Design Phase</u>

After approval by TennCare of all Contractor services and deliverables required in the Project Initiation and Requirements Definition Phase, the Contractor shall develop the General System Design Document, which shall, at a minimum include the following:

1. An Operational Impact Analysis that details the procedures and infrastructure required to enable MMIS and the Contractor's system used by dental providers to work effectively together.

2. A Detailed Conversion Plan that specifies plans for conversion of fifteen (15) months of MMIS and the previous DBM contractor/processor's claims history, prior authorization and reference data.

3. A Software Release Plan that sets forth the project's implementation into production. This document shall explain procedures for coordinating system changes that shall have an operational or information impact on TennCare Programs and CoverKids Programs operations. It shall detail how TennCare, CoverKids and/or MMIS software releases are tested and coordinated

d. Technical Design Phase

During this phase, detailed specifications shall be developed for conversion and for the interface(s) between the MMIS and the Contractor's system. The Contractor shall develop detailed plans that address, but are not limited to, back-up and recovery, information security and system testing. The Contractor shall develop the System Interface Design Overview Document, which shall be completed after the Contractor has conducted a review of all previous design documents. In addition to the System Interface Design Overview Document, the Contractor shall provide the following system plan documents which shall include all applicable services and deliverables required in this Contract:

1. Unit Test Plan that includes test data, testing process, and expected results;

2. Back-up and Recovery Plan that includes processes for daily backup and recovery of system information;

3. Final Disaster Recovery Plan;

4. Information Security Plan that includes how the Contractor shall maintain confidentiality of TennCare and CoverKids data. This document shall include a comprehensive Risk Analysis; and

5. System, Integration, and Load and Test Plan

e. Development Phase

This phase includes activities that shall lead to implementation of the State DBM Programs. The Contractor shall` develop interface and conversion programs, develop system documentation, and develop Unit Test Plans. Where manual data entry screens are required, the Contractor shall develop these screens. Testing shall be performed on all phases and programs shall be documented. System testing shall require reports to substantiate and document the testing. These reports shall include but are not limited to number of tests run, number of requirements tested, number of tests passed, number of tests failed, and number of tests retested after initial failure. The Contractor must maintain an issues log which details any testing failures and includes the resolution for those issues. During final User Acceptance Testing (UAT) with TennCare, only TennCare can approve the Contractor's issue resolutions. The Contractor shall perform testing activities that shall include the following:

1. System test to validate the appropriate adjudication of a claim which shall include a description of the test procedure, expected results, and actual results;

2. Integration testing shall test external system impacts, downstream MMIS applications, and all interfaces. It shall include a description of the test procedure, expected results, and actual results; and

3. Load and Stress testing shall include volume and efficiency to ensure that the system is able to process the volume of TennCare and CoverKids dental claims. It shall include a description of the test procedure, expected results, and actual results.

f. Implementation/Operations Phase

During this phase the Contractor and TennCare shall assess the operational readiness of all required system components. This shall result in the establishment of the operational production environment in which all TennCare and CoverKids dental claims shall be accurately and reliably processed, adjudicated and paid. TennCare shall have final approval for the elements of the operational production environment. The Contractor's Implementation/Operations Phase services shall include, but are not limited to, the following:

1. The Contractor shall develop and prepare the operations documentation of all procedures of the Contractor's performance. This shall include, but may not be limited to: automated operations, data entry operations, prior authorization operations/interfaces, check and remittance fulfillment and member notifications.

2. With the approval of TennCare, the Contractor shall develop production and report distribution schedules.

3. The Contractor shall update the operations training plan for TennCare approval. The Contractor shall schedule and conduct training and develop the training materials for TennCare and CoverKids staff, dental providers, and other identified stakeholders.

4. The Contractor and TennCare shall prepare a final conversion plan and perform final conversion activities that include procedures for testing the conversion data. The conversion plan shall include loading fifteen (15) months of claims history from the current system. The plan shall also include migrating current prior authorizations overrides with their end dates into the Contractor's system, running other conversion programs, performing manual functions, performing quality control, reporting on outcomes, and converting files in preparation for system operation.

g. Readiness Review

The State may conduct an on-site review to assess the readiness of the Contractor to effectively administer and provide the services as defined in this Contract. The Contractor shall complete all implementation actions prior to the TennCare Programs Go-Live date and the CoverKids Program Go-Live date, respectively, and the Alternative TPPOHP Program Go-Live Date , if applicable, and according to the implementation timeline provided by the Contractor and approved by TennCare. The Contractor shall receive TennCare's sign-off that each action has been completed successfully. Implementation action steps shall include, at a minimum, the following items:

1. Benefit plan designs loaded, operable and tested;

2. Perform comprehensive systems testing (including interface testing with all third parties) and quality assurance audits, with results reported to the TennCare prior to the TennCare Programs Go-Live and the CoverKids Program Go-Live dates, respectively, and the Alternative TPPOHP Program Go-Live Date , if applicable;

3. Eligibility feed formats loaded and tested end to end;

4. Operable and tested toll-free numbers;

5. Account management, Help Desk and Prior Authorization staff hired and trained;

6. Established billing/banking requirements;

7. Complete notifications to the outgoing State DBM contractor's dental providers regarding the upcoming change of State DBM contractor;

8. Each component shall be completed by an agreed upon deadline, in an implementation timeline provided by Contractor and approved by TennCare. Implementation action requirements may include other items necessary to meet the claims processing commencement date of May 1, 2019 for the TennCare DBM Programs and July 1, 2020 for the CoverKids DBM Program; and

9. Claims history and existing prior authorizations and overrides from the outgoing State DBM contractor shall be successfully migrated into the Contractor's system.

10. Satisfactory Completion of the requirements of Contract Section A.100.

11. No less than sixty (60) days prior to the TennCare Programs Go-Live, as defined in Contract Section A.3.a, the Contractor must be prepared to receive and load a mass 834 file for the base TennCare member population with future eligibility begin dates.

12. After delivery from the State of the base line TennCare member population, the Contractor must be prepared to receive and load daily 834 files which will contain new members and changes as applicable for the base line population with future eligibility begin dates.

13. No less than thirty (30) days prior to the TennCare Programs Go-Live date, the Contractor must be prepared to submit HIPAA complaint X12 837D encounter files to TennCare.

h. TennCare ECF CHOICES DBM Program Readiness Review

The Contractor shall participate in a readiness review prior to the implementation of the Contractor's management of dental benefits in the TennCare ECF CHOICES DBM Program, in addition to any other readiness requirements under Section A.3.g of this Contract. This readiness review specific to the TennCare ECF CHOICES DBM Program will be conducted during a timeframe determined by TennCare, and will include, at a minimum, development of the Contractor's TennCare ECF CHOICES DBM Program Participating Dental Provider network, requirements to develop and amend policies, procedures, and other documents related to this Contract for TennCare review and approval and demonstration of systems readiness to meet the requirements of this Contract for TennCare's review and approval.

A.4. Services

The Contractor shall administer the dental benefit for the TennCare Children's DBM Program, TennCare ECF Choices DBM Program, TPPOHP DBM Program, and CoverKids DBM Program as specified in this Contract. The Contractor shall make maximum efforts to ensure minimum

disruption in service to enrollees and a smooth interface of any claims processing or system changes to transfer necessary information without material disruption during implementation of the Contract requirements and shall manage the State DBM Programs in a manner that ensures an adequate network(s) of qualified dental providers for whom the Contractor is responsible. These providers shall render high quality, medically necessary, cost effective dental care. Furthermore, the Contractor shall exercise every available means, including but not limited to, its provider agreements, office reference manuals and Contractor's policies and procedures, to ensure that the State DBM Programs are managed in this manner.

A.5. State DBM Programs Benefit Packages

The Contractor shall be responsible for ensuring that benefits are provided to eligible enrollees in accordance with TennCare rules, court orders and other applicable law for each of the State DBM Programs covered by this Contract.

a. TennCare Children's DBM Program.

The Contractor shall be responsible for ensuring that the following benefits are provided to eligible enrollees in the TennCare Children's DBM Program in accordance with federal requirements, TennCare rules, court orders and other applicable law:

1. Preventive, diagnostic and treatment services conferred on behalf of children under age twenty-one (21) - Any limitations described in this Contract shall be exceeded to the extent necessary to be in compliance with applicable court orders relating to Early, Periodic Screening, Diagnostic and Treatment (EPSDT) requirements. By amendment to this Contract, TennCare may at any time alter the covered benefits for the TennCare Standard enrollees under age twenty-one (21).

2. Orthodontics – In order for orthodontic services to be covered, all orthodontic services must be prior authorized by the Contractor and must be determined to be medically necessary in accordance with TennCare rules. Orthodontic services are only covered for individuals under age twenty-one (21) as medically necessary to treat a handicapping malocclusion. The Contractor's dental providers shall furnish all records required by then current TennCare Rules to validate a handicapping malocclusion, which may include but are not limited to: dental records from the treating dentist, orthodontic records and treatment plan, radiographs of impacted teeth, OrthoCAD, or study casts or photographs of study models and/or photographs of intraoral tissue lacerations, the orthodontic readiness form, and medical records from the primary care physician. Pediatrics growth data or similar information required by then current TennCare Rules shall be required for orthodontic appeals related to nutritional deficiency and speech/language records shall be provided for orthodontic appeals related to speech pathology. TennCare reimbursement for orthodontic services begun before age twenty-one (21) will end on the individual's 21st birthday. Orthodontic treatment shall not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for TennCare and the services are determined to be medically necessary in accordance with TennCare Rules.

3. Age twenty-one (21) and Older - When the Contractor denies a claim or prior authorization request submitted by or on behalf of an individual over age twenty-one (21), despite the fact that the individual's age may render him/her ineligible for TennCare benefits, the Contractor nonetheless agrees to render such denial in writing and in accordance with the appeals process set forth in Grievances and Appeals, Sections A.116 – A.132 of this Contract.

4. Non-Traditional Fluoride Varnish and Dental Screening Program - The Contractor shall implement a program that would allow non-traditional providers (such as Primary Care Physicians, Pediatricians, Physician Assistants, Nurse Practitioners and Public Health Nurses) to conduct dental screenings and apply fluoride varnish to the teeth of TennCare enrollees six (6) months through five (5) years of age. Non-traditional providers will be reimbursed for such services within the age range of six (6) months through five (5) years only if fluoride varnish application and dental screening are also conducted at the same visit. The Contractor shall be responsible for non-traditional provider network development, including provider credentialing, provider billing, provider reimbursement, provider training and applicable reporting to TennCare. Non-traditional providers shall submit current dental terminology (CDT) procedure codes D1206 (for fluoride varnish) and D0190 (for a dental screening) directly to the Contractor utilizing a standard ADA claim form. Non-traditional providers will be reimbursed using maximum allowable rates of $20.50 per fluoride varnish application and $12.00 for a dental screening. Each enrollee is permitted two (2) such visits per year. The Contractor shall have this program operational within three (3) months of TennCare Programs Go-Live date but no later than May 1, 2019, or be subjected to damages under the liquidated damages provisions in Attachment B. The Contractor shall manage the encounter data files for TennCare enrollees receiving fluoride varnish and dental screenings by non-traditional providers in accordance with the specifications, format and timeframes outlined by the TennCare.

b <u>TennCare ECF Choices DBM Program</u>

1. The Contractor shall, pursuant to requirements set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols, administer covered adult dental benefits to eligible adults age twenty-one (21) and older who have an intellectual or developmental disability and are enrolled in the TennCare ECF CHOICES DBM Program. This includes all applicable requirements set forth in this Contract unless specifically identified as non-applicable to the TennCare ECF CHOICES PBM Program in Section A.5.b.13.

2. A Member enrolled in TennCare ECF CHOICES DBM Program shall receive covered dental services only as specified in the Member's approved Person Centered Support Plan ("PCSP"). The Contractor shall provide only the following covered dental benefits in the TennCare ECF CHOICES DBM Program:

   (a) Adult dental services as provided under the State's Section 1915(c) waivers for individuals with intellectual disabilities, which include specific preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments as medically

necessary to relieve pain and infection, as well as adjunctive sedation services, which may include medically necessary and appropriate deep sedation or general anesthesia, provided in the dentist's office by and billed by the dentist.

(b) Such services will be reimbursed in accordance with the maximum reimbursement rate listed in the TennCare ECF CHOICES DBM Program Dental Fee Schedule which shall be provided by TennCare. Orthodontic services are excluded from coverage in the TennCare ECF CHOICES DBM Program.

3. All Covered Services for children under age 21 enrolled in the TennCare ECF CHOICES DBM Program are provided through the TennCare EPSDT program as provided in Contract Sections A.4 and A.5. Therefore, dental services shall not be covered under the TennCare ECF CHOICES DBM Program for children under age 21 years, since it would duplicate TennCare EPSDT benefits.

4. Covered Services for eligible adults age 21 and older in the TennCare ECF CHOICES DBM Program shall be limited to a maximum of $5,000 per member per calendar year, and a maximum of $7,500 per member across three (3) consecutive calendar years. A Member's Managed Care Organization (MCO) may elect, at its sole discretion, to exceed these limits as a Cost-Effective Alternative Service, when the provision of such additional dental services would be medically appropriate and offer a more Cost-Effective Alternative Service to other covered services the Member would otherwise require.

5. Adult dental services in the TennCare ECF CHOICES DBM Program shall be provided only as specified in the member's PCSP. The MCO shall be responsible for ensuring that the amount approved for dental services in the PCSP does not exceed the limitations specified in Contract Section A.5.b.4, except when the MCO elects to exceed such limit as a Cost-Effective Alternative Service. Upon inclusion of dental services in an ECF CHOICES member's PCSP, the Contractor shall work with the Member's MCO support coordinator to assist the Member in selecting a contracted TennCare ECF CHOICES DBM Program Participating Dental Provider. A copy of the PCSP or relevant portions of the PCSP, as determined by TennCare, shall be provided to the TennCare ECF CHOICES DBM Program Participating Dental Provider by the Member's MCO pursuant to a process approved by TennCare.

6. Coordination of TennCare ECF CHOICES DBM Program dental benefits between the Contractor and members' MCOs shall be conducted in accordance with this Contract and any protocols and procedures developed by TennCare.

7. Upon selection of an TennCare ECF CHOICES DBM Program Participating Dental Provider and subject to the amount approved for dental services in the member's PCSP, each TennCare ECF CHOICES DBM Program member shall undergo a thorough dental evaluation prior to receiving Covered Services, unless the Member has had such an evaluation in the ninety (90) days prior to such service request. The results of that evaluation will be a proposed treatment plan

that will include both short-term dental needs (i.e. cavities detected during the exam to be filled) and long-term dental services (i.e. cleaning every six months), which shall be incorporated into the Member's PCSP, as determined by the Member or his/her authorized representative. Notwithstanding the proposed treatment plan developed by the TennCare ECF CHOICES DBM Program Participating Dental Provider, the total cost of dental services that may be authorized are subject to the amount approved for dental services in the member's PCSP.

8. TennCare ECF CHOICES DBM Program Participating Dental Providers may perform any Medically Necessary Covered Services determined to be needed after the dental evaluation referenced in Section A.5.b.7 above (or if an evaluation is not required, refer to A.5.b.7.) even if the treatment plan has not yet been incorporated into the PCSP, unless such service is of a type that requires prior authorization under this Contract, subject to the amount authorized for dental services in the member's PCSP. If the total cost of services proposed in the treatment plan exceed the amount authorized for dental services in the member's PCSP, the Participating Dental Provider shall not proceed to perform such services, except as specifically approved by the member or his/her authorized representative, and with full disclosure that other services proposed in the treatment plan will not be provided based on the current amount approved for dental services in the member's PCSP.

9. The Contractor shall not authorize nor reimburse dental services for ECF CHOICES members that are not covered under the TennCare ECF CHOICES DBM Program, except for dental services approved by a Member's MCO as a Cost-Effective Alternative Service. The Contractor shall track dental expenditures for each ECF CHOICES member and shall not authorize nor reimburse dental services for an ECF CHOICES member that exceed the amount approved for such services in the member's PCSP. Upon request, the Contractor shall also make available to TennCare ECF CHOICES DBM Program Participating Dental Providers the total dental expenditures that have been authorized and reimbursed for each ECF CHOICES Member served by any other TennCare ECF CHOICES DBM Program Participating Dental Providers in order to ensure that dental services are not provided to the member in excess of the amount approved for such services in the member's PCSP. Any authorization and reimbursement of dental services for TennCare ECF CHOICES DBM Program members that exceed the amount approved for such services in a Member's PCSP may subject the Contractor to liquidated damages pursuant to Attachment B.

10. The Contractor shall be responsible for the submission of encounter data to TennCare regarding Covered Services provided under the Contract and the TennCare ECF CHOICES DBM Program, including Covered Services authorized by a member's MCO as a Cost-Effective Alternative Service.

11. The Contractor shall only contract with dentists and dental providers who have completed TennCare's electronic provider registration process, have been issued

a current valid Medicaid Provider number, and been placed in an eligible pool of providers which the Contractor can select from. All decisions regarding the Contractor's provider network, including but not limited to, which providers are permitted to participate in the Contractor's provider network, are the sole responsibility of the Contractor and made by the Contractor in its sole discretion.

12. TennCare shall deliver the most current version of the TennCare ECF CHOICES DBM Program Dental Fee Schedule referenced in section A.5.b.2(b) to the Contractor in writing promptly upon (and in no event more than three (3) business days following) its approval for use. This fee schedule is updated annually to reflect any additions, deletions and modifications made to the Code on Dental Procedures and Nomenclature /Current Dental Terminology (CDT) as published by the American Dental Association. The revised fee schedule becomes effective each January.

13. Requirements set forth in this Contract pertaining to TennCare dental benefits for children under age twenty one (21) that are not applicable to the Contractor's administration of dental benefits in the TennCare ECF CHOICES DBM Program are set forth in Contract Sections A.9, A.10.d, A.44, A.45, A.47, A.50, A.51, A.60, A.61, A.106, A.110, A.113, A.114, A.115, and A.164.

c. TPPOHP DBM Program Benefits

1. The Contractor shall provide enrollees in the TPPOHP DBM Program the following benefits from the date it receives notification of the TPPOHP DBM Program member's diagnosis of pregnancy until two (2) months postpartum. Covered benefits include the following services:

   (a) Diagnostic

   (b) Preventive – Fluoride treatments, Silver Diamine Fluoride (SDF), and teeth cleaning

   (c) Restorative – Fillings

   (d) Periodontal – Scaling and Deep Cleaning

   (e) Oral Surgery – Extractions (simple, surgical, and soft tissue impacted), as well as

   (f) Adjunctive General Services – Emergency relief of pain and nitrous oxide analgesia.

2. Applicable current dental terminology codes for the TPPOHP DBM Program include:

D0000's Codes Diagnostic	D1000's Codes Preventive	D2000's Codes Restorative	D4000's Codes Periodontal	D7000's Codes Oral Surgery	D9000's Codes Adjunctive

					General Services
D0120	D1110	D2140	D4341	D7140	D9110
D0140	D1206	D2150	D4342	D7210	D9230
D0150	D1208	D2160	D4355	D7220	
D0160	D1354	D2161		D7250	
D0220		D2330			
D0230		D2331			
D0270		D2332			
D0272		D2335			
D0273		D2391			
D0274		D2392			
D0330		D2393			
		D2394			
		D2920			
		D2931			

3. Once the Contractor is notified of the pregnancy status of a TPPOHP DBM Program enrollee, it shall establish a dental home for the enrollee and notify the enrollee in writing about their dental home. The Contractor shall send dental home contact information to the enrollee and information regarding how to access benefits and the resources available in the TPPOHP DBM Program. The Contractor shall also facilitate setting up dental appointments between the enrollee and their dental home dentist(s), including but not limited to scheduling appointments and contacting the dentist on behalf of the enrollee..

4. The Contractor shall provide education and outreach to TPPOHP DBM Program enrollees, including but not limited to, mailings that include the following two brochures, as approved by the State: *A Pregnant Women's Guide to Healthy Gums* and *A Guide to Your Young Child's Oral Health*. The Contractor shall also send enrollees a reminder notice to schedule an appointment with their dental home, as well as provide additional call and digital strategies as options for supplemental outreach to increase access and utilization.

5. The Contractor shall mail letters, as approved by the State, to participating TennCare dentists and physicians that describe the TPPOHP DBM Program objectives and the importance of screening pregnant women for oral health. The

dentist packets shall include research links to articles on the oral health of mothers in relationship with babies, as well as a copy of the TPPOHP DBM Program welcome materials for new TPPOHP DBM Program members.

d. CoverKids DBM Program Benefits.

The Contractor shall be responsible for ensuring that the benefits itemized below in the CoverKids DBM Program Dental Service Category table are provided for CoverKids enrollees under age nineteen (19).

CoverKids DBM Program Dental Service Category

DENTAL BENEFITS	GROUP ONE CHILD	GROUP TWO CHILD	AMERICAN INDIAN/ ALASKAN NATIVE (AI/AN) CHILD
Preventive -- Fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a calendar year up to age 14 -- Dental sealants for permanent molars, no limit -- 2 cleanings per calendar year -- Silver Diamine Fluoride (SDF) four applications per tooth per lifetime	No copayment	No copayment	No copayment
Diagnostic Services -- 2 oral exams per calendar year	No copayment	No copayment	No copayment
Emergency Services -- 2 visits per calendar year during office hours -- 2 visits per calendar year after office hours	$15 copayment	$5 copayment	No copayment
Restorative Services -- Stainless steel crowns -- Routine fillings (silver or tooth colored)	$15 copayment	$5 copayment	No copayment
Extractions	$15 copayment	$5 copayment	No copayment
Radiographs -- Bitewing x-rays no more	No copayment	No copayment	No copayment

frequently than once per calendar year (2 years of age and older -- Full mouth x-rays no more frequently than once every three calendar years			
Therapeutic Pulpotomy	$15 copayment	$5 copayment	No copayment
Anesthesia	$15 copayment	$5 copayment	No copayment
Other Dental Services	$15 copayment	$5 copayment	No copayment
Orthodontics Services • **12-month waiting period***	$15 copayment	$5 copayment	No copayment
Deductibles	None	None	None
Annual Benefit Maximum per child	$1,000	$1,000	$1,000
Lifetime Orthodontics Maximum amount person**	$1250	$1250	$1250
Annual Out of Pocket Maximum as a Percentage (%) of Family Income per calendar year	5%	5%	Not applicable

Note: The copayments indicated above are the maximum amounts allowable per visit. No more than one (1) copayment shall be charged for a single visit.

* Children enrolled in the CoverKids DBM Program are required to have twelve (12) months of continuous coverage before they can obtain CoverKids DBM Program orthodontic benefits.

** The Lifetime Orthodontics Maximum limit is not applicable to the family's five percent (5%) cost sharing.

1. The benefit shall not exceed one thousand dollars ($1,000) per child per calendar year. For the purpose of the annual maximum, the time period shall be the twelve (12) months of the calendar year beginning with the child's original effective date of coverage (beginning of a month). Calendar year 2020 will begin no later than January 1, 2020 and extend to December 31, 2020.

2. Notwithstanding the benefit cap of one thousand dollars ($1,000) per child, the Contractor shall, at a minimum, provide to each enrollee the services required by the CoverKids DBM Program basic dental package detailed below.

COVERKIDS DBM PROGRAM DENTAL SERVICE CATEGORY Provided during a calendar year without consideration of the benefit cap of $1,000		
Type of Dental Service	**Frequency during a calendar year**	**Service by Dental Code**
Preventive	No less than one (1) service	D1120
Diagnostic Services	No less than one (1) service	D0120 D0150
Emergency Services	No less than two (2) services	D9110 D9440
Restorative Services	No less than two (2)services	D2140 D2150 D2160 D2330 D2331
Extractions	No less than two (2) services	D7140 D7210 D7250
Radiographs	No less than one (1) service	D0210 D0220 D0230 D0270 D0272
Anesthesia	Whenever medically indicated	D9230 D9248
Orthodontics	12 month waiting period	D8020 D8050 D8060 D8070 D8080 D8090 D8210 D8220 D8660 D8670 D8680

COVERKIDS DBM PROGRAM DENTAL SERVICE CATEGORY Provided during a calendar year without consideration of the benefit cap of $1,000		
Type of Dental Service	**Frequency during a calendar year**	**Service by Dental Code**
		D8690 D8692 D8999

3. The complete list of CoverKids DBM Program dental service categories by CDT Codes, subject to medical necessity determination by the Contractor, is located in Contract Attachment D, Dental Service Categories by Dental CDT Codes.

4. The Contractor shall maintain a year to date calculation of all copayments required from CoverKids enrollees. The Contractor shall also maintain, in its enrollment database, an indicator which identifies enrollees that are subject to the application of the five percent (5%) out of pocket cap during any specific calendar year. This five percent (5%) out of pocket maximum is accumulated across all benefits (medical, vision, and dental). The Contractor shall coordinate with the MCO in order to calculate the accumulated out of pocket maximum.

5. In instances where an enrollee is no longer required to pay a copayment for a service because the enrollee has met the five percent (5%) out of pocket cap through medical, dental or a combination of these, the Contractor shall pay the provider the full allowable amount. In these cases, the Contractor shall apply the allowable amount less the applicable copayment to the $1,000 payment cap.

A.6. TennCare DBM Programs Enrollee Cost Share Responsibilities

The Contractor and its providers and subcontractors shall not require any cost sharing responsibilities of enrollees for covered services, except to the extent that cost sharing responsibilities are required for those services in the various TennCare DBM Programs and in accordance with applicable rules and regulations or approved policies and procedures. The Contractor and its providers and subcontractors shall not charge enrollees for missed appointments. Enrollees shall not be held liable for payments in the event of the Contractor's insolvency, or in the event the State does not pay the Contractor, or the Contractor does not pay its provider.

a. TennCare Children's DBM Program

1. Enrollee Cost Share Responsibilities. The Contractor and its providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TennCare in accordance with TennCare rules and regulations

or TennCare approved policies and procedures for TennCare enrollees, nor may the Contractor and its providers and subcontractors charge enrollees for missed appointments. Enrollees may not be held liable for payments in the event of the Contractor's insolvency- or in the event the State does not pay the Contractor, or the Contractor does not pay its provider.

Cost sharing responsibilities shall apply to services for children under age twenty one (21) years of age enrolled in TennCare Standard per TennCare Rule 1200-13-14-.05 other than the preventive services described in Section A.4 and specified in the table below. Co-payments shall be applied on a sliding scale according to the enrollee's income. The procedure code listing for preventive services is as follows:

TennCare Standard Preventive Dental Services for Children Under 21 Years of Age

D1110	Prophylaxis –adult (when billed for children over age 13 and under age 21)
D1120	Prophylaxis child
D1206	Topical Fluoride Varnish
D1208	Topical Application of Fluoride
D1310	Nutritional Counseling for Control of Dental Disease
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease
D1330	Oral Hygiene Instructions
D1351	Sealant per tooth
D1352	Preventive Resin Restoration
D1353	Sealant Repair – Per Tooth
D1354	Interim Caries Arresting Medicament Application/ Silver Diamine Fluoride

2. The current sliding scale schedule to be used in determining applicable cost sharing responsibilities for TennCare Standard enrollees under age twenty one (21) years of age is described in the following chart:

Co-Pay	**0 to 100% of Poverty**	**101-199% of Poverty**	**200% and Above Poverty**
Dental visits	0	$5 per visit	$20 per visit

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

(b) The Contractor shall be expressly prohibited from waiving or using any alternative cost sharing schedules, unless required and approved in writing by TennCare. Further, the Contractor shall not discourage enrollees from paying applicable co-payment obligations. If, and at such time as changes occur to the cost sharing rules, the Contractor will be notified of new co-payment rates.

(c) The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service. A provider or a collection agency acting on the provider's behalf shall not bill the enrollee for more than the allowable copay. If the Contractor discovers that the enrollee is being inappropriately billed, it shall notify the provider or collection agency to cease and desist billing immediately. After notification by the Contractor, if a provider continues to bill an enrollee, the Contractor shall refer the provider to the Tennessee Bureau of Investigations (TBI).

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

(a) If the services are not covered by TennCare and the provider informed the enrollee the services were not covered prior to providing the service. This shall include any services provided to a member who is an ECF CHOICES member ("ECF CHOICES Member") that exceed the amount approved in the ECF CHOICES Member's PCSP. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service; or

(b) If the person'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; or

(c) If the person's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable cost share amounts shall be refunded when a claim is submitted to the Contractor if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. In this case, the monies collected

shall be refunded by the provider as soon as a claim is submitted and shall not be held conditionally upon payment of the claim.

4. Dental services in the TennCare ECF CHOICES DBM Program shall be reimbursed only when the TennCare ECF CHOICES DBM Program member was enrolled in the TennCare ECF CHOICES DBM Program at the time the service was delivered, and subject to the amount approved for such services in the ECF CHOICES Member's PCSP. The procedure codes listing for TennCare ECF CHOICES DBM Program preventive services are as follows:

Preventive Services – TennCare ECF CHOICES DBM Program

D1110	Prophylaxis –adult
D1206	Topical Fluoride Varnish
D1208	Topical Application of Fluoride
D1352	Preventive Resin Restoration
D1354	Interim Caries Arresting Medicament Application/ Silver Diamine Fluoride

b. TennCare ECF CHOICES DBM Program Cost Sharing

The Contractor is not responsible for administering any cost share responsibilities for dental services in the TennCare ECF CHOICES DBM Program. Collection of any Patient Liability amounts due from an ECF CHOICES Member pursuant to federal post-eligibility provisions shall be the responsibility of the member's MCO.

c. TPPOHP DBM Program Cost Sharing

The Contractor is not responsible for administering any cost share responsibilities for the TPPOHP DBM Program. Collection of any Patient Liability amounts due from a TPPOHP DBM Program member pursuant to federal post-eligibility provisions shall be the responsibility of the member's MCO.

d. CoverKids DBM Program Cost Sharing.

1. Contract Sections A.6.d.1 through A.6.d.4 shall only apply to enrollees in the CoverKids DBM Program. The Contractor shall report cost sharing requirements, based upon claims filed by providers, to the Medical Plan Administrator on a daily basis. The Medical Plan Administrator provides comprehensive health coverage to CoverKids members. The information, which shall include patient name, date of service and patient copayment/coinsurance, shall be transmitted to the Medical Plan Administrator in an encrypted, secure electronic file via that data transfer method specified in advance by the State. The Medical Plan Administrator shall report to the Contractor on a daily basis the information on CoverKids enrollees who have met or exceeded the five percent (5%) out of pocket maximum. The Medical Plan Administrator and the Contractor shall enter

into a business associates agreement, as required by the federal Health Insurance Portability and Accountability Act.

2. When advised by the Medical Plan Administrator that the CoverKids enrollee has reached or exceeded the out of pocket maximum, the Contractor shall provide information through written correspondence to the CoverKids enrollee advising him/her that for the balance of the plan year he/she will no longer be required to pay copayments/coinsurance for covered CoverKids DBM Program dental expenses. The Contractor shall not have responsibility for the reimbursement to the family when the five percent (5%) out of pocket maximum has been met. In situations where the CoverKids enrollee's family has exceeded the five percent (5%) out of pocket maximum, the Medical Plan Administrator and the Contractor shall be responsible for notifying the providers of the provider's responsibility to reimburse the family.

3. The Contractor shall maintain a process, through a service center, that enables providers to verify that the CoverKids DBM Program enrollee has reached or exceeded their annual out of pocket maximum.

4. Network providers and collection agencies acting on the provider's behalf may not bill enrollees for any amounts other than the applicable cost sharing responsibilities applicable to the CoverKids DBM Program. Providers may seek payment from an enrollee in the following situation: If the service(s) is not covered by the CoverKids DBM Program, the provider shall inform the enrollee that the service(s) is not covered prior to providing the service. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge receipt of this information. If the enrollee still requests the non-covered service, the provider shall obtain such acknowledgment in writing prior to rendering the non-covered service. The provider may bill the enrollee the total amount specified in the provider participation agreement. Non-covered services will not apply to any service or benefit maximum accumulators. Where the enrollee is a minor, the provider shall not provide any non-covered service without first advising the enrollee's parent or guardian in writing that the service is not covered and obtaining a written acknowledgement signed by the enrollee's parent or guardian.

A.7. Adherence to Program Rules and Regulations

The Contractor shall perform all services under this Contract and shall comply with all applicable administrative rules, written policies, protocols and procedures, that pertain to the individual State DBM Programs, and as they may be amended from time to time. It is the responsibility of the Contractor to keep up to date on enacted rules and State DBM Programs' policies, protocols and procedures.

A.8. Corrective Action Plans

A corrective action plan (CAP) is a plan to correct Contractor's noncompliance with the Contract that the Contractor prepares at TennCare's request and submits to TennCare for review and approval. A CAP can be requested by TennCare at any time and it is a requirement of this Contract that Contractor respond timely to the CAP request and take all CAP actions that have been approved by TennCare. Failure to comply with a CAP request or an approved CAP may

result in Liquidated Damages as set forth on Attachment B. The CAP process includes the following:

a. Notice of Deficiency: If TennCare determines that the Contractor or Contractor's subcontractor or provider is not in compliance with a requirement of this Contract, TennCare will issue a notice of deficiency identifying the deficiency and request a CAP detailing how the Contactor intends to correct the deficiency. The Notice of Deficiency will also contain the deadline for the proposed CAP to be forwarded to TennCare for approval and may also contain recommendations or requirements the Contractor must include or address in the CAP.

b. Proposed CAP: Upon receipt of a Notice of Deficiency, the Contractor shall prepare a proposed CAP and submit it to TennCare for approval within the time frame specified by TennCare. The proposed CAP shall comply with all recommendations and requirements of the Notice of Deficiency and contain a proposed time by which the noncompliance will be corrected.

c. CAP Approval and Implementation: TennCare will review the proposed CAP and work with the Contactor to revise it as needed. Once approved, the Contractor shall be responsible for ensuring that all actions and documentation required by the CAP are completed in compliance with the Contract and CAP, to TennCare's satisfaction.

d. Notice of Completed CAP: Upon satisfactory completion of the implemented CAP, TennCare shall provide written notice to the Contractor. Until written approval is received by the Contractor, the approved CAP shall be deemed to not have been satisfactorily completed.

A.9. Provider Performance Measures

As directed by TennCare, the Contractor may be required to create a provider ranking process measuring Provider performance for one or more selected performance measures, for one (1) or all of the State DBM Programs. These rankings shall be shared with providers who fall below the mean, and the Contractor's role shall be to encourage such providers through education and behavior modification to improve their ranking.

ENROLLEE MATERIALS

A.10. Enrollee Materials Requirements

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

a. Member Handbook

1. The Contractor shall develop a member handbook based on a template provided by TennCare and update its member handbook when major changes occur within the State DBM Programs, with the Contractor or upon request by TennCare. The member handbooks shall contain the actual date it was printed either on the handbook or on the first page within the handbook. Member handbooks must be distributed to enrollee within thirty (30) days of receipt of notice of enrollment in a State DBM Program. In situations where there is more than one (1) enrollee in a TennCare case, it shall be acceptable for the Contractor to mail one (1) member handbook to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to the enrollee. If an individual is enrolled and added into an existing case, a new or updated member handbook must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to another enrollee in the existing case.

2. Upon notice by TennCare of State DBM Program benefit changes, the Contractor shall make the appropriate revisions to the member handbook. For the TennCare Children's DBM Program, two (2) separate versions of the Contractor's TennCare Member Handbook are necessary for the specific population being serviced for the purpose of describing Medicaid Benefits to the TennCare populations and Standard benefits to the Medicaid Standard population. The Contractor shall also draft separate Member Handbooks for each of the TennCare DBM Programs. The Contractor shall not disseminate the member handbook until all revisions are approved by TennCare prior to dissemination.

3. Once materials are approved by TennCare, the Contractor shall submit an electronic version (pdf) of the final product, unless otherwise specified by TennCare, within thirty (30) calendar days from the print date. If the print date exceeds thirty (30) calendar days from the date of approval, the Contractor shall submit a written notification to the TennCare Member Materials Coordinator to specify a print date. Should TennCare request original prints be submitted in hard copy, photo copies may not be submitted as a final product. Upon request, the Contractor shall provide additional original prints of the final product to TennCare. When large distributions of the member handbook occur, the Contractor must submit to TennCare the date the information was mailed to the enrollees along with an invoice or a specific document to indicate the date and volume of handbooks mailed. Each member handbook shall, at a minimum, be in accordance with the following guidelines:

   (a) Must be in accordance with all applicable requirements as described in this contract.

   (b) Shall include a table of contents;

   (c) Shall include an explanation on how enrollees will be notified of member specific information such as effective date of enrollment.

(d) Shall include a description of services provided including limitations, exclusions and out-of-plan use;

(e) Shall include a description of applicable cost share responsibilities for eligible individuals including an explanation that providers and/or the DBM may utilize whatever legal actions that are available to collect these amounts;

(f) Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to providers outside of the plan. The handbook should advise enrollees 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;

(g) Shall explain that prior authorization is required for some services, including non-emergency services provided by a non-contract provider, that such services will be covered and reimbursed only if such prior authorization/service authorization is received before the service is provided; that all prior authorizations/service authorizations are null and void upon expiration of a member's TennCare eligibility; and that the member shall be responsible for payment for any services provided after the member's eligibility has expired;

(h) Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the Contractor's service area;

(i) Shall include grievance/appeal procedures as described in Sections A.116 through A.132 of the Contract;

(j) Shall include written policies on enrollee rights and responsibilities as described in Section A.144;

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

(l) Shall include notice to the member that it is the member's responsibility to notify the Contractor, TennCare, and DHS (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify DHS (or for SSI eligibles, SSA) could result in the member not receiving important eligibility and/or benefit information;

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

contact the plan or CoverKids regarding questions about CoverKids. The CoverKids Call Center number is 1-866-620-8864;

(n) Shall include information that the enrollee has a right to receive services without being treated in a different way because of race, color, national origin, language, sex, age, religion, or disability and that they have a right to file a complaint. Information shall also be provided on how to obtain communication assistance services, such as, auxiliary aids or services and how to access language interpretation and translation services as well as a statement that these services are free. .;

(o) Shall include information educating enrollees of their rights and necessary steps to amend their data in accordance with HIPAA regulations;

(p) Shall include other information on requirements for accessing services to which they are entitled under the contract including, but not limited to, factors such as physical access and non-English languages spoken as required in 42 § CFR 438.10;

(q) Shall include a copy of TennCare's discrimination complaint forms;

(r) Shall include information about preventive services; and

(s) Shall include information about the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and how to access component services.

b. Member Newsletter

The Contractor shall, at a minimum, distribute on a quarterly basis a newsletter to all State DBM Program enrollees which is intended to educate the enrollee about the managed care system, proper utilization of services, and encourage utilization of preventive care services.

1 The Contractor shall include the following information, in each newsletter:

(a) Specific articles or other specific information as described when requested by TennCare. Such requests by TennCare shall be limited to two hundred (200) words and shall include sufficient notification of information to be included;

(b) The TennCare taglines and nondiscrimination notice, which includes the procedures on how to obtain auxiliary aids or services in order to achieve effective communication and how to access language interpretation and translation services which will include a statement that these services are free. This information shall comply with the Contract requirements set forth in A.13 and at a minimum be available in the English and Spanish newsletters ; and

(c) The TennCare taglines, nondiscrimination notice, and any other TennCare information on how individuals with disabilities can request assistance with accessing services or other program benefits. This information shall comply with the Contract requirements set forth in A.13 and at a minimum be available in the English and Spanish newsletters.

2. The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the Contractor shall also submit to TennCare, five (5) final printed originals, unless otherwise specified by TennCare, of the newsletters and documentation from the DBM's mail room or outside vendor indicating the quantity and date mailed to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in this Contract.

3. The Contractor shall also include in the newsletter notice to the enrollee 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 and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, , Title IX of the Education Amendments of 1972, and 42 U.S.C.A. § 18116 and a Contractor contact phone number for doing so. The notice shall be in the English and Spanish newsletters.

c. Provider Directory

The Contractor shall be responsible for providing information on how to access the provider directory, including the right to request a hard copy, how to contact member services, and how to access the searchable version of the provider directory on the Contractor's website to new enrollees within thirty (30) calendar days of receipt of notification of enrollment in the plan. The Contractor shall also be responsible for redistribution of updated provider information on a regular basis and shall make available a complete and updated provider directory at least on an annual basis.

1. The provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network providers, and identification of providers accepting new patients.

2. Enrollee provider directories, and any revisions thereto, shall be submitted to TennCare for approval prior to distribution to enrollees. The text of the directory shall be in Microsoft Word or Adobe (pdf) format. In addition, the provider information used to populate the enrollee provider directory shall be submitted as a TXT file or such format as otherwise approved by TennCare and be produced using the same extract process as the actual enrollee provider directory.

3. In situations where there is more than one (1) enrollee in a TennCare case, it shall be acceptable for the Contractor to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than

one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.

4 The Contractor shall provide a Provider Listing specific to each TennCare DBM Program, which shall include a breakdown by specialist. However, all provider directories shall be approved by TennCare prior to the Contractor's distribution.

d. Dental Notices The Contractor shall be responsible for distributing dental appointment notices annually to the head of household for all TennCare enrollees who have not had a dental service within the past year.

A.11. Permissible Communication Activities

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

a. Distribution of general information through mass media;

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

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

A.12. Prohibited Communication Activities

The following information and activities are prohibited. Failure to comply with prohibited communication activities provisions may result in the imposition by TennCare of one or more Liquidated Damages as provided in Section E.10 and Attachment B of this Contract.

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

b. Overly aggressive solicitation, such as repeated telephoning;

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

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

e. Direct solicitation of potential enrollees;

f. Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;

g. Assertions or statements (whether oral or written) that the enrollee must enroll with the Contractor in order to obtain benefits or in order not to lose benefits;

h. Assertions or statements (whether written or oral) that the Contractor is endorsed by CMS, the federal or state government or similar entity;

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

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

A.13. Written Material Guidelines

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

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

c. All written materials shall be printed with the notice of non-discrimination and taglines as required by TennCare and set forth in TennCare's tagline template. In addition to any other requirements specified in the member materials requirement sections, the Contractor may also provide required member materials/information electronically or on its website pursuant to the specifications set forth in the A. 165 the nondiscrimination section of this Contract, TennCare's tagline template, and the following requirements: (1) the material/information must be placed on the Contractor's website in a location that is prominent and readily accessible for applicants and members to link to from Contractor's home page; (2) the material/information must be provided in a format that can be electronically saved and printed; and (3) if a member or applicant requests that the Contractor mail them a copy of the material/information, the Contractor must mail free of charge the material/information to them within five (5) days of that request. To the extent that the Contractor and its providers and/or subcontractors are using electronic and information technology to fulfill its obligations under this Contract, the entities shall comply with requirements set forth in Section A.165 the nondiscrimination section of this Contract;

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

1. The Seal of the State of Tennessee;

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

3. The CoverKids[sm] name unless the initials “SM” denoting a service mark, are superscripted to the right of the name;

4. The word “free” can only be used if the service is no cost to all enrollees;

5. Any of the Program names and logos, unless permission is given by the State.

e. Within ninety (90) calendar days of notification from TennCare, all vital Contractor documents related to this Contract shall be translated and available to each Limited English Proficiency (“LEP”) group identified by TennCare in accordance with the applicable standards set forth below:

1. If a LEP group constitutes five percent (5%) or 1,000, whichever is less, of the population targeted under this Contract, vital documents shall be translated into that LEP language. Translation of other documents, if needed, can be provided orally; or

2. If there are fewer than fifty (50) individuals in a language group that is part the population targeted under this Contract that reaches the five percent (5%) trigger in (a), the Contractor shall inform those individuals that it does not provide written translation of vital documents but provides written notice in that group’s primary language of the right to receive competent oral interpretation of those written materials, free of cost.

3. At a minimum, all vital Contractor documents shall be translated and available in Spanish.

f. All written member materials shall notify enrollees that auxiliary aids or services and language interpretation and translation services are available at no expense to the member and how to access those services.

g. All written member materials shall ensure effective communication with individuals with disabilities at no expense to the member. Effective Communication may be achieved by providing auxiliary aids or services, including, but may not be limited to: Braille, large print, and audio and shall be based on the needs of the individual enrollee. The Contractor and its providers and direct service subcontractors shall be required to comply with Title III of the Americans with Disabilities Act of 1990 in the provision of auxiliary aids and services to enrollees to achieve effective communication. In the event that the provision of auxiliary aids and services to an enrollee is not readily achievable by the Contractor’s providers or direct service subcontractors, the Contractor shall provide the enrollee with the auxiliary aid or service that would result in effective communication with the enrollee.

h. The Contractor shall provide written notice of any changes in policies or procedures described in written materials previously sent to enrollees at least thirty (30) days before the effective date of the change to provide TennCare an opportunity to review prior to the changes taking effect.

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

j. The Contractor shall use the TennCare approved glossary of required Spanish terms in the Spanish translation of all member materials.

