STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMNISTRATION
DIVISION OF TENNCARE

REQUEST FOR PROPOSALS FOR Dental Benefits Manager

RFP # 31865-00636

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1 INTRODUCTION

The State of Tennessee, Department of Finance and Administration (F&A), Division of TennCare (TennCare), hereinafter referred to as “the State,” issues this Request for Proposals (RFP) to define minimum contract requirements; solicit responses; detail response requirements; and, outline the State’s process for evaluating responses and selecting a contractor to provide the needed goods or services.

Through this RFP, the State seeks to procure necessary goods or services at the most favorable, competitive prices and to give ALL qualified respondents, including those that are owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises, an opportunity to do business with the state as contractors, subcontractors or suppliers.

1.1 Statement of Procurement Purpose

The State seeks to identify a Contractor for the statewide provision of Dental Benefits Management (DBM) services for five (5) separate State DBM Programs (collectively referred to as the “State DBM Programs”), which include:

1) TennCare Children’s DBM Program, which is part of the TennCare Program, and administers dental services to approximately 900,000 eligible enrollees under age 21;
2) TennCare Adult DBM Program, which is part of the TennCare Program, and administers dental services to approximately 600,000 eligible enrollees age 21 and older;
3) TennCare Employment and Community First (ECF) CHOICES DBM Program and 1915© DBM Program, which administers covered adult dental benefits to approximately 11,000 eligible adults age 21 and older who have an intellectual or developmental disability and are enrolled in TennCare ECF CHOICES or a Section 1915(c) Home and Community Based Services Waiver; and
4) CoverKids DBM Program, which is part of the federal Children’s Health Insurance Program (CHIP), referred to in Tennessee as the CoverKids Program (CoverKids) which is a self-funded health plan providing certain dental benefits to approximately 35,000 eligible enrollees under age 19 enrolled in CoverKids medical coverage.

The services that the Contractor shall 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.

The Contractor will be paid a capitated amount for administering the following programs: TennCare Children’s DBM Program, TennCare Adult DBM Program, and the CoverKids DBM Program. All other programs will be based on an administrative services fee arrangement. The TennCare Dental Providers will be reimbursed on a fee-for-service basis by the Contractor.

These programs shall be administered as fully insured programs with the Contractor to be paid a set amount per eligible enrollee per month per respective State DBM Program. The capitated amounts per eligible enrollee per month based on the specific State DBM Program can be found in Contract Section A.

The Contractor will be paid an administrative fee and bill claim amounts directly to TennCare for the following dental programs:

- 1915(c) program
- ECF CHOICES

The monthly capitated payments to the Contractor based on the specific State DBM Program shall be the only payment, other than the administrative fees described above, the State will make relating to these DBM

Programs and the Contractor shall be responsible for payment of all Dental Providers services, administrative fees, and all other costs and expenses of any kind associated with the State DBM Programs, whether specifically described or mentioned herein or not.

Medicaid Modernization Program (MMP) – Legacy to Modular Transformation. TennCare and CMS are adopting a modular approach to Medicaid Management Information System (MMIS) that will provide the most efficient and cost-effective long-term solution for meeting TennCare' business needs. The MMP initiative will move TennCare's information technology operations from a largely single-solution platform to a set of loosely coupled Modules.

MMIS Modules will be integrated through an Integration Service Layer (ISL), leveraging a Service Oriented Architecture (SOA) through a multi-year endeavor and involving several concurrent projects, State agencies, and Medicaid Modernization Program Vendors and Partners (MMPVP).

The dental home model is a key component of TennCare's overall vision to transform the existing TennCare and CoverKids DBM 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.

1.1.1 This procurement is for provision of DBM services for the four (4) separate State DBM Program population groups identified in Section 1.1 above. TennCare currently has a single DBM contract covering the State DBM Programs described above. The maximum liability in the *pro forma* Contract Section C.1 in RFP Attachment 6.6 will be populated based on the Cap rates and associated volumes as projected to complete the scope of work in the *pro forma* contract.

1.1.2 There is no cost proposal associated to this procurement. Rates are set by TennCare's actuary.

1.2 Scope of Service, Contract Period, & Required Terms and Conditions

The RFP Attachment 6.6., *Pro Forma* Contract details the State's requirements:

- Scope of Services and Deliverables (Section A);
- Contract Period (Section B);
- Payment Terms (Section C);
- Standard Terms and Conditions (Section D); and,
- Special Terms and Conditions (Section E).

The *pro forma* contract substantially represents the contract document that the successful Respondent(s) must sign.