STAFFING

A.14. General Staffing Requirements

The Contractor shall have total responsibility for hiring and management of any and all Contractor staff as determined necessary to perform the services in accordance with the terms of this Contract. The Contractor shall provide a proposed staffing plan (Staffing Plan) for review and approval by TennCare in accordance with the timelines required by the Project Plan. The Staffing Plan shall include at a minimum, key staff as identified below and corresponding job descriptions. The Contractor's failure to provide and maintain key staff may result in liquidated damages as described in Section E.10 and Attachment B of this Contract.

A.15. Office Location

The Contractor shall maintain a physical office in Metropolitan-Davidson County, Tennessee, or in a Tennessee county contiguous to Metropolitan-Davidson County. Only members of "key" staff as defined in section A.17. are required to be located in Metropolitan-Davidson County or a county contiguous to Metropolitan-Davidson County, however, the Contractor may assign at their discretion additional non-key members in the Tennessee local office.

A.16. Staff Requirements

a. The Contractor shall be responsible for assuring that all persons, whether they be employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render services under applicable state law and/or regulations. Failure to adhere to this provision may result in one (1) or more of the following sanctions that shall remain in effect until the deficiency is corrected:

1. TennCare may refuse to approve or may rescind the approval of subcontracts with unlicensed persons;

2. TennCare may refer the matter to the appropriate licensing authority for action;

3. TennCare may assess liquidated damages provided by Attachment B of this Contract; and

4. TennCare may terminate this Contract for cause defined by Section D.6. of this Contract.

b. The Contractor shall provide to TennCare documentation verifying that all staff employed by the Contractor or employed as a sub-contractor are licensed to practice in his or her area of specialty. This documentation shall be supplied at the execution of this Contract and annually thereafter, due annually on September 1 of each year of the Contract. Failure to provide documentation verifying that all staff employed by the Contractor, or

employed as a sub-contractor, are licensed may result in liquidated damages as set forth in Attachment B.

c. The Contractor shall provide TennCare with copies of resumes and job descriptions for all persons employed under this Contract. TennCare reserves the right, at its sole discretion, to require that Contractor staff and sub-contracted staff exhibiting performance deficiencies and/or lack of knowledge, skills or demonstrated expertise necessary to perform contracted activities, shall no longer be allowed to work on matters arising under this Contract.

d. The Contractor shall ensure that all Contractor staff and sub-contracted staff are trained and knowledgeable regarding all applicable aspects of the State DBM Programs. Contractor's staff shall provide quality consultation and technical assistance services regarding all matters pertaining to the State DBM Programs' dental benefits.

e. A training plan shall be submitted and approved by TennCare within ten (10) business days of the execution of this Contract. Contractor shall be responsible for providing training to any newly hired Contractor staff and sub-contracted staff prior to those individuals performing any services relating to the State DBM Programs. Training for newly hired Contracted staff and sub-contracted staff shall be approved by TennCare in advance.

f. The Contractor shall employ competent staff in all key positions listed below. If any key position becomes vacant, the Contractor shall employ an adequate replacement within sixty (60) days of the vacancy unless TennCare grants an exception in writing to this requirement. Failure to fill vacancies within sixty (60) days may result in liquidated damages as set forth in Attachment B.

g. The Contractor shall, at a minimum, have at least fifty percent (50%) of its staff available during the hours of 8:00 a.m. to 4:30 p.m. Central Standard Time, Monday through Friday, as required to fulfill the scope of services specified in this Contract. If the Contractor is not adequately staffed, TennCare may assess liquidated damages for each occurrence as set forth in Attachment B.

h. The Contractor shall provide staff that is current and knowledgeable in their respective areas of expertise. This staff shall provide quality consultation and technical assistance services regarding all matters pertaining to the State DBM Programs' dental benefits.

i. In addition to dedicated staff as specified in Contract Section A.17, the Contractor shall demonstrate good faith effort to include, among other staff or contractors, professionals who have expertise in providing and/or administering dental services to individuals with intellectual and developmental disabilities.

A.17. Key Staff

The Contractor shall maintain sufficient levels of staff, including supervisory and support staff, with appropriate training, work experience, and expertise to perform all contract requirements on an ongoing basis and be available to attend meetings as requested by TennCare. Key Staff personnel shall be assigned solely to work on matters arising under this Contract unless specific permission to the contrary is given by TennCare. The Contractor shall request approval from the State for all Key Staff candidates prior to assigning them to work on this Contract. The State may,

in its sole discretion, require the Contractor's proposed Key Staff candidates to interview with the State. The State shall have the discretion to approve or disapprove of the Contractor's and any of its subcontractor's Key Staff, or to require the removal or reassignment of any Contractor's employee or subcontractor personnel found unacceptable to the State for work under this Contract only. Unless otherwise approved in advance in writing by the State, all of Contractor's Key Staff shall be full time staff who are one hundred percent (100%) dedicated to working on this Contract and may not hold more than one (1) Key Staff position at the same time. Unless specifically stated to the contrary in Section A.17, key staff are required to be physically located in the Davidson County Tennessee office. Key Staff shall include but are not limited to the following positions:

a. DBM Project Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Project Director one hundred percent (100%) dedicated to this Contract who has day-to-day authority to manage the total project. The Project Director shall be readily available to TennCare staff during regular working hours. The Project Director shall be physically located in the Contractor's Tennessee location as specified in Contract Section A.15.

b. DBM Dental Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Dental Director one hundred percent (100%) dedicated to this Contract who has day-to-day authority to manage the clinical aspects of the project. A dentist who is licensed by the Tennessee Board of Dentistry, in good standing, and physically located in the State of Tennessee shall serve as full-time DBM Dental Director to oversee and be responsible for the proper provision of medically necessary covered services for enrollees. The DBM Dental Director shall be closely involved in the monitoring of program integrity, quality, utilization management and utilization review, provider corrective action, site visits, credentialing processes, and Performance Improvement Projects (PIPs). The DBM Dental Director shall serve on the Peer Review Committee as chairperson, and on the Quality Monitoring Program (QMP) Committee and Credentialing Committee. The DBM Dental Director shall attend all TennCare Dental Advisory Committee (TDAC) meetings and be on the quarterly meeting agenda when needed to present recommendations regarding changes to clinical guidelines.

c. Staff Dentist for the TennCare ECF CHOICES DBM Program - The Contractor shall designate and maintain, subject to TennCare approval, a full-time staff dentist reporting to the DBM Dental Director. The Staff Dentist shall be primarily focused on benefits provided under the TennCare ECF CHOICES DBM Program, but may also support the CoverKids DBM Program and the TPPOHP DBM Program as time permits. The Staff Dentist shall be licensed by the Tennessee Board of Dentistry, be in good standing, and physically located in the State of Tennessee. The Staff Dentist shall have at least five (5) years of experience directing dental services for people with I/DD or have completed a residency or certification program specific to the provision of dental services for people with I/DD and at least two (2) years of experience providing dental services for people with I/DD and demonstrate to TennCare the ability to lead and direct adult dental services for the TennCare ECF CHOICES DBM Program. The Staff Dentist shall be responsible for the clinical oversight of TennCare ECF CHOICES DBM Program adult dental benefits, including, but not limited to, quality, utilization management and utilization review, site visits and credentialing of providers for the TennCare ECF CHOICES DBM Program dental network, development of clinical practice standards and clinical policies and

procedures, PIPs pertaining to the TennCare ECF CHOICES DBM Program, provider corrective actions, leadership in training and development of the TennCare ECF CHOICES DBM Program dental provider network, and development of statewide capacity to provide dental services to individuals with I/DD broadly, including children with I/DD receiving dental services pursuant to EPSDT or the CoverKids DBM Program, and participation in meetings as requested by TennCare. The Staff Dentist shall be hired no later than sixty (60) calendar days prior to TennCare Programs Go-Live Date.

d. EPSDT Outreach Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, a full-time EPSDT Outreach Coordinator, physically located in Tennessee, whose primary duties include development and implementation of the Contractor's strategy to increase enrollee utilization of dental services by TennCare enrollees under the age of twenty-one (21) years of age.

e. Regulatory Compliance Manager – The Contractor shall designate and maintain, subject to TennCare approval, a full-time Regulatory Compliance Manager, physically located in Tennessee. The Regulatory Compliance Manager shall possess a thorough knowledge regarding investigations related to provider fraud and abuse in the TennCare program and will be the key staff handling day-to-day provider investigation related to inquiries from TennCare and TBI MFCU.

f. Provider Network Director – The Contractor shall designate and maintain, subject to TennCare approval, a Provider Network Director, physically located in Tennessee, responsible for network development and management to ensure that there is a statewide dental network adequate to make services, service locations and service sites available and accessible in accordance with the terms and conditions for access and availability outlined in the Contract, and a TennCare ECF CHOICES DBM Program network of participating Dental Providers, including both traditional and preventative dental services and specialists such as oral surgeons who have experience and/or expertise in serving individuals with intellectual and developmental disabilities with preferred contracting standards as defined in Section A.21 of this Contract. The Provider Network Director shall coordinate with other areas of the Contractor's organization that may impact provider recruitment, retention or termination, including for the TennCare ECF CHOICES DBM Program, and the TennCare Staff Dentist for the ECF CHOICES DBM Program. The Provider Network Director will also ensure that the provider enrollment file and the Insure Kids Now (IKN) files are accurate and delivered to TennCare timely, and that TennCare ECF CHOICES DBM Program Participating Dental Providers are clearly identified. The Provider Network Director shall have a provider service line staffed adequately to respond to providers' questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in this Contract.

g. Provider Representatives – The Contractor shall designate and maintain, subject to TennCare approval, a minimum of three (3) full-time Provider Representatives physically located in Tennessee to educate and assist participating dental providers in working with all State DBM Programs, including, but not limited to, management of TennCare ECF CHOICES DBM Program dental benefits and benefit limits, CoverKids DBM Program benefits and benefit limits, and TPPOHP DBM Program benefits and benefit limits. Each of the three (3) full-time Provider Representatives shall be assigned to work in one Grand Region within the state of Tennessee and shall be completely familiar with the operation

of all of the applicable State DBM Programs in their respective region. For the TennCare ECF CHOICES DBM Program, Provider Representatives shall educate and assist TennCare ECF CHOICES DBM Program participating dental providers in working with utilization management programs specific to TennCare ECF CHOICES DBM Program adult dental benefits, including, but not limited to, management of adult dental benefits and benefit limits, prior authorizations requests (including initial evaluation and treatment plan approval), electronic billing, compliance initiatives, or other program requirements as specified by TennCare.

h. Data Research Analyst – The Contractor shall designate and maintain, subject to TennCare approval, one (1) Data Research Analyst responsible for generating daily, weekly, monthly, quarterly and yearly reports required by the Contract, in addition to all ad hoc requests made by TennCare, in formats requested by TennCare. The Data Research Analyst shall be expert in data that is warehoused by Contractor on behalf of TennCare and shall be available to assist TennCare staff with Contractor's decision support systems. The Data Research Analyst shall provide expertise and assistance in provider post utilization review, establishing benchmarks for procedures prone to provider fraud and abuse that don't require prior authorization, evaluation of provider's treatment patterns, identification of provider outliers, and drawing statistically valid random sample (SVRS) of dental records, utilizing a ninety five percent (95%) confidence interval, specific to the procedure(s) where the provider is an outlier. The Data Research Analyst position is not required to be located in Tennessee office.

i. System Liaison- The Contractor shall designate and maintain, subject to TennCare approval, one (1) system liaison responsible for, but not limited to, the planning and timely coding of edits to the Contractor's system when requested by TennCare, and the quality control of such edits to ensure proper functioning within the system, and to ensure that newly entered system changes and edits do not affect existing edits within Contractor's system causing unanticipated adverse system events affecting TennCare's claims, enrollees and providers. The System Liaison shall be responsible for all testing of new programs or modules to be used by Contractor to manage TennCare's business. The System Liaison shall also be responsible for the maintenance and management of Contractor's website, including updating. The System Liaison position is not required to be located in the Tennessee office.

j. Member Materials and Marketing Coordinator – The Contractor shall designate and maintain, subject to TennCare approval, one (1) Member Materials and Marketing Coordinator responsible for ensuring that all member materials including, but not limited to, member handbooks, provider directories, member newsletters, dental reminder notices, fact sheets, notices or any other materials necessary to provide information to enrollees as developed by the Contractor, including materials specific to adult dental benefits in the TennCare ECF CHOICES DBM Program, are approved by TennCare and disseminated timely.

k. Fraud and Abuse Investigators – One (1) Fraud and Abuse Investigator dedicated to TennCare who shall be responsible for all fraud and abuse detection activities for the State DBM Programs, including the Fraud and Abuse Compliance Plan, and who shall be the Key Staff person handling day-to-day provider investigation-related inquiries from TennCare. This Fraud and Abuse Investigator shall be assisted, on an as-needed basis, with up to two (2) other designated Fraud and Abuse Investigators and one (1) staff

person, all of whom may be located in the Contractor's corporate offices, but who have full knowledge of provider investigations related to the State DBM Programs and shall work with the TennCare Office of Program Integrity (OPI).

l. MCO and DBM Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, a full-time MCO Coordinator, physically located in Tennessee. The MCO Coordinator shall develop, prior to program implementation and maintain thereafter through the duration of this Contract, a system for data exchange with the MCOs and the Contractor, including, but not limited to, functionality to exchange the following information: referrals; treatment plans; stratification of proposed treatment plan procedures; authorizations; and other information as determined necessary by TennCare. Additionally, the MCO and DBM Coordinator shall be responsible for the requirements set forth in Section A.49.

m. The Contractor shall identify in writing the name and contact information for the Key Staff persons within thirty (30) days of Contract award. Any changes in Key Staff persons listed in this section during the term of this Contract shall be made within ten (10) business days after receipt of any required approvals from TennCare. The identity of each of the Key Staff persons listed above shall be disclosed on the Contractor's web site.

A.18. Support Staff. The Contractor shall provide sufficient support staff to conduct daily business in an orderly manner, including but not limited to, such functions as administration, accounting and finance, prior authorizations, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews. These Support Staff shall include:.

a. Appeals Support Staff (clerical and professional) to perform Contractor's obligations related to the TennCare Appeal Process;

b. Dentist Consultants, including at a minimum, general dentist(s), pediatric dentist(s),oral surgeon(s), and orthodontist(s), whose primary duties are rendering medical necessity determinations. Medical necessity determinations shall be rendered by Contractor both (i) in response to requests for prior authorization from the treating provider, and (ii) during the TennCare Appeal Process, in response to TennCare's request for Contractor to render a Reconsideration determination;

c. Non-discrimination Compliance Coordinator to be responsible for Contractor compliance with all applicable Federal and State civil rights laws and regulations,. Compliance with the aforementioned federal and state laws and regulations is not required to be the sole function of the Non-discrimination Compliance Coordinator. However, the Contractor shall identify the designated compliance staff member who will serve as Non-discrimination Compliance Coordinator to TennCare by name. The Contractor shall report to TennCare in writing, to the attention of the Director of Civil Rights Compliance, within ten (10) calendar days of the commencement of any period of time that the Contractor does not have a designated staff person to serve as the Non-discrimination Compliance Coordinator. If the Contractor reassigns this function to a staff person other than the previously designated Non-discrimination Compliance Coordinator, the name of the staff member who assumed these duties shall be reported in writing to TennCare within ten (10) calendar days of the change;

d. Care Coordinators and Claim Coordinators appointed by the Contractor in order to coordinate and resolve issues related to MCO/DBM coordination issues as described in Care Coordination Sections A.47 – A.51 of this Contract. Further, the Contractor shall appoint a Care Coordination Committee and a Claims Coordination Committee made up of the Care/Claim Coordinators and other staff as appropriate. A list with the names and phone numbers of said representatives shall be provided by the DBM to the MCO and TennCare;

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

f. The provider service lines shall be adequately staffed and trained to accurately respond to questions regarding the State DBM Programs, including but not limited to, EPSDT, and adult dental benefits provided under the TennCare ECF CHOICES DBM Program. The Contractor shall adequately staff the provider service line to assure that the average wait time for assistance does not exceed ten (10) minutes. Difficult provider network questions and or complaints shall be referred and fielded by the Provider Network Director. Supervision of provider representatives as described below, is also the responsibility of the Provider Network Director, and

g. Grievances and Appeals Division– The Contractor shall designate and maintain, subject to TennCare approval, a Grievances and Appeals Division (Appeals Division) comprised of sufficient numbers of appropriately trained and licensed physicians, clinicians, professional and support staff necessary to process and resolve enrollee grievances and appeals in accordance with applicable TennCare and federal policy and regulation. Since medical expertise is required in order to perform medical necessity and prior authorization determinations during both the Contractor Reconsideration process and during the State Fair Hearing process, the Appeals Division professional staff must, at a minimum, include the following:

1. one (1) general dentist,

2. one (1) pediatric dentist,

3. one (1) oral surgeon, and

4. one (1) orthodontist.

PROVIDER NETWORK, ACCESS, AND AVAILABILITY OF CARE

A.19. General Requirements

The Contractor shall maintain and administer dental provider network(s) covering the entire State of Tennessee service area to serve eligible enrollees, in accordance with this Contract with coverage to be effective on the respective TennCare Programs Go-Live and CoverKids Program Go-Live dates and the Alternative TPPOHP Program Go-Live Date , if applicable. The Contractor

shall arrange for the provision of all covered services described in this Contract. The Contractor shall maintain under contract, a state-wide provider network, including General Dentists and Dental Specialists, adequate to make services, service locations, and service sites available and accessible in accordance with the terms and conditions for access and availability outlined for each of the respective State DBM Programs in Contract Section A.20. Each State DBM Programs enrollee shall be required to obtain covered services from any general or pediatric dentist in the Contractor's network(s) accepting new patients. Nothing in this Contract shall be construed to preclude the Contractor from closing portions of the network(s) to new providers when all conditions of access and availability are met.

A.20. Access to Care

The Contractor shall maintain a network of State DBM Program dental providers with a sufficient number of providers who accept new enrollees in accordance with the geo access standards required under this Contract so that appointment waiting times do not exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care. The Contractor shall ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. Services must be available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. Performance on access to care shall be monitored by the Contractor. Additional monitoring of these standards may be conducted by TennCare and/or the External Quality Review Organization (EQRO). The Contractor shall consider the following when establishing its networks:

a. The anticipated Medicaid and CoverKids enrollment;

b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid and CoverKids populations represented in the DBM;

c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid and CoverKids services;

d. The numbers of network providers who are not accepting new Medicaid and CoverKids patients;

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

f. Mobile dental clinics shall not be considered in determining sufficient network access.

A.21. Network for TennCare ECF CHOICES DBM Program Providers

a. The Contractor shall be responsible for establishing a TennCare ECF CHOICES DBM Program network of dental providers, furnishing both traditional and preventative dental services and specialists such as oral surgeons who have experience and/or expertise in serving individuals with intellectual and developmental disabilities. The TennCare ECF CHOICES DBM Program network shall meet the Access to Care and Transport Distance requirements in Sections A.19, A.20, and A.23 of this Contract. TennCare prefers that the TennCare ECF CHOICES DBM Program network of dental providers meet the

following requirements, hereinafter referred to as TennCare ECF CHOICES DBM Program Dental Provider Requirements:

1. A minimum of two (2) years of experience providing dental services to individuals with intellectual or developmental disabilities, including successful treatment of at least twenty (20) individuals with intellectual or developmental disabilities;

2. Completion of residency, internship, certification of continuing education, or other training specific to providing dental services to individuals with intellectual or developmental disabilities, including, in particular, training regarding alternative adjunctive techniques and modalities that may be used to facilitate the delivery of dental services and reduce the inappropriate use of sedation;

3. Demonstration of the regular use of modalities to reduce the use of sedation services, when appropriate, and demonstration of best practices with respect to alternative approaches to reduce the rate of dental sedation in serving individuals with intellectual and developmental disabilities; and

4. Such other standards as may be developed or approved by TennCare.

b. However, if the Contractor cannot meet the Access to Care and Transport Distance requirements in Sections A.19, A.20, and A.23 of this Contract for the TennCare ECF CHOICES DBM Program network with dental providers that meet the TennCare ECF CHOICES DBM Program Dental Provider Requirements, then the Contractor shall not be required to contract with dental providers that meet the TennCare ECF CHOICES DBM Program Dental Provider Requirements. However, the Contractor shall demonstrate to TennCare that the TennCare ECF CHOICES DBM Program Dental Provider Requirements are being thoughtfully considered in developing the TennCare ECF CHOICES DBM Program network by reporting information, if any, about the number of dental providers in the TennCare ECF CHOICES DBM Program network that meet the TennCare ECF CHOICES DBM Program Dental Provider Requirements. Development of the TennCare ECF CHOICES DBM Program network shall include ongoing efforts to identify and contract with providers who have such expertise and/or experience, as well as assisting dental providers in developing expertise in serving individuals with intellectual and developmental disabilities in order to participate in the TennCare ECF CHOICES DBM Program.

A.22. Provider Enrollment File for ECF CHOICES

The Contractor shall include in the provider enrollment file the appropriate TennCare ECF CHOICES DBM Program service code to designate those TennCare ECF CHOICES DBM Program Participating Dental Providers contracted to provide services for TennCare ECF CHOICES DBM Program members in the existing provider file layout.

A.23. Transport Distance and Time

The Contractor shall maintain under contract a statewide network of dental providers to provide the covered services specified in Sections A.4 and A.5, Obligations of the Contractor, including adult dental benefits provided through the TennCare ECF CHOICES DBM Program. The Contractor shall make services, service locations and service sites available and accessible so that transport distance and time to general dental and dental specialty providers shall not exceed

an average of thirty (30) miles or forty-five (45) minutes for general dental services; sixty (60) miles or sixty (60) minutes for oral surgery services; sixty (60) miles or sixty (60) minutes for orthodontic services; and, seventy (70) miles or seventy (70) minutes for pediatric dental services, as measured by GeoAccess Software. The Contractor shall not refuse to credential a qualified provider, on the sole basis of the network already meeting the contractual distance accessibility standard, if there is a subset of enrollees in the proposed service area that must travel beyond the average standard to access dental care. The Contractor shall maintain under contract a network of TennCare ECF CHOICES DBM Program Participating Dental Providers who have experience and/or expertise in serving individuals with intellectual and developmental disabilities with preferred contracting standards as defined in Section A.21 of this Contract, with seventy-five percent (75%) of such services, service locations, and service sites available and accessible so that transport distance to these providers shall not exceed an average of thirty (30) miles or forty-five (45) minutes, as measured by GeoAccess Software, and one hundred percent (100%) of such services, service locations, and service sites shall be available and accessible so that transport distance to these providers shall not exceed an average of sixty (60) miles or sixty (60) minutes, as measured by GeoAccess software.

A.24. Office Wait Time

The Contractor shall ensure that the office waiting time shall not exceed forty-five (45) minutes.

A.25. Provider Choice

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

A.26. Out of Network Providers

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

A.27. Cultural Competency

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

A.28. Public Health Entities

The Contractor is encouraged to contract for the provision of oral health services with public health clinics and schools of dentistry in Tennessee and may, at the discretion of TennCare, be required to secure such contracts. In addition, where such entities are not utilized, the Contractor must demonstrate that both adequate network capacity and an appropriate range of services for enrollees exist to serve the expected needs in a service area without contracting with public health entities. Documentation assuring adequate network capacity and services as specified by the State must be submitted by the Contractor.

MEMBER AND ADMINISTRATIVE SERVICES

A.29. Members Services Hotline

The Contractor shall provide a Member Services Line and Provider Services Line, providing statewide, toll-free phone lines manned by qualified benefit specialists and for the exclusive purpose of handling inquiries from enrollees and providers. This line shall be available on regular business days Monday through Friday. Since Tennessee spans two time zones, this service shall be operated from 7:00 a.m. Central Standard Time to 5:00 p.m. Central Standard Time and corresponding hours during periods of Daylight Savings Time. The member service lines shall be adequately staffed and individuals trained to accurately respond to questions regarding covered services, to assist members in locating a participating dental provider, and other issues including but not limited to EPSDT. Additionally, individuals shall be trained to accurately respond to questions and concerns regarding the TennCare ECF CHOICES DBM Program, including but not limited to, Covered Services and providing assistance locating a TennCare ECF CHOICES DBM Program Participating Dental Provider. The Average Speed of Answer (ASA) is defined as the amount of time elapsing between the time a call is received into the phone system and when a live member services representative answers the phone. During operational hours, the Contractor's Member Services Line and Provider Services Line shall provide free real time, third-party telephonic oral interpreter services to callers who are Individuals with Limited English Proficiency. The Contractor's Member Services Line and Provider Services Line shall be equipped with a Telecommunications Relay Service ("TRS") in order to service the hearing and speech impaired populations.

Service Level Performance Standards. The Contractor shall provide sufficient staff for "live" answering services during operational hours to meet the following performance standards for each queue within the Member Services Line and the Provider Services Line. For all Performance Standards measured in percentages, calculations for said percentages shall be made using the following standard: less than five-tenths (.5) of a percentage point will round down to the nearest percentage point and five-tenths (.5) and over will round up to the nearest percentage point.

a. Daily Maximum Speed of Answer: The Service Center shall answer one hundred percent (100%) of non- abandoned calls within five (5) minutes, or three hundred (300) seconds.

b. Daily Abandonment Rate. The Service Center shall maintain an average daily abandonment rate of five percent (5%) or less, excluding calls abandoned before thirty (30) seconds.

c. Daily Average Speed of Answer. The Service Center shall maintain a Daily Average Speed of Answer (ASA) of sixty (60) seconds or less. Calls answered in less than sixty (60) seconds but placed on hold within the first sixty (60) seconds of answer shall be deemed a failure to satisfy the ASA requirement.

d. Blocked Call Rate. The Service Center shall maintain a Blocked Call Rate of one percent (1 %) or less at all times without exception.

A.30. Interpreter and Translation Services

a. The Contractor shall develop written policies and procedures for the provision of language interpreter and translation services, including providing auxiliary aids and services to any member who needs such services, including but not limited to, members with Limited English Proficiency and members who are hearing impaired.

b. The Contractor shall provide language interpreter and translation services including auxiliary aids and services free of charge to members.

c. Language interpreter and translation services shall ensure effective communication with enrollees. This assistance should be available in the form of auxiliary aids, which include, but are not limited to in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.

A.31. TDD/TDY

The Contractor shall make free of charge TDD/TDY services available to enrollee.

A.32. Appointment Assistance

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

A.33. Inquiries, Correspondence, Complaints, and Problems

The Contractor shall maintain a full service staff to respond to inquiries, correspondence, complaints and problems. The Contractor shall answer, in writing, within ten (10) business days ninety percent (90%) of all written inquiries from Enrollees concerning requested information, including the status of claims submitted and benefits available, its clarifications and revisions.

A.34. Revisions to Benefits

The State shall consult with Contractor on proposed revisions to the benefits. When so requested, the Contractor shall provide information regarding:

a. Industry practices;

b. The overall cost impact to the program;

c. Any cost impact to the Contractor's fee;

d. Impact upon utilization management performance standards;

e. Necessary changes in the Contractor's reporting requirements, and

f. System changes.

A.35. Meetings

a. Both parties of this Contract shall meet periodically, but no less than quarterly, to discuss any problems and/or progress on matters outlined by either party.

1. The Contractor shall have in attendance the representatives from its organizational units required to respond to topics indicated by the State's agenda. The Contractor shall provide advice, assistance and information to the State regarding applicable existing and proposed Federal and State laws and regulations affecting managed care entities.

2. The State shall have in attendance, when requested by the Contractor, the representatives from its organizational units required to respond to topics indicated by the State's agenda.

b. The Contractor shall meet and confer at least twice each calendar year with representatives of a dental services provider organization designated by the State to discuss plan operations and network participation issues. The State shall be provided an opportunity to attend and observe the Contractor's sessions.

A.36. Customer Satisfaction Survey

The Contractor shall perform, following review and approval of the proposed survey by the State, Participant customer satisfaction surveys. The survey shall be conducted no more frequently than once during each calendar year at a time mutually agreed upon by the State and the Contractor but no later than the month of October. The survey shall involve a statistically valid random sample of parents and/or guardians of enrollees. The State reserves the right to review and mandate changes in the survey it feels are necessary to obtain valid, reliable, unbiased results. Those changes may include, but are not limited to, changes in the research design, units of analysis or observation, study dimension, sample size, sample frame, sample method, coding, or evaluation method. Based upon the results of the survey, the Contractor and the State shall jointly develop an action plan to correct problems or deficiencies identified through this activity.

a. The Participant Satisfaction shall be measured utilizing the most current National Committee on Quality Assurance (NCQA) Adult Participant Satisfaction Survey question that measures overall satisfaction.

b. The level of overall customer satisfaction, as measured annually by a State approved enrollee satisfaction survey(s), will be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and ninety percent (90%) in all subsequent year(s) within the Contract term. Failure to comply may result in monetary assessment as listed in Attachment B.

A.37. Provider Satisfaction Survey

The Contractor shall conduct a provider satisfaction survey of the participating network dentists and dental specialists, following approval by the State of the form, content and proposed administration of the survey, each October or November and report the results to the State by January 30 of the following year.

UTILIZATION MANAGEMENT

A.38. Policies and Procedures

The Contractor shall have written policies and procedures for utilization management and review, which include, at minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of medical services. The Contractor may place appropriate limits on a covered benefit. In accordance with the TennCare medical necessity rule, the Contractor may establish procedures for the determination of medical necessity and for the use of medically appropriate cost effective alternative benefits. See 42 CFR §438.3(e)(2) and 42 CFR §438.210(a)(4).

The Contractor shall provide an electronic copy and two (2) paper copies of its dental management policies and procedures to TennCare for approval during Readiness Review and at any time the policies or procedures are updated or changed.

The policies and procedures shall contain the following elements:

a. The policies and procedures shall contain mechanisms to detect both underutilization and overutilization.

b. Prior Authorization and Concurrent Review Requirements.

1. The Contractor shall use written criteria based on sound clinical evidence to make utilization decisions. The written criteria shall specify procedures for appropriately applying the criteria. The Contractor shall apply objective and evidence-based criteria and take individual circumstances of the enrollee into account when making medical necessity decisions.

2. Prior authorization and concurrent review decisions shall be supervised by qualified dental professionals.

3. Documented efforts shall be made to obtain all necessary information (including pertinent clinical information), and to consult with the treating dentists as appropriate.

4. The reasons for decisions shall be clearly documented and available to the enrollees.

5. There shall be well publicized and readily-available appeals mechanisms for both providers and enrollees.

6. Prior Authorization and service appeal-related decisions shall be made in a timely manner as required by the exigencies of the situation.

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

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

9. The Contractor shall ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope

of a required service solely because of the diagnosis, type of illness, or condition of the enrollee.

c. Policies specific to Covered Services provided pursuant to the TennCare ECF CHOICES DBM Program, including adjunctive sedation services, shall comply with the requirements of Section A.107.

A.39. Utilization Management for the TennCare ECF CHOICES DBM Program

The Contractor shall conduct utilization management and prior authorization for Covered Services under the TennCare ECF CHOICES DBM Program as may be required for the specific services included in members PCSPs, including any dental services approved by the MCO as a Cost-Effective Alternative Service, subject to the amount approved for such services in the member's PCSP. This information shall be communicated to the Contractor by the member's MCO.

A.40. Utilization Management of Anesthesia for TennCare ECF CHOICES DBM Program

The Contractor shall coordinate with the member's MCO regarding utilization management of intravenous sedation or other anesthesia provided in an outpatient facility in instances where an attempt has been made to provide dental treatment to a TennCare ECF CHOICES DBM Program member in the dental office setting unsuccessfully, and it is necessary to treat the patient in a medical facility.

A.41. Prior Authorization

Policies and procedures shall clearly identify any services for which the Contractor will require network providers to obtain authorization prior to the provision of the service as well as any additional submissions (such as radiographs) that may be required for approval of a service. TennCare shall have thirty (30) days to review and approve or request modifications to the policies and procedures. Should TennCare not respond in the required amount of time, the Contractor shall not be penalized as a result of implementing the policies and procedures. However, failure to respond timely shall not preclude the State from requiring the Contractor to respond or modify the policy or operating guideline prospectively. PA policies and procedures shall be consistent with the following requirements and with the requirements set forth in Sections A.116 through A.132.

a. PA Decision Timeframe. In accordance with 42 CFR § 438.210, Contractor shall notify the requesting provider of its PA decision within fourteen (14) days of receiving a standard PA request. If provider indicates that the PA request is expedited or urgent, Contractor shall notify the requesting provider of its PA decision as expeditiously as the situation warrants, but no later than within seventy two (72) hours. Additionally, for any decision to deny a service authorization request (or to authorize a service in an amount, duration, or scope that is less than requested), Contractor shall issue a written Notice of Adverse Benefit Determination (NABD) to the enrollee on whose behalf the PA request was submitted. These requirements are fully delineated in Sections A.116 through A.132 of this Contract.

b. Prior authorization shall not be required for referrals from the Public Health Screening Program, Primary Care Physicians, and for preventive services as defined in A.5.

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

d. All adult benefits provided under the TennCare ECF CHOICES DBM Program shall be prior-authorized.

A.42. Provider's Submission of Additional Information.

If, after Contractor renders an adverse PA determination in response to a request for Services, the requesting network provider submits additional information in support of the original PA request, then the Contractor shall render a new PA determination which accounts for newly-submitted information. Such information may include: dental records from the treating dentist, orthodontic records and treatment plan, radiographs of impacted teeth, OrthoCAD, or study casts or photographs of study models and/or photographs of intraoral tissue lacerations, the hospital readiness form and/or the orthodontic readiness form, and medical records from the primary care physician. Pediatrics growth data are to be provided for orthodontic appeals related to nutritional deficiency and speech/language records are to be provided for orthodontic appeals related to speech pathology.

A.43. Retrospective Utilization Review

The Contractor shall conduct retrospective treatment utilization review of Covered Services provided to members of all State DBM Programs. This review will require the Contractor to establish benchmarks for procedures that do not require prior authorization, but which are susceptible to fraud or abuse. Examples of procedures that do not require prior authorization, but which may be susceptible to fraud or abuse, include pulpotomies, placement of stainless steel crowns, or any other dental procedure that has been identified by TennCare, CMS, or Contractor as being susceptible to fraud and abuse. The Contractor shall evaluate the dental provider's treatment practice as compared with other in-network providers performing similar procedures based on provider specialty and identify those whose treatment utilization pattern deviates significantly from their peer's norm. The process will incorporate basic provider profiling, test edits, and Statistical Process Controls (SPC). SPC is a methodology of evaluating normal statistical variability or "noise" within any type of process. Normally the statistical limits are set at plus or minus three standard deviations so that any determination outside of these upper and lower control limits is expected to be a significant deviation from the network group being measured. Benchmarking analysis is mandatory as outlined above, and must be provided to TennCare upon request. All outlier reports will be submitted to TennCare quarterly through the Office of Program Integrity. If the type of finding elicited in the retrospective treatment utilization review process necessitates chart audit of a dental provider, then the Contractor will draw a statistically valid random sample (SVRS) of dental records, utilizing a ninety five percent (95%) confidence interval consistent with US DHHS convention, specific to the procedure(s) where the provider is an outlier compared with the benchmark. The Contractor, utilizing dental expert(s) will perform an initial chart audit of the entire SVRS sample. If the initial audit findings reveal evidence of fraud, abuse, non-compliance with medical necessity criteria or quality of care issues then the Contractor is required by this contract to present a convenience sample of at least 10% of the findings to be reviewed by its Provider Peer Review Committee for the purpose of agreement between reviewers. Utilization review by the Provider Peer Review Committee must be conducted in a blinded manner.

The Contractor's Provider Peer Review Committee shall be made up of licensed Tennessee dentists in good standing with the Tennessee Board of Dentistry. Committee members shall be familiar with the State DBM Programs. At a minimum, the Contractor shall provide each member of its Provider Peer Review Committee with a copy of TennCare's Medicaid Rules, TennCare's Medical Necessity Rules as well as the medical necessity guidelines presented in the Provider Office Reference Manual. The Contractor shall also provide orientation and medical necessity training for every member who serves on its Peer Review Committee before members are permitted to review case files. Section A.136 of this contract describes the Contractor's Provider Peer Review Committee. This committee will review the case files generated by the utilization review process. The Provider Peer Review Committee is required to determine if they agree or disagree with the findings presented at each meeting and establish in writing its consensus findings and recommendations. After the Provider Peer Review Committee has completed its review and established written findings and recommendations, these are forwarded back to the Contractor for careful consideration and appropriate formal action. The Contractor shall forward to the TennCare Dental Director and Office of Program Integrity, a quarterly update including a summary of its investigations, Provider Peer Review Consensus findings and recommendations as well as, all formal actions taken.

a. The Contractor's utilization review process intervention includes various options that safeguard children, improve quality of care, assure fiscal viability of the program and comport with TennCare's mission. These options include issuance of written corrective action plans, documentation of provider and staff education, recoupment of provider payments or any combination of these actions. Additionally, in accordance with its Provider Service Agreement, the Contractor may terminate a dental provider with or without cause with thirty (30) days' notice.

b. Contractor's utilization review process shall include review of procedures that do not require prior authorization. If such a review demonstrates that a provider is not adhering to TennCare's medical necessity criteria or Contractor criteria in the provision of a procedure(s), the Contractor must initiate written corrective action for that provider. Corrective action may include, but is not limited to, requiring any of the following:

    1. Provider and staff education;

    2. Prior authorization for that procedure(s) and,

    3. Second opinion by a Contractor-designated dentist in cases involving "extensive" treatment plans and/or in cases where the dentist is requesting treatment in a medical facility (hospital operating room or ambulatory treatment center).

c. The Contractor is responsible for Retrospective Utilization Review activities specific to services provided in the ECF CHOICES program.

A.44. Emergent and Urgent Care

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

a. The Contractor may not deny payment for treatment obtained when a representative of the Contractor instructs the eligible enrollee to seek emergency services as defined in 42 § CFR 438.114 (a) and must cover and pay for emergency services regardless of whether the provider that furnishes the service has a contract with the Contractor as long as the Provider has a valid TennCare Medicaid ID number. Under the terms of this Contract and the TennCare MCO Contractor Risk Agreement, the MCO is responsible for the provision of treatment for emergency medical conditions and is also responsible for the facilities and physician charges for dental services provided in a hospital emergency room.

b. The Contractor may not deny payment for treatment obtained when an eligible enrollee had an emergency medical condition, where it is the Contractor's responsibility to pay, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 § CFR 438.114 (a) of the definition of emergency medical conditions. Under the terms of this Contract and the TennCare MCO Contractor Risk Agreement, the MCO is responsible for the provision of treatment for emergency medical conditions and is also responsible for the facilities and physician charges for dental services provided in a hospital emergency room.

A.45. Continuity of Care

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

A.46. Referral Requirements

A patient must be referred by a general dentist or pediatric dentist to a dental specialist (e.g., endodontist, oral surgeon, orthodontist, periodontist, prosthodontist) for the initial visit for services requiring specialized expertise. Subsequent visits to the same specialist in a course of treatment do not require separate referrals. The Contractor shall:

a. 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, and

b. have a mechanism in place to allow special needs enrollees and enrollees determined to require an ongoing course of treatment direct access to specialists as appropriate.

CARE COORDINATION

A.47. Transition Period

In the event an enrollee is receiving medically necessary covered dental services the day before the effective date of this Contract, the Contractor shall authorize the continuation of said services without any form or prior authorization and regardless of whether the services are being provided by a provider within or outside the Contractor's provider network. In order to ensure uninterrupted service delivery, the Contractor shall accept authorization files from the previous DBM and/or TennCare as directed to identify enrollees for whom prior authorizations were issued prior to the effective date of this Contract. To the extent that the authorizations are for covered services and are within the parameters of the TennCare approved policies and procedures for prior

authorizations as outlined in Section A.41 of this Contract, the Contractor will accept and honor those prior authorizations for the first ninety days of this Contract. The Contractor shall coordinate with the previous DBM so that dental inquiries received on or after the TennCare Programs Go-Live date and the CoverKids Program Go-Live date, respectively, and the Alternative TPPOHP Program Go-Live Date , if applicable, are redirected to the Contractor.

A.48. Web Portal

The Contractor shall develop, prior to program implementation and maintain thereafter through the duration of this Contract, a web portal that allows MCOs and the Contractor to access treatment plans, budget statuses for each individual in ECF CHOICES and for each enrollee in the TennCare Programs and the CoverKids Program receiving dental services, and other information as determined necessary by TennCare.

A.49. Coordination Between MCO and Contractor

The Contractor understands and acknowledges that each TennCare Managed Care Organization (MCO) has contracted with TennCare to perform the service and claims coordination requirements contained in this section A.49. The Contractor understands and acknowledges that it and the MCOs are responsible for coordinating benefit and claims requests with each other in accordance with TennCare requirements. The Contractor shall coordinate dental and medical services in accordance with the provisions in this Section A.49.

a. The MCO bears responsibility for providing enrollee with transportation to obtain Contractor-covered services. For example, if the Contractor approves a prior authorization request for orthodontic treatment, the MCO is responsible for providing transportation to and from the treatment location.

b. Whereas the Contractor shall be responsible for covering medically necessary, authorized dental extractions, the question of whether the Contractor or MCC bears responsibility for covering the attendant medical, facility, and anesthesia services depends on where such anesthesia services are administered and who administers them.

    1. The Contractor shall be responsible for Contractor-approved anesthesia services, which are either (i) performed by a dental provider, or (ii) performed in a dentist's office.

    2. The MCO bears responsibility for facility, medical and anesthesia services related to medically necessary and approved dental services that are not either (i) performed by a dental provider, or (ii) performed in a dentist's office.

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

the MCO such as obtaining and sharing medical/pediatric information to identify nutritional deficiencies and speech and hearing evaluations to identify speech pathology amenable to orthodontics. TennCare will work to facilitate implementation of said policies and procedures.

d. Services and Responsibilities - Coordination of dental services, shall at a minimum, include:

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

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

3. Maintenance of confidentiality;

4. Cooperation with the MCO regarding training activities provided by the MCO.

5. Results of any identification and assessment of any enrollee with special health care needs (as defined by the State) so that those activities need not be duplicated;

6. Mechanisms to assess each enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms shall use appropriate health care professionals, and

7. If applicable, the development of treatment plans for enrollees with special health care needs that are developed by the enrollee's primary care provider with enrollee participation and in consultation with any specialists caring for the enrollee. These treatment plans must be approved by the Contractor in a timely manner, if approval is required, and be in accord with any applicable State quality assurance and utilization review standards.

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

f. Resolution of Requests for Authorization - The Contractor 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 an

enrollee. Contractor 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 Contractor and MCO. The Contractor 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 an enrollee and the party believes care is the responsibility of the other party, the Care Coordinator for the receiving party will contact the respective Care Coordinator of the other party by the next business day after receiving the request for prior authorization. The receiving party shall immediately inform the requesting provider that receiving party is responsible for rendering a decision to the prior authorization request. In accordance with applicable law, this prior authorization decision (and any attendant Adverse Benefit Determination) shall be rendered within fourteen (14) days or as expeditiously as the enrollee's condition requires. The Contractor and the MCO shall 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 Contract. The parties shall 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 fifteen (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 TennCare. Both parties are responsible for enforcing hold harmless protection for the enrollee.

g. Claim Resolution Authorization

1. The Contractor shall designate one or more Claim Coordinators to coordinate with the MCO Claim Coordinators to quickly determine whether the Contractor or the MCO is responsible for responding to a provider's prior authorization request or claim submission. The Contractor shall provide TennCare and each of TennCare's Managed Care Organization with the identities and contact information of each of the Contractor's designated Claim Coordinators.

2. When either party receives a disputed claim for payment from a provider for an enrollee 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.

3. The Contractor and the MCO shall 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 Contract, or, if the parties fail to agree within ten (10) calendar days of the execution of this Contract, the Claim Coordination Committee shall consist of two (2) representatives of each party. The Claim Coordination Committee shall review any disputes and negotiate responsibility among the parties. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request

from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party will reimburse and abide by the prior decisions of that party. Reimbursement will be made within ten (10) business days of the Claim Coordination Committee's decision.

4. 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 the Contractor and the 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.

5. If the meeting between the CEOs, or their designee(s), of the Contractor and the MCO does not successfully resolve the dispute within ten (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.

6. The process as described above shall be completed within thirty (30) days of receiving the claim for payment. In the event the parties cannot agree within thirty (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 TennCare: claims shall be processed in accordance with the requirements of the MCO's and Contractor's respective Agreements with the State of Tennessee. Moreover, the party that first received the request or claim from the provider shall also make written request of all requisite documentation for payment and shall provide written reasons for any denial.

7. 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.

8. The State, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) days of the receipt of the required information. The decision may reflect a split payment responsibility that will designate specific proportions to be shared by the MCO and the Contractor 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 thirty (30) calendar days of the date of the state's Decision, the State may deduct amounts of the DBM's payment responsibility from any current or future amount owed the party.

9. Denial, Delay, Reduction, Termination or Suspension - The parties agree that any claims payment dispute or request for authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate services to an eligible enrollee. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any enrollee shall insure that the enrollee is treated immediately and payment for the claim shall be approved or disapproved based on the definition of emergency medical condition at 42 CFR §438.114(a).