1.3 Nondiscrimination

No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of a Contract pursuant to this RFP 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, Tennessee state constitutional, or statutory law. The Contractor pursuant to this RFP shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

1.4 RFP Communications

1.4.1 The State has assigned the following RFP identification number that must be referenced in all communications regarding this RFP:

RFP # 31865-00636

1.4.2 **Unauthorized contact about this RFP with employees or officials of the State of Tennessee except as detailed below may result in disqualification from consideration under this procurement process.**

1.4.2.1 Prospective Respondents must direct communications concerning this RFP to the following person designated as the Solicitation Coordinator:

Donovan Morgan
Division of TennCare
310 Great Circle Road, Nashville, TN 37228
(615) 741-0041
Donovan.Morgan2@tn.gov

1.4.2.2 Notwithstanding the foregoing, Prospective Respondents may alternatively contact:

a) staff of the Governor's Office of Diversity Business Enterprise for assistance available to minority-owned, woman-owned, service-disabled veteran-owned, businesses owned by persons with disabilities, and small businesses as well as general, public information relating to this RFP (visit https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/governor-s-office-of-diversity-business-enterprise--godbe--/godbe-general-contacts.html for contact information); and

b) the following individual designated by the State to coordinate compliance with the nondiscrimination requirements of the State of Tennessee, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and associated federal regulations:

Talley A. Olson, Esq.
Division of TennCare, Office of Civil Rights Compliance
310 Great Circle Road, Nashville, TN 37228
(615) 507-6841
Talley.A.Olson@tn.gov

1.4.3 Only the State's official, written responses and communications with Respondents are binding with regard to this RFP. Oral communications between a State official and one or more Respondents are unofficial and non-binding.

1.4.4. Potential Respondents must ensure that the State receives all written questions and comments, including questions and requests for clarification, no later than the Written Questions & Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.4.4.1 Tennessee's Central Procurement Office (CPO) requires, per *CPO Policy #2013-009 Business Conduct and Ethics*, that all Organizational Conflict of Interest (OCI) pertaining to this procurement be disclosed to CPO. An OCI is defined as: "Organizational Conflict of Interest" means, as to Procurements, contracts or proposed contracts with the State, a circumstance arising out of a Contracting Party's existing or past activities, business or financial interests, Immediate Familial relationships, contractual relationships, or organizational structure (e.g., parent entities, subsidiaries, Affiliates, etc.) that results in: (i) Impaired Objectivity of a Contracting Party; (ii) An Unfair Competitive Advantage for any Respondent with respect to a Procurement; (iii) Biased Ground Rules; or (iv) Impropriety, as determined by the Chief Procurement Officer, with respect to any of the State's Procurements or contracts.

Examples of an Organizational Conflict of Interest include:

(1) When a Respondent would be evaluating the contract performance of its own services.
(2) A Respondent or proposed subcontractor is an existing TennCare contractor and has access to nonpublic, competitively useful information.
(3) If a Respondent employs a former TennCare employee.
(4) A Respondent participates in drafting a portion of the solicitation being procured.

1.4.4.2 CPO Policy #2013-009 requires OCIs be disclosed along with an OCI mitigation plan to avoid or mitigate the conflict. Potential Respondents must ensure that the State receives OCI disclosures no later than the Written Questions & Comments Deadline detailed in RFP Section 2, Schedule of Events.

The OCI mitigation plan must contain, at a minimum, the following requirements:

(1) A description of the OCI and how it is currently being handled by your organization;
(2) The proposed steps your organization will take to avoid or mitigate the conflict during this procurement;
(3) The person(s) responsible for reporting OCIs; and
(4) How the proposed plan will be communicated to employees and subcontractors.

1.4.4.3. Respondents are required to disclose the existence of OCIs that are known or discovered at any time during the procurement process. The disclosure requirement continues through the term of any contract awarded pursuant to the procurement. Upon request, any Respondents and the awardee must disclose all facts bearing on an OCI.

1.4.5 Respondents must assume the risk of the method of dispatching any communication or response to the State. The State assumes no responsibility for delays or delivery failures resulting from the Respondent's method of dispatch. Actual or digital "postmarking" of a communication or response to the State by a specified deadline is not a substitute for the State's actual receipt of a communication or response. It is encouraged for Respondents to submit bids digitally.

1.4.6 The State will convey all official responses and communications related to this RFP to the prospective Respondents from whom the State has received a Notice of Intent to Respond (refer to RFP Section 1.8).

1.4.7 The State reserves the right to determine, at its sole discretion, the method of conveying official, written responses and communications related to this RFP. Such written communications may be transmitted by mail, hand-delivery, facsimile, electronic mail, Internet posting, or any other means deemed reasonable by the State. For internet posting, please refer to the following website: https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/supplier-information/request-for-proposals--rfp--opportunities1.html.

1.4.8 The State reserves the right to determine, at its sole discretion, the appropriateness and adequacy of responses to written comments, questions, and requests related to this RFP. The State's official, written responses will constitute an amendment of this RFP.

1.4.9 Any data or factual information provided by the State (in this RFP, an RFP amendment or any other communication relating to this RFP) is for informational purposes only. The State will make reasonable efforts to ensure the accuracy of such data or information, however it is the Respondent's obligation to independently verify any data or information provided by the State. The State expressly disclaims the accuracy or adequacy of any information or data that it provides to prospective Respondents.

1.5 Assistance to Respondents With a Handicap or Disability

Prospective Respondents with a handicap or disability may receive accommodation relating to the communication of this RFP and participating in the RFP process. Prospective Respondents may contact the Solicitation Coordinator to request such reasonable accommodation no later than the Disability Accommodation Request Deadline detailed in the RFP Section 2, Schedule of Events.

1.6 Respondent Required Review & Waiver of Objections

1.6.1 Each prospective Respondent must carefully review this RFP, including but not limited to, attachments, the RFP Attachment 6.6., *Pro Forma* Contract, and any amendments, for questions, comments, defects, objections, or any other matter requiring clarification or correction (collectively called "questions and comments").

1.6.2 Any prospective Respondent having questions and comments concerning this RFP must provide them in writing to the State no later than the Written Questions & Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.6.3 Protests based on any objection to the RFP shall be considered waived and invalid if the objection has not been brought to the attention of the State, in writing, by the Written Questions & Comments Deadline.

1.7 Pre-Response Conference

A Pre-response Conference will be held at the time and date detailed in the RFP Section 2, Schedule of Events. Pre-response Conference attendance is not mandatory, and prospective Respondents may be limited to a maximum number of attendees depending upon overall attendance and space limitations.

The conference will be held at:

Join on your computer, mobile app or room device

Click here to join the meeting

Meeting ID: 243 023 388 774

Passcode: gcLoN3

Download Teams | Join on the web

Join with a video conferencing device
stateoftn@m.webex.com
Video Conference ID: 117 857 767 0
Alternate VTC instructions

Or call in (audio only)
+1 629-209-4396,,443567238# United States, Nashville
Phone Conference ID: 443 567 238#
Find a local number | Reset PIN

The purpose of the conference is to discuss the RFP scope of goods or services. The State will entertain questions, however prospective Respondents must understand that the State's oral response to any question at the Pre-response Conference shall be unofficial and non-binding. Prospective Respondents must submit all questions, comments, or other concerns regarding the RFP in writing prior to the Written Questions & Comments Deadline date detailed in the RFP Section 2, Schedule of Events. The State will send the official response to these questions and comments to prospective Respondents from whom the State has received a Notice of Intent to Respond as indicated in RFP Section 1.8 and on the date detailed in the RFP Section 2, Schedule of Events.

1.8 Notice of Intent to Respond

Before the Notice of Intent to Respond Deadline detailed in the RFP Section 2, Schedule of Events, prospective Respondents should submit to the Solicitation Coordinator a Notice of Intent to Respond (in the form of a simple e-mail or other written communication). Such notice should include the following information:

- the business or individual's name (as appropriate);
- a contact person's name and title; and
- the contact person's mailing address, telephone number, facsimile number, and e-mail address.

A Notice of Intent to Respond creates no obligation and is not a prerequisite for submitting a response, however, it is necessary to ensure receipt of any RFP amendments or other notices and communications relating to this RFP.

1.9 Response Deadline

A Respondent must ensure that the State receives a response no later than the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events. The State will not accept late responses, and a Respondent's failure to submit a response before the deadline will result in disqualification of the response. It is the responsibility of the Respondent to ascertain any additional security requirements with respect to packaging and delivery to the State of Tennessee. Respondents should be mindful of any potential delays due to security screening procedures, weather, or other filing delays whether foreseeable or unforeseeable.