10. Emergencies - Prior authorization shall not be required for emergency services prior to stabilization. Federal law requires the emergency screenings be provided at the Emergency Department. The enrollee's MCO is responsible for payment for the screening or any medical care required to stabilize the patient. If the screening reveals that a dental problem exists, the Contractor shall be notified and is responsible for providing any necessary emergency services.

h. Claims Processing Requirements - All claims shall be processed in accordance with the requirements of the MCO's and Contractor's respective Contracts with the State of Tennessee.

i. Appeal of Decision - The Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Uniform 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.

j. Duties and Obligations - The existence of a claims dispute under this Contract 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. § 56-32-126(b), a provider may elect to resolve the claims payment dispute through independent review.

k. Confidentiality - The Contractor 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 Contractor and MCO standards. These standards will apply to

both Contractor'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 enrollees. The Contractor 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 Contractor's performance of this Contract, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, Section E.2 of this Contract, 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 TennCare, 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.

l. Access to Service - The Contractor shall establish methods of referral from the MCO which assure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

A.50. Tracking System

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

A.51. Provider Listing for MCO Primary Care Providers

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

PROVIDER SERVICES

A.52. Informational Sessions

The Contractor shall provide continuing informational sessions for participating Dental Providers throughout the State.

a. The Contractor shall hold at least two informational sessions per year for each Grand Region in the state. Such informational sessions shall address state and federal law pertaining to the provision of TennCare Programs and CoverKids Program. At a minimum, such informational sessions shall address (i) the extent and limits of TennCare dental and orthodontic treatment coverage rules (i.e., handicapping malocclusion, orthodontic readiness form, documentation of nutritional problems [pediatric growth records], speech/hearing evaluations [may include school records]), and medical necessity rule and (ii) those requirements that shall be satisfied by dental providers in order to ensure compliance with federal EPSDT law, Children and Youth with Special Needs (CYSHCN), and services under TennCare Rules. The Contractor shall submit all

proposed material to TennCare for approval at least sixty (60) days prior to the informational session. TennCare shall have fifteen (15) days to review and request changes, if necessary. If changes are requested, the Contractor shall resubmit the material within ten (10) days of receipt of TennCare's comments.

b. The Contractor shall monitor provider compliance with TennCare coverage rules, medical necessity rules, TennCare policies and with requirements of EPSDT and clinical criteria guidelines presented in TennCare's Office Reference Manual. The Contractor shall promptly address compliance deficiencies, other than fraud, waste or abuse identified through such monitoring by imposing Corrective Action Plans, including behavior management, recoupment of funds, additional training and/or termination of the Dental Provider's contract. Cases of possible fraud, waste or abuse must be reported to the TBI and TennCare's Director of Program Integrity. If the appropriate authority determines that the conduct in question does not constitute fraud, waste or abuse then the Contractor may impose the corrective measure mentioned in this section.

c. The Contractor shall handle the day to day management of the Provider network(s) so as to insure the provision of safe and effective dental care. The State must be able to protect its enrollees from unsafe medical care. Therefore, the State reserves the right in extreme and unusual cases, at its sole discretion, to disapprove certain corrective actions recommended by the Contractor for a given Provider.

d. The Contractor shall require that participating Dental Providers file TennCare-associated claims directly with the Contractor, or its subcontractors. The Contractor shall provide written instructions to participating Dental Providers addressing claims submission requirements. The Contractor shall confer participating Dental Providers with any assistance reasonably necessary to ensure provider compliance with applicable claims payment policy.

e. On a quarterly basis, the Contractor shall provide TennCare with documentation substantiating its compliance with the obligations addressed in this section

A.53. Education for ECF CHOICES Providers

The Contractor shall identify residency and internship opportunities, certification programs, continuing dental education courses, educational training/webinars, and best practices information relating to dentistry for individuals with I/DD and disseminate such information to contracted ECF CHOICES Participating Dental Providers, including alternative adjunctive techniques and modalities that may be needed to facilitate the delivery of dental services, and the appropriate use of sedation to ensure that sedation services are only provided based upon the needs of the individual and not the convenience of the ECF CHOICES Participating Dental Provider. The Contractor shall further identify subject matter experts on dentistry for individuals with I/DD and facilitate presentation to ECF CHOICES Participating Dental Providers on topics including the delivery of dental services to this population and the appropriate use of dental sedation, and shall also identify ECF CHOICES Participating Dental Providers who exhibit best practices for individuals with I/DD and facilitate peer-to-peer learning opportunities between such providers and other providers in the Contractor's ECF CHOICES dental network.

A.54. ECF CHOICES Participating Dental Providers

ECF CHOICES Participating Dental Providers shall render high quality, Medically Necessary, cost effective dental care for ECF CHOICES members. The Contractor shall exercise every available means through this Contract, provider agreements, office reference manual, policies and procedures, and educational programs to ensure that dental benefits in the ECF CHOICES program are managed in this manner.

A.55. Provider Manual.

The Contractor shall produce and distribute a dental program criteria manual to assist Participating Dental Providers. The manual shall clearly define covered services, limitations, exclusions, and utilization management procedures, including, but not limited to: prior authorization requirements, medical necessity guidelines for dental procedures, and special documentation requirements, including but not limited to Hospital readiness form, orthodontic readiness form, documentation of nutritional deficiencies (general pediatric records including growth data), and speech/hearing evaluations (may include school records) for treatment of enrollees. The manual shall include a detailed description of billing requirements for Participating Dental Providers and shall contain a copy of Contractor's paper billing form and electronic billing format. The Contractor shall ensure that the manual remains up-to-date and reflects changes in applicable law or revisions to TennCare or Contractor policy. The initial version of the manual and any subsequent revisions thereto shall be submitted to TennCare and The TennCare Division, Tennessee Department of Commerce and Insurance (TDCI) for review and approval prior to distribution. Participating Dental Providers shall be apprised of revisions to the manual by the Contractor, by means of written or electronic notice, to be sent thirty (30) days in advance of the implementation of the new policy or procedure. The Provider Manual shall include a supplement or manual component specific to ECF CHOICES Participating Dental Providers.

A.56. Practice Guidelines

The Contractor shall adopt practice guidelines that meet the following requirements, including the appropriate use of intravenous sedation or other anesthesia as part of the delivery of dental benefits to individuals with intellectual and developmental disabilities and other guidelines specific to the oral health and dental care needs of individuals with intellectual and developmental disabilities:

a. Must comply fully with TennCare Medical necessity rule found at 1200-13-16, as applicable;

b. Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field, which shall comply with Tenn. Code Ann. § 63-5-101, *et seq.* and any rules promulgated thereunder;

c. Consider the needs of the enrollees;

d. Are adopted in consultation with contracting health care professionals;

e. Are reviewed and updated periodically as appropriate; and

f. Are disseminated to all affected providers and, upon request, to enrollees and potential enrollees.

NETWORK DEVELOPMENT AND MANAGEMENT

A.57. Providers Providing On-Going Treatment

If an enrollee is in a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services to such enrollee and the Contractor is aware of such ongoing course of treatment, the Contractor shall immediately provide the enrollee written notice on the date that the Contractor becomes aware of such unavailability. Each notice shall include all components identified in the notice template to be provided by TennCare. The timing requirement for the provision of this notice shall be waived in instances where a provider becomes physically unable to care for enrollees due to illness, a provider dies, the provider moves from the service area and fails to notify the Contractor or when a provider fails credentialing, and instead shall be made immediately upon the Contractor becoming aware of the circumstances. The Contractor may utilize single case agreements to facilitate timely access to care, as needed.

A.58. Other Provider Termination

If a provider ceases participation in the State DBM Programs, the Contractor shall make a good faith effort to give a thirty (30) day written notice of termination of a contracted provider immediately after receipt or issuance of termination notice to each enrollee who received his/her primary care from or was seen on within the previous two (2) years by the terminated provider.

A.59. Notice of Network Deficiency

Upon final notification from TennCare of a network(s) deficiency, which shall be based on the requirements of this Contract, the Contractor shall immediately provide written notice to enrollees living in the affected area of a provider shortage in the Contractor's network(s). The notice content shall be reviewed and approved by TennCare prior to distribution.

A.60. Notice of Subcontractor Termination

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

A.61. Provider Terminations

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

PROVIDER AGREEMENTS

A.62. General Requirements

The Contractor shall assure that medically necessary, covered services as specified in this Contract are provided. The Contractor shall enter into agreements with providers and/or provider subcontracting entities or organizations which will provide medically necessary services to the enrollees in exchange for payment from the Contractor for services rendered. The Contractor shall ensure that the Provider Agreement remains up-to-date and reflects applicable law or revisions to TennCare rules and Contractor policy. The initial provider template and revisions thereto must be submitted to TennCare and the TDCI for review and approval prior to distribution. Participating providers shall be apprised of revisions to the Provider Agreement by the Contractor through written notice thirty (30) days in advance of the implementation of the new template.

The Contractor is neither required to contract with providers beyond the number necessary to meet the needs of the enrollees, nor precluded from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollees. No provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the Contractor to TennCare to assure that all activities under this Contract are carried out.

There is no requirement that the Contractor enter into an agreement with a provider merely because the provider was a TennCare provider prior to the contract start date. The Contractor shall make every effort to enter into provider agreements with those entities whose practices exhibit a substantive balance between Medicaid and commercial patients. The Contractor shall enter into provider agreements that require a Patient-Centered Dental Home as defined in Contract Section A.63 for enrollees in the TennCare Children's DBM Program, CoverKids DBM Program and the TPPOHP DBM Program. Mobile clinic providers should only be utilized in areas underserved by community providers willing to provide a dental home for members enrolled in the above DBM Programs. There will be granted an exception to this policy discouraging use of mobile providers in the case of state or local governmental programs designed to reach specific underserved populations, i.e. school children. Nothing in this Contract requires the Contractor to enter into agreements with dental providers if the Contractor believes such agreements might adversely affect the dental provider network.

A.63. Patient-Centered Dental Home (PCDH)

The Contractor shall establish a Patient-Centered Dental Home (PCDH), which is defined as a place where an enrollee in the TennCare Children's DBM Program, CoverKids DBM Program and the TPPOHP DBM Program has oral health care delivered in a comprehensive, continuously accessible, coordinated and family centered way by a dentist participating in the above identified DBM programs.

One of the primary reasons for establishing the PCDH is to ensure that enrollees in the TennCare Children's DBM Program, CoverKids DBM Program, and the TPPOHP DBM Program have access to a participating primary care dentist who is identified through member assignment. Provider acceptance and involvement is essential to success of the PCDH for beneficiaries. Members can either choose their dental home dentist or be assigned a dentist for care.

Individual primary care dentists must be able to access their roster of dental home assignments through their provider web portal established by the Contractor.

The dental home model is key component of TennCare's overall vision to transform the existing TennCare and CoverKids dental programs from dental restorative programs to more balanced programs that emphasize prevention and control of oral diseases through engagement of the DBM Contractor and its network of participating providers, to improve the health and quality of life for members.

The Contractor shall establish a robust oral disease prevention strategy. This strategy must, at a minimum, include prevention of early childhood caries through the "routine" use of topical fluorides such as fluoride varnish, as well as Silver Diamine Fluoride (SDF) for arresting the caries process, as well as for Operating Room (OR) diversion by offering parents or guardians of child members a minimally invasive in-office dental treatment alternative to treatment under general anesthesia in a medical facility.

The oral disease prevention strategy must also include routine provider application of dental sealants for pit and fissure surfaces of first and second permanent molar teeth, as soon as these teeth have fully erupted into the oral cavity.

The Contractor shall also develop an individual confidential provider performance report (PPR) for the TennCare program that is sent to participating primary care dentists on a quarterly basis. The PPR is a provider educational tool to afford providers in the network the opportunity to see how their practice compares with their peers and the overall network average in cost, access, and preventive care. The preventive component of the PPR must include network benchmark averages for dental sealants for the 6-9 year old age group and 11-15 year old age group. The preventive component of PPR must also include comparisons to the SDF network benchmark and topical fluoride network benchmark. It is anticipated that sharing confidential feedback with providers through the PPR will result in a shift by those performing under the network benchmark average to modify their practice pattern to meet or exceed network benchmarks. In order to encourage quality and cost improvement, additional member assignments to a dental home will be based upon the PPR. This will ensure that TennCare members have access to dental home providers demonstrating a commitment to providing the highest quality care.

A.64. Provider Agreement Execution

The Contractor shall execute provider agreements that will be between the Contractor and the dental provider, not between the provider and TennCare. These agreements shall require providers to maintain all federal, state and local licenses, certifications, and permits, without restriction, required to provide quality dental services to enrollees and shall comply fully with all applicable Federal and State laws, rules, policies, court orders and regulations. All template provider agreements and revisions thereto must be approved in advance by TDCI. The Contractor shall submit one copy of all template provider agreements and copies of the face and signature pages of all executed agreements to TennCare

A.65. Provider Medicaid ID Required

The Contractor shall not execute a Provider Agreement with any Provider Person or Provider Entity that does not have a valid TennCare Provider ID number. The Contractor shall verify each individual and group TennCare Provider ID with TennCare electronically utilizing a means specified by TennCare. TennCare will provide demographic and other data for each individual and group provider authorized by TennCare to be used by the Contractor. Providers without a TennCare Provider ID number should be directed to the TennCare Provider Portal through which

the provider can provide the necessary information to receive a valid TennCare ID number. The Contractor shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who do not meet all the parameters of the credentialing process as outlined in Sections A.138 and A.139. Providers must obtain or have re-verified their existing TennCare provider ID number upon initial contracting, re-verification by the Contractor or TennCare, change in ownership of the Provider, or as otherwise directed by TennCare or Contractor. Provider agrees to disclose all Business Transaction information as required by 42 CFR § 455.105 upon request of TennCare.

A.66. Required Provider Agreement Provisions

All provider agreements executed by the Contractor, and all provider agreements executed by subcontracting entities or organizations, pursuant to this Section A.66 shall, at a minimum meet the following requirements: (No other terms or conditions agreed to by the Contractor and provider shall negate or supersede the following requirements.)

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

b. Specify the effective dates of the provider agreement;

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

d. Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without approval of the Contractor and state that any claims submitted or paid under such unapproved contracts are considered to be false claims and subject to recoupment by either Contractor or TennCare;

e. Identify the population covered by the provider agreement;

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

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

h. Specify the amount, duration and scope of services to be provided by the provider; specify that the provider comply with TennCare medical necessity rules listed at 1200-13-16;

i. Provide that emergency services for eligible enrollees be rendered without the requirement of prior authorization. However, the required documentation must be submitted post-treatment for retro authorizations in order for the dentist to receive payment.

j. If the provider performs laboratory services, the provider must meet all applicable requirements of the Clinical Laboratory Improvement Act (CLIA) of 1988 at such time that the Center for Medicare and Medicaid Services (CMS) mandates the enforcement of the provisions of CLIA;

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

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

m. Enrollee Records-Consent. As a condition of participation in the TennCare/CoverKids Program, enrollees have given the State, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, The Tennessee Attorney General, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider 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, the State or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ.

n. Enrollee Records – Access. Pursuant to 42CFR438.3 the State, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, The Tennessee Attorney General, DHHS Office of Inspector General (DHHS OIG), and DOJ CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the MCO, PIHP, PAHP, PCCM or PCCM entity, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work

is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Said records will be made available at no cost to the requesting agency. At the discretion of the requesting agency "access" may include an examination of the records located in any electronic health records system as well as related information such as metadata and audit trails..

o. Provide for monitoring, whether announced or unannounced, of services rendered to enrollees pursuant to the agreement between the provider and the Contractor to ensure that services are performed in accordance with existing law;

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

q. Specify that the Contractor shall monitor the quality of services delivered under the agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TennCare. In the event of a conflict between a Providers opinion as to the appropriate level of care and the TennCare medical necessity rules in 1200-13-16, the TennCare medical necessity rules shall prevail as the controlling standard;

    1. Specify that the Contractor initiate corrective action if a participating provider is not complying with state and federal laws and regulations and TennCare policies;

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

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

s. Require dental providers safeguard information about enrollees according to applicable state and federal laws and all HIPAA regulations including, but not limited to, 42 CFR § 431 Subpart F, §438 Subpart E, and all applicable Tennessee statutes and TennCare rules and regulations;

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

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

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

w. Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in T.C.A. § 56-32-126 and Section A.87 of this Contract;

x. Specify the provider shall accept payment or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the enrollee's third

party payor) plus the amount of any applicable cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the enrollee being served;

y. Specify that at all times during the term of the agreement, the dental provider shall indemnify and hold TennCare harmless from all claims, losses, or suits relating to activities undertaken pursuant to the provider agreement between the Contractor and the provider;

z. Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the Plan's enrollees and the Contractor under the agreement. The provider shall provide such insurance coverage at all times during the agreement and upon execution of the provider agreement furnish the Contractor with written verification of the existence of such coverage;

aa. Specify both the Contractor and the provider agree to recognize and abide by all state and federal laws, regulations, rules, policies, court orders and guidelines applicable to the health plan, as well as verify that the dental provider continues to be properly licensed by the State Board of Dentistry;

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

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

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

ee. Include provisions for resolution of disputes either by arbitration or another process mutually agreed to by the parties. Specify the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve non-emergency claims denied in whole or in part by the Contractor as provided at T.C.A. § 56-32-126(b);

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

gg. Specify that the Contractor shall give providers prior written notice of a determination that a reduction in the provider fee schedule is necessary under this Contract and further, specify that the Contractor shall give providers thirty (30) days prior written notice of said reductions;

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

ii. Specify that the dental provider shall comply with the appeal process and prior authorization process by timely supplying Contractor with all of the information, records and documentation that Contractor requires, and by assisting an enrollee in the appeal process in accordance with applicable law and policy;

jj. Specify that the dental provider shall make TennCare enrollee's aware of their right to appeal adverse decisions affecting services by displaying notices in public areas of their facility(s) in accordance with TennCare Rules, 1200-13-13-.11 and 1200-13-14-.12;

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

ll. All provider agreements must include language which informs providers of the package of benefits that EPSDT offers and the periodicity schedule with which those benefits must be provided. All provider agreements must contain language that references the EPSDT benefit package and periodicity schedule, including the information as described in Early Periodic Screening, Diagnosis and Treatment, Sections A.114 and A.115 of this Contract, or includes language that states those requirements;

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

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

oo. Specify that the provider warrants that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractors, or consultant to the provider in connection with any work contemplated or performed relative to the agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration;

pp. The provider agreements shall include the following nondiscrimination provisions: Specify that the provider agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the provider on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal and, State laws and regulations;

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

2. Require the provider to agree to cooperate with TennCare and the Contractor during discrimination complaint investigations, and

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

qq. Contracts must comply with requirements set forth in the Balanced Budget Act 1997 in 42 CFR §§ 422.208 and 422.210 as it applies to physician incentive plans,

rr. Require that the provider attest that they nor any of their employees are not currently nor have ever been sanctioned by HHS-OIG or been prevented from participating in a federally funded program such as TennCare, and

ss. Specify that every dental provider besides public health providers and dental specialists who may have limited their scope of practice to a particular specialty area, agree through the Contractor's Provider Agreement to provide the full range of medically necessary dental procedures to TennCare enrollees with the understanding that referrals to dental specialists for complex procedures is anticipated.

tt. Provider understands that payment TennCare is conditioned upon the invoice or bill and the underlying transaction complying with Medicaid laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute, and the Stark law and federal requirements on disclosure, debarment and exclusion screening), and is conditioned on Subcontractor's compliance with all applicable conditions of participation in Medicaid. Subcontractor understands and agrees that each invoice or bill submitted by Subcontractor to TennCare constitutes a certification that Subcontractor has complied with all applicable Medicaid laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), in connection with payment and the services provided under this Agreement.

uu. Claims Attestation-: Per 42 CFR §§ 455.18 and 455.19: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws." Acknowledgement by provider of this second statement shall be made for all claims submitted by the Provider by either an actual or electronic signature during either the claims submission or claims payment process.

A.67. Provider Discrimination Prohibited

The Contractor shall have in place written policies and procedures for the selection and/or retention of providers and policies and procedures must not discriminate against particular provider that specialize in conditions that require costly treatment. The Contractor shall not discriminate in the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. The Contractor's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination.

A.68. Provider Non-Inclusion Notice

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

A.69. Provider Advocacy for Enrollee

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

a. for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

b. for any information the enrollee needs in order to decide among all relevant treatment options;

c. for the risks, benefits, and consequences of treatment or non-treatment; and

d. for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

A.70. Provider Identification of Third Party Liability (TPL)

The Contractor shall ensure that the dental provider shall use the best available information to identify enrollees with primary insurance other than TennCare or CoverKids. TennCare is always the payor of last resort. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the Contractor receives notification from TennCare of the enrollee's eligibility.

A.71. False Claims Act Requirements

The Contractor shall specify that the dental provider shall be compliant with Section 6032 of the Deficit Reduction Act of 2005 (DRA) with regard to policy development, employee training and whistle blower protection related to The False Claims Act, 31 U.S.C. § 3729-3733 et seq.

A.72. Notification of Claims Against Contractor

The Contractor shall give TennCare and 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. The Contractor shall ensure that all tasks related to the provider agreement are performed in accordance with the terms of this Contract.

A.73. Dentists Majority Ownership/Control

The Bureau of TennCare requires that dental practices providing services to enrollees be controlled by licensed dentists. No practice in which majority ownership or majority partnership interests are controlled by a non-licensed dentist(s) shall be allowed to contract with the program. Change in ownership of any practice requires a re-credentialing of the practice. A change in ownership which results in licensed dentist(s) having less than majority ownership will preclude the entity from being re-credentialed with the State DBM Programs. In the event of a conflict as to the appropriate level of care, between the TennCare medical necessity rules in 1200-13-16 and either the Providers opinion, the Provider's internal Practice guidelines, or Practice production goals, then the TennCare medical necessity rules shall prevail as the controlling standard.

A.74. ECF CHOICES

The Contractor shall draft a dental provider agreement or amendment to the existing dental provider agreements entered into with Participating Dental Providers specific to dental benefits provided under the ECF CHOICES DBM Program, which agreement shall be approved by TennCare and TDCI prior to contracting with any ECF CHOICES Participating Dental Provider. The dental provider agreement or amendment specific to the dental benefits provided under the ECF CHOICES DBM Program shall incorporate, at a minimum, the coverage criteria in Contract Sections A.107 and A.108.

SUBCONTRACTORS

A.75. Legal Responsibility

The Contractor shall be responsible for the administration and management of all aspects of this Contract and the health plan covered thereunder. , including all work relating to this Contract performed by Contractor's subcontractors or other entities on behalf of the Contractor. For the purposes of this Contract, the terms "subcontract" and "subcontractor" shall be distinguished from the terms "Provider" and "Provider Agreement", which are defined in Contract Section 62. A subcontract with a subcontractor shall refer to any agreement other than a Provider Agreement entered into by the Contractor and a third party for the performance of requirement in this Contract, such as but not limited to, claims processing and call center operations.

This Contract does not grant Contractor the unconditional right to subcontract the performance of any portion of this Contract. The Contractor shall include in all subcontracts a prohibition against the subcontractor entering into any subsequent agreements or subcontracts for any of the work

contemplated to be performed by the subcontractors for purposes of this Contract, without prior written approval of the Contractor and TennCare. In addition, all subcontracts shall include a provision making the subcontract subject to all applicable provisions of this Contract between TennCare and the Contractor and confirming the subcontractor's agreement to be bound by, and comply with, all provisions and requirements of this Contract.

No subcontract or other agreement relating to Contractor's duties and/or the requirements of this Contract shall terminate or reduce the Contractor's legal responsibility to TennCare to satisfactorily perform all requirements under this Contract.

Contractor's subcontractors shall not bill enrollees any amount greater than would be owed if the Contractor provided the services directly to the enrollees (i.e. no balance billing by providers). The Contractor must evaluate each prospective subcontractor's ability to perform the activities specified in the subcontract. Contractor must include in each subcontract, appropriate provisions for terminating the subcontract and/or imposing other remedies or sanctions if the subcontractor's performance is inadequate. The Contractor's written agreement with the subcontractors must address the methodology for identifying deficiencies in subcontractor performance and providing corrective action plans to address such deficiencies.

A.76. Prior Approval

If the Contractor elects to utilize a subcontractor, the Contractor shall obtain TennCare's prior written approval of the proposed subcontract before entering into the subcontract. TennCare may, in its sole discretion, withhold its approval of the proposed subcontract. Once a subcontract and subcontractor have been approved by the State and the subcontract is executed by all participating parties, a copy of the signature page of the fully executed subcontract shall be sent to the State within thirty (30) days of execution. The Contractor shall also obtain prior written approval from TennCare for any revisions, amendments, extensions, assignments or other changes to previously approved subcontracts and provide a copy of the fully executed signature page of each such pre-approved subcontract modification document to TennCare within thirty (30) days of execution.

A.77. Subcontractor Nondiscrimination Provisions

If the Contractor delegates its responsibilities under this Agreement to subcontractors, the Contractor shall require the direct service subcontractors to comply with the following nondiscrimination requirements:

a. Specify that the subcontractor agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of the delegated responsibilities pertaining to this Contract or in the employment practices of the subcontractor on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal and State laws and regulations;

b. Specify that the subcontractor have written procedures and policies for the provision of free language interpretation and translation services including auxiliary aids and services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;

c. Require the subcontractor to agree to cooperate with TennCare and the Contractor during discrimination complaint investigations, and

d. Require the subcontractor to assist TennCare enrollees in obtaining discrimination complaint forms and contact information for the Contractor's Nondiscrimination Office.

A.78. Assignability of Subcontracts

Claims processing subcontracts must include language that requires that the subcontract agreement shall be assignable from the Contractor to the State, or its designee: i) at the State's discretion upon written notice to the Contractor and the affected subcontractors; or ii) upon Contractor's request and written approval by the State. Further, the subcontract agreement must include language by which the subcontractors agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the Contractor.

A.79. Claims Processing

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

A.80. HIPAA Requirements.

The Contractor shall require all its subcontractors adhere to the HIPAA regulation requirements stipulated in Contract Section D.20.

A.81. Notice of Subcontractor Termination

When a previously approved subcontract that relates to the provision of services to enrollees or claims processing services pursuant to this Contract is being terminated between the Contractor and its subcontractor, the Contractor shall give at least thirty (30) days prior written notice of the termination to TennCare and the TennCare Division, TDCI. Such notice shall include, at a minimum, whether the Contractor intends to change to another subcontractor for the provision of said services, the identity of the current subcontractor and, if applicable, the identity of the proposed subcontractor who will assume the current subcontractor's responsibilities, the effective date for termination and/or change to another subcontractor, as well as any other pertinent information that may be required by TennCare. In addition to prior written notice, the Contractor shall also provide TennCare with a copy of the proposed subcontract it intends to use, and, if applicable, a transition plan, when requested, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontracting requirements may result in the application of liquidated damages as described in Attachment B and Section E.10. of this Contract. TennCare reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

A.82. Notice of Approval

Approval of subcontracts shall not be considered granted unless TennCare issues its approval in writing

A.83. Subcontract Relationship and Delegation

In addition to any other requirements for subcontracting set forth in this Contract, if the Contractor delegates responsibilities to a subcontractors, the Contractor shall assure that the subcontracting relationship and subcontracting document(s) comply with the requirements of the Balanced Budget Act of 1997, including but not limited to, compliance with the applicable provisions of 42 CFR § 438.230(b) and 42 CFR§ 434.6 as described below.

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

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

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

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

CLAIMS PROCESSING REQUIREMENTS

A.84. General Requirements

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

A.85. Electronic Billing System

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

Claim Type	Claim Form
Dental	*ADA*

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

A.86. HIPAA

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

A.87. Timeliness and Accuracy of Payment

The Contractor agrees to comply with prompt pay claims processing requirements in accordance with T.C.A. §56-32-126 and shall ensure that ninety percent (90%) of claims for payment of services delivered to an enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of receipt of such claims. The Contractor shall process, and if appropriate pay, within sixty (60) days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee. "Pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to Contractor. "Process" means the Contractor must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. If requested by the provider, the Contractor shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment. The status report shall contain appropriate explanatory remarks related to payment or denial of the claims. The Contractor shall contract with independent reviewers for the purposes of said reviewers to review disputed claims as provided by T.C.A. § 56-32-126. Failure to comply with the aforementioned claims processing requirements shall result in the Contractor being required to implement a corrective action plan and shall result in the application of liquidated damages as described in Section E.10 and Attachment B of this Contract.

A.88. Enrollee Eligibility

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

A.89. Payment in Full

When eligibility has been established by TennCare and the enrollee has incurred dental expenses for dental services which are medically necessary and are covered benefits under the applicable State DBM Program plan, the Contractor shall reimburse the provider in accordance with Section A.158 of this Contract. If the service was provided by an out of network provider, whom the Contractor has agreed to pay only for a specific service, the Contractor shall assure

that the enrollee is held harmless by the provider for the costs of the service or procedure. The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor or appropriate denial made by the Contractor.

MANAGEMENT INFORMATION SYSTEMS REQUIREMENTS

A.90. Data Mapping.

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

A.91. Daily Enrollment Updates.

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

A.92. Contractor Interface Requirements.

Successful operation of the program requires ongoing interfaces with MMIS and the Contractor's system. The TennCare interface standard for data transfers will be via VPN to TennCare's SFTP server. In order to ensure the security and confidentiality of all transmitted files, the Contractor must have a system that is ARRA HITECH security compliant.

A.93. Requirements Prior To Operations

a. Licensure

1. Before the start date of operations and prior to accepting TennCare enrollees, the Contractor must hold all necessary, applicable business and professional licenses, including appropriate licensure from the Tennessee Department of Commerce and Insurance (TDCI). The Contractor must hold a license to act as an Administrator pursuant to Tennessee Code Annotated § 56-6-410, unless otherwise licensed pursuant to Tennessee Code Annotated § 56-6-401(3). The contract must include evidence that the Contractor either holds a current license to act as an Administrator in Tennessee or has submitted an application to TDCI to obtain such licensure.

2. If the Contract is amended to require the Contractor to bear financial risk of TennCare covered dental services, the Contractor must obtain an appropriate license from TDCI to operate as a risk-bearing entity prior to the start date of such operations.

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

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

requirements.

b. Readiness Review

1. Prior to the start date of operations, as determined by TennCare, the Contractor shall demonstrate to TennCare's satisfaction that it is able to meet the requirements of this Contract.

2. The Contractor shall cooperate in a readiness review conducted by TennCare to review the Contractor's readiness to begin operations. This review may include, but is not limited to, desk and on-site review of documents provided by the Contractor, a walk-through of the Contractor's operations, system demonstrations (including systems connectivity testing), and interviews with Contractor's staff. The scope of the review may include any and all requirements of this Contract as determined by TennCare.

3. The Contractor shall work in cooperation with TennCare to ensure that their information system, claims processing system, encounter files, eligibility files and all other systems, files and/or processes satisfy all functional and informational requirements of the State Dental Programs. The Contractor shall assist TennCare in the analysis and testing of these systems prior to the delivery of services. The Contractor shall provide system access to allow TennCare to test the Contractor's system through the TennCare network. Any software or additional communications network required for access shall be provided by the Contractor.

4. Based on the results of the review activities, TennCare will issue a letter of findings and, if needed, will request a corrective action plan from the Contractor. TennCare enrollees may not be enrolled with the Contractor until TennCare has determined that the Contractor is able to meet the requirements of this Contract.

5. If the Contractor is unable to demonstrate its ability to meet the requirements of this Contract, as determined by TennCare, within the time frames specified by TennCare, TennCare may terminate this Contract in accordance with Section D.6 of this Contract and shall have no liability for payment to the Contractor.

A.94. Provider Assistance.

The Contractor shall be available Monday thru Friday, 7:00 am – 5:00 pm Central Time and corresponding hours during periods of Daylight Savings Time to respond to provider inquiries related to prior authorization requests and claims status.

A.95. Help Desk for Prior Approval Operations.

a. The Contractor shall maintain a toll-free telephone access to support the prior authorization process, available between the hours of 7:00 a.m. and 5:00 pm, Central Time, Monday through Friday to respond to questions about prior authorization requests.

b. Service Level Performance Standards. The Contractor shall provide sufficient staff for "live" answering services during operational hours to meet the following performance

standards for each queue within the Service Center. For all Performance Standards measured in percentages, calculations for said percentages shall be made using the following standard: less than five-tenths (.5) of a percentage point will round down to the nearest percentage point and five-tenths (.5) and over will round up to the nearest percentage point.

1. Daily Maximum Speed of Answer: The Service Center shall answer one hundred percent (100%) of non- abandoned calls within five (5) minutes, or three hundred (300) seconds.

2. Daily Abandonment Rate. The Service Center shall maintain an average daily abandonment rate of five percent (5%) or less, excluding calls abandoned before thirty (30) seconds.

3. Daily Average Speed of Answer. The Service Center shall maintain a Daily Average Speed of Answer (ASA) of sixty (60) seconds or less. Calls answered in less than sixty (60) seconds but placed on hold within the first sixty (60) seconds of answer shall be deemed a failure to satisfy the ASA requirement.

4. Blocked Call Rate. The Service Center shall maintain a Blocked Call Rate of one percent (1 %) or less at all times without exception.

c. Failure by the Contractor to meet the aforementioned Service Level Performance Standards may result in Liquidated Damages as set out in Attachment B.

A.96. Data Validation Edits and Audits.

The Contractor's claims processing system shall perform the following validation edits and audits:

a. Prior Authorization - The system shall determine whether a covered service requires prior authorization, and if so, whether approval was granted by the Contractor;

b. Valid Dates of Service - The system shall assure that dates of services are valid dates, are no older than one hundred eighty (180) days from the date of prior authorization, if such prior authorization was required, and are not in the future. For orthodontics, the system shall assure that dates of service are valid dates meeting TennCare Rules 1200-13-13.04 and 1200-13-14.04;

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

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

e. Provider Validation - The system shall approve for payment only those claims received from providers eligible to provide dental services and have a National Provider Identifier (NPI) per HIPAA Legislation requirements;

f. Enrollee Validation - The system shall approve for payment only those claims for enrollees eligible to receive dental services at the time the service was rendered;

g. Eligibility Validation – The system shall confirm the enrollee for whom a service was provided was eligible on the date the service was incurred;

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

i. Rejected Claims - The system shall determine whether a claim is HIPAA compliant and therefore acceptable for adjudication and reject claims that are not, prior to reaching the adjudication system, and,

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

A.97. Data Exchange with Managed Care Organizations and Pharmacy Benefits Manager

The Contractor shall develop, prior to program implementation and maintain thereafter through the duration of this Contract, a system for data exchange with MCOs and PBM, including, but not limited to, functionality to exchange with MCOs and the PBM the following information: referrals; treatment plans; stratification of proposed treatment plan procedures; authorizations; and other information as determined necessary by TennCare. This shall be achieved in part by the development and maintenance of a web portal as required by Contract Section A.48.

A.98. Prior Approval Request Tracking.

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

A.99. System Security.

The Contractor shall apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and to communicate the results in an Information Security Plan provided prior to the delivery of services. The risk analysis shall also be made available to appropriate Federal agencies. The following specific security measures should be included in the system design documentation and operating procedures:

a. Computer hardware controls that ensure acceptance of data from authorized networks and providers only;

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

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

d. Multilevel passwords, identification codes or other security procedures that shall be used by State agency or Contractor personnel;

e. All Contractor MIS software changes are subject to TennCare approval prior to implementation, and

f. System operation functions shall be segregated from systems development duties.

A.100. Disaster Preparedness and Recovery at the Automated Claims Processing Site.

The Contractor shall submit evidence that they have a Business Continuity/Disaster Recovery plan for their Central Processing Site. If requested, test results of the plan shall be made available to TennCare. The plan shall be able to meet the requirements of any applicable state and federal regulations, the TennCare rules, policies, and guidelines, and the State of Tennessee's STS. The Contractor's Business Continuity/Disaster Recovery Plan shall include sufficient information to show that they meet the following minimum requirements:

a. 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 shall be in the form of a formal Disaster Recovery Plan. The Contractor shall 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;

b. Employees at the site shall be familiar with the emergency procedures;

c. Smoking shall be prohibited at the site;

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

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

f. The site shall be protected by an automatic fire suppression system; and

g. The site shall be backed up by an uninterruptible power source system.

A.101. Transition Upon Termination Requirements.

Prior to the end of the Contract term or extension of the Contract term, or In the event of a Contract Termination or Partial Takeover pursuant to Contract Sections D.5, D.6 and E.11, the State may contract with a successor contractor (Successor Contractor) to assume Contactor's duties and requirements upon termination of this Contract. This will result in a period of transition during which Contractor continues to provide services while the Successor Contractor prepares to assume those services, with a switch over from the Contractor to the Successor Contractor occurring on an Implementation date specified by the State. The Contractor shall be required to participate as directed by the State, at no additional cost, in assisting with the transition by providing information relating to Contractor's duties and attending meetings with the State and/or Successor Contractor.

Contractor shall help State and/or Successor Contractor develop a Transition Plan. Contractor shall at all times act in good faith towards the State and/or Successor Contractor to facilitate as smooth a transition as possible. The State shall not be liable to the Contractor for any costs and expenses relating these deliverables or to the services provided by the Contractor during the transition period, other than as set forth in Contract Section C.3.

A.102. Additional System Requirements

a. The Contractor's DBM system must be capable of accepting and consuming information from an 837D file, which will be sent from the internal Provider Data Management System (PDMS) on a weekly basis.

b. The Contractor's DBM system must be capable of receiving, consuming, and sending eligibility and enrollment data from an 834 file which will be sent and received from the State of Tennessee on a weekly basis, or such other schedule as the State may determine..

c. The Contractor's DBM system must be capable of receiving, consuming, and sending eligibility and enrollment data from an 834 file from TEDS for CoverKids on a regular basis, as determined by the State from the State of Tennessee's Eligibility & Enrollment System.

d. The Contractor's DBM system must send X12 compliant data as outlined in the Tennessee 837D Companion Guide.

e. The DBM system must be capable of providing data to TennCare's Fraud and Abuse reporting department.

A.103. Technical Requirements for TPPOHP DBM Program

At the TennCare Programs Go-Live date and the CoverKids Program Go-Live, respectively, and the Alternative TPPOHP Program Go-Live Date , if applicable, the Contractor's DBM system shall accept and consume eligibility information and other program data from MMIS in the form of an 834 file for purposes of the TPPOHP DBM Program. However, TennCare may require system changes in support of the TPPOHP DBM Program during the term of the Contract. If TennCare requires such changes at a future date, then the Contractor shall make the necessary system changes under TennCare's direction. These changes could include but are not limited to new or augmented interfaces, reporting, data collection and flagging to make the program successful. TennCare shall notify Contractor six (6) months in advance of required changes in order for Contractor to implement said changes.

A.104. Tennessee Eligibility Determination System (TEDS)

Upon implementation of TEDS, the Contractor shall continue the eligibility interface with TennCare and the Contractor must be in sync with the State's Tennessee Eligibility and Determination System (TEDS). All outbound 834 files from the state shall be loaded to the Contractor's database within twenty-four (24) hours of receipt from the State. This requirement includes any 834 transactions that must be handled manually by the Contractor. Additionally, should TennCare require, the Contractor's DBM system shall receive a second eligibility file for

the CoverKids population as well have the ability to capture new data made available in the 834 file.

COVERED BENEFITS

A.105. Covered Benefits

The Contractor shall provide or arrange for the provision of Covered Benefits to enrollees in accordance with the terms of the applicable TennCare DBM Program, including but not limited to, Section A.5 of this Contract.

A.106. Medical Necessity Determination

All Medical Necessity Determinations shall abide by the specific definitions and guidelines set forth in the statutes and TennCare Rules, including T.C.A. § 71-5-144 and TennCare Rules 1200-13-16-.01 through 1200-13-16-.08, and any and all amendments and/or revisions thereof. The Contractor shall not impose service limitations that are more restrictive than the limits described in this Contract. However, this provision shall not limit the Contractor's ability to establish procedures for the determination of medical necessity. The determination of medical necessity shall be made on a case by case basis. The Contractor shall not employ or permit others acting on its behalf, to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each enrollee and his/her medical history. The Contractor shall have the ability to place tentative limits on a service, however, such tentative limits placed by the Contractor shall be exceeded when medically necessary based on a enrollee's individual characteristics. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The Contractor may deny services that are non-covered, except as otherwise required by EPSDT or unless otherwise directed to provide by TennCare and/or an administrative law judge. Any procedures used to determine medical necessity shall be consistent with the definition of medical necessity defined by this Contract and applicable TennCare rules. All medically necessary services shall be covered for enrollees in accordance with their respective State DBM Program, in accordance with EPSDT requirements, including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. Braces may be covered for enrollees age twenty-one (21) and over as per the individual enrollee's Dental Benefit, TennCare Rules 1200-13-13.04 and 1200-13-14.04. Effective upon receipt of written notification from TennCare, the Contractor is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of twenty-one (21).

A.107. Coverage Criteria Determinations for Sedation for ECF CHOICES

The Contractor shall also determine coverage criteria for adjunctive sedation services, including appropriate deep sedation or general anesthesia provided in the dental office setting for individuals with intellectual and developmental disabilities enrolled in the ECF CHOICES program, and shall minimize the need for intravenous sedation or general anesthesia whenever possible and medically appropriate. Sedation services are only provided based upon the needs of the Member and not the convenience of the provider. The coverage criteria shall be included in the Office Reference Manual (ORM) and shall be incorporated into the provider agreement. Instances where sedation services may be appropriate include dental services for ECF CHOICES members:

a. Who are extremely uncooperative, fearful, anxious, unmanageable, or physically resistant; and

b. Have dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain, infection, loss of teeth, or other increased oral or dental morbidity; and

c. For which dental treatment under local anesthesia, and other alternative adjunctive techniques and modalities have not been successful in producing a successful result and which, under general anesthesia, can be expected to produce a superior result;

A.108. Coverage Criteria Determinations for ECF CHOICES

The Contractor shall establish coverage criteria for authorization of dental treatment of individuals with intellectual and developmental disabilities, as needed, in medical facilities including an ECF specific In-Patient and Out-Patient Hospital Readiness Pre-Admission Forms.

A.109. Prior Authorization for Covered Services

The Contractor and/or its subcontractors shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services; have effective 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, subcontractor 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 were misrepresented 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 that include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCC to act timely upon a request. The Contractor shall 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 shall have written procedures documenting access to Dental Specialty Consultants to assist in making medical necessity determinations. A 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.

a. Adverse Prior Authorization Decision necessitates issuance of Notice of Adverse Benefit Determination. The Contractor shall clearly document and communicate the reasons for each denial in a manner sufficient for the provider and enrollee to understand the denial basis. The Notice of Adverse Benefit Determination shall meet the requirements set forth in Section A.119.

1. Provider Notice - The Contractor shall 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. After notice to the provider is issued, the Contractor shall make a reviewer available to discuss any denial decisions. The information given to the provider shall include the contact information for the reviewer.

2. Enrollee Notice. Contractor shall abide by the notice provisions in TennCare Rule 1200-13-13-.11 and 1200-13-14-.11.

b. Appeals Related to Prior Authorization/Medical Necessity Denials - The Contractor is responsible for eliciting the necessary, pertinent medical history information from the treating health care provider(s) for making medical necessity determinations. If a treating health care provider is uncooperative in supplying needed information, the Contractor shall take action (e.g. sending a provider representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem. Upon request, documentation of such action shall be made available to TennCare. Pursuant to TennCare Rule 1200-13-16-.06(4) providers who do not provide requested medical record information for purposes of making a medical necessity determination for a particular medical item or service, shall not be entitled to payment for the provision of such medical item or service.

c. The Contractor shall provide the individualized medical record information from the treating health care provider(s) that supports a decision relevant to a medical appeal. The Contractor shall take the necessary action to fulfill this responsibility within the required appeal timelines specified by TennCare and/or applicable regulation. This includes going to the provider's office to obtain the medical record information including but not limited to the provider's treatment plan, records from the referral dentist, medical records from the primary physician, radiographs, OrthoCAD, study model, study casts, photographs of models, the hospital readiness form and orthodontic readiness form. Should a provider fail or refuse to respond to the Contractor's efforts to obtain medical information and the appeal is decided in favor of the enrollee, then the Contractor shall use its discretion or follow a TennCare directive to impose appropriate financial penalties against the provider.

A.110. EPSDT

The Contractor shall provide EPSDT services as medically necessary to children under the age of twenty-one (21), who are eligible for EPSDT, in accordance with federal regulations described in 42 CFR part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under twenty-one (21), whether or not such services are covered under the State DBM Program plan and without regard to established service limits. When appropriate, this requirement shall be met by either direct provision of the service by the Contractor or by referral in accordance with 42 CFR 441.61.