2 RFP SCHEDULE OF EVENTS

2.1 The following RFP Schedule of Events represents the State's best estimate for this RFP.

EVENT	TIME (central time zone)	DATE
1. RFP Issued		January 3, 2024
2. Disability Accommodation Request Deadline	2:00 p.m.	January 8, 2024
3. Pre-response Conference	2:00 p.m.	January 11, 2024
4. Notice of Intent to Respond Deadline	2:00 p.m.	January 12, 2024
5. Written "Questions & Comments" Deadline and Organizational Conflict of Interest Disclosure Deadline	2:00 p.m.	January 24, 2024
6. State Response to Written "Questions & Comments"		March 1, 2024
7. Response Deadline	2:00 p.m.	March 22, 2024
8. State Schedules Respondent Oral Presentation		April 1, 2024
9. Respondent Oral Presentation	8:00 a.m. – 4:30 p.m.	April 15-17, 2024
10. State Completion of Technical Response Evaluations		May 3, 2024
11. State Notice of Intent to Award Released and RFP Files Opened for Public Inspection		May 20, 2024
12. End of Open File Period		May 27, 2024
13. State sends contract to Contractor for signature		June 11, 2024
14. Contractor Signature Deadline		June 18, 2024

2.2 The State reserves the right, at its sole discretion, to adjust the RFP Schedule of Events as it deems necessary. Any adjustment of the Schedule of Events shall constitute an RFP amendment, and the State will communicate such to prospective Respondents from whom the State has received a Notice of Intent to Respond (refer to section 1.8, Notice of Intent to Respond).

3 RESPONSE REQUIREMENTS

3.1 Response Form

A response to this RFP must only consist of a Technical Response.

3.1.1 **Technical Response**. RFP Attachment 6.2., Technical Response & Evaluation Guide provides the specific requirements for submitting a response. This guide includes mandatory requirement items, general qualifications and experience items, and technical qualifications, experience, and approach items all of which must be addressed with a written response and, in some instances, additional documentation.

> **NOTICE: A technical response must not include any pricing or cost information. If any pricing or cost information amounts of any type (even pricing relating to other projects) is included in any part of the technical response, the state may deem the response to be non-responsive and reject it.**

3.1.1.1 A Respondent should duplicate and use the RFP Attachment 6.2., Technical Response & Evaluation Guide to organize, reference, and draft the Technical Response by duplicating the attachment, adding appropriate page numbers as required, and using the guide as a table of contents covering the Technical Response.

3.1.1.2 A response should be economically prepared, with emphasis on completeness and clarity and should NOT exceed the page limits allocated to each Technical Response & Evaluation Guide section in Attachment 6.2 (maps, graphs, charts, as noted and included as an appendix will not count against the page limit). A response, as well as any reference material presented, must be written in English and must be written on standard 8 ½" x 11" pages (although oversize exhibits are permissible) and all text must be at least a 12 point font. Smaller font is permitted for tables and graphics, as long as all tables and graphics remain legible and easily viewed. All response pages must be numbered.

3.1.1.3 All information and documentation included in a Technical Response should correspond to or address a specific requirement detailed in the RFP Attachment 6.2., Technical Response & Evaluation Guide. All information must be incorporated into a response to a specific requirement and clearly referenced. Any information not meeting these criteria will be deemed extraneous and will not contribute to evaluations.

3.1.1.4 .The State may determine a response to be non-responsive and reject it if:

a) the Respondent fails to organize and properly reference the Technical Response as required by this RFP and the RFP Attachment 6.2., Technical Response & Evaluation Guide; or

b) the Technical Response document does not appropriately respond to, address, or meet all of the requirements and response items detailed in the RFP Attachment 6.2., Technical Response & Evaluation Guide.

3.2 Response Delivery

3.2.1 A Respondent must ensure that the original Technical Response document meets all form and content requirements, including all required signatures, as detailed within this RFP, as may be amended.

3.2.2 A Respondent must submit original Technical Response document and copies as specified below.

3.2.2.1 Digital Media Submission

3.2.2.1.1 Technical Response

The Technical Response document should be in the form of one (1) digital document in "PDF" format properly recorded on its own otherwise blank USB flash drive and should be clearly identified as the:

"RFP # 31865-00636 TECHNICAL RESPONSE ORIGINAL"

and ONE (1) digital copies of the Technical Response and ONE (1) digital redacted copy

of the Technical Response in accordance with 3.1.1.4. each in the form of one (1) digital document in "PDF" format properly recorded on its own otherwise blank, USB flash drive labeled:

"RFP # 31865-00636 TECHNICAL RESPONSE COPY"

The customer references should be delivered by each reference in accordance with RFP Attachment 6.4. Reference Questionnaire.

3.2.2.2 E-mail Submission

3.2.2.2.1 Technical Response

The Technical Response document should be in the form of one (1) digital document in "PDF" format or other easily accessible digital format attached to an email to the Solicitation Coordinator. Both the subject and file name should both be clearly identified as follows:

"RFP # 31865-00636 TECHNICAL RESPONSE"

The customer references should be delivered by each reference in accordance with RFP Attachment 6.4. Reference Questionnaire.