A.111. Standards of Care

The standards of care shall be taken from published recommendations of nationally recognized authorities, such as: the American Dental Association; the American Academy of Pediatric Dentistry; the American Academy of Developmental Medicine and Dentistry; and the American Association of Oral and Maxillofacial Surgeons. The standard of care for the community shall be recognized. Participating Dental Providers shall not differentiate or discriminate in the treatment of any enrollee on the basis of race, color, sex, religion, national origin, age, handicap, health, economic status, or payment source. In the event of a conflict between a Provider's opinion as to the appropriate standard of care and the TennCare medical necessity rules in 1200-13-16 the TennCare medical necessity rules shall provide the controlling standard.

A.112. Transportation

Transportation to covered services is a covered service for TennCare enrollees and is the responsibility of the enrollee's MCO. Should transportation to a dental service be necessary for an enrollee, the Contractor shall coordinate with the appropriate MCO to ensure that the transportation is provided.

A.113. Coordination with and Management of Public Health's School Based Dental Encounter Data Files

The Contractor shall manage the encounter data files for TennCare enrollees seen in the Tennessee Department of Health's School Based Dental Prevention Program (SBDPP) in accordance with the specifications, format and timeframes outlined in the TennCare's Policy regarding the School Based Encounter File found at the following link http://www.tennessee.gov/tenncare/forms/schoolbasedencounter.pdf. TennCare children with urgent dental treatment needs and unmet dental treatment needs identified in the SBDPP shall require Contractor to arrange care for these children according to the access standards identified in Section A.23 of this Contract. Close coordination between the Oral Health Services Section of the Tennessee Department of Health and the Contractor will be necessary to facilitate referral arrangements and to ensure that encounter data files from the SBDPP are incorporated into encounter data files provided to TennCare.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

A.114. EPSDT Dental Services

Contractor shall require Dental Providers to follow practice guidelines for preventive health services identified by TennCare including EPSDT. EPSDT includes timely provision of exams, cleaning, fluoride treatment, silver diamine fluoride treatments, sealants and referral for treatment of Child Enrollees. Performance objectives have been established for providing EPSDT services. Contractor shall be evaluated on those performance objectives using the annual CMS 416 report which measures the following: any dental service provided using ADA CDT codes D0100-D9999; preventive dental services provided using ADA CDT codes D1000-D1999; and dental treatment services provided using ADA CDT codes D2000-D9999.

A.115. Contractor's Outreach Activities

The Contractor shall conduct regularly scheduled outreach activities designed to educate enrollees about the availability of EPSDT services and to increase the number of children receiving services.

a. Within forty-five (45) days of TennCare Programs Start Date, the Contractor shall submit a proposed outreach plan.

1. The Contractor's plan shall identify the target populations, service areas, specific outreach activities, including numbers of screens to be conducted, schedule for completion and include copies of any material to be released to enrollees.

2. The proposed plan and any related material shall require approval by TennCare. TennCare shall have thirty (30) days to review material and provide notice of approval or notice to make changes.

3. A minimum of seventy-five (75) outreach events per year shall be conducted with no less than fifteen (15) per quarter, equally distributed across all three regions. At least twenty-five (25) of the member related activities and/or events must be conducted in rural areas each year. Results of the Contractor's CMS 416 dental screening rates as well as county demographics must be utilized in determining counties for targeted activities and in developing strategies for specific populations.

4. The Contractor shall contact a minimum of twenty-five (25) state agencies or community-based organizations per quarter, to either educate them on services available through the Contractor or to develop outreach and educational activities. Collaborative activities should include those designed to reach enrollees with limited English proficiency, special health care needs, or those who are pregnant.

5. The Annual Outreach Plan shall be updated annually and submitted no later than August 15 in a format specified by TennCare. The Annual Outreach Plan will be effective for the Federal Fiscal Year, which is October 1-September 30. An annual Year-End Update of the Plan shall be due no later than sixty (60) days following the end of a Federal Fiscal Year in a format specified by TennCare. The Year-End Update shall include, but is not limited to, an assessment of the events that were conducted in the previous Federal Fiscal Year.

6. The Contractor shall be responsible for distributing annual notices to enrollees of their dental benefit encouraging them to schedule a dental appointment.

b. The Contractor is required to participate in the Managed Care Contractor (MCC) and Tennessee Department of Health Collaborative, and is required to submit quarterly a dental article for publication in the MCO teen newsletter or other member newsletter as required by TennCare according to a timeframe prescribed by TennCare.

c. The Contractor shall submit quarterly reports of outreach activities in a format specified by TennCare thirty (30) days after the end of each Federal Fiscal Year quarter.

d. If the Contractor's CMS 416 dental screening rate is below eighty percent (80%), the Contractor shall conduct a new initiative, approved by TennCare, to increase participation of all children who have not received screenings.

Failure to comply with the requirements of this Section may result in the application of liquidated damages as provided in Section E.10. and Attachment B of this Contract.

GRIEVANCES AND APPEALS

A.116. TennCare Children's DBM Program, TennCare ECF CHOICES DBM Program, and TPPOHP DBM Program

Contract Sections A.116 through A.132 shall only apply to the TennCare Children's DBM Program, TennCare ECF CHOICES DBM Program, and TPPOHP DBM Program.

A.117. Appeal Process Changes

a. The Contractor shall be a Prepaid Ambulatory Health Plan (PAHP), as defined in 42 CFR § 438.2, and shall provide all services required in compliance with applicable provisions of the Centers for Medicare and Medicaid Services (CMS) final Managed Care Rule (CMS Managed Care Rule) set forth in 42 CFR §§ 431, 433, 438, 440, 455, 457, 496, *et seq*., and all other applicable State and federal statutes, rules and requirements. CMS has determined that the Reconsideration phase of TennCare's existing State Fair Hearing (SFH) process satisfies the part 438 requirement for a Contractor-level appeal process. Accordingly, enrollees will not be required to exhaust an appeal with the Contractor before requesting a SFH.

b. As permitted under federal and state law, TennCare, at its sole discretion, may delegate back to itself any portion of this Grievances and Appeals Section (Contract Sections A.116 through A.132 that the Contractor is obligated to perform. The Contractor understands that the Grievance and Appeal process requirements are always subject to change based on legal developments and on TennCare's interpretation of its obligations under new or existing law.

c. Eligibility Appeals. Contractor understands that if it receives an appeal related to TennCare eligibility (as distinguished from a service-related appeal), the eligibility appeal must be sent to TennCare's Division of Eligibility within one business day of receipt.

d. Contractor Appeals Staff.

1. The Contractor shall have a designated business unit responsible for processing Grievances and SFH requests (Contractor's Appeals Unit) in accordance with applicable provisions of 42 CFR 438 Subpart F and TennCare Program requirements. The Contractor shall supply TennCare with the names, responsibilities and contact information of these staff members. The Contractor's Appeals Unit shall include sufficient numbers of appropriately trained and licensed dentists, physicians, clinicians, and support staff necessary to timely process and resolve Grievances and SFH requests in accordance with the terms of this contract. The Grievance and SFH process requirements are subject to change based on changes in State and federal law, statutes, rules and policies and on the State's interpretation of its obligations under new or existing law.

2. The Contractor shall provide general and targeted education to Contractor's Appeal Unit staff and to its TennCare providers regarding the Grievance and SFH process. This training shall cover the TennCare provider's rights and obligations concerning the Grievance and SFH Process, including but not limited to, provider's obligation to timely supply medical or other records necessary for resolving the Grievance or SFH. Additionally, the provider training must include training on the requirements related to Prior Authorization; Medical Necessity; Utilization Review; Continuation of Benefits pending the appeal's resolution; filing appeals on an enrollee's behalf (and on the enrollee consent forms necessary to do so); and the specific requirements related to expedited and standard appeal resolution.

3. The Contractor must provide written notice and written instruction to its contracted providers regarding provider responsibility in the Appeal process.

A.118. Enrollee Grievance and State Fair Hearing (SFH) Process.

a. Grievance System. Contractor shall have a formally structured internal Grievance System in place for TennCare enrollees, as required by 42 CFR §438.402(a)-(b) and 42 CFR §438.228(a).

b. TennCare SFH System. TennCare, on written approval from CMS, has delegated back to itself certain aspects of the appeal process set forth under 42 CFR 438 subpart F. Specifically, Contractor will not have its own internal Appeal System for enrollee appeals. Enrollees will not exhaust an internal appeal process with Contractor before being permitted to request a SFH. Accordingly, the provisions in 42 CFR § 438.402 that relate to a Contractor-level appeal system do not apply under this Contract. The Enrollee will be offered these protections through the SFH process and through the SFH's Reconsideration phase.

c. Prior Authorization (PA) Determination Timeframe. In accordance with 42 CFR § 438.210, Contractor shall respond to the requesting provider within 14 days of receiving the PA request. If the Contractor determines that following the 14-day timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited service authorization decision and provide notice as expeditiously as the enrollee's health condition requires.

d. Adverse Prior Authorizations Determinations. Contractor's decision to deny provider's PA request (either in whole or in part) triggers additional requirements. If Contractor denies a provider's PA request, Contractor must notify the requesting provider and Contractor must issue a written Notice of Adverse Benefit Determination (NABD) to the enrollee on whose behalf the PA request was submitted. Contractor's NABD must be issued on the same day as the adverse PA decision (that is, within 14 days of receiving the PA request, or sooner, in accordance with the previous paragraph, if the enrollee's health condition requires). The NABD must satisfy the notice content requirements prescribed by 42 CFR §438.404(b) and the notification standards prescribed by 42 CFR §438.10. [42 CFR §438.3(s)(6); 42 CFR §438.210(d)(1); 42 CFR §438.404]

1. When Contractor is required to provide written notice to enrollee, Contractor shall do so using TennCare-approved notice templates.

e. Reasonable Assistance with Grievance and Request for SFH.

1. In accordance with 42 CFR §438.406(a) and 42 CFR §438.228(a), Contractor shall give enrollees any reasonable assistance in completing grievance and SFH request forms and other procedural steps related to a grievance or SFH request. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with Teletypewriter/Telephone/ Telecommunication Device for the Deaf (TTY/TDD) and interpreter capability.

2. In accordance with 42 CFR §438.406(b) and 42 CFR §438.228(a), Contractor shall acknowledge receipt of an enrollee grievance. If Contractor receives an

enrollee appeal or SFH request, Contractor must, within one business day, submit the appeal or SFH request to TennCare. TennCare will send enrollee an acknowledgement letter and inform enrollee that matter will be treated as a request for a SFH.

f. Decision-Makers.

1. In accordance with 42 CFR §438.406(b)(2) and 42 CFR §438.228(a), Contractor shall ensure that decision makers on grievances, and decision-makers responsible for rendering a medical review of Contractor's proposed ABD during the Reconsideration stage of the SFH process, were not:

(a) Involved in any previous level of review or decision-making; or

(b) Subordinates of any individual who was involved in a previous level of review or decision-making.

2. Clinical Expertise of Decision-Maker. In accordance with 42 CFR §438.406(b)(2) and 42 CFR §438.228(a), the decision-maker shall have appropriate clinical expertise, as determined by TennCare, in treating the enrollee's condition or disease if the decision involves one (1) of the following:

(a) the Reconsideration phase of an SFH request involving a denial based on lack of medical necessity;

(b) grievance regarding denial of expedited resolution of a request for SFH; or

(c) grievance or SFH request involving clinical issues.

3. Decision-makers shall take into account all comments, documents, records, and other information submitted during the PA or SFH process without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

A.119. Notice of Adverse Benefit Determination Requirements

a. Notice of Adverse Benefit Determination (NABD). In accordance with 42 CFR §438.404(b), the Contractor shall issue a NABD to the enrollee, which explains the Adverse Benefit Determination the Contractor has made or intends to make and the reasons for the adverse benefit determination.

b. The NABD shall explain the reasons for the Adverse Benefit Determination, including the right of the enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's Adverse Benefit Determination. Such information includes, but is not limited to, medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. See 42 CFR §438.404(b)(2).

c. In accordance with 42 CFR §438.404(b), and §438.402(b)-(c), the NABD shall explain the enrollee's right to request a SFH to contest Contractor's Adverse Benefit Determination.

d. In accordance with 42 CFR §438.404(b), the NABD shall explain the procedures for exercising the enrollee's rights to request a SFH, and, the circumstances under which the SFH process can be expedited.

e. In accordance with 42 CFR 438.404(b)(6), the NABD shall explain the enrollee's right to have benefits continue pending the resolution of the SFH, how to request that benefits be continued, and the circumstances, consistent with TennCare policy, under which the enrollee may be required to pay the costs of continued services.

f. Contractor's NABD templates shall be prior-approved by TennCare and shall be written in a format and language that, at a minimum, meets applicable notification standards set forth at 42 CFR §438.10, and the notice-content requirements prescribed by 42 CFR §438.404(b).

A.120. Notice of Adverse Benefit Determination Timing

a. When the Contractor's Adverse Benefit Determination is a termination, suspension, or reduction of previously authorized Medicaid-covered service, the Contractor must mail the notice of Adverse Benefit Determination at least ten (10) days before the date of action. See 42 CFR §438.404(c)(1); 42 CFR §431.211.

b. The Contractor may mail the notice of Adverse Benefit Determination as few as five (5) days prior to the date of action if the TennCare agency has facts indicating probable fraud by the enrollee, and the facts have been verified, if possible, through secondary sources. See 42 CFR §438.404(c)(1); 42 CFR §431.214.

c. Timing for NABD. The Contractor shall give notice of Adverse Benefit Determination as expeditiously as the enrollee's condition requires within fourteen (14) calendar days following receipt of the request for service, for authorization decisions that deny or limit services. See 42 CFR §438.210(d)(1); 42 CFR §438.404(c)(3).

d. If the Contractor fails to timely render a PA determination, the Contractor shall issue the NABD to enrollee on the date that the PA timeframe expires. [42 CFR §438.404(c)(5)]

e. Timing of NABD for Denial of Reimbursement. Pursuant to 42 CFR §438.404(c)(2),the Contractor shall issue NABD on the date of determination when the action is a denial of enrollee's request for of reimbursement for benefits enrollee paid for out-of-pocket.

f. The Contractor may extend the 14 calendar day notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional calendar days if the enrollee or the provider requests extension. See 42 CFR §438.404(c)(4); 42 CFR §438.210(d)(1)(i).

g. The Contractor may extend the 14 calendar day notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional calendar days if the Contractor justifies to the TennCare agency a need for additional information and shows how the extension is in the enrollee's best interest. See 42 CFR §438.210(d)(1)(ii); 42 CFR §438.404(c)(4).

h. If the Contractor extends the 14 calendar day notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services, the Contractor

must give the extension and inform the enrollee of the right to file a Grievance if the enrollee disagrees with the decision. See 42 CFR §438.210(d)(1)(ii); 42 CFR §438.404(c)(4)(i).

i. If the Contractor extends the 14 calendar day notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services, the Contractor must issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. See 42 CFR §438.210(d)(1)(ii); 42 CFR §438.404(c)(4)(ii).

j. If the Contractor determines that following the standard authorization timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited service authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. See 42 CFR §438.210(d)(2)(i); 42 CFR §438.404(c)(6).

k. The Contractor may extend the seventy-two (72) hour expedited service authorization decision time period by up to fourteen (14) calendar days if the enrollee requests an extension, or if the Contractor justifies to the TennCare agency the need for additional information and how the extension is in the enrollee's interest. See 42 CFR §438.210(d)(2)(ii); 42 CFR §438.404(c)(6).

A.121. Who May File Appeals and Grievances

a. Grievances. The Contractor shall allow enrollees to file grievances.

b. Appeal requests filed with Contractor instead of with TennCare. Contractor shall, within one business day or sooner, forward to TennCare any enrollee appeal requests that are filed with Contractor. TennCare will acknowledge receipt and treat the appeal request as a request for a SFH. [42 CFR §438.402(c)(1); 42 CFR §438.408]

c. The Contractor shall allow enrollee-authorized representatives, acting on behalf of the enrollee and with the enrollee's written consent, to file a grievance or request a SFH. The enrollee's provider may serve as an authorized representative, but (pursuant to 42 CFR §438.402(c)) enrollee's provider may not file a request for continuation of benefits. [42 CFR §438.402(c)(1)(i) - (ii); 42 CFR §438.408]

A.122. Timeframes for Filing State Fair Hearing Requests

Enrollee must file a request for a SFH within sixty (60) calendar days from the date on the Contractor-issued NABD. [42 CFR 438.402(c)(2)(ii)]

A.123. Process for Filing a Standard or Expedited SFH Request

a. Enrollee may request a SFH either orally or in writing. [42 CFR 438.402(c)(3)(ii)]

b. Enrollee's treating provider, or an enrollee-authorized representative acting on behalf of the enrollee, may file a request for SFH either orally or in writing. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

c. Unless the SFH warrants expedited resolution, the oral filing of a request for SFH shall be followed by a written, signed request for SFH. [42 CFR 438.402(c)(3)(ii)]

d. The filing date of an oral request for SFH is the date of the oral request, not the date on which it is ultimately followed by a written, signed request for SFH. [42 CFR 438.406(b)(3)]

e. When enrollee files a request for an expedited SFH, TennCare will issue an On Request Report (ORR) to Contractor. The ORR requires Contractor to determine whether the prospective SFH warrants expedited or standard resolution and, within one business day of the ORR's issuance, notify TennCare of its decision.

1. If the enrollee's SFH request warrants expedited resolution, the Contractor shall complete its Reconsideration review and submit its Reconsideration decision to TennCare, along with the other information requested in the ORR, within seventy-two (72) hours of the time that the SFH request was filed.

2. If the Contractor determines that the SFH request warrants standard resolution, Contractor shall complete its Reconsideration review and submit its Reconsideration decision to TennCare, along with the other information requested in the ORR, within 14 days of the time that the SFH request was filed.

3. A benefit under dispute warrants expedited resolution if the Contractor determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]

4. Contractor's Reconsideration response to TennCare must contain the following:

(a) complete case file,

(b) medical records and history pertaining to the benefit under dispute,

(c) NABD issued to enrollee,

(d) PA Decision issued to requesting provider,

(e) written medical necessity review substantiating Contractor's PA decision,

(f) written Reconsideration medical necessity review upholding or reversing original PA decision, and

(g) any additional information requested by TennCare or pertaining to the matter under dispute.

A.124. Timeframes for Resolving Standard and Expedited Appeals

TennCare and Contractor must resolve enrollee's SFH as expeditiously as the enrollee's health condition requires. Standard Appeals must be resolved within ninety (90) calendar days of receipt; Expedited Appeals must be resolved within 3 business days of TennCare's receipt of Contractor's Reconsideration Response.

A.125. Required Content for Notice of SFH Resolution

a. TennCare must provide enrollee with a written and dated notice of SFH resolution. The notice of SFH resolution must be in a format and language that meets 42 CFR §438.10. For Appeal decisions not wholly in the enrollee's favor, the notice must explain how enrollee may exercise the right to appeal the SFH decision.

b. If the notice of resolution concerns an expedited Appeal, in addition to the written notice described above, the Contractor must make reasonable effort to confer oral notice. See 42 CFR §438.408(d)(2)(ii).

A.126. Continuation of Benefits

a. The Contractor must not accept a continuation of benefits request from a provider, since providers are prohibited from requesting continuation of benefits pursuant to 42 CFR §438.402(c)(1)(ii) and §438.420(b)(5). The Contractor must continue the enrollee's benefits while SFH request is in process if all of the following occur:

1. The enrollee files the request for SFH within sixty (60) calendar days following the date on the Adverse Benefit Determination notice.

2. The contested issue at the SFH involves the termination, suspension, or reduction of a previously authorized Medicaid service.

3. The enrollee's services were ordered by an authorized provider.

4. The period covered by the original authorization has not expired.

5. Enrollee files the request for continuation of benefits within ten (10) calendar days of the date on the notice of Adverse Benefit Determination, or if enrollee files the request before the intended effective date of the proposed Adverse Benefit Determination. See; 42 CFR §438.420(b)(1)-(5); 42 CFR §438.402(c)(2)(ii).

b. If, at the enrollee's request, the Contractor continues or reinstates the enrollee's benefits while the State Fair Hearing is pending, the benefits must be continued until one of the following occurs:

1. The enrollee withdraws the request for State Fair Hearing; or

2. A State Fair Hearing decision adverse to the enrollee is issued. See 42 CFR §438.420(c)(1)-(3); 42 CFR §438.408(d)(2).

c. If the State Fair Hearing resolution reverses the Contractor's initial Adverse Benefit Determination, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires (but no later than seventy-two (72) hours from the date it receives notice reversing the determination). See 42 CFR §438.424(a).

A.127. TennCare Directives

a. The Contractor shall timely comply with any TennCare Directive. Contractor must authorize provision of, or reimbursement for, the benefits which were being contested at the SFH (SFH) within seventy-two (72) hours of receiving a TennCare Directive instructing Contractor to so. For example, if TennCare determines during the SFH process that the benefits under dispute are medically necessary, TennCare will issue a Directive instructing Contractor to authorize provision of the benefits under dispute. The Directive will instruct Contractor to approve provision of the benefit within seventy-two (72) hours of the Directive's issuance, or sooner if the enrollee's health condition requires. [42 CFR §438.424(a)]

b. If, during the Contractor Reconsideration phase of the SFH process, the Contractor overturns its initial denial of the contested benefit, the Contractor shall authorize provision of the benefit as promptly as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination). [42 CFR §438.424(a)]

c. Proof of Compliance with TennCare Directive. After authorizing provision of, or reimbursement for, the contested benefit, the Contractor shall take measures to ensure that enrollee actually receives the now-authorized benefit. The Contractor must timely provide TennCare with evidence substantiating Contractor's compliance with the TennCare Directive.

d. The Contractor shall pay for disputed services received by the enrollee while the appeal was pending when the Contractor or the SFH officer reverses Contractor's initial adverse decision on the disputed benefits. [42 CFR §438.424(b)]

A.128. Grievances

a. The Contractor must allow an enrollee to file an oral or written Grievance with an Contractor at any time. See 42 CFR §438.402(c)(2)(i); 42 CFR §438.402(c)(3)(i).

b. The Contractor must resolve each Grievance and provide notice of Grievance resolution as expeditiously as the enrollee's health condition requires, within ninety (90) calendar days from the day the Contractor receives the Grievance. See 42 CFR §438.408(a); 42 CFR §438.408(b)(1).

c. The Contractor must issue a written acknowledgment of receipt of the Grievance within five (5) business days. This written acknowledgement need not be conferred if the Contractor issues the notice of Grievance resolution within five (5) business days of receiving the Grievance.

d. The Contractor must issue a written, dated notice of Grievance resolution in a format and language that meets 42 CFR §438.10. See 42 CFR §438.408(d)(1).

A.129. Grievance and SFH-Related Recordkeeping Requirements

a. The Contractor must maintain Grievance and SFH-related records for at least 10 years and must make such records readily available to the TennCare agency or to CMS upon request. See 42 CFR §438.416(a); 42 CFR §438.416(c).

b. The Contractor's record of Grievance or SFH request must include:

1. A general description of the reason for the Grievance or SFH request;
2. The date received;
3. The date of each review or, if applicable, review meeting;
4. The date of resolution and how it was resolved; and
5. The identity of the enrollee for whom the SFH request or Grievance was filed. See 42 CFR §438.416(b)(1)-(6).

A.130. Provision of Information about Enrollee Grievance and Appeal Rights

a. The Contractor shall inform its contracted Providers and subcontractors about the Grievance and SFH process and shall inform them of the toll-free number for filing oral Grievances and requests for SFH with TennCare and for filing oral Grievances with Contractor. See 42 CFR §438.414; 42 CFR §438.10(g)(2)(xi); and

b. The Contractor must include information about the enrollee's Grievance, and State Fair Hearing rights in the following materials:

1. Notice of Adverse Benefit Determination;
2. Provider and subcontractor contracts with Contractor;
3. Member Handbook and Provider Manual;
4. Provider training materials; and
5. Contractor website.

A.131. Corrective Action by Contractor

a. The Contractor shall devote a portion of its regularly scheduled QM/QI committee meetings to the review of enrollee SFH requests and to addressing identified deficiencies with the Contractor's grievance and appeal-related processes.

b. A failure of twenty percent (20%) or more of appealed cases over a sixty (60) day period regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and governing appeal procedures may result in liquidated damages as specified in Attachment B.

A.132. CoverKids Enrollee Grievance and Appeal System.

This Contract Section A.132 shall only apply to the CoverKids DBM Program. Contractor shall have a Grievance and Appeal System in place for CoverKids enrollees, as required by 42 CFR 457.1260. The Contractor shall use the same Grievance and Appeal System for CoverKids that it uses for TennCare enrollees set forth in Contract Sections A.116 through A.131 above, with the exception that CoverKids enrollees do not have a right to receive continuation of benefits, and do not have a right to receive a SFH. As permitted under federal and State law, TennCare, at its sole discretion, may delegate back to itself and the State any portion of the appeal process that the Contractor is obligated to perform.

CoverKids enrollees shall have the right to file appeals regarding adverse benefit determinations taken by the Contractor. For purposes of this requirement, appeal shall mean a member's right to contest any denied claim.

a. The Contractor shall have sufficient support staff (clerical and professional) available to process appeals. Staff shall be knowledgeable about applicable state and federal law, CoverKids rules and regulations, and governing appeal procedures, as they become effective.

b. 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 shall be taken by the Contractor regarding the handling and disposition of an appeal.

c. The Contractor shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, CoverKids rules and regulations, and appeal procedures as they become effective. When the Contractor approves or denies an appeal, the Contractor will assure that the enrollee is notified of its decision.

d. The Contractor is responsible for eliciting pertinent medical history information from the treating provider(s), as needed, for purposes of making medical necessity determinations. Outreach shall be in the form of phone call, facsimile, and/or email. The Contractor shall take whatever action necessary to fulfill this responsibility within the required appeal timelines as specified by TennCare and/or applicable CoverKids rules and regulations.

e. Upon receipt of a TennCare generated On Request Report (ORR), the Contractor shall determine if an administrative review by the Contractor has been completed. If the administrative review has been completed by the Contractor, the Contractor shall include in the ORR response all information reviewed by the Contractor in reaching its decision. If the Contractor's administrative review has not been completed, the Contractor shall review its previous decision and issue a written decision to the parent or authorized representative within thirty (30) days of receipt of the request for review. If the parent or authorized representative requested an expedited review and the Contractor completed an expedited review, the ORR shall be returned to TennCare within one (1) business day. If the parent or authorized representative requested a standard review and the Contractor completed a standard review, the ORR shall be returned to TennCare within two (2) business days. In ORR responses the Contractor shall provide to the State all information utilized to process the enrollee's review request for State informal review and State committee review.

QUALITY OF CARE

A.133. Quality and Appropriateness of Care

The Contractor shall prepare for TennCare approval a written description of a Quality Monitoring Program (QMP) as described in Section A.142, a utilization review program and peer review program to include policies and procedures outlining the objectives, scope, activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of dental services. The plans shall describe the staff responsible and the role of the Dental Director.

A.134. Committee Meeting Requirements

The Contractor shall provide the TennCare Dental Director with ten (10) days advance notice of all regularly scheduled meetings of the Quality Monitoring Program Committee and Peer Review Committee. To the extent allowed by law, the Dental Director of TennCare, or his/her designee, may attend the committee meetings at his/her option. The Contractor shall provide the State a copy of the written minutes for each meeting shall be forwarded to TennCare per Sections A.135.f and A.136.f of this Contract.

A.135. Quality Monitoring Program (QMP) Committee

a. The Contractor shall have a QMP Committee with established parameters for the role, structure, and the function of the committee defined. The Committee shall include a designated senior executive who is responsible for program implementation, the Contractor's Dental Director, and dental plan providers.

b. This Committee shall analyze and evaluate the results of QMP activities, recommend policy decisions, ensure that providers are involved in the QMP, institute needed action, and ensure that appropriate follow-up occurs.

c. The QMP Committee shall review and approve the written QMP and associated work plan (as described in Section A.142 of this Contract) prior to submission to TennCare.

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

1. Oversight of QMP - There is documentation that the Governing Body has approved the overall QMP and the annual QMP work plan.

2. QMP Progress Reports - The Governing Body receives written reports at least quarterly from the QMP Committee describing actions taken, progress in meeting QMP objectives, and improvements made.

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

e. The QMP Committee shall meet on a regular basis (no less than quarterly) with specified frequency to oversee QMP activities. This frequency is sufficient to demonstrate that the structure/committee is following-up with specified frequency to oversee QMP activities.

f. The QMP Committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of

the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review.

g. The Contractor shall provide the Dental Director of TennCare with ten (10) calendar days advance notice of all regularly scheduled meetings of the QMP Committee. To the extent allowed by law, the Dental Director of TennCare, or his/her designee, may attend the QMP Committee meetings at his/her option.

A.136. Provider Peer Review Committee

The Contractor shall establish a Provider Peer Review Committee composed of dentists currently licensed in Tennessee and in good standing with the Tennessee Board of Dentistry. This Committee shall meet regularly (no less than quarterly) as necessary to review the processes, outcomes and appropriateness of dental care provided to enrollees by participating providers. The Contractor shall submit the names of proposed committee members to TennCare within thirty (30) days of the TennCare Programs Start Date. The Contractor's Dental Director shall be the Provider Peer Review Committee chairperson. The Committee shall include at least five (5) Participating Dentists who file at least thirty-five (35) TennCare claims per year and not otherwise employed by the current Contractor. This requirement will be waived for the first three (3) months of the contract period if the Contractor can prove an equivalent mechanism for provider peer review during that period.

a. The Committee shall review and provide detailed written findings, recommendations and appropriate corrective action for any participating dental provider who has provided inappropriate care.

b. The Contractor shall coordinate with TennCare's Office of Program Integrity regarding imposition of sanctions and any other corrective actions including termination of a Participating Dental Provider who has provided inappropriate care. The Contractor should also notify the Tennessee Board of Dentistry when indicated.

c. The Contractor shall coordinate with TennCare in regard to issues involving fraud or abuse by any participating dental provider.

d. The Contractor shall coordinate with TennCare regarding recoupment related to Fraud and abuse.

e. The Committee shall review and recommend appropriate action on appeals or inquiries provided by Enrollees, Participating Dental Providers, TennCare or other persons regarding quality of care, access or other issues related to the State DBM Programs.

f. The Committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review.

A.137. Advisory Committee

The Contractor shall participate in an Advisory Committee empowered to review and make recommendations to the Contractor and TennCare concerning the State DBM Programs. Recommendations approved by the Advisory Committee are not binding to TennCare. The

Committee shall meet on a schedule established by TennCare, which shall be no less than biannually. The Committee shall consist of not more than twenty (20) members, three (3) of whom shall be appointed by the Contractor. The Contractor will submit the names of proposed members to TennCare within thirty (30) days after the execution of this Contract. TennCare shall appoint all other committee members. Members may be selected from participating dentists serving TennCare enrollees and other parties interested in improving oral health care in Tennessee. TennCare shall also appoint the committee chairperson. The Committee shall review and make recommendations regarding other policies of the Contractor relative to services provided under this Contract.

A.138. Credentialing and Re-credentialing

The Contractor is responsible for ensuring that the Dental Specialists and other oral health professionals, who are under contract to the organization, are qualified to perform their duties. The Contractor is responsible for provider selection policies and procedures that cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Since the Board of Dentistry requires that dental professionals renew licensure every two (2) years, it is the responsibility of the Contractor to ensure that a copy of the current, valid license is maintained on file at the Contractor's location for every dental professional in the network(s).

a. Timely Credentialing - It is the Contractor's responsibility to completely process a credentialing/recredentialing application within thirty (30) calendar days after the receipt of the following from the provider: a completed application, including all necessary documentation and attachments, a Medicaid ID number and signed provider agreement/contract.

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

c. Oversight by Governing Body - The Governing Body, or the group or individual, to which the Governing Body has formally delegated the credentialing function, and TennCare shall review and approve the credentialing policies and procedures.

d. Credentialing Entity - The Contractor's credentialing policies and procedures shall designate a Credentialing Committee or other peer review body which makes recommendations regarding credentialing decisions.

e. Process - The Contractor's initial credentialing process shall obtain and review verification of the following information, at a minimum:

1. Primary Verification:

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

(b) valid DEA certificate, as applicable;

(c) confirmation of highest level of education and training received;

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

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

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

(g) any revocation or suspension of a state license or DEA number.

2. Secondary Verification (self reported)

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

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

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

(d) the application process includes a statement by the applicant and an investigation of said statement regarding:

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

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

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

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

(5) current malpractice coverage and limits;

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

(7) current or former listing on the national sex offender registry; and

(8) current or former listing on the Tennessee Sex Offender Registry.

3. The Contractor must verify licensure and valid DEA certificate, as applicable, within one hundred eighty (180) calendar days prior to the credentialing date.

4. Any information obtained shall be evaluated to determine whether any or all of said information would impact a practitioner’s ability to conform to the standards established by the Contractor in accordance with the requirements placed on the Contractor by this Contract. The Contractor may decide, based on information

obtained in the credentialing process, not to contract with a provider. If credentialing is denied the provider must be notified in writing and the reasons for the denial must be specified.

5. A site review shall be required by the Contractor for a dentist's office for which the Contractor receives a grievance from an enrollee.

f. Recredentialing - A process for the periodic reverification of clinical credentials (recredentialing, reappointment, or recertification) shall be described in the Contractor's policies and procedures.

1. There is evidence that the procedure is implemented at least every three (3) years.

2. There is verification of State licensure at least every three (3) years,

3. The Contractor shall conduct periodic review of information from the National Practitioner Data Bank, along with performance data, on all dentists to decide whether to renew the participating dentist agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing on items listed in subsections '"f 1" through "f-2" above.

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

(a) enrollee grievances;

(b) results of quality reviews;

(c) utilization management;

(d) member satisfaction surveys; and

(e) reverification of hospital privileges and current licensure.

g. Reporting Requirement – The Contractor shall have a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.

h. Appeals Process – The Contractor shall have a provider appellate process for instances where the Contractor chooses to reduce, suspend or terminate a practitioner's privileges with the organization.

i. If credentialing is denied, the provider must be notified in writing by the Contractor and the reason for the denial must be specified.

j. Credentialing of providers with multiple service locations - Except for public health or accredited schools of dentistry in Tennessee, no entity owning or operating multiple practice locations nor any individual provider nor group of providers operating multiple practice locations, may be credentialed by the Contractor at more than one location at the time of the initial credentialing by the Contractor. All requests for satellite office credentialing will be based upon proven delivery of good quality dental care at the initial

location and subject to careful individual review of the new location's dentist, dental associates and entire dental staff. The requirement of one initial location may be waived, at the sole discretion of the Contractor, only for providers in good standing who are current TennCare providers, with a proven record of delivery of quality dental care, at the time of the Contract start date. Prior to credentialing satellite offices, the Contractor must conduct a thorough and documented site visit which takes into account the impact of the satellite on existing TennCare dental provider network in that community. Such documentation must be made available to TennCare on request.

A.139. Credentialing for ECF CHOICES Participating Dental Providers

The Contractor shall be responsible for credentialing and contracting ECF CHOICES Participating Dental Providers sufficient in number to provide appointment availability for Covered Services to eligible ECF CHOICES members within the time frames specified in Section A.20. For both credentialing and recredentialing processes, the Contractor shall conduct a site visit for all ECF CHOICES Participating Dental Providers, which shall include observation of the provider's physical environment (to ensure accessibility), review of the provider's practices with respect to serving individuals with intellectual or developmental disabilities, including the provider's use of adjunctive sedation services for individuals with I/DD and the provider's use of alternative adjunctive techniques and modalities to reduce the use of sedation services, when appropriate, and the provider's willingness to participate in education and training opportunities to further develop capacity and expertise to provide dental services to individuals with I/DD.

A.140. Standards for Facilities

The Contractor shall maintain standards for facilities in which enrollees receive care. A requirement for adherence to these standards shall be contained in all of the Contractor's provider contracts. These standards address:

a. Compliance with existing State and local laws regarding safety and accessibility;

b. Availability of emergency equipment;

c. Storage of drugs, and

d. Inventory control for expired medications

A.141. Performance Reviews

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

A.142. Quality Monitoring Program

The Contractor shall have a written Quality Monitoring Program (QMP) that clearly defines its quality improvement structures, processes, and related activities to pursue opportunities for improvement on an ongoing basis.

a. At a minimum the Contractor shall adhere to the following requirements for the QMP:

   1. Have a QMP Committee that oversees the QMP functions as described in Section A.135 of this Contract.

   2. Have an annual work plan that identifies QMP activities, yearly objectives, time frames for completion, and persons responsible for oversight of QMP activities and objectives.

   3. Have resources – staffing, data sources and analytical resources – devoted to it. The QMP must have sufficient material resources, and staff with the necessary education, experience, or training, to effectively carry out its specified activities.

   4. Evaluate the QMP annually and updated as appropriate.

b. The QMP shall also include written processes for taking appropriate Remedial/Corrective Action whenever, as determined under the QMP, inappropriate or substandard services are furnished, or services that should have been furnished were not. These written remedial/corrective action procedures include:

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

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

   3. Specific actions to be taken;

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

   5. The schedule and accountability for implementing corrective actions;

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

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

c. The Contractor shall use the results of QMP activities to improve the quality of dental health with appropriate input from providers and members.

d. The Contractor shall take appropriate action to address service delivery, including continuity and coordination of care, access to care, utilization of services, health education, and emergency services; patient safety; provider; and other QMP issues as they are identified.

e. The written QMP, associated work plan, and evaluation of the QMP shall be submitted to TennCare annually. The evaluation of the QMP shall address QM studies and other activities completed; trending of clinical and service indicators and other performance

data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP.

f. The Contractor shall make all information about its QMP available to providers and members. The Contractor shall include in all its provider contracts and employment agreements, for dentists and non-dentist providers, a requirement securing cooperation with the QMP.

A.143 Performance Improvement Projects (PIPs)

a. The Contractor shall perform at least one (1) clinical and one (1) non-clinical PIP in a format specified by TennCare.

b. The Contractor shall ensure that CMS protocols for PIPs are adhered to and that the following are documented for each activity:

1. Rationale for selection as a quality improvement activity;

2. Specific population targeted, include sampling methodology if relevant;

3. Metrics to determine meaningful improvement and baseline measurement;

4. Specific interventions (enrollee and/or provider);

5. Relevant clinical practice guidelines; and

6. Date of re-measurement.

c. The Contractor shall ensure that the topics selected as PIPs reflect the population served by the Contractor in terms of age groups, disease categories, and special risk status.

d. The Contractor shall identify benchmarks and set achievable performance goals for each of its PIPs. The Contractor shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.

e. After three (3) years, the Contractor shall, using evaluation criteria established by TennCare, determine if one or all PIPs should be continued. Prior to discontinuing a PIP, the Contractor shall identify a new PIP and must receive TennCare's approval to discontinue the previous PIP and perform the new PIP.

A.144. Enrollee Rights and Responsibilities

The Contractor shall demonstrate a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities.

a. Written Policy and Procedure on Enrollee Rights - The Contractor shall have a written policy and procedure that recognizes the following rights of enrollees including but not limited to the following:

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

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

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

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

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

6. to be guaranteed the right to request and receive a copy of his or her dental records;

7. to request that his or her dental records be amended or corrected as specified in 45 CFR part 164;

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

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

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

10. to exercise an advance directive, and include information about state law.

b. Written Policy and Procedure on Enrollee Responsibilities - The Contractor shall have a written policy and procedure that addresses enrollees' responsibility for cooperating with those providing dental care services. This written policy addresses enrollee's responsibility for:

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

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

c. Communication of Policies to Providers - A copy of the Contractor's policies and procedures on enrollee's rights and responsibilities shall be provided to all participating providers.

d. Communication of Policies and Procedures to Enrollees - Upon enrollment, Contractor shall provide enrollees a written statement that includes information on the following:

1. rights and responsibilities of enrollees;

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

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

(b) the procedures for obtaining out-of-area coverage;

3. provisions for emergency coverage;

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

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 notifying those enrollees affected by the termination or change in any benefits, services, or service delivery office/site;

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

8. procedures for changing practitioners; and

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

e. Enrollee Grievance and Appeal Procedures - Contractor shall have a system(s), linked to the QMP, for resolving enrollee's grievances and appeals. This system includes:

1. procedures for registering and responding to grievances and appeals in a timely fashion (organizations should establish and monitor standards for timeliness);

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

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

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

5. an appeal process for adverse actions.

f. Steps to Assure Accessibility of Services - The Contractor shall take steps to promote accessibility of services offered to enrollees. These steps include:

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

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

(a) how to obtain services during regular hours of operations;

(b) how to obtain emergency care, and

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

g. Written Information for Enrollees shall comply with the requirements of this Contract, which includes, but is not limited to:

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

2. Written information is available as set forth in Contract Section A.13., Written Material Guidelines.

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

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

2. The organization requires that patient care offices/sites have implemented mechanisms that guard in all forms, including but not limited to electronic and physical, against the unauthorized or inadvertent disclosure of confidential information to persons outside of the dental care organization.

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

(a) it is required by law;

(b) it is necessary to coordinate the enrollee's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment, or

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

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

5. In accordance with the requirements set forth at 45 C.F.R 164.501, Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.

i. Treatment of Minors - - The Contractor shall have written policies regarding the appropriate treatment of minors.

j. Assessment of Enrollee Satisfaction - The Contractor shall conduct periodic surveys of enrollee satisfaction with its services.

1. The surveys shall include content on perceived problems in the quality, availability, and accessibility of care.

2. As a result of the surveys, the Contractor shall:

   (a) identify and investigate sources of dissatisfaction;

   (b) outline action steps to follow-up on the findings, and

   (c) inform providers of assessment results.

3. The Contractor shall reevaluate the effects of the above enrollee satisfaction survey and notify TennCare within ten (10) business days regarding any ongoing problems determined by the survey.

A.145. Dental Record Standards

a. Accessibility and Availability of Dental Records

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

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

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

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

      (a) Enrollee Identification Information - Each page in the record contains the enrollee's name or enrollee ID number;

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

      (c) Entry Date - All entries are dated;

      (d) Entry Submission - Written submission of treatment for every date of service;

      (e) Provider Identification - All entries are identified as to author;

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

(g) Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (No Known Allergies - NKA) is noted in an easily recognizable location;

(h) Past Medical History - (for enrollees seen three or more times) Past medical history is easily identified including serious accidents, operations, illnesses. . For orthodontics requested secondary to speech pathology, obtain speech/language records, or orthodontics requested for a nutritional problem, pediatric records of diagnosis, growth records, and treatment for nutritional deficiency. For children, past medical history relates to prenatal care and birth;

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

(j) Diagnostic information;

(k) Medication information;

(l) Identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record;

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

(n) Referrals and Results Thereof, and

(o) Emergency Care.

2. Enrollee Visit Data – All patient encounters must be recorded in writing and dated. Documentation of individual encounters must provide adequate evidence of, at a minimum:

(a) History and Physical Examination - Appropriate subjective and objective information is obtained for the presenting grievance;

(b) Plan of Treatment;

(c) Diagnostic Tests;

(d) Treatment rendered, medications by dosage, dispensed or prescribed;

(e) Proper Monitoring of patients when in-office sedation is administered, including but not limited to recording percentage of nitrous oxide and/or oxygen percentage to achieve clinical sedation and documentation of patient recovery following termination of nitrous;

(f) Appropriate Charting of conditions and treatment;

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

(h) Consultations, Referrals and Specialist Reports - Notes from any consultations are in the record. Consultation, lab and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans. Consultations for speech/language pathology include supporting documentation that the condition must be non-responsive to speech therapy without orthodontic treatment, and

(i) All Other Aspects of Patient Care, Including Ancillary Services. Signature of rendering provider.

c. Record Review Process

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

2. The record assessment system addresses documentation of the items listed in Section A.145.b above.

DATA AND REPORTING REQUIREMENTS

A.146. Data Base

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

a. Enrollee Name;
b. Enrollee Identification Number (SSN);
c. Enrollee MCO;
d. Dates of Service;
e. Specific service provided by procedure ADA Code;
f. Servicing Provider Number (Medicaid #);
g. Participating Dental Provider Name;
h. Payment status;
i. Billed Charge Amount;
j. Allowed Amount;
k. Payment Amount;
l. Received Date;
m. Payment Date; and
n. Any other data element required by common dental practice, ADA Guidelines, federal or state law

A.147. Reporting Requirements

At a minimum, the Contractor shall provide to TennCare the deliverables related to reports, plans, studies or files including timeframes as outlined in Attachment C.

a. All deliverables must be presented in a format/record layout approved by TennCare. The Contractor shall also provide such additional reports, or make revisions in the data elements or format of the reports upon request of TennCare without additional charge to TennCare. TennCare shall provide written notice of such requested revisions of format changes in a Notice of Required Report Revisions.

b. The Contractor shall furnish to TennCare an electronic Decision Support System (DSS) described as a data gathering and storage system sufficient to meet the requirements of this Contract.

c. The Contractor shall also furnish TennCare staff with access to the Contractor's DSS allowing TennCare to retrieve paid claims data, along with a user interface that shall allow user defined queries to address managerial concerns that would normally be requested in an ORR. The capability shall not diminish the Contractors responsibility for responding to requests for ORRs.

d. Additional reporting requirements as established by TennCare in collaboration with the Contractor for Covered Services provided pursuant to the ECF CHOICES DBM Program, TPPOHP DBM Program and CoverKids DBM Program, including, but not limited to, ECF CHOICES dental service utilization and a separate report for utilization of adjunctive dental sedation, an accounting of Member utilization as compared to authorized amounts for dental services in Members' PCSPs, network adequacy and capacity for ECF CHOICES, and ECF CHOICES network training and development.

e. The Contractor shall be responsible to offer assistance to TennCare associates using the Contractor's DSS as needed, including both dental staff and other departmental staff's users.