3.2.3 For email submissions, the Technical Response document must be dispatched to the Solicitation Coordinator in **separate** e-mail messages. For paper and digital media submissions, a Respondent must separate, seal, package, and label the documents and copies for delivery as follows:

3.2.3.1 The Technical Response original document and digital copies must be placed in a sealed package that is clearly labeled:

"DO NOT OPEN… RFP # 31865-00636 TECHNICAL RESPONSE FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.2 The separately, sealed Technical Response components may be enclosed in a larger package for mailing or delivery, provided that the outermost package is clearly labeled:

"RFP # 31865-00636 SEALED TECHNICAL RESPONSE FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.3 Any Respondent wishing to submit a Response in a format other than digital may do so by contacting the Solicitation Coordinator.

3.2.4 A Respondent must ensure that the State receives a response no later than the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events at the following address:

Donovan Morgan
Division of TennCare
310 Great Circle Road, Nashville, TN 37228
(615) 741-0041
Donovan.Morgan2@tn.gov

3.3 Response & Respondent Prohibitions

3.3.1 A response must not include alternate contract terms and conditions. If a response contains such terms and conditions, the State, at its sole discretion, may determine the response to be a non-responsive counteroffer and reject it.

3.3.2 A response must not restrict the rights of the State or otherwise qualify either the offer to deliver goods or provide services as required by this RFP. If a response restricts the rights of the State or otherwise qualifies either the offer to deliver goods or provide services as required by this RFP or the Cost Proposal, the State, at its sole discretion, may determine the response to be a non-responsive counteroffer and reject it.

3.3.3 A response must not propose alternative goods or services (*i.e.*, offer services different from those requested and required by this RFP) unless expressly requested in this RFP. The State may consider a response of alternative goods or services to be non-responsive and reject it.

3.3.4 A Respondent must not provide, for consideration in this RFP process or subsequent contract negotiations, any information that the Respondent knew or should have known was materially incorrect. If the State determines that a Respondent has provided such incorrect information, the State will deem the Response non-responsive and reject it.

3.3.5 A Respondent must not submit more than one Technical Response in response to this RFP, except as expressly requested by the State in this RFP. If a Respondent submits more than one Technical Response, the State will deem all of the responses non-responsive and reject them.

3.3.6 A Respondent must not submit a response as a prime contractor while also permitting one or more other Respondents to offer the Respondent as a subcontractor in their own responses. Such may result in the disqualification of all Respondents knowingly involved. This restriction does not, however, prohibit different Respondents from offering the same subcontractor as a part of their responses (provided that the subcontractor does not also submit a response as a prime contractor).

3.3.7 The State shall not consider a response from an individual who is, or within the past six (6) months has been, a State employee. For purposes of this RFP:

3.3.7.1 An individual shall be deemed a State employee until such time as all compensation for salary, termination pay, and annual leave has been paid;

3.3.7.2 A contract with or a response from a company, corporation, or any other contracting entity in which a controlling interest is held by any State employee shall be considered to be a contract with or proposal from the employee; and

3.3.7.3 A contract with or a response from a company, corporation, or any other contracting entity that employs an individual who is, or within the past six (6) months has been, a State employee shall not be considered a contract with or a proposal from the employee and shall not constitute a prohibited conflict of interest.

3.3.8 This RFP is also subject to Tenn. Code Ann. § 12-4-101—105.

3.4 Response Errors & Revisions

A Respondent is responsible for any and all response errors or omissions. A Respondent will not be allowed to alter or revise response documents after the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events unless such is formally requested, in writing, by the State.

3.5 Response Withdrawal

A Respondent may withdraw a submitted response at any time before the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events by submitting a written request signed by an authorized Respondent representative. After withdrawing a response, a Respondent may submit another response at any time before the Response Deadline. After the Response Deadline, a Respondent may only withdraw all or a portion of a response where the enforcement of the response would impose an unconscionable hardship on the Respondent.

3.6 Additional Services

If a response offers goods or services in addition to those required by and described in this RFP, the State, at its sole discretion, may add such services to the contract awarded as a result of this RFP. Notwithstanding the foregoing, a Respondent must not propose any additional cost amounts or rates for additional goods or services.

NOTICE: If a Respondent fails to submit a Cost Proposal exactly as required, the State may deem the response non-responsive and reject it.

3.7 Response Preparation Costs

The State will not pay any costs associated with the preparation, submittal, or presentation of any response.

4 GENERAL CONTRACTING INFORMATION & REQUIREMENTS

4.1 RFP Amendment

The State at its sole discretion may amend this RFP, in writing, at any time prior to contract award. However, prior to any such amendment, the State will consider whether it would negatively impact the ability of potential Respondents to meet the response deadline and revise the RFP Schedule of Events if deemed appropriate. If an RFP amendment is issued, the State will convey it to potential Respondents who submitted a Notice of Intent to Respond (refer to RFP Section 1.8, Notice of Intent to Respond). A response must address the final RFP (including its attachments) as amended.