TennCare may impose liquidated damages under Section E.10 and Attachment B of the Contract based upon Contractor's failure to timely submit Standard Reports in the required format and medium.

A.148. Reports

a. The Contractor shall provide the following reports every month:

1. PI TIPs
2. Encounter data report (837D)
3. Provider Enrollment File

b. The Contractor shall provide the following reports every quarter:

1. TennCare/EPSDT Report
2. Non-Traditional FI Varnish Program Report
3. "Insure Kids Now" (IKN) File
4. DBM Quarterly TennCare Kids Report
5. Quarterly Utilization by Std Dev

6. Quarterly Disclosure Rate Report
7. Enrollee cost-sharing liabilities

c. The Contractor shall provide the following reports once a year:

1. Annual Outreach Plan
2. Annual Access Report
3. DBM Community Outreach Plan Annual Evaluation
4. Annual Disclosure Form

A.149. Public Filings

The Contractor shall promptly furnish TennCare with copies of all public filings, including correspondence, documents and all attachments on any matter arising out of this Contract.

A.150. Enrollee Cost Sharing Report

The Contractor shall report enrollee cost-sharing liabilities on a quarterly basis in the manner and form described by TennCare.

A.151. Management Reports

The Contractor shall submit Management Reports by which the State can assess the State DBM Programs costs and usage, in a mutually agreeable electronic format (MSWord, MSExcel, etc.), of the type, at the frequency, and containing the detail in Attachment C. Reporting shall continue for the twelve (12) month period following termination of the Contract. The Contractor shall also generate and submit to the State, within five (5) working days of the end of each Contract quarter a Quarterly Network Changes Report, also in electronic format.

ENROLLMENT AND DISENROLLMENT

A.152. General Requirements

TennCare is responsible for the enrollment of enrollees in the Contractor's plan. The Contractor shall accept daily eligibility data from the State (DCS or TennCare Select for Immediate eligibility for children in state custody).

a. The Contractor shall accept the enrollee in the health condition the enrollee is in at the time of enrollment. The Contractor shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services. The Contractor shall not discriminate in enrollment, disenrollment, and reenrollment against individuals on the basis of health status or need for health care services. The Contractor shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

b. 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. The Contractor shall be responsible for arranging for the provision of services and payment of all covered services during presumptive period of enrollment. In order to give children entering into DCS custody adequate access to medical services,

including EPSDT, until a final determination can be made on their eligibility, the Contractor shall accept notice from DCS and/or TennCare Select of TennCare "immediate" eligibility. If the child is not currently enrolled, the Contractor shall immediately build a forty-five (45) day eligibility record effective on the date the child was placed in state custody and identify the child as a child in state custody. The Contractor shall be responsible for arranging for the provision of services and payment of all covered services during immediate eligibility period of enrollment.

c. In regards to EPSDT reporting, the Contractor shall continue to only report on those children whose TennCare eligibility status is permanent, who are assigned to the DBM. EPSDT reporting requirements shall not be applicable to ECF CHOICES Members.

A.153. Disenrollment

TennCare is responsible for the disenrollment of enrollees from the Contractor's plan. The Contractor shall not disenroll enrollees. The Contractor, may, however, provide TennCare with any information it deems appropriate for TennCare's use in making a decision regarding loss of eligibility or disenrollment of a particular Enrollee.

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

b. The Contractor's responsibility for disenrollment shall be to inform TennCare promptly when the Contractor knows or has reason to believe that an enrollee may satisfy any of the conditions for disenrollment described in TennCare policy and/or TennCare rules and regulations. Actions taken by TennCare cannot be grieved by the Contractor.

THIRD PARTY LIABILITY

A.154. General Requirements

The Contractor shall not withhold payment for services provided to an enrollee if third party liability or the amount of liability cannot be determined, or payment will not be available within a reasonable time. All funds recovered from third parties will be treated as offsets to claims payments. The Contractor shall provide any information necessary to assist and shall cooperate in any manner necessary as requested by TennCare, with a Cost Recovery Vendor at such time that TennCare acquires said services.

A.155. Reasonable Efforts

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

A.156. Amount of Payment

If the Contractor has determined that third party liability exists for part or all of the services provided to an enrollee by a provider, the Contractor shall pay the provider only the amount, if any, by which the provider's allowable claim exceeds the amount of third party liability. Cost sharing responsibilities permitted pursuant to Section A.6 of this Contract shall not be considered third party resources for purposes of this requirement.

A.157. TPL Data

The Contractor shall provide Third Party Resource (TPR) data to any provider having a claim denied by the Contractor based upon a TPR. TPR shall include subrogation recoveries. The amount of any subrogation recoveries collected by the Contractor outside of the claims processing system shall be the property of the State. On a monthly basis, the Contractor shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported.

PROVIDER PAYMENT

A.158. Dental Service Payments

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

A.159. Interest

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

A.160. Subrogation Recoveries

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

A.161. Service Dates

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

A.162. Covered Services

The State shall only assume responsibility for payment of providers for the provision of covered services as specified in Section A.5 of this Contract and payment of providers or enrollees in response to a directive from TennCare or an Administrative Law Judge. Otherwise, in the event the Contractor makes payment for a non-covered service, the State shall not be responsible for the payment of said service. Payments for covered services specified shall not include payment for enrollee cost-sharing amounts. Payments for non-medically necessary services are considered to be payments for non-covered services under this section. The State may recoup funds paid by Contractor for non-covered or not medically necessary from the Contractor.

A.163. Allowable Rates

TennCare has established and maintained the TennCare Dental Fee Schedules for this Contract by which all claims are paid for the TennCare DBM Programs. The TennCare Dental Fee Schedules for TennCare DBM Programs shall be provided by TennCare. All dentists and dental specialists providing services to enrollees in the TennCare DBM Programs shall be reimbursed on a fee-for-service basis where one maximum allowable dental fee schedule per TennCare DBM Program for all providers is used. The provider will be reimbursed at the lesser of billed charges or the maximum allowable fee listed in the approved TennCare Dental Fee Schedule. The Contractor shall not deviate from the approved reimbursement rates, unless TennCare provides written permission to do so. The TennCare Dental Fee Schedules are not applicable to the CoverKids DBM Program and the Fee Schedule for the CoverKids Program shall be developed and provided by the Contractor.

RISK SHARING REQUIREMENTS

A.164. Risk Sharing Requirements

The Risk Sharing Requirements in this Section A.164 shall only apply to the TennCare Children's DBM Program. The Contractor shall operate as a partial risk-bearing entity for dental services with shared savings and losses as described below. The Contractor must notify the State of any person or corporation that has 5% or more ownership or controlling interest in the entity and such person or corporation must submit financial statements. The Contractor, unless a Federally Qualified HMO, must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the debts if the entity becomes insolvent.

a. Risk sharing calculations are influenced by three variables: annual service expenditures, annual dental participation ratio (Refer to Attachment E for a description and calculation of the annual dental participation ratio), and percentage risk level chosen by the DBM. To calculate the actual saving or loss amount, the difference between the target service expenditure baseline amount and the actual service expenditure for the period is calculated and savings or loss amounts are multiplied by the appropriate risk level percentage chosen by the DBM. In cases, where the DBM posts a savings, this initial

gross bonus payment amount is then adjusted by the participation ratio achieved for the period. This adjustment is designed to ensure that any cost savings come from better management of the program and not from a reduction in the number of enrollees receiving services. If the participation ratio achieved is three (3) or more percentage points below the established target for the period, this would disqualify the DBM from any profit sharing for that period.

b. There can only be profit sharing if: a) there is a savings based on the established annual target service expenditure and, b) the Contractor achieves a participation ratio above a specified minimum. The specified minimum in year one (1) is 50.6% at or below which there is no profit sharing awarded despite any savings. Profit sharing will be based upon the following formula: Actual savings achieved, multiplied by the appropriate risk sharing percentage giving the gross bonus payment amount. The gross bonus payment amount will then be reduced at a proportional rate, within a tenth of a decimal point, for each reduction in the participation ratio below the target established. This proportional rate adjustment is called the adjustment factor. The adjustment factor is then applied to the gross savings bonus amount to yield the actual bonus payment amount. Refer to Tables 1 below for sample calculation under this process. There is an upper and lower limit of $8 million per year in the amount of savings bonuses earned or loss payments made by the Contractor.

c. An initial target service expenditure baseline will be established by TennCare based on historical trends. Appropriate adjustments to year one (1) target service expenditure baseline will be made if there are changes to the TennCare Children's DBM Program Dental Fee Schedule, significant changes to enrollment, or TennCare directed changes to the medical necessity guidelines during the year. In year two (2) and in year three (3) the annual target service expenditure will be adjusted based on the target participation ratio, the prevailing TennCare Children's DBM Program Dental Fee Schedule, overall utilization patterns, enrollment changes and other budgetary factors. Both the target service expenditure rate and the target participation ratio will be released to the Contractor no later than thirty (30) days after commencement of the fiscal year.

The Contractor will not be penalized for budget overruns, where the increase above target service expenditure amount is also accompanied by a participation ratio which also exceeds the target ratio and the service expenditure is attributable to the participation ratio achieved. Nevertheless, because this scenario does not meet the goal of budget predictability and there is no savings, there will be no bonus sharing either.

d. The Contractor must meet one of the following licensure requirements to operate as a risk bearing entity.

1. Dental Service Plan – licensed pursuant to TCA Title 56, Chapter 30;

2. Prepaid Limited Health Service Organization – licensed pursuant to TCA Title 56, Chapter 51;

3. Insurance Company – licensed pursuant to TCA Title 56, Chapter 2;

4. Hospital and Medical Service Corporation – licensed pursuant to TCA Title 56, Chapter 29, or

5. Health Maintenance Organization – licensed pursuant to TCA Title 56, Chapter 32.

Table 1 – Risk Level Scenario Calculations

DBM % Risk Level	**Target Utilization** Year 1 **56.9%** Year 2 Year 3			**Service Expenditure Target** Year 1 **16.65 PMPM** **$172M** Year 2 Year 3			**DBM Bonus**	**DBM Loss**
50%	56.9%			$162 M			$5 M	
50%	55.4%			$162M			$2.5M	
50%	53.9%			$162M			$0	
50%	56.9%			$182 M				$5 M
50%	56.9%			$192 M				$8 M

A.165. Non-Discrimination Compliance Requirements

The Contractor agrees that the following requirements apply to the Contractor's administration of the Division of TennCare's ("TennCare") TennCare DBM programs.

a. Nondiscrimination General Requirements. The Contractor agrees to comply with the applicable federal and state civil rights laws, which may include, but are not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and 42 U.S.C. § 18116 (codified at 45 C.F.R. pt. 92). The Contractor shall comply with Section D.9 of this Contract regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.

1. The Contractor shall designate a Nondiscrimination Compliance Coordinator ("NCC") that shall be responsible for compliance with the nondiscrimination requirements set forth in this Contract. Contractor agrees that its NCC will work

directly with TennCare's Civil Rights Compliance Director in order to implement and coordinate nondiscrimination compliance activities.

The Contractor's NCC shall develop a nondiscrimination training plan within thirty (30) days of the implementation of this Contract and shall provide a copy of such training plan to TennCare on an annual basis and upon request. If needed, the NCC may request an extension of time for this due date. Thereafter, this training plan shall be updated as needed to conform to changes in Federal and State law and provided to TennCare as set forth above.

On an annual basis, the NCC shall be responsible for making nondiscrimination training available to all Contractor staff and to its subcontractors that are considered to be recipients of federal financial assistance under this contract. The Contractor shall be able to show documented proof that the training was made available to the Contractor's staff and to its subcontractors that are considered to be recipients of federal financial assistance under this contract.

2. The Contractor shall, at a minimum, emphasize nondiscrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.

3. Prior to implementation of this Contract, Contractor shall provide its written policies and procedures that demonstrate nondiscrimination in the provision of services provided under this Contract to TennCare. These policies shall include topics, such as, the provision of language services to individuals with Limited English Proficiency and individuals requiring communication assistance in alternative formats and providing other forms of assistance to individuals with disabilities. Effective Communication may be achieved by providing interpretation and translation services and other forms of auxiliary aids or services, including, Braille and large print and shall be based on the needs of the individual and/or the individual's representative. These nondiscrimination policies and procedures shall be approved in writing by TennCare.

4. The Contractor shall keep such records as may be necessary in order to submit timely, complete and accurate compliance reports that may be requested by the U.S. Department of Health and Human Services ("HHS"), the U.S. Department of Justice ("DOJ"), TennCare, and the Tennessee Human Rights Commission ("THRC") or their designees. If requested, the information shall be provided in a format and timeframe specified by HHS, DOJ, TennCare, or THRC. The requested information may be necessary to enable HHS, DOJ, TennCare, or THRC to ascertain whether the Contractor is complying with the applicable civil rights laws. For example, the Contractor should have available data showing the manner in which services are or will be provided by the program in question, and related data necessary for determining whether any persons are or will be denied such services on the basis of prohibited discrimination. Further examples of data that could be requested can be found at 45 C.F.R. § 80.6 and 28 C.F.R. § 42.406.

5. The Contractor shall permit access as set forth in the applicable civil rights laws, such as, 45 C.F.R. § 80.6 to HHS, DOJ, TennCare, and THRC or their designees during normal business hours to such of its books, records, accounts, and other sources of information, and its facilities as may be pertinent to ascertain whether the Contractor is complying with the applicable civil rights laws.

6. The Contractor shall use and have available to individuals TennCare's discrimination complaint forms for the TennCare program(s) covered under this contract. These discrimination complaint forms shall be provided to individuals upon request and be available on the Contractor's website. TennCare's discrimination complaint forms are vital documents and must be available at a minimum in the English, Spanish, Arabic languages. TennCare's Director of Civil Rights Compliance shall work with the Contractor's NCC on providing the Contractor with TennCare's discrimination complaint forms that are required under this contract.

   The Contractor shall provide assistance to individuals that request that the Contractor assist them with filing discrimination complaints with the TennCare program(s) covered under this contract. The Contractor shall inform its employees and its providers and subcontractors that are considered to be recipients of federal financial assistance under this contract about how to assist individuals with obtaining discrimination complaint forms and assistance with submitting the forms to the TennCare program(s) covered under this contract.

7. Significant publications and significant communications, including small sized publications and communications that are targeted to beneficiaries, participants, enrollees, applicants, and members of the public shall be printed with the notice of nondiscrimination and LEP taglines as required by TennCare and set forth in TennCare's tagline templates. Written materials specific to TennCare's programs' members shall be prior approved in writing by TennCare prior to the materials being sent to these individuals.

8. Within ninety (90) calendar days of notification from TennCare, all vital Contractor documents related to this Contract shall be translated and available to each Limited English Proficiency ("LEP") group identified by TennCare in accordance with the applicable standards set forth below:

   (a) If a LEP group constitutes five percent (5%) or 1,000, whichever is less, of the population targeted under this Contract, vital documents shall be translated into that LEP language. Translation of other documents, if needed, can be provided orally; or

   (b) If there are fewer than fifty (50) individuals in a language group that is part the population targeted under this Contract that reaches the five percent (5%) trigger in (a), the Contractor shall inform those individuals that it does not provide written translation of vital documents but provides written notice in that group's primary language of the right to receive competent oral interpretation of those written materials, free of cost.

(c) At a minimum, all vital Contractor documents shall be translated and available in Spanish.

9. In accordance with the requirements set forth in 42 U.S.C. § 300kk, the Contractor must develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language, and disability status for the population targeted under this Contract and the parents or legal guardians of minors or legally incapacitated individuals targeted under this Contract. In collecting this data the Contractor shall use the Office of Management and Budget (OMB) standards, at a minimum, for race and ethnicity measures. Data collection standards for Race, Ethnicity, Sex, Primary Language, and Disability Status are available from the Office of Minority Health and on its website located at: http://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=53.

b. The Contractor shall submit the following nondiscrimination compliance deliverables to TennCare as follows:

1. Annually, TennCare shall provide the Contractor with a Nondiscrimination Compliance Questionnaire. The Contractor shall answer the questions contained in the Compliance Questionnaire and submit the completed Questionnaire to TennCare within sixty (60) days of receipt of the Questionnaire with any requested documentation, which shall include, the Contractor's Assurance of Nondiscrimination. The signature date of the Contractor's Nondiscrimination Compliance Questionnaire shall be the same as the signature date of the Contractor's Assurance of Nondiscrimination. The Nondiscrimination Compliance Questionnaire deliverables shall be in a format specified by TennCare.

(a) As part of the requested documentation for the Nondiscrimination Compliance Questionnaire, the Contractor shall submit copies of its nondiscrimination policies and procedures that demonstrate nondiscrimination in the provision of its services, programs, or activities provided under this Contract. These policies shall include topics, such as, the provision of language assistance services for LEP individuals and those requiring effective communication assistance in alternative formats, and providing assistance to individuals with disabilities. Any nondiscrimination policies and procedures that are specific to TennCare program members shall be prior approved in writing by TennCare.

(b) Also as part of the requested documentation for the Nondiscrimination Compliance Questionnaire the Contractor shall include reports that capture data for all language and communication assistance services used and provided by the Contractor under this Contract. One report shall contain the names of the Contractor's language and communication assistance service providers, the languages that interpretation and translation services are available in, the auxiliary aids or services that were provided and that are available, the hours the language assistance services are available, and the numbers individuals call to access language and communication assistance services. A separate report that captures a listing of language and communication assistance services

that were requested by members (i.e. Arabic; Braille) and the methods used to provide the language and alternative communication service to the members (i.e. interpretation; translation). Upon request the Contractor shall provide a more detailed report that contains the requestor's name and identification number, the requested service, the date of the request, the date the service was provided, and the name of the service provider.

2. The Contractor shall submit a quarterly Non-discrimination Compliance Report which shall include the following:

   (a) A summary listing that captures the total number of the Contractor's new hires that have completed civil rights/nondiscrimination training and cultural competency training and the dates the trainings were completed for that quarter;

   (b) A listing of the total number of the Contractor's employees that have completed annual civil rights training and cultural competency training and the dates completed for that quarter, if annual training was provided during that quarter.

   (c) An update of all written discrimination complaints filed by individuals, such as, employees, members, and subcontractors in which the discrimination allegation is related the provision of and/or access to TennCare covered services provided by the Contractor, which the Contractor is assisting TennCare with resolving. This update shall include, at a minimum: identity of the complainant, complainant's relationship to the Contractor, circumstances of the complaint; type of covered service related to the complaint, date complaint filed, the Contractor's resolution, date of resolution, and the name of the Contractor staff person responsible for adjudication of the complaint. For each complaint reported as resolved the Contractor shall submit a copy of the complainant's letter of resolution.

   (d) The Contractor shall provide a listing of all discrimination claims that are reported to the Contractor that are claimed to be related to the provision of and/or access to TennCare's covered services provided by the Contractor. The listing shall include, at a minimum: identity of the complainant, complainant's relationship to the Contractor, circumstances of the complaint; type of covered service related to the complaint, date complaint filed, the Contractor's resolution, date of resolution. When such reports are made, the Contractor shall offer to provide the discrimination complaint forms to the individual making the report.

   (e) The language and communication assistance report shall capture a summary listing of language and communication assistance services that were requested by members (i.e. Arabic; Braille) and the methods used to provide the language and alternative communication service to the members (i.e. interpretation; translation). Upon request the Contractor shall provide a more detailed report that contains the

requestor's name and identification number, the requested service, the date of the request, the date the service was provided, and the name of the service provider.

c. Discrimination Complaint Investigations. All discrimination complaints against the Contractor and its employees and its subcontractors that are considered to be recipients of federal financial assistance under this contract shall be resolved according to the provisions of this Section and the below subsections:

1. Discrimination Complaints against the Contractor and/or Contractor's Employees. When complaints concerning alleged acts of discrimination committed by the Contractor and/or its employees related to the provision of and/or access to one of TennCare's programs are reported to the Contractor, the Contractor's NCC shall send such complaints within two (2) business days of receipt to TennCare. TennCare shall investigate and resolve all alleged acts of discrimination committed by the Contractor and/or its employees. The Contractor shall cooperate with TennCare during the investigation and resolution of such complaints. TennCare reserves the right to request that the Contractor's NCC assist with conducting the initial investigations and to suggest resolutions of alleged discrimination complaints. If TennCare requests that the Contractor's NCC assist TennCare with conducting the initial investigation, the Contractor's NCC within five (5) business days from the date of the request shall start the initial investigation. The Contractor's NCC shall provide TennCare with all requested information, including but not limited to, the identity of the party filing the complaint; the complainant's relationship to the Contractor; the circumstances of the complaint; date complaint filed; and the Contractor's suggested resolution. TennCare shall review the Contractor's initial investigations and determine the appropriate resolutions for the complaints as set forth in subsection c below. During the complaint investigation, the Contractor shall have the opportunity to provide TennCare with any information that is relevant to the complaint investigation. Any documentation or materials related to such investigation shall be considered confidential and not subject to disclosure to any third party, unless disclosure is otherwise required by law.

2. Discrimination Complaints against the Contractor's Subcontractors that are recipients of federal financial assistance under this Contract. Should complaints concerning alleged acts of discrimination committed by the Contractor's subcontractors related to the provision of and/or access to one of TennCare's programs be reported to the Contractor, the Contractor's nondiscrimination compliance officer shall inform TennCare of such complaints within two (2) business days from the date Contractor learns of such complaints. If TennCare requests that the Contractor's nondiscrimination compliance officer assist TennCare with conducting the initial investigation, the Contractor's nondiscrimination compliance officer within five (5) business days from the date of the request shall start the initial investigation. Once an initial investigation has been completed, the Contractor's nondiscrimination compliance officer shall report his/her determinations to TennCare. At a minimum, the Contractor's nondiscrimination compliance officer's report shall include the identity of the party filing the complaint; the complainant's relationship to the Contractor; the

circumstances of the complaint; date complaint filed; and the Contractor's suggested resolution. TennCare shall review the Contractor's initial investigations and determine the appropriate resolutions for the complaints as set forth in subsection (3) below. TennCare reserves the right to investigate and resolve all complaints concerning alleged acts of discrimination committed by the Contractor's subcontractors that are recipients of federal financial assistance under this Contract. The Contractor's Providers and Subcontractors that are recipients of federal financial assistance under this Contract shall cooperate with TennCare and the Contractor during discrimination investigations and resolutions.

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

d. Electronic and Information Technology Accessibility Requirements. To the extent that the Contractor is using electronic and information technology to fulfill its obligations under this Contract, the Contractor agrees to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508"), the Americans with Disabilities Act, and 45 C.F.R. pt. 92. To comply with the accessibility requirements for Web content and non-Web electronic documents and software, the Contractor shall use W3C's Web Content Accessibility Guidelines ("WCAG") 2.0 AA (For the W3C's guidelines see: http://www.w3.org/TR/WCAG20/) (Two core linked resources are Understanding WCAG 2.0 http://www.w3.org/TR/UNDERSTANDING-WCAG20/ and Techniques for WCAG 2.0 http://www.w3.org/TR/WCAG20-TECHS/).

1. Contractor agrees to perform regularly scheduled (i.e., automatic) scans and manual testing for WCAG 2.0 AA compliance for all user content and applications in order to meet the standards for compliance. The Contractor must ensure that any system additions, updates, changes or modifications comply with WCAG 2.0 AA. Commercial Off-the-shelf ("COTS") products may be used to verify aspects of WCAG 2.0 AA compliance.

2. Additionally, the Contractor agrees to comply with Title VI of the Civil Rights Act of 1964. In order to achieve Title VI compliance the Contractor should add a system function that allows users to translate the content into a language other than English. This requirement may be satisfied by the provision of a link to Google translate or other machine translate tool.

3. Should the system or a component of the system fail to comply with the accessibility standards, the Contractor shall develop and submit to TennCare for approval a noncompliance report that identifies the areas of noncompliance, a plan to bring the system or component into compliance, an alternative/work around that provides users with the equivalent access to the content, and a timeframe for achieving that compliance. TennCare shall review the noncompliance report to determine whether or not it is acceptable and should be implemented. Once the noncompliance report is approved by TennCare the Contractor may implement the compliance plan. TennCare, in its sole discretion, shall determine when a satisfactory compliance plan resolution has been reached and shall notify the Contractor of the approved resolution. If Contractor is unable to obtain content that conforms to WCAG 2.0 AA, it shall demonstrate through its reporting to TennCare that obtaining or providing accessible content would fundamentally alter the nature of its goods and services or would result in an undue burden.

e. Ethical/Moral/Religious Directives. Should the Contractor not cover a TennCare covered service because of moral/ethical or religious reasons, the Contractor shall provide a list of these services to TennCare. This list shall be used by TennCare to provide information to TennCare members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.

1. Should the Contractor contract with providers and/or subcontractors to deliver services to TennCare members pursuant to the Contractor's obligations under this agreement and the providers or subcontractors cannot provide a TennCare covered service because of moral/ethical or religious reasons, the Contractor shall provide a list of these services to TennCare. This list shall be used by the Contractor and TennCare to provide information to TennCare members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.

2. In the event, a provider agreement includes Ethical and Religious Directives provisions, the provider agreement shall include the following requirements:

(a) The Provider shall provide a list of the services it does not deliver due to the Ethical and Religious Directives to the Contractor. The Contractor shall furnish this list to TennCare, notating those services that are TennCare covered services. This list shall be used by the Contractor and TennCare to provide information to TennCare members about where and how the members can obtain the services that are not being delivered by the Provider due to Ethical and Religious Directives.

(b) At the time of service, the Provider shall inform TennCare members of the health care options that are available to the TennCare members, but

are not being provided by the Provider due to the Ethical and Religious Directives, but the Provider is not required to make specific recommendations or referrals. In addition, the Provider shall inform TennCare members that the member's MCO has additional information on providers and procedures that are covered by TennCare.

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

PROGRAM INTEGRITY

A.166. Contracting with Excluded Providers Prohibited

The Contractor shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare or CoverKids programs. All provider agreements executed by the Contractor shall:

a. Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the provider agreement or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions);

b. Include a statement that as a condition of participation in TennCare, the provider shall give TennCare, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, the Tennessee Bureau of Investigation Medicaid Fraud and Abuse Unit (TBI MFCU), Department of Health and Human Services Office of the Inspector General (DHHS OIG), Department of Justice (DOJ), and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the Contractor, TennCare or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ;

c. Provide that TennCare, as a condition of payment, DHHS OIG, Office of the Comptroller of the Treasury, 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 Contract including, but not limited to medical records, billing records, financial

records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Record requests shall be filled as required by as required by 63-2-101(i). In addition, the TBI MFCU/OIG/TennCare Office of Program Integrity shall be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG/TennCare Office of Program Integrity. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TennCare, the Office of the Inspector General (OIG), TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions;

d. Require the provider to comply with fraud and abuse requirements of this Contract; and

e. Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The provider shall be required to immediately report to the Contractor any exclusion information discovered. The provider shall be informed that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare enrollees;

A.167. Requirement for Medicaid provider ID Number

The Contractor shall ensure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number. This requirement does not apply to payment for emergency services provided by out-of-state providers.

A.168. OIG Statement

The following statement shall be clearly posted in all facilities performing services to TennCare enrollees: “To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to www.state.tn.us/tenncare and click on ‘Report Fraud’. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454.”

A.169. Explanation of Benefits (EOBs) and Related Functions

The Contractor shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TennCare. EOBs shall be designed to address requirements found in 42 CFR 455.20 and 433.116 as well as requirements associated with a change in TennCare policy and may include claims for services with benefits limits. On a monthly basis, the Contractor shall sample a minimum of one hundred (100) claims and associated EOBs.

The sample shall be based on a minimum of twenty-five (25) claims per check run. The EOBs shall be examined for correctness based on how the associated claim was processed and for adherence to the EOB requirements. The Contractor shall ensure that the examined EOBs constitute a representative sample of EOBs from all types of services and provider types. To the extent that the Contractor and/or TennCare considers a particular type of service or provider to warrant closer scrutiny, the Contractor shall over sample as needed. Based on the EOBs sent to TennCare enrollees, the Contractor shall track any grievances received from enrollees and resolve the grievances according to its established policies and procedures. The resolution may be enrollee education, provider education, or referral to TennCare, TBI and/or OIG. The Contractor shall use the feedback received to modify or enhance the EOB sampling methodology.

A.170. Return of Overpayments

In accordance with the Affordable Care Act and TennCare policy and procedures, the Contractor and its subcontractors and providers shall report overpayments and, when it is applicable, return overpayments within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may result in a penalty pursuant to state or federal law.

A.171. False Claims Act

The Contractor and its subcontractors and Providers shall comply with the provisions of 42 U.S.C. § 1396a(a)(68) *et seq*., as applicable, regarding policies and education of employees as regards the terms of the False Claims Act and whistleblower protections.

A.172. General Requirements

The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21). 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. The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. The Contractor shall suspend payment to any provider upon notification from TennCare that such provider has had a Credible Allegation of Fraud found against them pursuant to Section 6402(h) of the Affordable Care Act. This payment suspension shall be effective from when written notice was received by the Contractor until the Contractor receives notice from TennCare that the payment suspension has been canceled.

A.173. Cooperation

The Contractor shall cooperate with all appropriate state and federal agencies, including the TennCare Office of Program Integrity and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU), as well as the Office of the Inspector General (OIG),. Additionally, the Contractor shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Contract. The Contractor shall report all confirmed or suspected fraud and abuse to the appropriate agency as follows:

a. Suspected fraud and abuse in the administration of the program shall be reported to the TennCare Office of Program Integrity, TBI MFCU, and the OIG, and

b. All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU, and the TennCare Office of Program Integrity, and

c. All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG.

d. The Contractor shall simultaneously notify TBI MFCU and TennCare Office of Program Integrity in a timely manner regarding all internal (such as data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to TennCare providers' billing anomalies and/or to safety of TennCare enrollees (http://www.tbi.state.tn.us/tbi_tips.shtml:ProgramIntegrity.TennCare@tn.gov). Along with a notification, the Contractor shall take steps to triage and/or substantiate these tips and simultaneously provide timely updates to TBI MFCU and the TennCare Office of Program Integrity when the concerns and/or allegations of any tips are authenticated.

A.174. Fraud Reporting Form

The Contractor shall use the Fraud Reporting Forms currently used by TennCare Program Integrity or such other form as may be deemed satisfactory by the agency to whom the report is to be made under the terms of this Contract.

A.175. Penalty for Failure to report

Pursuant to TCA § 71-5-2603(d) the Contractor shall be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to OIG, the TennCare Office of Program Integrity, or TBI MFCU, as appropriate.

A.176. Preliminary Investigation

a. The Contractor shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written 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:

1. Contact the subject of the investigation about any matters related to the investigation;

2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

b. The Contractor shall promptly provide the results of its preliminary investigation and all administrative, data analytics, financial and medical records relating to the delivery of items or services for which TennCare monies are expended to the TennCare Office of

Program Integrity or to another agency upon that agency's request, designated by the agency that received the report and 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. The State shall not transfer its law enforcement functions to the Contractor. This section applies even if the source of the reported activity is an audit or investigation done by another State or federal agency (e.g. Comptroller's Office, licensing agency) as these investigations or audits often have Program Integrity implications. The Contractor shall promptly provide the results of its preliminary investigation to the agency to whom the incident was reported, or to another agency designated by the agency that received the report.

A.177. Records Availability

The Contractor and providers shall, upon request and as required by this Contract or state and/or federal law, make available to the TennCare Office of Program Integrity, TBI MFCU, and/or 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 TennCare Office of Program Integrity, TBI MFCU, and/or OIG shall be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TennCare Office of Program Integrity, TBI MFCU, and/or OIG. The Contractor shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section.

A.178. Compliance Plan Requirement

The Contractor shall have a state approved fraud and abuse compliance plan which includes policies and procedures in place for ensuring protections against actual or potential fraud and abuse. The detailed fraud and abuse compliance plan shall define how the Contractor shall adequately identify and report suspected fraud and abuse by recipients, providers, subcontractors, and the Contractor. The fraud and abuse compliance plan shall include a requirement that the Contractor shall report all suspected fraud and abuse to the TennCare Office of Program Integrity (OPI). The fraud and abuse compliance plan shall be updated, if applicable, and submitted to TennCare OPI on an annual basis. The Contractor shall meet with the state to discuss the monitoring tools and controls necessary to protect against theft, embezzlement, fraudulent practices, or other types of fraud and program abuse. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the State of Tennessee and/or federal laws and regulations.

A.179. Compliance Plan Contents

The Contractor's fraud and abuse compliance plan shall address, at a minimum, the following requirements:

a. Written Policies and Procedures – The Contractor shall develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to

comply with all applicable federal and state standards for the prevention, detection, and reporting of incidents of potential fraud and abuse, by members, providers, subcontractors, and the Contractor.

b. Compliance Officer – The Contractor shall designate a Compliance Officer and a Compliance Committee, accountable to senior management, to coordinate with TennCare and other state agencies on any fraud or abuse case.

c. Training and Education – The Contractor shall establish effective program integrity training and education for the Compliance Officer and all Contractor staff, employees, providers, and subcontractors.

d. Effective Lines of Communication between Contractor Staff – The Contractor shall establish effective lines of communication between the Compliance Officer and other Contractor staff.

e. Well-Publicized Disciplinary Guidelines – The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines.

f. Prevention and Detection of Potential or Actual Fraud and Abuse – The Contractor's fraud and abuse compliance plan shall include a description of the specific controls in place for prevention and detection of potential or actual fraud and abuse, such as:

1. Claims edits
2. Post-processing review of claims
3. Provider profiling and credentialing
4. Prior authorization
5. Utilization management
6. Relevant subcontractor and provider agreement provisions; and
7. Written provider and member material regarding fraud and abuse reporting.

g. Internal Monitoring and Auditing – The Contractor shall establish and implement procedures for internal monitoring and auditing. These activities and their reporting mechanism shall be defined in the fraud and abuse compliance plan.

h. Process for Reporting Potential or Actual Fraud and Abuse – The Contractor shall provide information and a procedure for members, providers, Contractor staff, employees and subcontractors to report incidents of potential or actual fraud and abuse to the Contractor. The Contractor shall require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TennCare OPI and TBI MFCU, and that enrollee fraud and abuse be reported to OIG.

i. Development of Corrective Action Initiatives – The Contractor's fraud and abuse compliance plan shall include provisions for corrective action initiatives.

j. Model Compliance Plan for MCOs - The Contractor's fraud and abuse compliance plan shall have provisions regarding compliance with the applicable requirements of the Model Compliance Plan for Medicaid MCOs issued by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG).

k. Cooperation with State and Federal Investigations – The Contractor's fraud and abuse compliance plan shall include provisions for cooperating with all fraud and abuse investigation efforts by TennCare and Other state and federal offices.

l. Confidential Reporting – The Contractor's fraud and abuse compliance plan shall contain provisions for the confidential reporting of plan violations to the Compliance Officer, or other designated person.

m. Prohibition against Retaliation – The Contractor's fraud and abuse compliance plan shall ensure that the individuals of individuals reporting compliance plan violations are protected and that there is no retaliation against such persons.

n. Internal Procedures – The Contractor's fraud and abuse compliance plan shall contain specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations.

A.180. Annual False Claims Act Compliance Plan

On an annual basis, the Contractor shall submit its policies for employees, contractors, and agents that comply with Section 1902(a)(68) of the Social Security Act. These policies shall be submitted by July 1 of each year.

A.181. Quarterly Utilization Outlier Report

The Contactor shall submit to TennCare Office of Program Integrity a Quarterly Utilization Outlier Report listing peer benchmarks and outliers by specialty types and by category of services.

A.182. Quarterly Ownership Disclosure Report

The Contractor shall submit to TennCare Office of Program Integrity a quarterly Disclosure Submission Rate report which shall provide the percentage of providers for which the Contractor has obtained a complete and current disclosure form in accordance with 42 CFR 455, TennCare policies and procedures, and this Contract. The rate shall be provided for all tax-reporting entities with billing activities during the prior quarter. The quarterly report shall include a companion listing which shall include all tax-reporting entities with reimbursement amounts received in the prior reporting quarter along with the disclosure status. For all subcontractors and providers with a signed contract and/or with billing activities, the Contractor shall maintain a minimum of ninety-five percent (95%) compliance on all entities excluding providers who bill under emergency provisions. Should the Contractor attain a disclosure rate below ninety-five percent (95%), the Contractor shall be subject to liquidated damages as specified in Attachment B and shall submit a corrective action plan that shall address the root causes of the non-compliance.

A.183. Monthly Excluded Individuals Report

The Contractor shall submit to TennCare Office of Program Integrity a monthly Program Integrity Exception List report that identifies employees or contractors that have been reported on the HHS-OIG LEIE (List of Excluded Individuals/Entities) (http://oig.hhs.gov/fraud/exclusions/exclusioins_list.asp), the Excluded Parties List System

(EPLS), and/or the listing of Monthly Disciplinary Actions issued by the Professional Health Board.

A.184. Quarterly Comprehensive Program Integrity Report

The Contractor shall submit to the TennCare Office of Program Integrity a Quarterly Report, due the last day of the month in the months of January, April, July and October of each year. This report shall include reporting on Program Integrity activities conducted by the plan in the preceding quarter. This plan shall be submitted using an Excel Workbook in the format prescribed by the TennCare Office of Program Integrity and contain the following informational tabs:

a. Tips Reported
b. Audits Performed
c. Referrals Made
d. Overpayments Identified
e. Overpayments Collected
f. Involuntary Terminations
g. Providers with Adverse PI Actions
h. Enrollees referred to OIG

A.185. Bi-Weekly Investigations Report

On the 1st and 15th of each month, the contractor shall be required to report any investigation activities that have been designated as either in need of investigation or upon which an investigation has begun, to the TennCare Office of Program Integrity in a format prescribed by TennCare. These activities are known as “TIPS” and should be reported as such. TIPS may or may not lead to a Referral. If an investigated TIP shows evidence of Fraud, Waste or Abuse, it will become a Referral, and should be submitted to the TennCare Office of Program Integrity in a format prescribed by TennCare. All activities surrounding Fraud, Waste and Abuse performed by the contractor shall be reported, in a format prescribed by the TennCare Office of Program Integrity, quarterly.

A. 186. Report Monitoring

The State will monitor the delivery and content of all required program integrity-related plans and reports and notify the Contractor of any violations, as well as any possible sanctions related to those violations. The Contractor shall have thirty (30) calendar days, following written notification, to correct all violations prior to assessment of liquidated damages by the State. The Contractor shall submit a corrective action plan to the State for each violation within five (5) business days of receipt of written notification of potential State program violations and/or written notification of possible sanctions. At the State’s option, such notices will be sent to the Contractor via electronic means or certified U.S. Mail.

A.187. Prohibition against Recoupment, Recovery, and/or Withhold of Overpayments.

a. The Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services, or claims upon which the recoupment or withhold are based meet the following criteria:

1. The improperly paid funds have already been recovered by the State of Tennessee, either by TennCare directly or as part of a resolution of a State or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or

2. When the issues, services, or claims that are the basis of the recoupment or withhold are currently being investigated by the State or are the subject of pending State or federal litigation or investigation.

b. The Contractor shall determine if the prohibition to recoup or withhold improperly paid funds is applicable utilizing methods as directed by OPI.

c. In the event the Contractor recoups, or otherwise obtains, funds in cases where overpayment recovery is prohibited under this section, or as otherwise directed by OPI, the Contractor will notify the Director of OPI and take action in accordance with written instructions from the Director of OPI.

WEBSITE

A.188. General Requirements

The Contractor shall have available an up-to-date web-site dedicated to TennCare that shall aid providers and enrollees in all aspects of the State DBM Programs. The web-site shall be available for TennCare approval at least one (1) month prior to the commencement of claims processing and be available on the internet two (2) weeks prior to the commencement of claims processing. The web-site shall contain a home page with general dental information with links to dedicated areas for providers and enrollees. Each of these sections shall contain information that shall answer, in an interactive format, the majority of questions that each group would ask. This shall include, but is not limited to:

a. Home Page, which includes:

1. General information related to dental benefit, and recent changes occurring within the State DBM Programs, including pertinent fact sheets, and

2. Navigation tool bar that links to enrollee information, provider information, finding a dentist, policy and guidelines.

b. Provider Page, which includes:

1. Applying to become a participating provider;

2. Provider credentialing and recredentialing;

3. Provider Office Reference Manual;

4. Current TennCare Dental Fee Schedules;

5. Program policies and procedures;

6. Procedures for obtaining Prior Authorizations (PA's);

7. Printable provider education material;

8. Provider newsletters;

9. Procedures for electronic billing;

10. Fluoride varnish program;

11. Information about Peer Review Committee, and

12. Call Center hours of operation and contact numbers.

c. Enrollee Page, which includes:

1. A description of services provided including limitations, exclusions and out-of-network use;

2. Member Handbook including provider directory;

3. Call Center hours of operation and contact numbers;

4. Copay information;

5. Transportation assistance;

6. Language assistance service;

7. Printable education material specific to enrollees, and

8. On-line search, by address or zip code, to locate the network dentists nearest to the enrollee.

9. Privacy and Security information regarding enrollee records;

10. Privacy Assistance for individuals with disabilities, and

11. Discrimination complaint forms and the Civil Rights Notice.

A.189. System requirements

The Contractor's system shall be a secure, HIPAA-compliant and data-encrypted electronic system. The system shall have the ability to be easily customized and have interactive communication capabilities to meet the needs of TennCare and its providers. The Contractor shall provide support and maintenance of the website and guarantee any data exchange between the Contractor and TennCare or its providers and enrollees shall be secure and compliant with current HIPAA guidelines concerning data encryption and/or password protection. TennCare shall transmit eligibility/enrollment information to the Contractor by the standard HIPAA 834 transaction defined by the TennCare Companion Guide.

CMS CERTIFICATION

A.190. CMS Certification

CMS Certification of Contractor's DBM System to Qualify for Enhanced Federal Financial Participation (FFP) Funding. If requested by the State, the Contractor shall assist the State, at no additional cost to the State, with the process of obtaining CMS certification of the Contractor's

DBM system used for the State DBM Programs to permit the State to obtain enhanced FFP funding for the DBM services provided by the Contractor. To the extent possible, the Contractor agrees to leverage its existing CMS certifications of DBM systems currently in use by the Contractor with Medicaid and CHIP Programs in other states to obtain CMS certification of the DBM system it uses in Tennessee.

PERFORMANCE OBJECTIVES

A.191. Administration and Management

The following performance indicators related to administration and management have been identified for on-going monitoring. The Contractor's failure to meet these benchmarks shall result in the Contractor being required to implement a corrective action plan or application of liquidated damages as specified in Section E.10 and Attachment B of this Contract.

Performance Indicator	Data Sources	Measure	Target	Benchmark
Prompt Pay	Processed Claims	# of claims paid timely in accordance with T.C.A. §56-32-126(b)(1)	100%	90% of provider claims for payment are paid within 30 days and 99.5% are paid within 60 days.
Claims Payment Accuracy	Monthly Claims Activity Report	# of claims paid accurately upon initial submission	100 %	97% accuracy upon initial submission
Approximate Waiting Time for Provider Response	Monthly Response Time Report	Average response time on provider services line	Average response time of 30 seconds	Average response time of 60 seconds
Abandonment rate for Member Services lines	Monthly Response Time Report	Percent of calls not answered; callers hang up while in queue	0 %	Less than 5 %of calls not answered
Approximate Waiting Time for Member Response	Monthly Response Time Report	Average Response Time on Member Services Line	Average response time of 30 seconds	Average response time of 60 seconds

A.192. EPSDT Monitoring

The following performance indicators related to EPSDT have been identified for on-going monitoring. The Contractor's failure to meet these benchmarks shall result in the Contractor being required to implement a corrective action plan as described in Contract Section A.8 and liquidated damages in Attachment B. Utilization benchmarks may be established by TennCare after discussion with Contractor for specific EPSDT services or procedures.

Performance Indicator	Data Sources	Measure	Benchmark
Annual EPSDT Dental	Claims encounter data; TennCare enrollment data	Dental Screening Percentage (DSP) (Refer to Attachment F)	80%

A.193. CoverKids Performance Guarantees

Contractor shall utilize the claims Encounter data for the CoverKids Program to calculate the Partial Enrollment Adjusted Ratio (PEAR), as provided in Attachment E, for the CoverKids Program. Based on this calculation, the Contractor shall ensure that the PEAR for the CoverKids Program is above fifty percent (50%) on an annual basis. The Contractor shall be subject to liquidated damages as specified in Attachment B for failure to maintain a PEAR above fifty percent (50%).