4.2 RFP Cancellation

The State reserves the right, at its sole discretion, to cancel the RFP or to cancel and reissue this RFP in accordance with applicable laws and regulations.

4.3 State Right of Rejection

4.3.1 Subject to applicable laws and regulations, the State reserves the right to reject, at its sole discretion, any and all responses.

4.3.2 The State may deem as non-responsive and reject any response that does not comply with all terms, conditions, and performance requirements of this RFP. Notwithstanding the foregoing, the State reserves the right to waive, at its sole discretion, minor variances from full compliance with this RFP. If the State waives variances in a response, such waiver shall not modify the RFP requirements or excuse the Respondent from full compliance, and the State may hold any resulting Contractor to strict compliance with this RFP.

4.4 Assignment & Subcontracting

4.4.1 The Contractor may not subcontract, transfer, or assign any portion of the Contract awarded as a result of this RFP without prior approval of the State. The State reserves the right to refuse approval, at its sole discretion, of any subcontract, transfer, or assignment.

4.4.2 If a Respondent intends to use subcontractors, the response to this RFP must specifically identify the scope and portions of the work each subcontractor will perform (refer to RFP Attachment 6.2., Section B, General Qualifications & Experience Item B.14.).

4.4.3 Subcontractors identified within a response to this RFP will be deemed as approved by the State unless the State expressly disapproves one or more of the proposed subcontractors prior to signing the Contract.

4.4.4 After contract award, a Contractor may only substitute an approved subcontractor at the discretion of the State and with the State's prior, written approval.

4.4.5 Notwithstanding any State approval relating to subcontracts, the Respondent who is awarded a contract pursuant to this RFP will be the prime contractor and will be responsible for all work under the Contract.

4.5 Right to Refuse Personnel or Subcontractors

The State reserves the right to refuse, at its sole discretion and notwithstanding any prior approval, any personnel of the prime contractor or a subcontractor providing goods or services in the performance of a contract resulting from this RFP. The State will document in writing the reason(s) for any rejection of personnel.

4.6 Insurance

The State will require the awarded Contractor to provide a Certificate of Insurance issued by an insurance company licensed or authorized to provide insurance in the State of Tennessee. Each Certificate of Insurance shall indicate current insurance coverages meeting minimum requirements as may be specified by this RFP. A failure to provide a current, Certificate of Insurance will be considered a material breach and

grounds for contract termination.

4.7 Professional Licensure and Department of Revenue Registration

4.7.1 All persons, agencies, firms, or other entities that provide legal or financial opinions, which a Respondent provides for consideration and evaluation by the State as a part of a response to this RFP, shall be properly licensed to render such opinions.

4.7.2 Before the Contract resulting from this RFP is signed, the apparent successful Respondent (and Respondent employees and subcontractors, as applicable) must hold all necessary or appropriate business or professional licenses to provide the goods or services as required by the contract. The State may require any Respondent to submit evidence of proper licensure.

4.7.3 Before the Contract resulting from this RFP is signed, the apparent successful Respondent must be registered with the Tennessee Department of Revenue for the collection of Tennessee sales and use tax. The State shall not award a contract unless the Respondent provides proof of such registration or provides documentation from the Department of Revenue that the Contractor is exempt from this registration requirement. The foregoing is a mandatory requirement of an award of a contract pursuant to this solicitation. To register, please visit the Department of Revenue's Tennessee Taxpayer Access Point (TNTAP) website for Online Registration and the Vendor Contract Questionnaire. These resources are available at the following: https://tntap.tn.gov/eservices/_/#1

4.8 Disclosure of Response Contents

4.8.1 All materials submitted to the State in response to this RFP shall become the property of the State of Tennessee. Selection or rejection of a response does not affect this right. By submitting a response, a Respondent acknowledges and accepts that the full response contents and associated documents will become open to public inspection in accordance with the laws of the State of Tennessee.

4.8.2 The State will hold all response information, including both technical and cost information, in confidence during the evaluation process.

4.8.3 Upon completion of response evaluations, indicated by public release of a Notice of Intent to Award, the responses and associated materials will be open for review by the public in accordance with Tenn. Code Ann. § 10-7-504(a)(7).

4.9 Contract Approval and Contract Payments

4.9.1 After contract award, the Contractor who is awarded the contract must submit appropriate documentation with the Department of Finance and Administration, Division of Accounts.

4.9.2 This RFP and its contractor selection processes do not obligate the State and do not create rights, interests, or claims of entitlement in either the Respondent with the apparent best-evaluated response or any other Respondent. State obligations pursuant to a contract award shall commence only after the Contract is signed by the State agency head and the Contractor and after the Contract is approved by all other state officials as required by applicable laws and regulations.

4.9.3 No payment will be obligated or made until the relevant Contract is approved as required by applicable statutes and rules of the State of Tennessee.

4.9.3.1 The State shall not be liable for payment of any type associated with the Contract resulting from this RFP (or any amendment thereof) or responsible for any goods delivered or services rendered by the Contractor, even goods delivered or services rendered in good faith and even if the Contractor is orally directed to proceed with the delivery of goods or the rendering of services, if it occurs before the Contract Effective Date or after the Contract Term.

4.9.3.2 All payments relating to this procurement will be made in accordance with the Payment Terms and Conditions of the Contract resulting from this RFP (refer to RFP Attachment 6.6., *Pro Forma* Contract, Section C).

4.9.3.3 If any provision of the Contract provides direct funding or reimbursement for the competitive purchase of goods or services as a component of contract performance or otherwise provides for the reimbursement of specified, actual costs, the State will employ all reasonable means

and will require all such documentation that it deems necessary to ensure that such purchases were competitive and costs were reasonable, necessary, and actual. The Contractor shall provide reasonable assistance and access related to such review. Further, the State shall not remit, as funding or reimbursement pursuant to such provisions, any amounts that it determines do not represent reasonable, necessary, and actual costs.

4.10 Contractor Performance

The Contractor who is awarded a contract will be responsible for the delivery of all acceptable goods or the satisfactory completion of all services set out in this RFP (including attachments) as may be amended. All goods or services are subject to inspection and evaluation by the State. The State will employ all reasonable means to ensure that goods delivered or services rendered are in compliance with the Contract, and the Contractor must cooperate with such efforts.

4.11 Contract Amendment

After Contract award, the State may request the Contractor to deliver additional goods or perform additional services within the general scope of the Contract and this RFP, but beyond the specified Scope, and for which the Contractor may be compensated. In such instances, the State will provide the Contractor a written description of the additional goods or services. The Contractor must respond to the State with a time schedule for delivering the additional goods or accomplishing the additional services based on the compensable units included in the Contractor's response to this RFP. If the State and the Contractor reach an agreement regarding the goods or services and associated compensation, such agreement must be effected by means of a contract amendment. Further, any such amendment requiring additional goods or services must be signed by both the State agency head and the Contractor and must be approved by other state officials as required by applicable statutes, rules, policies and procedures of the State of Tennessee. The Contractor must not provide additional goods or render additional services until the State has issued a written contract amendment with all required approvals.

4.12 Severability

If any provision of this RFP is declared by a court to be illegal or in conflict with any law, said decision will not affect the validity of the remaining RFP terms and provisions, and the rights and obligations of the State and Respondents will be construed and enforced as if the RFP did not contain the particular provision held to be invalid.

4.13 Next Ranked Respondent

The State reserves the right to initiate negotiations with the next ranked Respondent should the State cease doing business with any Respondent selected via this RFP process.

5 EVALUATION & CONTRACT AWARD

5.1 Evaluation Categories & Maximum Points

The State will consider qualifications, experience, technical approach in the evaluation of responses and award points in each of the categories detailed below (up to the maximum evaluation points indicated) to each response deemed by the State to be responsive.

EVALUATION CATEGORY	MAXIMUM POINTS POSSIBLE
General Qualifications & Experience (refer to RFP Attachment 6.2., Section B)	**20**
Technical Qualifications, Experience & Approach (refer to RFP Attachment 6.2., Section C)	**80**

5.2 Evaluation Process

The evaluation process is designed to award the contract resulting from this RFP not necessarily to the Respondent offering the lowest cost, but rather to the Respondent deemed by the State to be responsive and responsible who offers the best combination of attributes based upon the evaluation criteria. ("Responsive Respondent" is defined as a Respondent that has submitted a response that conforms in all material respects to the RFP. "Responsible Respondent" is defined as a Respondent that has the capacity in all respects to perform fully the contract requirements, and the integrity and reliability which will assure good faith performance.)

5.2.1 **Technical Response Evaluation.** The Solicitation Coordinator and the Proposal Evaluation Team (consisting of three (3) or more State employees) will use the RFP Attachment 6.2., Technical Response & Evaluation Guide to manage the Technical Response Evaluation and maintain evaluation records.

5.2.1.1 The State reserves the right, at its sole discretion, to request Respondent clarification of a Technical Response or to conduct clarification discussions with any or all Respondents. Any such clarification or discussion will be limited to specific sections of the response identified by the State. The subject Respondent must put any resulting clarification in writing as may be required and in accordance with any deadline imposed by the State.