A.194. Control Memorandum Process.

a. The Control Memorandum ("CM") process shall be utilized by the State to clarify Contract requirements, issue instruction to the Contractor, document action required of the Contractor, or request information from the Contractor. In addition, the CM process shall be used by the State to impose assessments of damages, either actual or liquidated. This process will be used to address issues or matters that do not require a contract amendment. Each CM must be in writing and indicate the date on which it was issued. CMs may provide relevant history, background, and other pertinent information regarding the issue(s) being addressed in the CM. Each CM will establish a deadline or timeframe for the Contractor's reply or other action. All CMs submitted to the Contractor must be signed and approved by the State's Project Director (or his/her designee). When the CM pertains to damages, either actual or liquidated, the State may issue consecutive CMs, as may be necessary or appropriate.

b. A CM may include one (1) or more of the five (5) components of the CM process described below:

1. On Request Report – a request directing the Contractor to provide information by the time and date set out in the CM.

2. Control Directive (CD) – instructions that require the Contractor to complete, within a designated timeframe, one (1) or more deliverables or to perform any

other request from the State that is within the scope of the Contract. The CD may include a Corrective Action Plan. A CD may also provide clarification of certain Contract terms. Once a CM/CD has been issued, it shall be considered to be incorporated into this Contract.

3. Notice of Potential Damages (Actual or Liquidated) (NPD) – notification to the Contractor that the State has determined that a potential Contract performance or compliance failure exists and that the State is contemplating assessing damages. The NPD shall identify the Contract provision(s) on which the State determination rests.

4. Notice of Calculation of Potential Damages (Actual or Liquidated) (NCPD) – notification to the Contractor that provides a calculation of the amount of potential damages that the State is contemplating assessing against the Contractor. NPDs and NPCDs may be issued consecutively or simultaneously.

5. Notice of Intent to Assess Damages (Actual or Liquidated) (NIAD) – notification to the Contractor that the State is assessing damages and specifying whether the damages, due to a performance or compliance failure, are actual damages or Liquidated Damages and setting out the performance or compliance failure underlying each intended damage assessment. The NIAD shall identify the NPD and NCPD upon which it is based. The NIAD shall specify the total amount and type of damages, whether actual or liquidated, that the State intends to assess. Following the issuance of an NIAD, the State may elect to withhold damages from payments due to Contractor. The State may not issue a NIAD without first issuing a NPD and a NPCD. The State may not obtain both Liquidated Damages and Actual Damages for the same occurrence of a Contract performance or compliance failure.

c. Damages for failure to comply with CM. The Contractor shall fully comply with all CMs. Failure to do so may result in the State pursuing recovery of damages, as defined in Section E.10, including Liquidated Damages as listed in Contract Attachment B, a corrective action plan, and/or termination of the Contract.

d. Appeal of Damages by Contractor. Contractor may appeal either the basis for NPD or calculation of NCPD potential damages, either actual or liquidated. To do so, the Contractor shall submit to the State's Project Director (or his/her designee) a written response to the NPD and/or NCPD within ten (10) business days of receipt of a CM which includes a NPD or a NCPD. The State's Project Director (or his/her designee) shall review the appeal and provide notice of his/her determination to the Contractor through a CM. If the Contractor disagrees with the State's Project Director's (or his/her designee) initial appeal determination or the State's Project Director (or his/her designee) is unable to resolve the appeal, the Contractor may submit a written request to the State's Project Director (or his/her designee) that the matter be escalated to senior management of the Agency. Contractor shall submit such a request for escalation within ten (10) business days of its receipt of the initial appeal determination from the State's Project Director (or his/her designee) or of notification by the State's Project Director that he/she is unable to resolve the appeal. The State's senior management shall provide written notice of its final determination to the Contractor within (10) days of the receipt of the appeal from the

Contractor. Upon appeal or escalation, the State shall not increase the amount of the potential damages.

A.195. Non-Disclosure and Contractors

The Contractor shall, as directed by the State and at no additional cost to the State, coordinate with, facilitate the prompt exchange of information between, and work collaboratively with any and all other State contractors and State agencies. If required in order for the Contractor to proceed with any part of the Scope of Services which involves sharing or obtaining information of a confidential, proprietary, or otherwise valuable nature with or from another State contractor or State agency, the Contractor may be requested to sign mutually agreeable documents, including but not limited to Non-Disclosure Agreements (Non-Disclosure Documents), which are reasonably necessary to maintain cooperation and collaboration among and with any and all other State contractors and State agencies in the performance of the Contract.

All information the Contractor may receive, have disclosed to it, or otherwise becomes known to Contractor during the performance of this Contract from any other State contractor or State agency, that the State contractor or State agency considers to be propriety or confidential in nature pursuant to a Non-Disclosure Document entered into between the Contractor and another State contractor or State agency, shall be governed by such Non-Disclosure Document.

Nothing in this Section, including failure to negotiate and enter into a Non-Disclosure Document acceptable to Contactor with another State contractor or State agency, shall be construed to relieve the Contractor of its duty to perform any requirements or deliverables under this Contract. Other than as permitted in Section C of this Contract, Payment Terms and Conditions, the Contractor shall not invoice the State for any such coordination services, and the State shall not be liable to the Contractor for payment of any such coordination services.

OBLIGATIONS OF THE STATE

A.196. State Provision of Rules and Policies

TennCare shall provide the Contractor, as necessary for the Performance of the Contractor obligations, the rules, policies and procedures regarding the benefits and claims payments applicable to coverage under the respective TennCare DBM Programs.

A.197. State Responsible for Enrollee Enrollment and Disenrollment

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

A.198. State Provides Online Enrollee Eligibility Verification for Providers

TennCare shall provide a means for dental providers to verify Enrollee eligibility online. The Contractor may provide additional means of eligibility verification to its contracted dentists.

A.199. State to Pay Contractor According to Contract Section C

TennCare shall pay the Contractor pursuant to Section C.3 of this Contract for the Contractor's performance of all duties and obligations hereunder. No additional payment shall be made to Contractor by TennCare for the services required under this Contract.

B. TERM OF CONTRACT:

B.1. This Contract shall be effective for the period beginning September 1, 2018 ("Effective Date") and ending on April 30, 2023 ("Term"). The State shall have no obligation for goods delivered or services provided by the Contractor prior to the Effective Date.

B.2. Renewal Options. This Contract may be renewed upon satisfactory completion of the Term. The State reserves the right to execute up to three (3) renewal options under the same terms and conditions for a period not to exceed twelve (12) months by the State, at the State's sole option. In no event, however, shall the maximum Term, including all renewals or extensions, exceed a total of ninety-two (92) months.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Seventy Nine Million Five Hundred and One Thousand Six Hundred Seventy Six Dollars and Zero cents ($79,501,676.00) ("Maximum Liability"). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract.

C.2. Compensation Firm. The payment methodology in Section C.3. of this Contract shall constitute the entire compensation due the Contractor for all goods or services provided under this Contract regardless of the difficulty, materials or equipment required. The payment methodology includes all applicable taxes, fees, overhead, and all other direct and indirect costs incurred or to be incurred by the Contractor.

C.3. Payment Methodology. The Contractor shall be compensated based on the payment methodology for goods or services authorized by the State in a total amount as set forth in Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in Section A.

b. The Contractor shall be compensated based upon the following payment methodology:

(1) For the transition period of September 1, 2018 – April 30, 2019, there shall be no cost to the State.

(2) For TennCare Children's DBM Program, TennCare ECF CHOICES DBM Program, and TPPOHP DBM Program services performed from May 1, 2019 through April 30, 2023, the following rates shall apply:

	Amount

Cost Item Description	(per compensable increment)
May 1, 2019 – April 30, 2023 **TennCare Children's DBM Program** Administrative Fee Per Child (Under Age 21) Eligible for Full Dental Benefit Package (per member per month) AND **TPPOHP DBM Program** Administrative Fee per TennCare Enrollee who is a Pregnant Woman (21 Years of Age and Older) Eligible for TPPOHP DBM Program Limited Benefits (per member per month)	$ 0.50 per member per month
TennCare ECF **CHOICES DBM Program** **May 1, 2019 – April 30, 2023** Administrative Fee Per Eligible Adult Enrolled in the TennCare ECF CHOICES DBM Program (per member per month)	$ 0.01 per member per month

(3) For CoverKids DBM Program services performed from July 1, 2020 (Go Live Date) through April 30, 2023, the following rates shall apply. There shall be no cost to the State for CoverKids DBM Program services prior to Go Live Date of July1, 2020.

Cost Item Description	**Amount** (per compensable increment)
CoverKids DBM Program **July 1, 2020 – April 30, 2023** Group One Child [1] (Monthly)	$ 14.70 Monthly Premium Rate / Per Member
CoverKids DBM Program **July 1, 2020 – April 30, 2023** Group Two Child [2] (Monthly)	$ 20.67 Monthly Premium Rate / Per Member

CoverKids DBM Program **July 1, 2020 – April 30, 2023** AI / AN Child [3] (Monthly)	$ 18.19 Monthly Premium Rate / Per Member

[1] ***Group One Child*** *is defined as a covered child who is in a family with an income between 150 percent and 250 percent of FPL.*

[2] ***Group Two Child*** *is defined as a covered child who is in a family with an income below 150 percent of FPL and therefore subject to reduced copayments.*

[3] ***AI / AN Child*** *is defined as a covered child who is (a) certified American Indian/Alaskan Native (AI/AN) and (b) a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Eligibility Determination Contractor to the Contractor for the coverage period.*

(5) Should Term Extension Option (Section B.2) be utilized, the following rates shall apply for services performed during extension periods:

Cost Item Description	**Amount** (per compensable increment)
TennCare Children's DBM Program Administrative Fee Per Child (Under Age 21) Eligible for Full Dental Benefit Package (per member per month) AND **TPPOHP DBM Program** Administrative Fee per TennCare Enrollee who is a Pregnant Woman (21 Years of Age and Older) Eligible for TPPOHP DBM Program Limited Benefits (per member per month)	$ .50 per member per month
TennCare ECF CHOICES DBM Program Administrative Fee Per Eligible Adult Enrolled in the ECF CHOICES Program (per member per month)	$ .01 per member per month
CoverKids DBM Program Group One Child (Monthly)	$ 14.70 Monthly Premium Rate / Per Member
CoverKids DBM Program Group Two Child	$ 20.67

(Monthly)	Monthly Premium Rate / Per Member
CoverKids DBM Program AI / AN Child [3] (Monthly)	$ 18.19 Monthly Premium Rate / Per Member

c. The Contractor shall assume risk levels for the TennCare Children's DBM Program only of at least 20% based on levels submitted in Cost Proposal (Contract Section A.164).

Risk Levels	
DBM Assumes 50% of Loss	DBM Share: 50% of any Savings

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

C.5. Invoice Requirements. The Contractor shall invoice the State only for goods delivered and accepted by the State or services satisfactorily provided at the amounts stipulated in Section C.3., above. Contractor shall submit invoices and necessary supporting documentation, no more frequently than once a month, and no later than thirty (30) days after goods or services have been provided to the following address:

Division of TennCare
310 Great Circle Road
Nashville, TN 37243

a. Each invoice, on Contractor's letterhead, shall clearly and accurately detail all of the following information (calculations must be extended and totaled correctly):

(1) Invoice number (assigned by the Contractor);
(2) Invoice date;
(3) Contract number (assigned by the State);
(4) Customer account name: Department of Finance and Administration, Division of Health Care Finance and Administration
(5) Customer account number (assigned by the Contractor to the above-referenced Customer);
(6) Contractor name;
(7) Contractor Tennessee Edison registration ID number;
(8) Contractor contact for invoice questions (name, phone, or email);
(9) Contractor remittance address;
(10) Description of delivered goods or services provided and invoiced, including identifying information as applicable;
(11) Number of delivered or completed units, increments, hours, or days as applicable, of each good or service invoiced;
(12) Applicable payment methodology (as stipulated in Section C.3.) of each good or service invoiced;
(13) Amount due for each compensable unit of good or service; and

(14) Total amount due for the invoice period.

b. Contractor's invoices shall:

(1) Only include charges for goods delivered or services provided as described in Section A and in accordance with payment terms and conditions set forth in Section C;
(2) Only be submitted for goods delivered or services completed and shall not include any charge for future goods to be delivered or services to be performed;
(3) Not include Contractor's taxes, which includes without limitation Contractor's sales and use tax, excise taxes, franchise taxes, real or personal property taxes, or income taxes; and
(4) Include shipping or delivery charges only as authorized in this Contract.

c. The timeframe for payment (or any discounts) begins only when the State is in receipt of an invoice that meets the minimum requirements of this Section C.5.

C.6. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice, or other matter. A payment by the State shall not be construed as acceptance of goods delivered, any part of the services provided, or as approval of any amount invoiced.

C.7. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment that is determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, to not constitute proper compensation for goods delivered or services provided.

C.8. Deductions. The State reserves the right to deduct from amounts, which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee, any amounts that are or shall become due and payable to the State of Tennessee by the Contractor.

C.9. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following, properly completed documentation.

a. The Contractor shall complete, sign, and present to the State the "Authorization Agreement for Automatic Deposit Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once this form is received by the State, payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee, may be made by ACH; and

b. The Contractor shall complete, sign, and return to the State the State-provided W-9 form. The taxpayer identification number on the W-9 form must be the same as the Contractor's Federal Employer Identification Number or Social Security Number referenced in the Contractor's Edison registration information.

D. MANDATORY TERMS AND CONDITIONS:

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

regulations. Depending upon the specifics of this Contract, this may include approvals by the Commissioner of Finance and Administration, the Commissioner of Human Resources, the Comptroller of the Treasury, and the Chief Procurement Officer. Approvals shall be evidenced by a signature or electronic approval.

D.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by email or facsimile transmission with recipient confirmation. All communications, regardless of method of transmission, shall be addressed to the respective Party at the appropriate mailing address, facsimile number, or email address as stated below or any other address provided in writing by a Party.

The State:
Deputy Commissioner
Department of Finance and Administration
Division of TennCare
310 Great Circle Road
Nashville TN 37243
Telephone # (615) 507-6444
FAX # (615) 253-5607

The Contractor:
Steven J. Brady
Director of Client and Provider Engagement
3322 West End Avenue, Suite 100
Nashville TN, 37203
Steven.Brady@dentaquest.com
Telephone # 615-642-8071
FAX # 844-260-6100

All instructions, notices, consents, demands, or other communications shall be considered effective upon receipt or recipient confirmation as may be required.

D.3. Modification and Amendment. This Contract may be modified only by a written amendment signed by all Parties and approved by all applicable State officials.

D.4. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State or federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate this Contract upon written notice to the Contractor. The State's exercise of its right to terminate this Contract shall not constitute a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. If the State terminates this Contract due to lack of funds availability, the Contractor shall be entitled to compensation for all conforming goods requested and accepted by the State and for all satisfactory and authorized services completed as of the termination date. Should the State exercise its right to terminate this Contract due to unavailability of funds, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages of any description or amount.

D.5. Termination for Convenience. The State may terminate this Contract for convenience without cause and for any reason. The State shall give the Contractor at least thirty (30) days written notice before the termination date. The Contractor shall be entitled to compensation for all conforming goods delivered and accepted by the State or for satisfactory, authorized services completed as of the termination date. In no event shall the State be liable to the Contractor for compensation for any goods neither requested nor accepted by the State or for any services neither requested by the State nor satisfactorily performed by the Contractor. In no event shall the State's exercise of its right to terminate this Contract for convenience relieve the Contractor of any liability to the State for any damages or claims arising under this Contract.

D.6. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor materially violates any terms of this Contract ("Breach Condition"),the State shall have the right to immediately terminate the Contract and withhold payments in excess of compensation for completed services or provided goods. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any Breach Condition and the State may seek other remedies allowed at law or in equity for breach of this Contract.

D.7. Assignment and Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the goods or services provided under this Contract without the prior written approval of the State. Notwithstanding any use of the approved subcontractors, the Contractor shall be the prime contractor and responsible for compliance with all terms and conditions of this Contract. The State reserves the right to request additional information or impose additional terms and conditions before approving an assignment of this Contract in whole or in part or the use of subcontractors in fulfilling the Contractor's obligations under this Contract.

D.8. Conflicts of Interest. The Contractor warrants that no part of the Contractor's compensation shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed under this Contract.

The Contractor acknowledges, understands, and agrees that this Contract shall be null and void if the Contractor is, or within the past six (6) months has been, an employee of the State of Tennessee or if the Contractor is an entity in which a controlling interest is held by an individual who is, or within the past six (6) months has been, an employee of the State of Tennessee.

D.9. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, creed, color, religion, sex, national origin, or any other classification protected by federal or state law. The Contractor shall, upon request, show proof of nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination. In addition, the Contractor shall comply with the provisions of Contract Section A.165. (Nondiscrimination Compliance Requirements) and this Section D.9 shall not be deemed to limit or abridge any requirement set forth in Section A.165.

D.10. Prohibition of Illegal Immigrants. The requirements of Tenn. Code Ann. § 12-3-309 addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the

other request from the State that is within the scope of the Contract. The CD may include a Corrective Action Plan. A CD may also provide clarification of certain Contract terms. Once a CM/CD has been issued, it shall be considered to be incorporated into this Contract.

3. Notice of Potential Damages (Actual or Liquidated) (NPD) – notification to the Contractor that the State has determined that a potential Contract performance or compliance failure exists and that the State is contemplating assessing damages. The NPD shall identify the Contract provision(s) on which the State determination rests.

4. Notice of Calculation of Potential Damages (Actual or Liquidated) (NCPD) – notification to the Contractor that provides a calculation of the amount of potential damages that the State is contemplating assessing against the Contractor. NPDs and NPCDs may be issued consecutively or simultaneously.

5. Notice of Intent to Assess Damages (Actual or Liquidated) (NIAD) – notification to the Contractor that the State is assessing damages and specifying whether the damages, due to a performance or compliance failure, are actual damages or Liquidated Damages and setting out the performance or compliance failure underlying each intended damage assessment. The NIAD shall identify the NPD and NCPD upon which it is based. The NIAD shall specify the total amount and type of damages, whether actual or liquidated, that the State intends to assess. Following the issuance of an NIAD, the State may elect to withhold damages from payments due to Contractor. The State may not issue a NIAD without first issuing a NPD and a NPCD. The State may not obtain both Liquidated Damages and Actual Damages for the same occurrence of a Contract performance or compliance failure.

c. Damages for failure to comply with CM. The Contractor shall fully comply with all CMs. Failure to do so may result in the State pursuing recovery of damages, as defined in Section E.10, including Liquidated Damages as listed in Contract Attachment B, a corrective action plan, and/or termination of the Contract.

d. Appeal of Damages by Contractor. Contractor may appeal either the basis for NPD or calculation of NCPD potential damages, either actual or liquidated. To do so, the Contractor shall submit to the State's Project Director (or his/her designee) a written response to the NPD and/or NCPD within ten (10) business days of receipt of a CM which includes a NPD or a NCPD. The State's Project Director (or his/her designee) shall review the appeal and provide notice of his/her determination to the Contractor through a CM. If the Contractor disagrees with the State's Project Director's (or his/her designee) initial appeal determination or the State's Project Director (or his/her designee) is unable to resolve the appeal, the Contractor may submit a written request to the State's Project Director (or his/her designee) that the matter be escalated to senior management of the Agency. Contractor shall submit such a request for escalation within ten (10) business days of its receipt of the initial appeal determination from the State's Project Director (or his/her designee) or of notification by the State's Project Director that he/she is unable to resolve the appeal. The State's senior management shall provide written notice of its final determination to the Contractor within (10) days of the receipt of the appeal from 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 agrees that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment G, semi-annually during the Term. If the Contractor is a party to more than one contract with the State, the Contractor may submit one attestation that applies to all contracts with the State. All Contractor 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 Term, 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 under this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work under this Contract. Attestations obtained from 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. Contractor's 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 Tenn. Code Ann. § 12-3-309 for acts or omissions occurring after its effective date.

e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not: (i) a United States citizen; (ii) a Lawful Permanent Resident; (iii) a person whose physical presence in the United States is authorized; (iv) allowed by the federal Department of Homeland Security and who, under federal immigration laws or regulations, is authorized to be employed in the U.S.; or (v) is otherwise authorized to provide services under the Contract.

D.11. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, for work performed or money received under this Contract, shall be maintained for a period of five (5) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.12. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.13. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.14. Strict Performance. Failure by any Party to this Contract to require, in any one or more cases, the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the Parties.

D.15. Independent Contractor. The Parties shall not act as employees, partners, joint venturers, or associates of one another. The Parties are independent contracting entities. Nothing in this Contract shall be construed to create an employer/employee relationship or to allow either Party to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one Party are not employees or agents of the other Party.

D.16 Patient Protection and Affordable Care Act. The Contractor agrees that it will be responsible for compliance with the Patient Protection and Affordable Care Act ("PPACA") with respect to itself and its employees, including any obligation to report health insurance coverage, provide health insurance coverage, or pay any financial assessment, tax, or penalty for not providing health insurance. The Contractor shall indemnify the State and hold it harmless for any costs to the State arising from Contractor's failure to fulfill its PPACA responsibilities for itself or its employees.

D.17. Limitation of State's Liability. The State shall have no liability except as specifically provided in this Contract. In no event will the State be liable to the Contractor or any other party for any lost revenues, lost profits, loss of business, decrease in the value of any securities or cash position, time, goodwill, or any indirect, special, incidental, punitive, exemplary or consequential damages of any nature, whether based on warranty, contract, statute, regulation, tort (including but not limited to negligence), or any other legal theory that may arise under this Contract or otherwise. The State's total liability under this Contract (including any exhibits, schedules, amendments or other attachments to the Contract) or otherwise shall under no circumstances exceed the Maximum Liability. This limitation of liability is cumulative and not per incident.

D.18. Limitation of Contractor's Liability. In accordance with Tenn. Code Ann. § 12-3-701, the Contractor's liability for all claims arising under this Contract shall be limited to an amount equal to two (2) times the Maximum Liability amount detailed in Section C.1. and as may be amended, PROVIDED THAT in no event shall this Section limit the liability of the Contractor for: (i) intellectual property or any Contractor indemnity obligations for infringement for third-party intellectual property rights; (ii) any claims covered by any specific provision in the Contract providing for liquidated damages; or (iii) any claims for intentional torts, criminal acts, fraudulent conduct, or acts or omissions that result in personal injuries or death.

D.19. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State to enforce the terms of this Contract.

In the event of any suit or claim, the Parties shall give each other immediate notice and provide all necessary assistance to respond. The failure of the State to give notice shall only relieve the

Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

D.20. HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Health Information Technology for Economic and Clinical Health ("HITECH") Act and any other relevant laws and regulations regarding privacy (collectively the "Privacy Rules"). The obligations set forth in this Section shall survive the termination of this Contract.

a. Contractor warrants to the State that it is familiar with the requirements of the Privacy Rules, and will comply with all applicable requirements in the course of this Contract.

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

c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by the Privacy Rules and that are reasonably necessary to keep the State and Contractor in compliance with the Privacy Rules. This provision shall not apply if information received or delivered by the parties under this Contract is NOT "protected health information" as defined by the Privacy Rules, or if the Privacy Rules permit the parties to receive or deliver the information without entering into a business associate agreement or signing another document.

d. The Contractor will indemnify the State and hold it harmless for any violation by the Contractor or its subcontractors of the Privacy Rules. This includes the costs of responding to a breach of protected health information, the costs of responding to a government enforcement action related to the breach, and any fines, penalties, or damages paid by the State because of the violation.

D.21. Tennessee Consolidated Retirement System. Subject to statutory exceptions contained in Tenn. Code Ann. §§ 8-36-801, *et seq*., the law governing the Tennessee Consolidated Retirement System ("TCRS"), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established under Tenn. Code Ann. §§ 8-35-101, *et seq*., accepts State employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor, if a retired member of TCRS, may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the Term.

D.22. Tennessee Department of Revenue Registration. The Contractor shall comply with all applicable registration requirements contained in Tenn. Code Ann. §§ 67-6-601 – 608. Compliance with applicable registration requirements is a material requirement of this Contract.

D.23. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

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

b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

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

d. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

The Contractor shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded or disqualified, or presently fall under any of the prohibitions of sections a-d.

D.24. Force Majeure. "Force Majeure Event" means fire, flood, earthquake, elements of nature or acts of God, wars, riots, civil disorders, rebellions or revolutions, acts of terrorism or any other similar cause beyond the reasonable control of the Party except to the extent that the non-performing Party is at fault in failing to prevent or causing the default or delay, and provided that the default or delay cannot reasonably be circumvented by the non-performing Party through the use of alternate sources, workaround plans or other means. A strike, lockout or labor dispute shall not excuse either Party from its obligations under this Contract. Except as set forth in this Section, any failure or delay by a Party in the performance of its obligations under this Contract arising from a Force Majeure Event is not a default under this Contract or grounds for termination. The non-performing Party will be excused from performing those obligations directly affected by the Force Majeure Event, and only for as long as the Force Majeure Event continues, provided that the Party continues to use diligent, good faith efforts to resume performance without delay. The occurrence of a Force Majeure Event affecting Contractor's representatives, suppliers, subcontractors, customers or business apart from this Contract is not a Force Majeure Event under this Contract. Contractor will promptly notify the State of any delay caused by a Force Majeure Event (to be confirmed in a written notice to the State within one (1) day of the inception of the delay) that a Force Majeure Event has occurred, and will describe in reasonable detail the nature of the Force Majeure Event. If any Force Majeure Event results in a delay in Contractor's performance longer than forty-eight (48) hours, the State may, upon notice to Contractor: (a) cease payment of the fees until Contractor resumes performance of the affected obligations; or (b) immediately terminate this Contract or any purchase order, in whole or in part, without further payment except for fees then due and payable. Contractor will not increase its charges under this Contract or charge the State any fees other than those provided for in this Contract as the result of a Force Majeure Event.

D.25 State and Federal Compliance. The Contractor shall comply with all applicable state and federal laws and regulations in the performance of this Contract. In addition, the Contractor shall comply

with the provisions of Contract Section E.16, (Applicable Laws, Rules, Policies and Court Orders), and this Section D.25 shall not be deemed to limit or abridge any requirement set forth in Section E.16, Applicable Laws, Rules, Policies and Court Orders.

D.26. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Tennessee Claims Commission or the state or federal courts in Tennessee shall be the venue for all claims, disputes, or disagreements arising under this Contract. The Contractor acknowledges and agrees that any rights, claims, or remedies against the State of Tennessee or its employees arising under this Contract shall be subject to and limited to those rights and remedies available under Tenn. Code Ann. §§ 9-8-101 - 407.

D.27. Entire Agreement. This Contract is complete and contains the entire understanding between the Parties relating to its subject matter, including all the terms and conditions of the Parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the Parties, whether written or oral.

D.28. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions of this Contract shall not be affected and shall remain in full force and effect. The terms and conditions of this Contract are severable.

D.29. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

D.30. Incorporation of Additional Documents. Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below:

a. any amendment to this Contract, with the latter in time controlling over any earlier amendments;
b. this Contract with any attachments or exhibits (excluding the items listed at subsections c. through f., below), which includes Attachment A, Terms and Definitions; Attachment B, Liquidated Damages; Attachment C, DBM Deliverable Requirements; Attachment D, Dental Service Categories by Dental CDT Codes; Attachment E, Annual Dental Participation Ratio; Attachment F, Dental Screening Percentage, and Attachment G, Attestation RE: Personnel Used in Contract Performance.
c. any clarifications of or addenda to the Contractor's proposal seeking this Contract;
d. the State solicitation, as may be amended, requesting responses in competition for this Contract;
e. any technical specifications provided to proposers during the procurement process to award this Contract; and
f. the Contractor's response seeking this Contract.

D.31. Iran Divestment Act. The requirements of Tenn. Code Ann. § 12-12-101 et.seq., addressing contracting with persons as defined at T.C.A. §12-12-103(5) that engage in investment activities in Iran, shall be a material provision of this Contract. The Contractor certifies, under penalty of perjury, that to the best of its knowledge and belief that it is not on the list created pursuant to Tenn. Code Ann. § 12-12-106.

D.32. Insurance. Contractor shall maintain insurance coverage as specified in this Section. The State reserves the right to amend or require additional insurance coverage, coverage amounts, and endorsements required under this Contract. Contractor's failure to maintain or submit evidence of

insurance coverage, as required, is a material breach of this Contract. If Contractor loses insurance coverage, fails to renew coverage, or for any reason becomes uninsured during the Term, Contractor shall immediately notify the State. All insurance companies providing coverage must be: (a) acceptable to the State; (b) authorized by the Tennessee Department of Commerce and Insurance ("TDCI"); and (c) rated A- / VII or better by A.M. Best. All coverage must be on a primary basis and noncontributory with any other insurance or self-insurance carried by the State. Contractor agrees to name the State as an additional insured on any insurance policy with the exception of workers' compensation (employer liability) and professional liability (errors and omissions) insurance. All policies must contain an endorsement for a waiver of subrogation in favor of the State. Any deductible or self insured retention ("SIR") over fifty thousand dollars ($50,000) must be approved by the State. The deductible or SIR and any premiums are the Contractor's sole responsibility. The Contractor agrees that the insurance requirements specified in this Section do not reduce any liability the Contractor has assumed under this Contract including any indemnification or hold harmless requirements.

To achieve the required coverage amounts, a combination of an otherwise deficient specific policy and an umbrella policy with an aggregate meeting or exceeding the required coverage amounts is acceptable. For example: If the required policy limit under this Contract is for two million dollars ($2,000,000) in coverage, acceptable coverage would include a specific policy covering one million dollars ($1,000,000) combined with an umbrella policy for an additional one million dollars ($1,000,000). If the deficient underlying policy is for a coverage area without aggregate limits (generally Automobile Liability and Employers' Liability Accident), Contractor shall provide a copy of the umbrella insurance policy documents to ensure that no aggregate limit applies to the umbrella policy for that coverage area. In the event that an umbrella policy is being provided to achieve any required coverage amounts, the umbrella policy shall be accompanied by an endorsement at least as broad as the Insurance Services Office, Inc. (also known as "ISO") "Noncontributory—Other Insurance Condition" endorsement or shall be written on a policy form that addresses both the primary and noncontributory basis of the umbrella policy if the State is otherwise named as an additional insured.

Contractor shall provide the State a certificate of insurance ("COI") evidencing the coverages and amounts specified in this Section. The COI must be on a form approved by the TDCI (standard ACORD form preferred). The COI must list each insurer's National Association of Insurance Commissioners (NAIC) number and be signed by an authorized representative of the insurer. The COI must list the State of Tennessee – CPO Risk Manager, 312 Rosa L. Parks Ave., 3rd floor Central Procurement Office, Nashville, TN 37243 as the certificate holder. Contractor shall provide the COI ten (10) business days prior to the Effective Date and again thirty (30) calendar days before renewal or replacement of coverage. Contractor shall provide the State evidence that all subcontractors maintain the required insurance or that subcontractors are included under the Contractor's policy. At any time, the State may require Contractor to provide a valid COI. The parties agree that failure to provide evidence of insurance coverage as required is a material breach of this Contract. If Contractor self-insures, then a COI will not be required to prove coverage. Instead Contractor shall provide a certificate of self-insurance or a letter, on Contractor's letterhead, detailing its coverage, policy amounts, and proof of funds to reasonably cover such expenses.

The State agrees that it shall give written notice to the Contractor as soon as practicable after the State becomes aware of any claim asserted or made against the State, but in no event later than thirty (30) calendar days after the State becomes aware of such claim. The failure of the State to

give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor or its insurer, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

The insurance obligations under this Contract shall be: (1)—all the insurance coverage and policy limits carried by the Contractor; or (2)—the minimum insurance coverage requirements and policy limits shown in this Contract; whichever is greater. Any insurance proceeds in excess of or broader than the minimum required coverage and minimum required policy limits, which are applicable to a given loss, shall be available to the State. No representation is made that the minimum insurance requirements of the Contract are sufficient to cover the obligations of the Contractor arising under this Contract. The Contractor shall obtain and maintain, at a minimum, the following insurance coverages and policy limits.

a. Commercial General Liability ("CGL") Insurance

    1) The Contractor shall maintain CGL, which shall be written on an ISO Form CG 00 01 occurrence form (or a substitute form providing equivalent coverage) and shall cover liability arising from property damage, premises and operations products and completed operations, bodily injury, personal and advertising injury, and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).
    The Contractor shall maintain single limits not less than one million dollars ($1,000,000) per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this policy or location of occurrence or the general aggregate limit shall be twice the required occurrence limit.

b. Workers' Compensation and Employer Liability Insurance

    1) For Contractors statutorily required to carry workers' compensation and employer liability insurance, the Contractor shall maintain:

        i. Workers' compensation in an amount not less than one million dollars ($1,000,000) including employer liability of one million dollars ($1,000,000) per accident for bodily injury by accident, one million dollars ($1,000,000) policy limit by disease, and one million dollars ($1,000,000) per employee for bodily injury by disease.

    2) If the Contractor certifies that it is exempt from the requirements of Tenn. Code Ann. §§ 50-6-101 – 103, then the Contractor shall furnish written proof of such exemption for one or more of the following reasons:

        i. The Contractor employs fewer than five (5) employees;

        ii. The Contractor is a sole proprietor;

        iii. The Contractor is in the construction business or trades with no employees;

        iv. The Contractor is in the coal mining industry with no employees;

v. The Contractor is a state or local government; or

vi. The Contractor self-insures its workers' compensation and is in compliance with the TDCI rules and Tenn. Code Ann. § 50-6-405.

c. Professional Liability Insurance

1) Professional liability insurance shall be written on an occurrence basis or on a claims-made basis. If this coverage is written on a claims-made basis, then:

i. The retroactive date must be shown, and must be on or before the earlier of the Effective Date of the Contract or the beginning of Contract work or provision of goods and services;

ii. Insurance must be maintained and evidence of insurance must be provided for at least five (5) full years from the date of the final Contract payment; and

iii. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date on or prior to the Contract Effective Date, the Contractor must purchase "extended reporting" or "tail coverage" for a minimum of five (5) full years from the date of the final Contract payment.

2) Any professional liability insurance policy shall have a limit not less than one million dollars ($1,000,000) per claim and two million dollars ($2,000,000) in the aggregate; and

3) If the Contract involves the provision of services by medical professionals, a policy limit not less than three million ($3,000,000) per claim and three million dollars ($3,000,000) in the aggregate for medical malpractice insurance.

d. Cyber Liability Insurance

1) The Contractor shall maintain cyber liability insurance in an amount not less than ten million dollars ($10,000,000) per occurrence or claim and ten million dollars ($10,000,000) annual aggregate, covering all acts, errors, omissions, negligence, and infringement of intellectual property (except patent and trade secret). Coverage shall be sufficiently broad to respond to all duties and obligations as is undertaken by the Contractor in the Contract and shall include network security and privacy risks, including but not limited to unauthorized access, failure of security, information theft, damage, destruction, or alteration of electronic information, breach of privacy perils, wrongful disclosure, collection, or other negligence in the handling of confidential and private information, and including coverage for related regulatory fines, defenses, and penalties.

2) Such coverage shall include data breach response expenses, in an amount not less than ten million dollars ($10,000,000) and payable whether incurred by the State or Contractor, including but not limited to consumer notification, whether or not required by law, computer forensic investigations, public relations and crisis management firm fees, credit file or identity monitoring or remediation services in the performance of services for the State or on behalf of the State hereunder.

3) The policy shall contain an affirmative coverage grant for contingent bodily injury and property damage emanating from the failure of the technology services or an error or omission in the content or information provided.

e. Crime Insurance

1) The Contractor shall maintain crime insurance, which shall be written on a "loss sustained form" or "loss discovered form" providing coverage for third party fidelity, including cyber theft and extortion if not provided as part of the Cyber Liability Insurance required by subsection d., above. The policy must not contain a condition requiring an arrest or conviction.

2) Any crime insurance policy shall have a limit not less than one million dollars ($1,000,000) per claim and one million dollars ($1,000,000) in the aggregate. Any crime insurance policy shall contain a Social Engineering Fraud Endorsement with a limit of not less than two hundred and fifty thousand dollars ($250,000).

3) This insurance may be written on a claims-made basis, but in the event that coverage is cancelled or non-renewed, the Contractor shall purchase an extended reporting or "tail coverage" of at least two (2) years after the Term.

f. Sexual Abuse & Molestation

1) The Contractor shall maintain sexual abuse & molestation insurance written on either an occurrence or a claims-made basis. This insurance may be written on a claims-made basis, but in the event that coverage is cancelled or non-renewed, the Contractor shall purchase an extended reporting or "tail coverage" of at least two (2) years after the Term.

2) Any sexual abuse & molestation insurance policy shall have a limit not less than one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) in the aggregate.

D.33. Major Procurement Contract Sales and Use Tax. Pursuant to Tenn. Code Ann. § 4-39-102 and to the extent applicable, the Contractor and the Contractor's subcontractors shall remit sales and use taxes on the sales of goods or services that are made by the Contractor or the Contractor's subcontractors and that are subject to tax.

E. SPECIAL TERMS AND CONDITIONS:

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, the special terms and conditions shall be subordinate to the Contract's other terms and conditions.

E.2. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State that is regarded as confidential under state or federal law shall be regarded as "Confidential Information." Nothing in this Section shall permit Contractor to disclose any Confidential Information, 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. Confidential Information shall not be disclosed except as required or

permitted under state or federal law. Contractor shall take all necessary steps to safeguard the confidentiality of such material or information in conformance with applicable state and federal law.

The obligations set forth in this Section shall survive the termination of this Contract.

E.3 State Ownership of Goods. The State shall have ownership, right, title, and interest in all goods provided by Contractor under this Contract including full rights to use the goods and transfer title in the goods to any third parties.

E.4. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's Response to RFP 31865-00490 (Attachment 6.2, Section B.15) and resulting in this Contract.

The Contractor shall assist the State in monitoring the Contractor's performance of this commitment by providing, as requested, a monthly report of participation in the performance of this Contract by small business enterprises and businesses owned by minorities, women, Tennessee service-disabled veterans, and persons with disabilities. Such reports shall be provided to the State of Tennessee Governor's Office of Diversity Business Enterprise in the TN Diversity Software available online at: https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810.

E.5 State Furnished Property. The Contractor shall be responsible for the correct use, maintenance, and protection of all articles of nonexpendable, tangible personal property furnished by the State for the Contractor's use under this Contract. Upon termination of this Contract, all property furnished by the State shall be returned to the State in the same condition as when received, less reasonable wear and tear. Should the property be destroyed, lost, or stolen, the Contractor shall be responsible to the State for the fair market value of the property at the time of loss.

E.6 Work Papers Subject to Review. The Contractor shall make all audit, accounting, or financial analysis work papers, notes, and other documentation available for review by the Comptroller of the Treasury or his representatives, upon request, during normal working hours either while the analysis is in progress or subsequent to the completion of this Contract.

E.7 Prohibited Advertising or Marketing. The Contractor shall not suggest or imply in advertising or marketing materials that Contractor's goods or services are endorsed by the State. The restrictions on Contractor advertising or marketing materials under this Section shall survive the termination of this Contract.

E.8. Lobbying. The Contractor certifies, to the best of its knowledge and belief, that:

a. No federally appropriated funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

b. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a

member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, “Disclosure Form to Report Lobbying," in accordance with its instructions.

c. The Contractor shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into and is a prerequisite for making or entering into this transaction imposed by 31 U.S.C. § 1352.

E.9. Intellectual Property Indemnity. 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 concerning or arising out of any claim of an alleged patent, copyright, trade secret or other intellectual property infringement. In any such claim or action brought against the State, the Contractor shall satisfy and indemnify the State for the amount of any settlement or final judgment, and the Contractor shall be responsible for all legal or other fees or expenses incurred by the State arising from any such claim. The State shall give the Contractor notice of any such claim or suit, however, the failure of the State to give such notice shall only relieve Contractor of its obligations under this Section to the extent Contractor can demonstrate actual prejudice arising from the State’s failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State of Tennessee in any legal matter, as provided in Tenn. Code Ann. § 8-6-106.

E.10. Liquidated Damages In the event of a Contract performance or compliance failure by the Contractor, the State may, but is not obligated to address such Contract performance or compliance failure and/or assess damages (“Liquidated Damages”) in accordance with Attachment B of the Contract. The State shall notify the Contractor of any amounts to be assessed as Liquidated Damages via the Control Memorandum process specified in Contract Section A.194. The Parties agree that due to the complicated nature of the Contractor’s obligations under this Contract it would be difficult to specifically designate a monetary amount for a Contractor performance or compliance failure, as these amounts are likely to be uncertain and not easily proven. Contractor has carefully reviewed the Liquidated Damages contained in Contract Attachment B and agrees that these amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of a Contract performance or compliance failure, are a reasonable estimate of the damages that would occur from a Contract performance or compliance failure, and are not punitive. The Parties agree that although the Liquidated Damages represent the reasonable estimate of the damages and injuries sustained by the State due to the Contract performance or compliance failure, they do not include any injury or damage sustained by a third party. The Contractor agrees that the Liquidated Damages are in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or any other sections of this Contract.

The State is not obligated to assess Liquidated Damages as a result of a Contract performance or compliance failure before availing itself of any other remedy. In the event of multiple Contract performance or compliance failures, the Parties recognize that the cumulative effect of these Contract performance failures may exceed the compensation provided by Liquidated Damages. The State may choose to avail itself of any other remedy available under this Contract or at law or equity. The Parties further recognize that the State may not obtain both Liquidated Damages and Actual Damages for the same occurrence of a Contract performance or compliance failure.

Without regard to whether the State has imposed Liquidated Damages or pursued any other remedy due to any action or inaction by the Contractor, the State may impose a corrective action plan or similar measure through a Control Memorandum. Such measure is neither punitive nor related to any damages the State might suffer.

E.11 Partial Takeover of Contract. The State may, at its convenience and without cause, exercise a partial takeover of any service that the Contractor is obligated to perform under this Contract, including any service which is the subject of a subcontract between Contractor and a third party (a "Partial Takeover"). A Partial Takeover of this Contract by the State shall not be deemed a breach of contract. The Contractor shall be given at least thirty (30) days prior written notice of a Partial Takeover. The notice hall specify the areas of service the State will assume and the date the State will be assuming. The State's exercise of a Partial Takeover shall not alter the Contractor's other duties and responsibilities under this Contract. The State reserves the right to withhold from the Contractor any amounts the Contractor would have been paid but for the State's exercise of a Partial Takeover. The amounts shall be withheld effective as of the date the State exercises its right to a Partial Takeover. The State's exercise of its right to a Partial Takeover of this Contract shall not entitle the Contractor to any actual, general, special, incidental, consequential, or any other damages irrespective of any description or amount.

E.12 Unencumbered Personnel. The Contractor shall not restrict its employees, agents, subcontractors or principals who perform services for the State under this Contract from performing the same or similar services for the State after the termination of this Contract, either as a State employee, an independent contractor, or an employee, agent, subcontractor or principal of another contractor with the State.

E.13. Personally Identifiable Information. While performing its obligations under this Contract, Contractor may have access to Personally Identifiable Information held by the State ("PII"). For the purposes of this Contract, "PII" includes "Nonpublic Personal Information" as that term is defined in Title V of the Gramm-Leach-Bliley Act of 1999 or any successor federal statute, and the rules and regulations thereunder, all as may be amended or supplemented from time to time ("GLBA") and personally identifiable information and other data protected under any other applicable laws, rule or regulation of any jurisdiction relating to disclosure or use of personal information ("Privacy Laws"). Contractor agrees it shall not do or omit to do anything which would cause the State to be in breach of any Privacy Laws. Contractor shall, and shall cause its employees, agents and representatives to: (i) keep PII confidential and may use and disclose PII only as necessary to carry out those specific aspects of the purpose for which the PII was disclosed to Contractor and in accordance with this Contract, GLBA and Privacy Laws; and (ii) implement and maintain appropriate technical and organizational measures regarding information security to: (A) ensure the security and confidentiality of PII; (B) protect against any threats or hazards to the security or integrity of PII; and (C) prevent unauthorized access to or use of PII. Contractor shall immediately notify State: (1) of any disclosure or use of any PII by Contractor or any of its employees, agents and representatives in breach of this Contract; and (2) of any disclosure of any PII to Contractor or its employees, agents and representatives where the purpose of such disclosure is not known to Contractor or its employees, agents and representatives. The State reserves the right to review Contractor's policies and procedures used to maintain the security and confidentiality of PII and Contractor shall, and cause its employees, agents and representatives to, comply with all reasonable requests or directions from the State to enable the State to verify and/or procure that Contractor is in full compliance with its obligations under this Contract in relation to PII. Upon termination or expiration of the Contract or at the State's direction at any time in its sole discretion, whichever is earlier, Contractor shall

immediately return to the State any and all PII which it has received under this Contract and shall destroy all records of such PII.

The Contractor shall report to the State any instances of unauthorized access to or potential disclosure of PII in the custody or control of Contractor ("Unauthorized Disclosure") that come to the Contractor's attention. Any such report shall be made by the Contractor within forty-eight (48) hours after the Unauthorized Disclosure has come to the attention of the Contractor. Contractor shall take all necessary measures to halt any further Unauthorized Disclosures. The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services for individuals whose PII was affected by the Unauthorized Disclosure. The Contractor shall bear the cost of notification to all individuals affected by the Unauthorized Disclosure, including individual letters and public notice. The remedies set forth in this Section are not exclusive and are in addition to any claims or remedies available to this State under this Contract or otherwise available at law.

E.14. Federal Funding Accountability and Transparency Act (FFATA). This Contract requires the Contractor to provide supplies or services that are funded in whole or in part by federal funds that are subject to FFATA. The Contractor is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the Contractor provides information to the State as required.

The Contractor shall comply with the following:

a. Reporting of Total Compensation of the Contractor's Executives.

(1) The Contractor shall report the names and total compensation of each of its five most highly compensated executives for the Contractor's preceding completed fiscal year, if in the Contractor's preceding fiscal year it received:

i. 80 percent or more of the Contractor's annual gross revenues from federal procurement contracts and federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

ii. $25,000,000 or more in annual gross revenues from federal procurement contracts (and subcontracts), and federal financial assistance subject to the Transparency Act (and subawards); and

iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at

http://www.sec.gov/answers/execomp.htm.).

As defined in 2 C.F.R. § 170.315, "Executive" means officers, managing partners, or any other employees in management positions.

(2) Total compensation means the cash and noncash dollar value earned by the

executive during the Contractor's preceding fiscal year and includes the following (for more information see 17 C.F.R. § 229.402(c)(2)):

i. Salary and bonus.

ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.

iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.

iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.

v. Above-market earnings on deferred compensation which is not tax qualified.

vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000.

b. The Contractor must report executive total compensation described above to the State by the end of the month during which this Contract is awarded.

c. If this Contract is amended to extend the Term, the Contractor must submit an executive total compensation report to the State by the end of the month in which the term extension becomes effective.

d. The Contractor will obtain a Data Universal Numbering System (DUNS) number and maintain its DUNS number for the term of this Contract. More information about obtaining a DUNS Number can be found at: http://fedgov.dnb.com/webform/

The Contractor's failure to comply with the above requirements is a material breach of this Contract for which the State may terminate this Contract for cause. The State will not be obligated to pay any outstanding invoice received from the Contractor unless and until the Contractor is in full compliance with the above requirements.

E.15 Survival. The terms, provisions, representations, and warranties contained D.11 (Records), D.19 (Hold Harmless), D.20 (HIPAA Compliance), E.2 (Confidentiality of Records), E.7 (Prohibited Advertising),E.9 (Intellectual Property) E.13 (Personally Identifiable Information), E.18 (Notification of Breach), E.20 (SSA Data), and E.24 (IRS Data) of this Contract shall survive the completion of performance, termination or expiration of this Contract.

E.16. Applicable Laws, Rules, Policies and Court Orders. The Contractor agrees to comply with all applicable federal and State laws, rules, regulations, sub-regulatory guidance, executive orders,

TennCare waivers, and all current, modified or future Court decrees, orders or judgments applicable to the State's TennCare program. Such compliance shall be performed at no additional cost to the State.

E.17. Business Associate. As the Contractor will provide services to TennCare pursuant to which the Contractor will have access to, receive from, create, or receive on behalf of TennCare Protected Health Information, or Contractor will have access to, create, receive, maintain or transmit on behalf of TennCare Electronic Protected Health Information (as those terms are defined under HIPAA and HITECH), Contractor hereby acknowledges its designation as a business associate under HIPAA and agrees to comply with all applicable HIPAA regulations and the terms in the associated Business Associate Agreement.

E.18. Notification of Breach and Notification of Suspected Breach. The Contractor shall notify TennCare's Privacy Office immediately upon becoming aware of and in no case later than forty-eight (48) hours after discovery of any incident, either confirmed or suspected, that represents or may represent unauthorized access, use or disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained or held by the Contractor, including any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the Contractor 's system. This includes, but is not limited to, loss or suspected loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and/or disks.

E.19. Transmission of Contract Deliverables. All information or data that is necessary for one or more deliverable set forth in this Contract shall be transmitted between TennCare and Contractor via the data transfer method specified in advance by TennCare. This may include, but shall not be limited to, transfer through TennCare's SFTP system. Failure by the Contractor to transmit information or data that is necessary for a deliverable in the manner specified by TennCare, may, at the option of TennCare, result in liquidated damages as set forth on Contract Attachment B, hereto.

E.20. Social Security Administration (SSA) Required Provisions for Data Security. The Contractor shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. §3541, *et seq.*), and related National Institute of Standards and Technology guidelines. In addition, the Contractor shall have in place administrative, physical, and technical safeguards for data.

a. The Contractor shall specify in its agreements with any agent or subcontractor that will have access to data 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;

b. The Contractor shall not duplicate in a separate file or disseminate, without prior written permission from TennCare, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the TennCare program. Should the Contractor propose a redisclosure of said data, the Contractor must specify in writing to TennCare the data the Contractor proposes to redisclose, to whom, and the reasons that justify the redisclosure. TennCare will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.

c. The Contractor agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.

d. The Contractor shall maintain a current list of the employees of such contractor with access to SSA data and provide such lists to TennCare at the start of the contract, subsequently at any time there are changes or upon request.

e. The Contractor shall restrict access to the data obtained from TennCare to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Contract. The Contractor shall not further duplicate, disseminate, or disclose such data without obtaining TennCare's prior written approval.

f. The Contractor shall provide appropriate training and ensure that its employees:

(1) properly safeguard PHI/PII furnished by TennCare under this Contract from loss, theft or inadvertent disclosure;

(2) understand and acknowledge that they are responsible for safeguarding this information at all times, regardless of whether or not the Contractor employee is at his or her regular duty station;

(3) ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;

(4) send emails containing PHI/PII only if the information is encrypted or if the transmittal is secure; and,

(5) limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

Contractor employees who access, use, or disclose TennCare or TennCare SSA-supplied data in a manner or purpose not authorized by this Contract may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

g. Loss or Suspected Loss of Data–If an employee of the Contractor becomes aware of suspected or actual loss of PHI/PII, the Contractor must contact TennCare immediately upon becoming aware to report the actual or suspected loss. The Contractor must provide TennCare with timely updates as any additional information about the loss of PHI/PII becomes available.

If the Contractor experiences a loss or breach of said data, TennCare will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the Contractor shall bear any costs associated with the notice or any mitigation.

h. TennCare may immediately and unilaterally suspend the data flow under this Contract, or terminate this Contract, if TennCare, in its sole discretion, determines that the Contractor has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Contract Section E.20.

i. This Section further carries out Section 1106(a) of the Act (42 U.S.C. 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. 3541 et seq.), and related National Institute of Standards and Technology ("NIST") guidelines as outlined in the CMPPA and IEA governing this data,, which provide the requirements that the SSA stipulates that the Contractor must follow with regard to use, treatment, and safeguarding data in the event data is exchanged with a federal information system.

j. Definitions

(1) "SSA-supplied data" or "data" as used in this section – information, such as an individual's social security number or income, supplied by the Social Security Administration to TennCare to determine entitlement or eligibility for federally-funded programs. This information is subject to provisions outlined in a Computer Matching and Privacy Protection Act Agreement (CMPPA) between SSA and the State of Tennessee, and Information Exchange Agreement (IEA) between SSA and TennCare..

(2) "Protected Health Information/Personally Identifiable Information" (PHI/PII)(45 C.F.R. 160.103; OMB Circular M-06-19) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

(3) "Individually Identifiable Health Information"– information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(4) "Personally Identifiable Information" – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

E.21. Medicaid and CHIP - The Contractor must provide safeguards that restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan:

a) Purposes directly related to the administration of Medicaid and CHIP include:

1) establishing eligibility;

2) determining the amount of medical assistance;

3) providing services for beneficiaries; and,

4) conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to Medicaid or CHIP administration.

b) The Contractor must have adequate safeguards to assure that:

1) Information is made available only to the extent necessary to assist in the valid administrative purposes of those receiving the information, and information

2) received under 26 USC is exchanged only with parties authorized to receive that information under that section of the Code; and, the information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.

c) The Contractor must have criteria that govern the types of information about applicants and beneficiaries that are safeguarded. This information must include at least--

1) Names and addresses;

2) Medical services provided;

3) Social and economic conditions or circumstances;

4) Contractor evaluation of personal information;

5) Medical data, including diagnosis and past history of disease or disability

6) Any information received for verifying income eligibility and amount of medical assistance payments, including income information received from SSA or the Internal Revenue Service;

7) Income information received from SSA or the Internal Revenue Service must be safeguarded according to Medicaid and CHIP requirements;

8) Any information received in connection with the identification of legally liable third party resources; and.

9) Social Security Numbers.

d) The Contractor must have criteria approved by TennCare specifying:

1) the conditions for release and use of information about applicants and beneficiaries:

2) Access to information concerning applicants or beneficiaries must be restricted to persons or Contractor representatives who are subject to standards of confidentiality that are comparable to those of TennCare;

3) The Contractor shall not publish names of applicants or beneficiaries;

4) The Contractor shall obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment to an authorized individual or entity;

5) If, because of an emergency situation, time does not permit obtaining consent before release, the Contractor shall notify TennCare, the family or individual immediately after supplying the information.

6) The Contractor's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.

   i) The Contractor shall notify TennCare of any requests for information on applicants or beneficiaries by other governmental bodies, the courts or law enforcement officials ten (10) days prior to releasing the requested information.

7) If a court issues a subpoena for a case record or for any Contractor representative to testify concerning an applicant or beneficiary, the Contractor must notify TennCare at least ten (10) days prior to the required production date so TennCare may inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

8) The Contractor shall not request or release information to other parties to verify income, eligibility and the amount of assistance under Medicaid or CHIP, prior to express approval from TennCare.

E.22. Employees Excluded from Medicare, Medicaid or CHIP. The Contractor does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly employ, in the performance of this Contract, employees who have been excluded from participation in the Medicare, Medicaid, and/or CHIP programs pursuant to Sections 1128 of the Social Security Act.

E.23. 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 federal General Accounting Office, federal Department of Health and Human Services, the Center for Medicare and Medicaid Services, or any other state or federal agency has or will benefit financially or materially from this Contract. This Contract may be terminated by TennCare as provided in Section D.6, 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, its agent, or employees.

E.24. Internal Revenue Service (IRS) Safeguarding Of Return Information:

a) Performance - In performance of this contract, the contractor agrees to comply with and assume responsibility for compliance by his or her employees with the following requirements:

(1) This provision shall not apply if information received or delivered by the Parties under this Contract is NOT "federal tax returns or return information" as defined by IRS Publication 1075 and IRC 6103.

(2) All work will be done under the supervision of the contractor or the contractor's employees. The contractor and the contractor's employees with access to or who

use FTI must meet the background check requirements defined in IRS Publication 1075.

(3) Any Federal tax returns or return information (hereafter referred to as returns or return information) made available in any format shall be used only for the purpose of carrying out the provisions of this contract. Information contained in such material will be treated as confidential and will not be divulged or made known in any manner to any person except as may be necessary in the performance of this contract. Disclosure to anyone other than an officer or employee of the contractor will be prohibited.

(4) All returns and return information will be accounted for upon receipt and properly stored before, during, and after processing. In addition, all related output will be given the same level of protection as required for the source material.

(5) The contractor certifies that the data processed during the performance of this contract will be completely purged from all data storage components of his or her computer facility, and no output will be retained by the contractor at the time the work is completed. If immediate purging of all data storage components is not possible, the contractor certifies that any IRS data remaining in any storage component will be safeguarded to prevent unauthorized disclosures.

(6) Any spoilage or any intermediate hard copy printout that may result during the processing of IRS data will be given to the agency or his or her designee. When this is not possible, the contractor will be responsible for the destruction of the spoilage or any intermediate hard copy printouts, and will provide the agency or his or her designee with a statement containing the date of destruction, description of material destroyed, and the method used.

(7) All computer systems receiving, processing, storing, or transmitting Federal tax information must meet the requirements defined in IRS Publication 1075. To meet functional and assurance requirements, the security features of the environment must provide for the managerial, operational, and technical controls. All security features must be available and activated to protect against unauthorized use of and access to Federal tax information.

(8) No work involving Federal tax information furnished under this contract will be subcontracted without prior written approval of the IRS.

(9) The contractor will maintain a list of employees authorized access. Such list will be provided to the agency and, upon request, to the IRS reviewing office.

(10) The agency will have the right to void the contract if the contractor fails to provide the safeguards described above.

b) Criminal/Civil Sanctions

(1) Each officer or employee of any person to whom returns or return information is or may be disclosed will be notified in writing by such person that returns or return information disclosed to such officer or employee can be used only for a purpose and to the extent authorized herein, and that further disclosure of any such returns or

return information for a purpose or to an extent unauthorized herein constitutes a felony punishable upon conviction by a fine of as much as $5,000 or imprisonment for as long as 5 years, or both, together with the costs of prosecution. Such person shall also notify each such officer and employee that any such unauthorized further disclosure of returns or return information may also result in an award of civil damages against the officer or employee in an amount not less than $1,000 with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC sections 7213 and 7431 and set forth at 26 CFR 301.6103(n)-1.

(2) Each officer or employee of any person to whom returns or return information is or may be disclosed shall be notified in writing by such person that any return or return information made available in any format shall be used only for the purpose of carrying out the provisions of this contract. Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of the contract. Inspection by or disclosure to anyone without an official need to know constitutes a criminal misdemeanor punishable upon conviction by a fine of as much as $1,000 or imprisonment for as long as 1 year, or both, together with the costs of prosecution. Such person shall also notify each such officer and employee that any such unauthorized inspection or disclosure of returns or return information may also result in an award of civil damages against the officer or employee [United States for Federal employees] in an amount equal to the sum of the greater of $1,000 for each act of unauthorized inspection or disclosure with respect to which such defendant is found liable or the sum of the actual damages sustained by the plaintiff as a result of such unauthorized inspection or disclosure plus in the case of a willful inspection or disclosure which is the result of gross negligence, punitive damages, plus the costs of the action. These penalties are prescribed by IRC section 7213A and 7431.

(3) Additionally, it is incumbent upon the contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a(i)(1), which is made applicable to contractors by 5 U.S.C. 552a(m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

(4) Granting a contractor access to FTI must be preceded by certifying that each individual understands the agency’s security policy and procedures for safeguarding IRS information. Contractors must maintain their authorization to access FTI through annual recertification. The initial certification and recertification must be documented and placed in the agency's files for review. As part of the certification and at least annually afterwards, contractors should be advised of the provisions of IRC Sections 7431, 7213, and 7213A. The training provided before the initial certification and annually thereafter must also cover the incident response policy and procedure for reporting unauthorized disclosures and data breaches. For both the initial certification and the annual certification, the contractor should sign, either with ink or electronic

signature, a confidentiality statement certifying their understanding of the security requirements.

Inspection - The IRS and the Agency with 24 hour notice, shall have the right to send its officers and employees into the offices and plants of the contractor for inspection of the facilities and operations provided for the performance of any work with FTI under this contract. The IRS and Agency's right of inspection shall include the use of manual and/or automated scanning tools to perform compliance and vulnerability assessments of information technology (IT) assets that access, store, process or transmit FTI. On the basis of such inspection, specific measures may be required in cases where the contractor is found to be noncompliant with contract safeguards.

E.25. Contractor Hosted Services and Confidential Data.

a. "Confidential State Data" is defined as data deemed confidential by State or Federal statute or regulation. The Contractor shall protect Confidential State Data as follows:

(1) The Contractor shall ensure that all Confidential State Data is housed in the continental United States, inclusive of backup data.

(2) The Contractor shall encrypt Confidential State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2 validated encryption technologies.

(3) The Contractor's processing environment containing Confidential State Data shall be in accordance with at least one of the following security standards: (i) International Standards Organization ("ISO") 27001; (ii) Federal Risk and Authorization Management Program ("FedRAMP"); or (iii) American Institute of Certified Public Accountants ("AICPA") Service Organization Controls ("SOC") 2 Type II certified. This requirement applies to the environment at the infrastructure level only, not the Application level. The Contractor shall provide proof of certification within six (6) months of the date of the Contract and thereafter annually and upon State request. During the six (6) month certification period, the Contractor shall provide monthly status updates to TennCare regarding the progress of the certification process. Should the Contractor not receive one of the enumerated certifications listed above within the designated six (6) month period, liquidated damages may be assessed or possibly contract termination as determined by TennCare may occur. *As applicable, contractor shall also meet the requirements of the most current version of Minimum Acceptable Risk Standards for Exchanges ("MARS-E") controls*

(4) The Contractor must comply with the State's Enterprise Information Security Policies. This document is found at the following URL: https://www.tn.gov/content/dam/tn/finance/documents/Enterprise-Information-Security-Policies-ISO-27002-Public.pdf.

(5) In the event that the operating system is an integral part of the application, the Contractor agrees to maintain Operating Systems at current, manufacturer supported versions. "Operating System" shall mean the software that supports a

computer's basic functions, such as scheduling tasks, executing applications, and controlling peripherals.

(6) The Contractor agrees to maintain the Application so that it will run on a current, manufacturer-supported Operating System. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. The Contractor shall make sure that the Application is at all times fully compatible with a manufacturer-supported Operating System; the State shall not be required to run an Operating System that is no longer supported by the manufacturer.

(7) If the Application requires middleware or database software, Contractor shall maintain middleware and database software versions that are at all times fully compatible with current versions of the Operating System and Application, to ensure that security vulnerabilities are not introduced.

(8) With advance notice from the State, and no more than one (1) time per year the Contractor agrees to allow the State to perform logical and physical audits of the Contractor's facility and systems that are hosting Confidential State Data.

(9) The Contractor must annually perform Penetration Tests and Vulnerability Assessments against its Processing Environment. "Processing Environment" shall mean the combination of software and hardware on which the Application runs. "Penetration Tests" shall be in the form of software attacks on the Contractor's computer system, with the purpose of discovering security weaknesses, and potentially gaining access to the computer's features and data. The "Vulnerability Assessment" shall have the goal of defining, identifying, and classifying the security holes (vulnerabilities) in the Contractor's computer, network, or communications infrastructure. The Contractor shall allow the State, at its option, to perform Penetration Tests and Vulnerability Assessments on the Contractor's Processing Environment.

b. Business Continuity Requirements. The Contractor shall maintain set(s) of documents, instructions, and procedures which enable the Contractor to respond to accidents, disasters, emergencies, or threats without any stoppage or hindrance in its key operations ("Business Continuity Requirements"). Business Continuity Requirements shall include:

(1) "Disaster Recovery Capabilities" refer to the actions the Contractor takes to meet the Recovery Point and Recovery Time Objectives defined below. Disaster Recovery Capabilities shall meet the following objectives:

i. Recovery Point Objective ("RPO"). The RPO is defined as the maximum targeted period in which data might be lost from an IT service due to a major incident: **Four (4) Hours**

ii. Recovery Time Objective ("RTO"). The RTO is defined as the targeted duration of time and a service level within which a business process must be restored after a disaster (or disruption) in order to avoid unacceptable

consequences associated with a break in business continuity: **Twelve (12) Hours**

(2) The Contractor shall perform at least one Disaster Recovery Test every three hundred sixty-five (365) days. A "Disaster Recovery Test" shall mean the process of verifying the success of the restoration procedures that are executed after a critical IT failure or disruption occurs. The Disaster Recovery Test shall use Data Sets which *are a reasonable approximation for production* data, and success shall be defined as the Contractor verifying that the Contractor can meet the State's RPO and RTO requirements. A "Data Set" is defined as a collection of related sets of information that is composed of separate elements but can be manipulated as a unit by a computer. The Contractor shall provide written confirmation to the State after each Disaster Recover Test that its Disaster Recovery Capabilities meet the RPO and RTO requirements.

c. Upon State request, the Contractor shall provide a copy of all Confidential State Data it holds. The Contractor shall provide such data on media and in a format determined by the State.

d. Upon termination of this Contract and in consultation with the State, the Contractor shall destroy all Confidential State Data it holds (including any copies such as backups) in accordance with the current version of National Institute of Standards and Technology ("NIST") Special Publication 800-88. The Contractor shall provide a written confirmation of destruction to the State within ten (10) business days after destruction.

IN WITNESS WHEREOF,

DENTAQUEST USA INSURANCE COMPANY, INC.:

7/31/18

CONTRACTOR SIGNATURE **DATE**

Steven J. Pollock CEO

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE

8/6/18

LARRY B. MARTIN, COMMISSIONER **DATE**

ATTACHMENT A

Terms and Definitions

1. Administrative Cost – All costs to the Contractor related to 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 TennCare under the terms of this Contract (including, but not limited to, claims processing, marketing, postage, personnel, rent) are considered to be an “administrative cost”.

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

3. AI/AN Child - a child covered by CoverKids who is a certified American Indian/Alaskan Native and a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Plan Administrator to the Dental Benefits Manager for the coverage period.

4. Benefits - A schedule of health care services to be delivered to enrollees covered by the Contractor

5. Auxiliary Aids and Services - include, but are not limited to:

    a. Qualified interpreters on-site or through video remote interpreting (VRI) services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;

    b. Qualified readers; taped texts; audio recordings; Brailled materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;

    c. Acquisition or modification of equipment or devices; and

    d. Other similar services and actions as defined in 28 CFR § 36.303.

6. CFR - Code of Federal Regulations

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

8. CMS - Centers for Medicare and Medicaid Services (formerly HCFA).

9. Community Service Area - Community Service Area (CSA) shall mean one (1) or more counties in a defined geographical area in which the Contractor is authorized to enroll providers and serve TennCare enrollees.

The following geographical areas shall constitute the twelve (12) Community Service Areas in Tennessee:

Northwest CSA	-	Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll and Benton
Southwest CSA	-	Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester and McNairy
Shelby CSA	-	Shelby County
Mid-Cumberland CSA	-	Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson and Rutherford
Davidson CSA	-	Davidson County
South Central CSA	-	Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore
Upper Cumberland CSA	-	Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, DeKalb, Putnam, Cumberland, White, Cannon, Warren and Van Buren
Southeast CSA	-	Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley and Marion
Hamilton CSA	-	Hamilton County
East Tennessee CSA	-	Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon and Roane
Knox CSA	-	Knox County
First Tennessee CSA	-	Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter and Johnson

10. Cost-effective Alternative Service – A service that is not a Covered Service but that is approved by TennCare and CMS and provided at an MCO's discretion. TennCare enrollees are not entitled to receive these services. Cost-effective alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in the MCO's judgment, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the MCO's judgment, would require more costly treatment in the future.

11. Covered Service - See Benefits at Contract Sections A.4, A.5, and A.105.

12. Cultural Competence - The level of knowledge-based skills required to provide effective clinical care to enrollees of particular ethnic or racial groups.

13. DBM – Dental Benefits Manager.

14. Department of Intellectual and Developmental Disabilities (DIDD) – The State agency having the statutory authority to plan, promote, provide and support the delivery of services for persons with intellectual and developmental disabilities, and which serves as the contracted operating agency for the State's 1915(c) home and community-based services waivers and is responsible for the performance of contracted functions for ECF CHOICES as specified in interagency agreement.

15. 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 TennCare to the Contractor.

16. ECF CHOICES Participating Dental Provider –A Participating Dental Provider contracted to serve Members age 21 and older enrolled in the ECF CHOICES program.

17. Effective Communication – means taking the appropriate steps to ensure that communications with disabled applicants, participants, members of the public, and their companions are as effective as communications with others by providing alternative formats such as auxiliary aids as defined in USCA.

18. Eligible Person - Any person certified by TennCare as eligible to receive services and benefits under the TennCare Program.

19. Emergency Services – Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act and that are needed to evaluate or stabilize an emergency medical condition.

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

21. Enrollee - Synonymous with "Member". A Medicaid recipient, Medicaid Waiver recipient, or CoverKids recipient who is currently assigned to a Managed Care Organization (MCO), Pre-paid Inpatient Health Plan (PIHP), Pre-paid Ambulatory Health Plan (PAHP) or Primary Case Care Management Program (PCCM) in a given managed care program. For purposes of the Appeal System-related provisions herein, "Enrollee" means enrollee, enrollee-authorized representative, or someone with written consent to act on enrollee's behalf.

22. Enrollee Month – A month of health care coverage for the TennCare eligible enrolled in a Dental Plan.

23 Enrollment - The process by which a person becomes a member of the Contractor's plan through TennCare.

24. EPSDT - The Early, Periodic Screening, Diagnosis, and Treatment services mandated by 42 U.S.C. § 1396d(e) and amended by OBRA 1989. EPSDT services shall mean:

    (a) Screening in accordance with professional standards, interperiodic screenings, and diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare enrollees under age twenty-one (21) and

(b) Health care, treatment, and other measures, described in 42 U.S.C. § 1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.

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

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

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

28. Grand Region – A defined geographical region that includes specified Community Service Areas in which a Contractor is authorized to enroll providers and serve TennCare enrollees. The following Community Service Areas constitute the three (3) Grand Regions in Tennessee:

East Grand Region	Middle Grand Region	West Grand Region
First Tennessee	Upper Cumberland	Northwest
East Tennessee	Mid Cumberland	Southwest
Knox	Davidson	Shelby
Southeast Tennessee	South Central	
Hamilton		

29. Handicapping Malocclusion – for the purposes of determining eligibility for orthodontia shall mean the presence of abnormal dental development that has at least one of the following:

(a) A medical condition and/or a nutritional deficiency with medical physiological impact, that is documented in the physician progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to medical treatment without orthodontic treatment.

(b) The presence of a speech pathology, that is documented in speech therapy progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to speech therapy without orthodontic treatment.

(c) Palatal tissue laceration from a deep impinging overbite where lower incisor teeth contact palatal mucosa. This does not include occasional biting of the cheek.

Anecdotal information is insufficient to document the presence of a handicapping malocclusion. Anecdotal information is represented by statements that are not supported by professional progress notes that the patient has difficulty with eating, chewing, or speaking. These conditions may be caused by other medical conditions in addition to the malalignment of the teeth.

30. Health Maintenance Organization (HMO) - An entity certified by the Department of Commerce and Insurance under applicable provisions of TCA Title 56, Chapter 32.

31. Immediate Eligibility – Temporary eligibility granted to a child upon entering into DCS Custody in order to give children in DCS adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility.

32. Limited English Proficient (LEP) – As defined at 42 CFR §438.10(a).

33. Managed Care Contractor (MCC) – shall mean: (a) A Managed Care Organization, Pharmacy Benefits Manager and/or a Dental Benefits Manager which has signed a TennCare Contractor Risk Agreement with the State and operates a provider network and provides covered health services to TennCare enrollees; or (b) A Pharmacy Benefits Manager, Behavioral Health Organization or Dental Benefits Manager which subcontracts with a Managed Care Organization to provide services; or (c) A State government agency (i.e., Department of Children's Services and Division of Intellectual Disabilities Services) that contracts with TennCare for the provision of services.

34. Managed Care Organization ("MCO") - An HMO which participates in the TennCare Program.

35. Medical Record - A single complete record kept at the site of the enrollee's treatment(s), which documents all of the treatment plans developed, medical services ordered for the enrollee and medical services received by the enrollee.

36. Medically Necessary - Is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in these rules, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in the Medical Necessity rule chapter at 1200-13-16.

37. NAIC – National Association of Insurance Commissioners.

38. Non-TennCare Provider – A provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.

39. Office of the Inspector General - A Unit established to help prevent, identify and investigate fraud and abuse within the healthcare system, most notably the TennCare system.

40. Out-of-Plan Services - Services provided by a non-TennCare provider.

41. Participating Dental Provider – A TennCare provider, as defined herein and in the TennCare Rules, who has entered into a contract with the Contractor to provide Covered Services. A Participating Dental Provider may be contracted to serve children under age 21, adults age 21 and older in ECF CHOICES, individuals enrolled in TPPOHP DBM Program, and CoverKids enrollees or to provide dental services to individuals in all populations.

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

43. Person-Centered Support Plan (PCSP) – As it pertains to ECF CHOICES, the PCSP is a written plan developed by the MCO support coordinator using a person-centered planning process that accurately documents the member's strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the member to help them achieve their preferred lifestyle and goals, and to meet their identified unmet needs (after considering the availability and role of unpaid supports provided by family members and other natural supports) through paid services provided by the MCO and other payor sources).

44. Potential Enrollee – A Medicaid recipient or Medicaid Waiver recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, and PCCM.

45. Prepaid Ambulatory Health Plan (PAHP) – As defined at 42 CFR §438.2. Contractor is

classified as a Prepaid Ambulatory Health Plan pursuant to the TennCare II Demonstration Project approved by CMS. Prepaid ambulatory health plan (PAHP) means an entity that—

(a) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
(b) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
(c) Does not have a comprehensive risk contract.

For example, a dental PAHP is a managed care entity that provides only dental services.

46. Presumptive Eligible - Temporary eligibility granted to a pregnant woman whose family income is at or below a specified percentage of the federal poverty level in order for the woman to receive prenatal care services.

47. Primary Care Physician - A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

48. Primary Care Provider - A primary care physician or registered professional nurse or physician assistant practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

49. Prior Authorization (PA) - The act of authorizing specific services or activities before they are rendered or activities before they occur.

50. Privacy/Security Incidents - Any use or disclosure that is not permitted under the Privacy and Security Rules (Privacy/Security Incident) that compromises the protected health information (PHI) that poses a potential for significant risk of financial, reputational, or other harm to the enrollee as determined by TennCare.

51. Program Integrity - The Program Integrity unit is responsible for assisting with the prevention, identification and investigation of fraud and abuse within the health care system.

52. Provider - An appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services. Providers are categorized as either TennCare Providers or Non-TennCare Providers. TennCare Providers may be further categorized as being one of the following: (a) Participating Providers or In-Network Providers; (b) Non-Participating Providers or Out-of-Network Providers; (c) Out-of-State Emergency Providers. Definitions of each of these terms are contained in this Attachment.

53. Provider Agreement - An agreement between an MCO or DBM and a provider or an MCO's or DBM's subcontractors and a provider of oral health care services which describes the conditions under which the provider agrees to furnish covered services to the MCO's or DBM's enrollees.

54. 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.

55. 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.

56. Service Location - Any location at which an enrollee obtains any oral health care service covered by the Contractor pursuant to the terms of this Contract.

57. Service Site - The locations designated by the Contractor at which enrollees shall receive oral health treatment and preventive services.

58. Services - The benefits described in this Contract, including but not limited to, Section A.3.

59. Shall - Indicates a mandatory requirement or a condition to be met.

60. Specialty Services – Includes Endodontics, Oral Surgery, Orthodontics, Pediatric Dentistry, Periodontics, Prosthodontics.

61. State - State of Tennessee.

62. Subcontract - An agreement that complies with all applicable requirements of this Contract entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract, (e.g., claims processing, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Contract. Agreements to provide covered services as described in Section A.4 of this Contract shall be considered Provider Agreements and governed by Sections A.62 – A.74 of this Contract. If a subcontractor will also be a Provider the requirements for Provider Agreements must also be met.

63. Subcontractor - Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract.

64. Targeted Service Expenditure Baseline – The amount of expenditure, adjusted for factors such as increased provider fees and increased enrollment, against which the actual service expenditures for the period are to be measured to ascertain any savings/loss for purposes of making the risk sharing calculation.

65. TennCare - The Single State Agency designated by the State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the Single State Agency in administering and/or enforcing the TennCare and CoverKids Programs and the terms of this Contract. Such entities include, but are not limited to, the Department of Finance and Administration, Division of TennCare (TennCare), the Department of Health (DOH), the Department of Children's Services (DCS), the Department of Intellectual and Developmental Disabilities (DIDD) the Department of Finance and Administration (F&A), the Department of Mental Health and Substance Abuse Services (DMH/SAS), the TennCare Oversight Division within the Tennessee Department of Commerce and Insurance (C&I) and the Tennessee Bureau of Investigation (TBI), Medicaid Fraud Control Unit (MFCU).

66. TennCare Provider - A provider who accepts as payment in full for furnishing benefits to an enrollee, the amounts paid pursuant to an approved agreement with an MCO or TennCare. Such payment may include copayments from the enrollee or the enrollee's responsible party. Except in the case of Out-of-State Emergency Providers, as defined in the TennCare Rules, a TennCare provider must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including the rules regarding provider billing of patients as found in Rule 1200-13-13-.08. TennCare Providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in

Medicare or Medicaid.

67. 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”.

68. Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The State agency responsible for the investigation of provider fraud and abuse in the State Medicaid Program.

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

70. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party payor.

71. Urgent Care - Services for urgent dental and oral conditions or injuries on the basis of the professional judgment of the enrollee’s treating dentist, other dental professional, primary care provider or a triage nurse who is trained in dental care and oral health care.

72. Utilization Rate – An adjusted proportion of enrollees in the TennCare Children’s DBM Program, ages 2-20, or enrollees in the CoverKids DBM Program, ages 2-18, with a minimum of ninety (90) days eligibility who have received any dental service during the past federal fiscal year.

73. Vital Documents – Consent and grievance forms, intake and application forms with the potential for important consequences, and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents shall be at a minimum available in Spanish.

ATTACHMENT B

LIQUIDATED DAMAGES

In the event of a Contract performance or compliance failure by Contractor and such Contract performance or compliance failure is not included in the following table with an associated Liquidated Damage amount, the parties hereby agree that the State may choose one of the following courses of action in order to obtain redressability for such Contract performance or compliance failure: (1) the State may assess actual damages resulting from the Contract performance or compliance failure against the Contractor in the event that such actual damages are known or are reasonably ascertainable at the time of discovery of such Contract performance or compliance failure or (2) if such actual damages are unknown or are not reasonably ascertainable at the time of discovery of the Contract performance or compliance failure, the State may (a) require the Contractor to submit a corrective action plan to address any such Contract performance or compliance failure and (b) assess liquidated damages against Contractor for an amount that is reasonable in relation to the Contract performance or compliance failure as measured at the time of discovery of the Contract performance or compliance failure. In the event that the State chooses to assess a Liquidated Damage for a Contract performance or compliance failure according to the immediately preceding sentence, in no event shall such Liquidated Damage be in excess of $1,000 for any single Contract performance or compliance failure.

TennCare may elect to apply the following liquidated damages remedies in the event the Contractor fails to perform its obligations under this Contract in a proper and/or timely manner. Upon determination by TennCare that the Contractor has failed to meet any of the requirements of this Contract in a proper and/or timely manner, TennCare will notify the Contractor in writing of the performance or compliance failure and of the potential liquidated damages to be assessed. Should the performance or compliance failure remain uncorrected for more than thirty (30) calendar days from the date of the original notification of the performance or compliance failure by TennCare, TennCare may impose an additional liquidated damage of Five Hundred Dollars ($500) per day from the date of the original notification to Contractor until said performance or compliance failure is resolved.

All liquidated damages remedies set forth in the following table may, at TennCare's election, be retroactive to the date of the initial occurrence of the failure to comply with the terms of the Contract as set forth in the notice of performance or compliance failure from TennCare and may continue until such time as the TennCare Deputy Commissioner, or the Deputy Commissioner's representative, determines the performance or compliance failure has been cured.

If liquidated damages are assessed, TennCare shall reduce the amount of any payment due to the Contractor in the next invoice by the amount of damages. In the event that damages due exceed the amount TennCare is to pay to Contractor in a given payment, TennCare shall invoice Contractor for the amount exceeding the amount payable to Contractor, and such excess amount shall be paid by Contractor within thirty (30) calendar days of the invoice date. In situations where the Contractor wishes to dispute any liquidated damages assessed by TennCare, the Contractor must submit a written notice of dispute, including the reasons for disputing the liquidated damages, to the TennCare Deputy Commissioner or the Deputy Commissioner's representative within thirty (30) calendar days of receipt of the notice from TennCare containing the total amount of damages assessed against the Contractor. If the Contractor fails to timely dispute a liquidated damages assessment as set forth herein, such failure shall constitute a bar to the Contractor seeking to have the assessment amount overturned in a forum or court of competent jurisdiction.

Liquidated damages will apply to the Contract performance or compliance failures listed below. Contractor acknowledges that the actual damages likely to result from Contract performance or compliance failures are difficult to estimate and may be difficult for the State to prove. The parties intend that the Contractor's payment of assessed liquidated damages will compensate the State for breach of

the Contractor obligations under this Contract. Liquidated damages do not serve as punishment for any breach by the Contractor.

	PROGRAM ISSUES		DAMAGE
1.	Failure by the Contractor to meet the standards for privacy, security, and confidentiality of individual data as evidenced by a breach of the security per Section E. 2. and E.18 and Contractor's failure to timely and reasonably comply with its obligation to appropriately respond to any such breach		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member . For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
2.	Failure by the Contractor to execute the appropriate agreements to effectuate transfer and exchange of enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party. (See E.17. and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member . For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
3.	Failure by the Contractor to seek express written approval from TennCare prior to the use or disclosure of enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States. (See E.13 and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member . For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first

			five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
4.	Failure by the Contractor to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of suspected breach per Sections (See E.18 and Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member . For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter.
5.	Failure to implement Non-Traditional Fluoride Varnish and Dental Screening Program within six months of contract start as referenced in Section A.5.a.4.		The damage that may be assessed shall be five hundred dollars ($500) per calendar day past expected implementation date.
6.	In the event the Contractor provides authorization and reimbursement of dental services for ECF CHOICES members that exceed the amount approved for such services in a member's PCSP as required by Contract Section A.5.b.9.		The damage that may be assessed shall be five hundred dollars ($500) per occurrence.
7.	Failure to obtain approval of member materials as required by Sections A.10 - A.13 of this Contract		The damage that may be assessed shall be five hundred dollars ($500) per day for each calendar day that TennCare determines the Contractor has provided enrollee material that has not been approved by TennCare.
8.			
8.	Failure to comply with licensure requirements in Section A.16 of this Contract.		The damage that may be assessed shall be five thousand dollars ($5,000) per calendar day that staff/provider/agent/ subcontractor is not licensed as required by applicable state law, plus,

			the amount paid to the staff/provider/agent/ subcontractor during that period.
9.	Failure to comply in any way with staffing requirements described in Sections A.14 - A.18 of this Contract.		The damage that may be assessed shall be two hundred and fifty dollars ($250) per calendar day for each day that staffing requirements described in Sections A.14 - A.18 of this Contract are not met.
10.	Provider network includes insufficient numbers and geographical disbursement of providers in order to satisfy the requirements outlined in the Access and Availability to Care section of this contract, Sections A.19 – A.28.		A maximum of twenty-five thousand dollars ($25,000) for failure to meet each of the listed standards, either individually or in combination on a monthly basis. The liquidated damage may be lowered to five thousand dollars ($5,000) in the event that the Contractor timely provides a corrective action plan that is accepted by TennCare
11.	TennCare-related Enrollee Appeals. Failure to confer a timely response to a request for Prior Authorization in accordance with 42 CFR §438.210 and Section A.41 of this contract.		TennCare may assess damages amounting to $500 for each day DBM is in default for each occurrence.
12.	Failure to maintain provider agreements in accordance with Sections A.62 – A.74 of this Contract.		TennCare may assess $5,000 per each occurrence of a provider agreement found to be non-compliant.
13.	Failure to comply with claims processing requirements described by Sections A.84–A.89 of this Contract and the performance requirements in Section A.191.		The damage that may be assessed shall be ten thousand dollars ($10,000) per month, for each month that TennCare determines that the Contractor is not in compliance with any of the requirements of Sections A.84–A.89 and A.191.
14.	Maintain an average daily abandonment rate of 5% or less for each queue on each day the Service Center is open for business excluding calls abandoned before thirty seconds as specified in Sections A.29 and A.95.		A maximum of five hundred dollars ($500) per queue per day for a daily abandonment rate of 6% - 10%. A maximum of one thousand five hundred dollars ($1,500) per day for a daily abandonment rate over 10%.
	Maintain an Average Speed of Answer (ASA) per queue per day of 60 seconds or less as specified in Sections A.29. and A.95. ASA is to be calculated from		A maximum of five hundred dollars ($500) per queue per day for an ASA of 61 seconds – 180 seconds. A maximum of one thousand five

15.	the time that a call comes into the queue from the IVR and when it is answered.		hundred dollars ($1,500) per queue per operating day for an ASA of 181 seconds or more.
16.	Maintain a daily blocked call rate of 1% or less as specified in Sections A.29 and A.95.		A maximum of one thousand dollars ($1,000) for each percentage point above 1%.
17.	The Contractor's shall answer 100% of calls each day within 300 seconds as specified in Section A.29 and A.95.		A maximum of five hundred dollars ($500) for each instance of each call answered within 301 seconds to 600 seconds during each operating day; provided, however total liquidated damages under this section shall not exceed twenty-five thousand dollars ($25,000) per operating day. A maximum of one thousand dollars ($1,000) for each instance of each call answered in 601 seconds or more during each operating day; provided, however total liquidated damages under this section shall not exceed fifty thousand dollars ($50,000) per operating day.
18.	Failure to maintain an appeal system as required by TennCare Rules, the provisions contained in the contract, and applicable provisions of 42 CFR 438 Subpart F in accordance with Sections A.116 – A.132 of this contract. Such failure may be evidenced by Contractor's failure to meet compliance requirements for any aspect of the appeal system.		TennCare may assess damages amounting to $1,500 for each day DBM is in default until a TennCare-approved corrective action plan is fully implemented by the DBM.
19.	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 Section A.152 of this Contract.		The damage that may be assessed shall be the actual amount paid by DCS and/or TennCare for necessary services or one thousand dollars ($1000) per occurrence, whichever is greater, to be deducted from monthly fixed administrative fee payments.
20.	Failure to comply with the program integrity provisions as described in Section A.166 through A.187. of this Contract		The damage that may be assessed is $500 per calendar day for each day that the Contractor does not comply with the program integrity provisions
	Maintain a Dental Screening Percentage (DSP) (Refer to Attachment		Liquidated Damages of up to $100,000.00 may be assessed for every

21.	F) greater than or equal to 80% as required in Section A.192.		1.0% decrease in DSP below 80%.
22.	Failure by the Contractor to have the PEAR for the CoverKids Program above 50 percent (50%) on an annual basis as required by Contract Section A.193.		A maximum of up to one hundred thousand dollars ($100,000) in liquidated damages for failure to have the PEAR for the CoverKids Program above 50 percent (50%) on an annual basis.
23.	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized by the TennCare Chief Medical Officer.		The damage that may be assessed shall be one thousand dollars ($1000) per occurrence.
24.	Failure to comply with distribution timeframes for providing Member Handbooks, Provider Directories, and Newsletters, as required by Contract Section A.10..		The damage that may be assessed shall be five thousand dollars ($5000) for each occurrence.
25.	Failure to complete or comply with Corrective Action Plans as required by TennCare in Contract A.8..		The damage that may be assessed shall be five hundred dollars ($500) per calendar day for each day the corrective action is not completed or complied with as required.
26.	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement/contract as required by Contract Section A.138. .		$5,000 per application that has not been approved and loaded into the Contractor's system or denied within (30) calendar days of receipt of a completed credentialing application and a signed provider agreement/contract if applicable. $1,000 per application per calendar day for each day beyond thirty (30) calendar days that a completed credentialing application has not been processed.
27.	Failure to report provider notice of termination of participation in the Contractor's Plan as required by Contract Section A.58.		The damage that may be assessed shall be two hundred dollars ($200) per calendar day for each day that Contractor fails to report provider notice of termination of participation.
	Failure to submit a Provider Enrollment File that meets TennCare's		$250 per day after the due date that the Provider Enrollment File fails to meet

28.	specifications as required by Contract Sections A.22 and A.148..		TennCare's specifications.
29.	The level of overall customer satisfaction, as measured annually by a State approved Enrollee Satisfaction survey(s), shall be equal to or greater than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the Contract term as required by Contract Section A.36.		$3000.00 per Enrollee Satisfaction survey(s), less than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the Contract term.
30.	Failure to disclose Lobbying Activities as specified in Section E.8.		The damage that may be assessed shall be one thousand dollars ($1000) per calendar day that disclosure is late.

ATTACHMENT C

DBM Deliverables Requirement

DBM Dental Deliverables	Scheduled Due Dates
Monthly Reports: • Batch Claims operation • PI Exclusion Report • PI TIPs (received on 1st and 15th)¥ • Involuntary Termination Report • Claims Lag Triangle • Claims Activity • Subrogation recoveries collected outside claims processing system • Encounter Data Report (837D) • Provider Enrollment File☼	**Thirty (30) calendar days after the end of each calendar month** Forty-eight (48) hours after weekly payment cycle By fifth business day each month

Quarterly Reports:
 	
• EOB Report
• Enrollee Cost Sharing
• Customer Service Report
  ○ Referral time by county
  ○ Phone response time
  ○ Request for assistance
• Non-Discrimination Compliance Reports
• Quarterly Financials/ Income Statements
• TennCare/EPSDT Report
• QMP Committee Meeting Minutes
• Quality Indicator
• PI Referral ¥
• Quarterly Program Integrity Report
• Non-Traditional Fl Varnish Program Report
• "Insure Kids Now" (IKN) File☼
• Quarterly Disclosure Rate Report
• Quarterly Member Newsletter
	Thirty (30) days after the end of each Federal Fiscal Year quarter (unless noted)
	
	Ten (10) days after the end of each federal

	quarter
Annual Reports/ Plans/Studies: • Annual Outreach Plan • Audited Financial Statements • Member Satisfaction Surveys* • Provider Satisfaction Surveys* • Non-Discrimination Compliance Plan & Assurance of Non-Discrimination • Annual Outreach Plan Year-End Update • Two (2) PIPs Dental Studies† • QMP Report‡ (QMP, work plan, and evaluation) • Licensure Documentation • Annual Access Report# • Fraud And Abuse Compliance Plan • DBM Annual Community Outreach Plan • DBM Community Outreach Plan Annual Evaluation • Annual Disclosure Form • EPSDT DBM Annual Outreach Plan • EPSDT DBM Year End Update	**Ninety (90) days after end of Federal Year (unless noted)** By August 15 each year By November 30 each year By June 30 each year By June 30 each year By September 15 each year By November 30 each year By July 1 each year By November 30 each year By March 30 each year By March 30 each year By August 15 each year By November 30 each year

Ad Hoc Reports:	Within ten (10) business days from the date of the request when reasonable unless otherwise specified by TennCare. As Requested
Progress Reports	Within three (3) business days from the date of request when reasonable unless otherwise specified by TennCare.
On Request Reports (ORRs) **Requests for Information (RFIs)**	As Requested

¥ PI TIPs Report and PI Referrals should be submitted via the Secured File Transport (SFTP) server and in format specifications designated by TennCare.

☼ File format shall comply with specifications as outlined by TennCare.

Management Reporting Requirements

Contract Management Reports by which the State can assess the CoverKids Dental program costs and usage. Reports shall be submitted in an electronic format as referenced in Section A.151 (Management Reports). Management Reports shall include:

1) Performance Guarantee Reports, as detailed at Contract Attachment C (each component to be submitted at the frequency indicated), shall include:

- Status report narrative
- Detail report on each performance measure by appropriate time period

2) **Quarterly CoverKids Dental Benefit Savings and Payments Report,** must be submitted as follows distinguishing between in-network and out-of-network:

GROUP ONE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

GROUP TWO CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						

Total						

AMERICAN INDIAN/ ALASKAN NATIVE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

3) Quarterly Provider and Out-of-Network Claims Utilization by:

- Submitted charges
- Benefits paid
- Member Utilization

4) Quarterly Enrollment Summary Plan Report:

Premium Category	Subscribers	Premium	Total Claims
Group One Child			
Group Two Child			
American Indian/ Alaskan Native Child			
Total			

5) Quarterly Network Changes Update Report, displaying the following:

- Present Network of Participating Providers by Specialty
- Additions to the Network by Name, Specialty and Location
- Terminations to the Network by Name, Specialty and Location
- Targeted areas for recruitment

ATTACHMENT D

Dental Service Categories by Dental CDT Codes

Subject to a medical necessity determination by the Contractor, the following services must be covered by the dental coverage provided through the CoverKids DBM Program (subject to service and monetary limits specified in Contract Section A.5.

DENTAL SERVICE CATEGORY	CDT CODES
PREVENTATIVE	
Prophylaxis Adult (14 years of age and older)	D1110
Prophylaxis Child (under 14 years of age)	D1120
Topical Fluoride Varnish	D1206
Topical Fluoride – Children and Adults	D1208
Oral Hygiene Instruction	D1330
Sealants	D1351
Interim caries arresting medicament application (Silver Diamine Fluoride) per tooth	D1354
DIAGNOSTIC SERVICES	
Periodic Oral Examination	D0120
Emergency Oral Exam (After Regular Hours)	D0140
Comprehensive Oral Examination - new or established patient	D0150
Detailed and Extensive Oral Evaluation – Problem Focused	D0160
Re-Evaluation – Limited, Problem Focused	D0170
Comprehensive Periodontal Evaluation – New or Established Patient	D0180
EMERGENCY SERVICES	
Palliative (emergency) treatment of dental pain (minor procedure)	D9110
Office Visit (after regular office hours)	D9440
PROFESSIONAL SERVICES	
Hospital Visit	D9420
Office Visit, Regular Hours	D9430

RESTORATIVE SERVICES	
Amalgam Restorations - Secondary and primary	
Amalgam One Surface, Primary or Permanent	D2140
Amalgam Two Surfaces, Secondary and primary	D2150
Amalgam Three Surfaces, Secondary and primary	D2160
Amalgam Four or More Surfaces, Primary or Permanent	D2161
Resin-Based Composite Restorations	
One Surface, Anterior	D2330
Two Surfaces, Anterior	D2331
Three Surfaces, Anterior	D2332
Four or More Surfaces or involving incisal angle (anterior)	D2335
Resin Based Composite Crown – Anterior	D2390
One Surface, Posterior	D2391
Two Surface, Posterior	D2392
Three Surface, Posterior	D2393
Four or More Surfaces, Posterior	D2394
Onlay – Metallic – Three Surfaces	D2543
Onlay – Metallic – Four or More Surfaces	D2544
Onlay – Porcelain/Ceramic – Four or More Surfaces	D2644
Crowns	
Crown - porcelain/ceramic	D2740
Crown - porcelain fused to high noble metal	D2750
Crown - porcelain fused to predominantly base metal	D2751
Crown - porcelain fused to noble metal	D2752
Crown – ¾ Cast Noble Metal	D2782
Crown – ¾ Porcelain/Ceramic	D2783

High Noble Metal Full Cast	D2790
Base Metal, Full Cast	D2791
Base Metal, Full Cast	D2792
Provisional Crown	D2799
Recement Inlay	D2910
Recement Crown	D2920
Prefabricated stainless steel Crown (primary tooth)	D2930
Prefabricated stainless steel Crown (permanent tooth)	D2931
Prefabricated resin crown - Composite Crown	D2932
Stainless Steel Crown, with resin window	D2933
Sedative Fillings	D2940
Core buildup including pins	D2950
Pin retention - per tooth, in addition to restoration	D2951
Cast post and core, in addition to crown	D2952
Prefabricated post and core	D2954
Laminate Veneer – Preformed	D2960
Veneer, Porcelain (Laboratory)	D2962
Additional Procedures to Construct New Crown under Existing Partial	D2971
Crown Repair	D2980
Unspecified Restorative Procedure	D2999
EXTRACTIONS	
Extraction, Coronal Remnants – Primary Tooth	D7111
Extraction, Erupted Tooth or Exposed Root	D7140
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	D7210
Removal of impacted tooth - soft tissue	D7220

Removal of impacted tooth - partially bony	D7230
Removal of impacted tooth - completely bony	D7240
Removal of Impacted Tooth – Completely Bony, with unusually complications	D7241
Surgical removal of residual tooth roots (cutting procedure)	D7250
Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth (health check)	D7270
Surgical access of an unerupted tooth (health check ONLY)	D7280
Placement of device to facilitate eruption of impacted tooth	D7283
Biopsy of oral tissue - hard	D7285
Biopsy of oral tissue - soft	D7286
RADIOGRAPHS	
Intraoral - Complete Series	D0210
Intraoral - First Film	D0220
Intraoral - Each Additional Film	D0230
Occlusal – Single Film	D0240
Bitewing Single Film	D0270
Bitewing Two Films	D0272
Bitewing Four Films	D0274
Vertical Bitewings 7 to 8 Films	D0277
Temporomandibular Joint – Films (Series)	D0321
Panoramic Film	D0330
Cephalometric Film	D0340
Oral/Facial Images (Includes Intra and Extraoral Images)	D0350
Cone Beam – Three Dimensional Image Reconstruction Using Existing Data	D0360
Collection of Microorganisms for Culture and Sensitivity	D0415
Adjunctive Diagnostic Test that aids in Detection of Mucosal Abnormalities	D0431

Pulp Vitality Test	D0460
Diagnostic Casts	D0470
THERAPEUTIC PULPOTOMY	
Pulp Cap, Direct (Excluding Final Restoration)	D3110
Pulp Cap, Indirect (Excluding Final Restoration)	D3120
Pulpotomy - Therapeutic	D3220
Gross pulpal debridgement - primary and permanent	D3221
Pulpal therapy, anterior -primary	D3230
Pulpal therapy, posterior -primary	D3240
ANESTHESIA	
Deep Sedation/General Anesthesia - first 15 minutes	D9222
Deep Sedation/General Anesthesia - each subsequent 15 minutes	D9223
Analgesia, anxiolysis, inhalation of nitrous oxide (prior approval required)	D9230
Intravenous moderate conscious sedation/ analgesia - first 15 minutes	D9239
Intravenous moderate conscious sedation/ analgesia – each subsequent15 minute increment	D9243
Non-Intravenous Conscious Sedation	D9248
OTHER DENTAL SERVICES	
Surgical	
Excision of Benign Lesion Up to 1.25 cm	D7410
Incision and drainage of abscess - intraoral soft tissue (health check)	D7510
Incision and drainage of abscess - extraoral soft tissue (health check)	D7520
PERIODONTAL PROCEDURES	
Gingivectomy or Gingivoplaty-four or more contiguous teeth or bounded teeth spaces per quadrant	D4210
Gingivectomy or gingivoplasty - one to three teeth per quadrant	D4211
Crown Lengthening, Hard and Soft Tissue	D4249

Osseous Surgery (Including Flapentry & Closure) 4 or more contiguous teeth	D4260
Osseous Surgery (Including Flap Entry and Closure) 1 to 3 teeth per quad	D4261
Bone Replacement Graft – first site in quadrant	D4263
Biologic Material to Aid in Soft and Osseous Tissue Regeneration	D4265
Guided Tissue Regeneration – Resorbable, per site, per tooth	D4266
Subepithelial Connective Tissue Graft	D4273
Provisional Splinting – Extracoronal	D4321
Periodontal Scaling and Root Planning four or more contiguous teeth or bounded teeth spaces per quadrant	D4341
Periodontal Scaling & Root Planning, 1 to 3 teeth, per quadrant	D4342
Full, Mouth Debridement to Enable Comprehensive Oral Evaluation and diagnosis on a subsequent visit	D4355
Localized Delivery of Chemotherapeutic Agents	D4381
Periodonal Maintenance Following Active Therapy	D4910
Unspecified Periodontal Procedure	D4999
Root Canals	
Endodontic therapy anterior tooth (excluding final restoration)	D3310
Endodontic therapy premolar tooth (excluding final restoration)	D3320
Endodontic therapy molar tooth (excluding final restoration)	D3330
Incomplete endodontic therapy	D3332
Retreatment of Previous Root Canal Therapy – Anterior	D3346
Retreatment of Previous Root Canal Therapy – premolar	D3347
Retreatment of Previous Root Canal Therapy - molar	D3348
Preventative Space Management Therapy	
Space maintainer - fixed – unilateral	D1510
Space maintainer – fixed – bilateral	D1515
Space maintainer - removable bilateral	D1525

Re-cementation of Space Maintainer	D1550
Prosthodontic Services, Removable Complete Dentures	
Complete denture maxillary	D5110
Complete denture mandibular	D5120
Immediate Upper Denture	D5130
Immediate Lower Denture	D5140
Partial Dentures	
Maxillary Partial-Resin Base (age 0-16 yr) (Including any Conventional Clasps, Rests and Teeth) (>age 16 yrs)	D5211
Mandibular Partial-Resin Base (age 0-16 yr) (Including Conventional Clasps, Rests and Teeth) (>age 16 yrs)	D5212
Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	D5213
Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	D5214
Maxillary Partial Denture – Flexible Base (Including, Clasps, Rest & Teeth)	D5225
Mandibular Partial Denture – Flexible Base (Including Clasps, Rests, & Teeth)	D5226
Removable Unilateral Partial Denture One Piece Casting- Chrome	D5281
Repairs to Dentures	
Repair broken complete denture base, mandibular	D5511
Repair broken complete denture base, maxillary	D5512
Replace missing or broken teeth - complete denture (each tooth)	D5520
Repair resin partial denture base, mandibular	D5611
Repair resin partial denture base, maxillary	D5612
Repair - cast partial framework, mandibular	D5621
Repair - cast partial framework, maxillary	D5622
Repair or replace broken clasp	D5630

Replace broken teeth - per tooth	D5640
Add tooth to existing partial denture	D5650
Add clasp to existing partial denture	D5660
Reline complete maxillary denture (chairside)	D5730
Reline complete mandibular denture (chairside)	D5731
Reline partial maxillary denture (chairside)	D5740
Reline partial mandibular denture (chairside)	D5741
Reline complete maxillary denture (laboratory)	D5750
Reline complete mandibular denture (laboratory)	D5751
Reline partial maxillary denture (laboratory)	D5760
Reline partial mandibular denture (laboratory)	D5761
Upper Denture – Temporary (Partial Stayplate)	D5820
Lower Denture – Temporary (Partial Stayplate)	D5821
Tissue Conditioning – Upper	D5850
Precision Attachment	D5862
IMPLANT SERVICES	
Surgical Placement of Implant Body; Endosteal Implant	D6010
Prefabricated Abutment	D6056
Custom Abutment	D6057
Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	D6059
Implant Supported Porcelain/Ceramic Crown	D6065
Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy…	D6066
Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Nobel Metal)	D6069
Porcelain Fused to High Noble Metal	D6240
Porcelain Fused to Base Metal	D6241
Porcelain Fused to Noble Metal	D6242

Retainer-Cast Metal for Resin Bonded Fixed Prosthesis	D6545
Crown – Porcelain/Ceramic	D6740
Porcelain fused to High Noble Metal	D6750
Porcelain Fused to Base Metal	D6751
Porcelain Fused to Nobel Metal	D6752
Recement Bridge	D6930
Precision Attachment	D6950
Prefabricated Post and Core (In Addition to Bridge Retainer)	D6972
Core Build Up for Retainer, Including Any Pins	D6973
ALVEOPLASTY	
Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quad	D7310
Alveololasty in Conjunction with Extractions; 1 to 3 teeth per quadrant	D7311
Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quad	D7320
APEXIFICATION/RECALCIFICATION	
Apexification/recalcification - initial	D3351
Apexification/recalcification - interim	D3352
Apexification/recalcification - final	D3353
APICOECTOMY/PERIRADICULAR SERVICES	
Apicoectomy - Separate Surgical Procedure	D3410
Apicoectomy premolar (First Root)	D3421
Apicoectomy - Molar (First Root)	D3425
Apicoectomy (each additional root)	D3426
Retrograde Filling (Per Root)	D3430
ORTHODONTICS	
Limited Orthodontic Treatment of the Transitional Dentition	D8020

Interceptive Orthodontic Treatment of the Primary Dentition	D8050
Interceptive Orthodontic Treatment of the Transitional Dentition	D8060
Comprehensive Orthodontic Treatment – Transitional Dentition	D8070
Comprehensive Orthodontic Treatment of the Adolescent Dentition	D8080
Comprehensive Orthodontic Treatment – Adult Dentition	D8090
Removable Appliance Therapy – Minor Habit Control	D8210
Fixed Appliance Therapy – Minor Habit Control	D8220
Pre-Orthodontic Treatment Visit	D8660
Periodic or Treatment Visit (As Part of Contract)	D8670
Orthodontic Retention	D8680
Orthodontic Treatment (Alternative Billing to Control Fee)	D8690
Replacement of Lost or Broken Retainer	D8692
Unspecified Orthodontic Procedure	D8999
DRUGS	
Therapeutic Drug Injection	D9610
Other Drugs/Medicaments	D9630
Application of Desensitizing Medicaments	D9910
Application of Desensitizing Resin for Cervical and/or Root Surface, per tooth	D9911
OTHER REPAIR PROCEDURE	
Occlusal Orthotic Device	D7880
Bone Replacement Grafy for Ridge Preservation; Per Site	D7953
Frenulectomy (frenectomy or frenotomy) - separate procedure	D7960
MISCELLANEOUS SERVICES	
Complications (Postsurgical) unusual circumstances	D9930
Occlusal Guard	D9940
Occlusal Adjustment, Limited	D9951
Odontoplasty 1 – 2 Teeth: Includes Removal of Enamel Projections	D9971

External Bleaching – Per Arch	D9972
Unspecified (To Be Described by Attending DDS)	D9999

Annual Dental Participation Ratio

Description

The weighted percentage of qualifying TennCare Children's DBM Program members 2 – 20 years of age and qualifying CoverKids DBM Program members 2 – 18 years of age who had one (1) or more qualifying dental services during the measurement year.

Eligible Population

TennCare Children's DBM Program members 2 – 20 years of age and CoverKids DBM Program members 2 – 18 years of age with a minimum of ninety (90) days of program and benefit. Age is determined at the mid-point of the reporting period.

Continuous Enrollment - Eligibles must be continuously enrolled for a minimum of ninety (90) days

Anchor Date - Mid-point of reporting period

Benefit - Dental

Qualifying Services

Claims with a qualifying paid service.

Codes to identify qualifying services[1] HCPCS/CDT: D0100 – D9999.

[1]CDT (Current Dental Terminology) is the equivalent dental version of the CPT Physician Procedural Coding System

Metric Formulation

Numerator - The sum of the FTE for qualifying eligibles with 1 or more qualifying services in the measurement year

Denominator - Sum of FTE for all qualifying eligibles

FTE equals the number of days eligible divided by 365.25

Mathematical Formulation

i. **Participant Ratio Weight for Individual *i***

$W_i = Fte / \sum_{i=1}^{I} Fte;$ Where I equals the total qualifying eligibles

Where $\sum_{i=1}^{I} W_i = 1$

ii. **Qualifying Service Indicator**

$$f(s) = \begin{cases} 1, & \text{if received qualifying service} \\ & 0, \text{ if not} \end{cases}$$

iii. **Participation Ratio for Individual *i***

$$PR_i = W_i * f(s)$$

iv. **Overall Participant Ratio**

$$PR = \sum_{i=1}^{I} PRi$$

ATTACHMENT F

Dental Screening Percentage

Eligible Population

Any member ages 3-20

Qualifying Service

Paid claims with a qualifying service.

Codes used to identify qualifying services	CDT: D0120, D0140, D0150, D0160, D0170, D0180, D0999, D9110

Metric Formulation

Numerator - Count of all qualifying services in the measurement year

Denominator - Expected number of dental screens in the measurement year

Mathematical Formulation

Average period of eligibility = (Total months of eligibility/ # of Eligible individuals)

Expected number of screens per eligible = (Annualized state dental periodicity schedule * Average period of eligibility)

Expected number of dental screens = (# of eligible individuals * Expected number of screens per eligible)

Dental Report FFY 2017		CATEGORY	TOTAL (sum of all age groups for non-ratio cells)	3-5	6-9	10-14	15-18	19-21
Line 1	# of Individual Eligibles (HCI)	Total (=CN+MN)						
Line 2c (Dental)	Annualized State Dental Periodicity Schedule			1.0	1.0	1.0	1.0	1.0
Line 3a	Total Months of Eligibility (HCI)	Total (=CN+MN)						
Line 3b (=3a/Line1/12)	Average Period of Eligibility	Total (=Line 3a total/Line 1 total/12)						
Line 4 (=2c*3b)	Exp. Dental Screenings per Eligible	Total (=2c * Line 3b total)						
Line 5 (=Line 4 * Line 1)	Expected # of Dental Screenings	Total (=CN+MN)						
	Actual # of Diagnostic Screenings (HCI)**							
Line 12a	Total Eligibles receiving any dental services	Total (=CN+MN)						
	Dental Screening Percentage (Line8/Line7)							
	Dental Participant Ratio (based on Line2A/LIne5)							

Dental Report:		CATEGORY	TOTAL (sum of all age groups for non-ratio cells)	3-5	6-9	10-14	15-18	19-20
Line 1a	Total Individuals Eligible for EPSDT (416 reported)	Total (=CN+MN)						
Line 2c (Dental)	Annualized State Dental Periodicity Schedule		1	1.0	1.0	1.0	1.0	1.0
Line 3a	Total Months of Eligibility	Total (=CN+MN)						
Line 3b	Average Period of Eligibility	Total (=CN+MN)						
Line 4 (=2c*3b)	Exp. Dental Screenings per Eligible	Total (=2c * Line 3b total)						
Line 5 (=Line 4 * Line 1a)	Expected # of Dental Screenings	Total (=CN+MN)						
	Actual # of Diagnostic Screenings (HCI calculated)**							
Line 12a	Total Eligibles receiving any dental services (HCI calculated)							
	Dental Screening Percentage = Actual # of Diagnostic Screenings /Expected # of Dental Screenings							
***Diagnostic Procedure codes used to identify the screens:*								
	cde_proc in ('D0120', 'D0140', 'D0150', 'D0160', 'D0170', 'D0180, 'D0999', 'D9110')							

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
EDISON VENDOR IDENTIFICATION NUMBER:	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. Attach evidence documenting the individual's authority to contractually bind the Contractor, unless the signatory is the Contractor's chief executive or president.

PRINTED NAME AND TITLE OF SIGNATORY

DATE OF ATTESTATION

RFP ATTACHMENT 6.7

BIDDER'S LIBRARY INDEX

(1) TennCare ECF CHOICES DBM Program Dental Fee Schedule

https://s3.amazonaws.com/files.formstack.com/uploads/1992725/32326700/388902163/ecf_choices_dental_fee_schedule_jan_2018_approved.docx

(2) TennCare Children's DBM Program Dental Fee Schedule

https://s3.amazonaws.com/files.formstack.com/uploads/1992725/32326724/388902163/tenncare_dental_fee_schedule_jan_2018_approved.xlsx

(3) TPPOHP DBM Program Dental Fee Schedule

https://www.tn.gov/content/dam/tn/tenncare/documents2/TPPOHPDentalFeeSchedule.pdf

(4) 834 Enrollment Outbound Companion Guide and accompanying 2300 Loop Definitions

https://www.tn.gov/content/dam/tn/tenncare/documents2/834EnrollmentOutbound.pdf

https://www.tn.gov/content/dam/tn/tenncare/documents2/8342300LoopDefinitions20131016.pdf

https://www.tn.gov/content/dam/tn/tenncare/documents2/8342300LoopDefinitions20131114.pdf

https://www.tn.gov/content/dam/tn/tenncare/documents2/8342300LoopDefinitions20150416.pdf

https://www.tn.gov/content/dam/tn/tenncare/documents2/8342300LoopDefinitionsCHIP.pdf

https://www.tn.gov/content/dam/tn/tenncare/documents2/8342300LoopDefinitions.pdf

(5) 837D Companion Guide

https://www.tn.gov/content/dam/tn/tenncare/documents2/837DCompanionGuide.pdf

RFP ATTACHMENT 6.8

HIPAA Business Associate Agreement

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT ("Agreement") is between The State of Tennessee, Division of TennCare ("TennCare" or "Covered Entity"), located at 310 Great Circle Road, Nashville, TN 37243 and _____

_____("Business Associate"), located at_____
_____, including all office locations and other business locations at which Business Associate data may be used or maintained. Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

The Parties acknowledge that they are subject to the Privacy and Security Rules (45 C.F.R. Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, and as amended by the final rule modifying the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act (HITECH). If Business Associate provides services to Covered Entity pursuant to one or more contractual relationships, said Agreements are detailed below and hereinafter referred to as "Service Agreements."

LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT:

_____ _____

_____ _____

In the course of performing services under a Service Agreement, Business Associate may come into contact with, use, or disclose Protected Health Information ("PHI"). Said Service Agreements are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security rules and regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, D and E, which require Covered Entity to have a written memorandum with each of its Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard PHI that Business Associate may receive (if any) from or on behalf of Covered Entity, and, therefore, execute this Agreement.

1. DEFINITIONS

All capitalized terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms defined in 45 C.F.R. Parts 160 through 164 or other applicable law or regulation. A reference in this Agreement to a section in the Privacy or Security Rule means the section as in effect or as amended.

1.1 "Commercial Use" means obtaining PHI with the intent to sell, transfer or use it for commercial, or personal gain, or malicious harm; sale to third party for consumption, resale, or processing for resale; application or conversion of data to make a profit or obtain a benefit contrary to the spirit of this Agreement, including but not limited to presentation of data or examples of data in a conference or meeting setting where the ultimate goal is to obtain or gain new business.

1.2 “Confidential Information” shall mean any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is supplied by TennCare to the Business Associate under this Agreement. Any information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, relating to individuals enrolled in the TennCare program (“TennCare enrollees”), or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained through the Business Associate’s performance under this Agreement, shall also be treated as “Confidential Information” to the extent that confidential status is afforded such information under state and federal laws or regulations. All confidential information shall not be subject to disclosure under the Tennessee Public Records Act.

1.3 “Electronic Signature” means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

1.4 “Marketing” shall have the meaning under 45 C.F.R. § 164.501 and the act or process of promoting, selling, leasing or licensing any TennCare information or data for profit without the express written permission of TennCare.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Compliance with the Privacy Rule. Business Associate shall fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose PHI other than as permitted or required by this Agreement, the Service Agreements, or as required by law. In case of any conflict between this Agreement and the Service Agreements, this Agreement shall govern.

2.2 HITECH Act Compliance. The Health Information Technology for Economic and Clinical Health Act (HITECH) was adopted as part of the American Recovery and Reinvestment Act of 2009. HITECH and its implementing regulations impose new requirements on Business Associates with respect to privacy, security, and Breach notification. Business Associate hereby acknowledges and agrees that to the extent it is functioning as a Business Associate of Covered Entity, Business Associate shall comply with any applicable provisions of HITECH. Business Associate and the Covered Entity further agree that the provisions of HIPAA and HITECH that apply to business associates and that are required to be incorporated by reference in a business associate agreement have been incorporated into this Agreement between Business Associate and Covered Entity. Should any provision not be set forth specifically, it is as if set forth in this Agreement in its entirety and is effective as of the Applicable Effective Date, and as amended.

2.3 Business Management. Business Associate may use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of Business Associate. Business Associate may provide data aggregation services relating to the Health Care Operations of TennCare, or as required by law. Business Associate is expressly prohibited from using or disclosing PHI other than as permitted by this Agreement, any associated Service Agreements, or as otherwise permitted or required by law, and is prohibited from uses or disclosures of PHI that would not be permitted if done by the Covered Entity.

2.4 Privacy Safeguards and Policies. Business Associate shall use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the Service Agreement(s), this Agreement or as required by law. This includes the implementation of Administrative, Physical, and Technical Safeguards to reasonably and appropriately protect the Covered Entity’s PHI against any reasonably anticipated threats or hazards, utilizing the technology commercially available to the Business Associate (See also Section 3.2). The Business Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, procedures, records of training and sanctions of members of its Workforce.

2.5 Business Associate Contracts. Business Associate shall require any agent, including a Subcontractor, to whom it provides PHI received from, maintained, created or received by Business Associate on behalf of Covered Entity, or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI or other confidential TennCare information, to agree, by written agreement with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information except for the provision

at section 4.6, which shall only apply to the Business Associate notwithstanding the requirements in this section 2.5.

2.6 Mitigation of Harmful Effect of Violations. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.7 Reporting of Violations in Use and Disclosure of PHI. Business Associate shall require its employees, agents, and Subcontractors to promptly report to Business Associate immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement and to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. The Business Associate shall report such violation to Covered Entity immediately upon becoming aware of, and in no case later than 48 hours after discovery.

2.8 Breach of Unsecured Protected Health Information. As required by the Breach Notification Rule, Business Associate shall, and shall require its Subcontractor(s) to, maintain systems to monitor and detect a Breach of Unsecured PHI, whether in paper or electronic form.

2.8.1 Business Associate shall provide to Covered Entity notice of a Breach of Unsecured PHI immediately upon becoming aware of the Breach, and in no case later than 48 hours after discovery.

2.8.2 Business Associate shall cooperate with Covered Entity in timely providing the appropriate and necessary information to Covered Entity.

2.8.3 Covered Entity shall make the final determination whether the Breach requires notification to affected individuals and whether the notification shall be made by Covered Entity or Business Associate.

2.9 Access of Individual to PHI and other Requests to Business Associate. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity in order to meet its requirements under 45 C.F.R. § 164.524. If Business Associate receives a request from an Individual for a copy of the Individual's PHI, and the PHI is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the Individual in a timely manner. If Business Associate receives a request for PHI not in its possession and in the possession of the Covered Entity, or receives a request to exercise other Individual rights as set forth in the Privacy Rule, Business Associate shall promptly forward the request to Covered Entity. Business Associate shall then assist Covered Entity as necessary in responding to the request in a timely manner. If a Business Associate provides copies of PHI to the Individual, it may charge a reasonable fee for the copies as the regulations shall permit.

2.10 Requests to Covered Entity for Access to PHI. The Covered Entity shall forward to the Business Associate in a timely manner any Individual's request for access to or a copy (in any form they choose, provided the PHI is readily producible in that format) of their PHI that shall require Business Associate's participation, after which the Business Associate shall provide access to or deliver such information as follows:

(a) The Parties understand that if either Party receives a request for access to or copies of PHI from an Individual which the Party may complete with only its own onsite information, the time for such response shall be thirty (30) days, with notification to the Covered Entity upon completion.
(b) If the Covered Entity receives a request and requires information from the Business Associate in addition to the Covered Entity's onsite information to fulfill the request, the Business Associate shall have fifteen (15) days from date of Covered Entity's notice to provide access or deliver such information to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (30) day requirement of 45 C.F.R. § 164.524.
(c) If the Party designated above as responding to the Individual's request is unable to complete the response to the request in the time provided, that Party shall provide the Individual, or Individual's designee, with a written

statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Party may extend the response time once for no more than thirty (30) additional days.

(d) Business Associate is permitted to send an Individual or Individual's designee unencrypted emails including Electronic PHI if the Individual requests it, provided the Business Associate has advised the Individual of the risk and the Individual still prefers to receive the message by unencrypted email.

2.11 Individuals' Request to Amend PHI. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526, regarding an Individual's request to amend PHI. The Business Associate shall make the amendment promptly in the time and manner designated by Covered Entity, but shall have thirty (30) days' notice from Covered Entity to complete the amendment to the Individual's PHI and to notify the Covered Entity upon completion.

2.12 Recording of Designated Disclosures of PHI. Business Associate shall document any and all disclosures of PHI by Business Associate or its agents, including information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

2.13 Accounting for Disclosures of PHI. The Business Associate agrees to provide to Covered Entity or to an Individual, or Individual's designee, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. The Covered Entity shall forward the Individual's request requiring the participation of the Business Associate to the Business Associate in a timely manner, after which the Business Associate shall provide such information as follows:

(a) If Covered Entity directs Business Associate to provide an accounting of disclosures of the Individual's PHI directly to the Individual, the Business Associate shall have sixty (60) days from the date of the Individual's request to provide access to or deliver such information to the Individual or Individual's designee. The Covered Entity shall provide notice to the Business Associate in time to allow the Business Associate a minimum of thirty (30) days to timely complete the Individual's request.

(b) If the Covered Entity elects to provide the accounting to the Individual, the Business Associate shall have thirty (30) days from date of Covered Entity's notice of request to provide information for the Accounting to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day period.

(c) If either of the Parties is unable to complete the response to the request in the times provided above, that Party shall notify the Individual with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Parties may extend the response time once for no more than thirty (30) additional days.

(d) The accounting of disclosures shall include at least the following information:
    (1) date of the disclosure;
    (2) name of the third party to whom the PHI was disclosed,
    (3) if known, the address of the third party;
    (4) brief description of the disclosed information; and
    (5) brief explanation of the purpose and basis for such disclosure.

(e) The Parties shall provide one (1) accounting in any twelve (12) months to the Individual without charge. The Parties may charge a reasonable, cost-based fee, for each subsequent request for an accounting by the same Individual if he/she is provided notice and the opportunity to modify his/her request. Such charges shall not exceed any applicable State statutes or rules.

2.14 Minimum Necessary. Business Associate shall use reasonable efforts to limit any use, disclosure, or request for use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.14.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, PHI shall be the

minimum necessary in accordance with the Privacy Rule requirements.

2.14.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.14.3 Business Associate shall adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity.

2.15 Privacy Compliance Review upon Request. Business Associate agrees to make its internal practices, books and records, including policies, procedures, and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of Covered Entity available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.16 Cooperation in Privacy Compliance. Business Associate agrees to fully cooperate in good faith and to assist Covered Entity in complying with the requirements of the Privacy Rule.

3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Compliance with Security Rule. Business Associate shall fully comply with the requirements under the Security Rule applicable to "Business Associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Security Safeguards and Policies. Business Associate shall implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule. This includes specifically, but is not limited to, the utilization of technology commercially available at the time to the Business Associate to protect the Covered Entity's PHI against any reasonably anticipated threats or hazards. The Business Associate understands that it has an affirmative duty to perform a regular review or assessment of security risks, conduct active risk management and supply best efforts to assure that only authorized persons and devices access its computing systems and information storage, and that only authorized transactions are allowed. The Business Associate will maintain appropriate documentation of its compliance with the Security Rule.

3.3 Security Provisions in Business Associate Contracts. Business Associate shall ensure that any agent to whom it provides Electronic PHI received from, maintained, or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI supplied by Covered Entity, shall execute a bilateral contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, incorporating the same restrictions and conditions in this Agreement with Business Associate regarding PHI except for the provision in Section 4.6.

3.4 Reporting of Security Incidents. The Business Associate shall track all Security Incidents as defined and as required by HIPAA and shall periodically report such Security Incidents in summary fashion as may be requested by the Covered Entity. The Covered Entity shall not consider as Security Incidents, for the purpose of reporting, external activities (port enumeration, etc.) typically associated with the "footprinting" of a computing environment as long as such activities have only identified but not compromised the logical network perimeter, including but not limited to externally facing firewalls and web servers. The Business Associate shall reasonably use its own vulnerability assessment of damage potential and monitoring to define levels of Security Incidents and responses for Business Associate's operations. However, the Business Associate shall expediently notify the Covered Entity's Privacy Officer of any related Security Incident, immediately upon becoming aware of any unauthorized acquisition including but not limited to use, disclosure, modification, or destruction of PHI by an employee or otherwise authorized user of its system of which it becomes aware.

3.4.1 Business Associate identifies the following key contact persons for all matters relating to this Agreement:

_____
_____
_____
_____
_____
_____
_____

Business Associate shall notify Covered Entity of any change in these key contacts during the term of this Agreement in writing within ten (10) business days.

3.5 Contact for Security Incident Notice. Notification for the purposes of Sections 2.8and 3.4 shall be in writing made by email/fax, certified mail or overnight parcel immediately upon becoming aware of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

TennCare Privacy Officer
310 Great Circle Rd.
Nashville Tennessee 37243
Phone: (615) 507-6855
Facsimile: (615) 734-5289
Email: Privacy.Tenncare@tn.gov

3.6 Security Compliance Review upon Request. Business Associate shall make its internal practices, books, and records, including policies and procedures relating to the security of Electronic PHI received from, created by or received by Business Associate on behalf of Covered Entity, available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's, Business Associate's compliance with the Security Rule.

3.7 Cooperation in Security Compliance. Business Associate shall fully cooperate in good faith to assist Covered Entity in complying with the requirements of the Security Rule.

3.8 Refraining from intimidation or retaliation. A Covered Entity or Business Associate may not threaten, intimidate, coerce, harass, discriminate against, or take any other retaliatory action against any Individual or other person for-- (a) Filing of a complaint under 45 C.F.R. § 160.306; (b) testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or (c) opposing any act or practice made unlawful, provided the Individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of PHI in violation of HIPAA.

4. USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Use and Disclosure of PHI for Operations on Behalf of Covered Entity. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform Treatment, Payment or Health Care Operations for, or on behalf of, Covered Entity as specified in Service Agreements, provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity.

4.2 Other Uses of PHI. Except as otherwise limited in this Agreement, Business Associate may use PHI within its Workforce as required for Business Associate's proper management and administration, not to include Marketing or Commercial Use, or to carry out the legal responsibilities of the Business Associate.

4.3 Third Party Disclosure Confidentiality. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities

of the Business Associate, provided that disclosures are required by law, or, if permitted by law, this Agreement, and the Service Agreement, provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as required by law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is Breached immediately upon becoming aware.

4.4 Other Uses Strictly Limited. Nothing in this Agreement shall permit the Business Associate to share PHI with Business Associate's affiliates or contractors except for the purposes of the Service Agreement(s) between the Covered Entity and Business Associate(s) identified in the "LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT" on page one (1) of this Agreement.

4.5 Covered Entity Authorization for Additional Uses. Any use of PHI or other confidential TennCare information by Business Associate, its Subcontractors, its affiliate or Contractor, other than those purposes of this Agreement, shall require express written authorization by the Covered Entity, and a Business Associate agreement or amendment as necessary. Activities which are prohibited include, but not are not limited to, Marketing or the sharing for Commercial Use or any purpose construed by Covered Entity as Marketing or Commercial use of TennCare enrollee personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws.

4.6 Prohibition of Offshore Disclosure. Nothing in this Agreement shall permit the Business Associate to share, use or disclose PHI in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without express written authorization from the Covered Entity.

4.7 Prohibition of Other Uses and Disclosures. Business Associate shall not use or disclose PHI that is Genetic Information for underwriting purposes. Moreover, the sale, marketing or the sharing for commercial use or any purpose construed by Covered Entity as the sale, marketing or commercial use of TennCare enrollee personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws, is prohibited.

4.8 Data Use Agreement - Use and Disclosure of Limited Data Set. Business Associate may use and disclose a Limited Data Set that Business Associate creates for Research, public health activity, or Health Care Operations, provided that Business Associate complies with the obligations below. Business Associate may not make such use and disclosure of the Limited Data Set after any cancellation, termination, expiration, or other conclusion of this Agreement.

4.9 Limitation on Permitted Uses and Disclosures. Business Associate will limit the uses and disclosures it makes of the Limited Data Set to the following: Research, public health activity, or Health Care Operations, to the extent such activities are related to covered functions**,** including business planning and development such as conducting cost-management and planning-related analysis related to managing and operating Business Associates functions, formulary development and administration, development and improvement of methods of payment or coverage policies, customer service, including the provision of data analysis for policy holders, plan sponsors, or other customers, to the extent such activities are related to covered functions, provided that PHI is not disclosed and disclosure is not prohibited pursuant to any other provisions in this Agreement related to Marketing or Commercial use.

4.10 Business Associate shall enter into written agreements that are substantially similar to this Business Associate Agreements with any Subcontractor or agent which Business Associate provides access to Protected Health Information.

4.11 Business Associates shall implement and maintain information security policies that comply with the HIPAA Security Rule.

5. OBLIGATIONS OF COVERED ENTITY

5.1 Notice of Privacy Practices. Covered Entity shall provide Business Associate with the notice of Privacy Practices

produced by Covered Entity in accordance with 45 C.F.R. § 164.520, as well as any changes to such notice.

5.2 Notice of Changes in Individual's Access or PHI. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses.

5.3 Notice of Restriction in Individual's Access or PHI. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use of PHI.

5.4 Reciprocity for Requests Received by Business Associate. The Parties agree that this Section (Section 5) is reciprocal to the extent Business Associate is notified or receives an inquiry from any Individual within Covered Entity's covered population.

6. TERM AND TERMINATION

6.1 Term. This Agreement shall be effective as of the date on which it has been signed by both parties and shall terminate when all PHI which has been provided, regardless of form, by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if the Parties agree that it is unfeasible to return or destroy PHI, subsection 6.3.5 below shall apply.

6.2 Termination for Cause. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to terminate this Agreement and Service Agreement in the event Business Associate fails to comply with, or violates a material provision of this Agreement and any provision of the Privacy and Security Rules.

6.2.1 Upon Covered Entity's knowledge of a Breach by Business Associate, Covered Entity shall either:

(a) Provide notice of breach and an opportunity for Business Associate to reasonably and promptly cure the breach or end the violation, and terminate this BAA if Business Associate does not cure the breach or end the violation within the reasonable time specified by Covered Entity; or

(b) Immediately terminate this BAA if Business Associate has breached a material term of this BAA and cure is not possible.

6.3 Effect of Termination. Upon termination of this Agreement for any reason, except as provided in subsections 6.3.2 and 6.3.5 below, Business Associate shall at its own expense either return and/or destroy all PHI and other confidential information received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision applies to all confidential information regardless of form, including but not limited to electronic or paper format. This provision shall also apply to PHI and other confidential information in the possession of sub-contractors or agents of Business Associate.

6.3.1 The Business Associate shall consult with the Covered Entity as necessary to assure an appropriate means of return and/or destruction and shall notify the Covered Entity in writing when such destruction is complete. If information is to be returned, the Parties shall document when all information has been received by the Covered Entity.

6.3.2 This provision (Section 6.3 and its subsections) shall not prohibit the retention of a single separate, archived file of the PHI and other confidential TennCare information by the Business Associate if the method of such archiving reasonably protects the continued privacy and security of such information and the Business Associate obtains written approval at such time from the Covered Entity. Otherwise, neither the Business Associate nor its Subcontractors and agents shall retain copies of TennCare confidential information, including enrollee PHI, except as provided herein in subsection 6.3.5.

6.3.3 The Parties agree to anticipate the return and/or the destruction of PHI and other TennCare confidential information,

and understand that removal of the confidential information from Business Associate's information system(s) and premises will be expected in almost all circumstances. The Business Associate shall notify the Covered Entity whether it intends to return and/or destroy the confidential with such additional detail as requested. In the event Business Associate determines that returning or destroying the PHI and other confidential information received by or created for the Covered Entity at the end or other termination of the Service Agreement is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible.

6.3.4 Except for Business Associate Agreements in effect prior to April 21, 2005 when the Security Rule became effective, for the renewal or amendment of those same Agreements, or for other unavoidable circumstances, the Parties contemplate that PHI and other confidential information of the Covered Entity shall not be merged or aggregated with data from sources unrelated to that Agreement, or Business Associate's other business data, including for purposes of data backup and disaster recovery, until the parties identify the means of return or destruction of the TennCare data or other confidential information of the Covered Entity at the conclusion of the Service Agreement, or otherwise make an express alternate agreement consistent with the provisions of Section 6.3 and its subsections.

6.3.5 Upon written mutual agreement of the Parties that return or destruction of PHI is unfeasible and upon express agreement as to the means of continued protection of the data, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

7. MISCELLANEOUS

7.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and/or Security Rule means the section as in effect or as amended.

7.2 Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended, including, but not limited to, changes required by the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

7.3 Survival. The respective rights and obligations of Business Associate under Confidentiality and Section6.3 of this Agreement shall survive the termination or expiration of this Agreement.

7.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

7.5 Headings. Paragraph Headings used in this Agreement are for the convenience of the Parties and shall have no legal meaning in the interpretation of the Agreement.

7.6 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by electronic mail, hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice. (For purposes of this section, effective notice to "Respective Party" is not dependent on whether the person named below remains employed by such Party.) The Parties agree to use their best efforts to immediately notify the other Party of changes in address, telephone number, and fax numbers and to promptly supplement this Agreement as necessary with corrected information.

Notifications relative to Sections 2.8 and 3.4 of this Agreement must also be reported to the Privacy Officer pursuant to Section 3.5.

COVERED ENTITY:	BUSINESS ASSOCIATE:
Wendy Long, MD, Director	_____
Division of TennCare	_____
310 Great Circle Rd.	_____
Nashville, TN 37243	_____
Fax: (615) 253-5607	_____

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

7.7 Transmission of PHI or Other Confidential Information. Regardless of the transmittal methods permitted above, Covered Entity and Business Associate agree that all deliverables set forth in this Agreement that are required to be in the form of data transfers shall be transmitted between Covered Entity and Business Associate via the data transfer method specified in advance by Covered Entity. This may include, but shall not be limited to, transfer through Covered Entity's SFTP system. Failure by the Business Associate to transmit such deliverables in the manner specified by Covered Entity may, at the option of the Covered Entity, result in liquidated damages if and as set forth in one (1) or more of the Service Agreements between Covered Entity and Business Associate listed above. All such deliverables shall be considered effectively submitted upon receipt or recipient confirmation as may be required.

7.8 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

7.9 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

7.10 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA and HITECH and without giving effect to principles of conflicts of law. Jurisdiction shall be Davidson County, Nashville, Tennessee, for purposes of any litigation resulting from disagreements of the parties for purpose of this Agreement and the Service Agreement (s).

7.11 Compensation. There shall be no remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative requirements of Tennessee State government and Services Agreement(s) referenced herein.

7.12 Validity of Execution. Unless otherwise agreed, the parties may conduct the execution of this Business Associate

Agreement transaction by electronic means. The parties may agree that an electronic record of the Agreement containing an Electronic Signature is valid as an executed Agreement.

IN WITNESS WHEREOF, the Parties execute this Agreement to be valid and enforceable from the last date set out below:

DIVISION OF TENNCARE

By: _____
Wendy Long, MD, Director
Date: _____

Division of TennCare
310 Great Circle Road
Nashville, TN 37243
Fax: (615) 253-5607

BUSINESS ASSOCIATE

By: _____
Steven J. Pollock, CEO
Date: 7/31/18