5.2.1.2 The Solicitation Coordinator will review each Technical Response to determine compliance with RFP Attachment 6.2., Technical Response & Evaluation Guide, Section A – Mandatory Requirements. If the Solicitation Coordinator determines that a response failed to meet one or more of the mandatory requirements, the Proposal Evaluation Team will review the response and document the team's determination of whether:

a) the response adequately meets RFP requirements for further evaluation;

b) the State will request clarifications or corrections for consideration prior to further evaluation; or,

c) the State will determine the response to be non-responsive to the RFP and reject it.

5.2.1.3 Proposal Evaluation Team members will independently evaluate each Technical Response (that is responsive to the RFP) against the evaluation criteria in this RFP, and will score each in accordance with the RFP Attachment 6.2., Technical Response & Evaluation Guide.

5.2.1.4 For each response evaluated, the Solicitation Coordinator will calculate the average of the Proposal Evaluation Team member scores for RFP Attachment 6.2., Technical Response & Evaluation Guide, and record each average as the response score for the respective Technical Response section.

5.2.1.5 The Solicitation Coordinator will invite each Respondent, who is apparently responsive and responsible, to make an Oral Presentation.

5.2.1.5.1 The Oral Presentations are mandatory. The Solicitation Coordinator will schedule Respondent Presentation during the period indicated by the RFP Section 2, Schedule of Events. The Solicitation Coordinator will make every effort to accommodate each Respondent's schedules.

When the Respondent Presentations schedule has been determined, the Solicitation Coordinator will contact Respondents with the relevant information as indicated by RFP Section 2, Schedule of Events.

5.2.1.5.2 Respondent Presentations are only open to the invited Respondent, Proposal Evaluation Team members, the Solicitation Coordinator, and any technical consultants who are selected by the State to provide assistance to the Proposal Evaluation Team.

5.2.1.5.3 Oral Presentations provide an opportunity for Respondents to explain and clarify their responses and for the State to test to better understand the practical application of the good or service as applicable. Respondents must not materially alter their responses and Presentations will be limited to addressing the items detailed in RFP Attachment 6.2., Technical Response & Evaluation Guide. Respondent pricing shall not be discussed during Oral Presentations. Evaluators may adjust Respondents' Technical Response scores based on Oral Presentations.

5.2.1.5.4 The State will maintain an accurate record of each Respondent's Oral Presentations session. The record of the Respondent's Oral Presentations shall be available for review when the State opens the procurement files for public inspection.

5.2.1.6 In the event a Proposal Evaluation Team member(s) is predetermined by TennCare as a partial Evaluation Team Member(s) to only evaluate specific RFP Attachment 6.2 Section C – Technical Qualifications, Experience, & Approach response items, RFP Attachment 6.5., Score Summary Matrix will be adjusted to appropriately weigh scoring for partial Evaluation Team Member(s) to support the competitive award process.

5.2.1.7 The Proposal Evaluation Team will review the Technical Response Evaluation record and any other available information pertinent to whether or not each Respondent is responsive and responsible. If the Proposal Evaluation Team identifies any Respondent that does <u>not</u> meet the responsive and responsible thresholds such that the team would <u>not</u> recommend the Respondent for potential contract award, the team members will fully document the determination.

5.2.2 **Clarifications and Negotiations:** The State reserves the right to award a contract on the basis of initial responses received, therefore, each response shall contain the Respondent's best terms and conditions from a technical standpoint. The State reserves the right to conduct clarifications or negotiations with one or more Respondents. All communications, clarifications, and negotiations shall be conducted in a manner that supports fairness in response improvement.

5.2.2.1 <u>Clarifications</u>: The State may identify areas of a response that may require further clarification or areas in which it is apparent that there may have been miscommunications or misunderstandings as to the State's specifications or requirements. The State may seek to clarify those issues identified during one or multiple clarification rounds. Each clarification sought by the State may be unique to an individual Respondent, provided that the process is conducted in a manner that supports fairness in response improvement.

5.2.2.2 <u>Negotiations</u>: The State may elect to negotiate with one or more Respondents by requesting revised responses or finalizing contract terms and conditions. The State reserves the right to conduct multiple negotiation rounds or no negotiations at all.

5.2.2.3 If the State determines that it is unable to successfully negotiate terms and conditions of a contract with the apparent best evaluated Respondent, the State reserves the right to bypass the apparent best evaluated Respondent and enter into terms and conditions contract negotiations with the next apparent best evaluated Respondent.

5.2.3 **Total Response Score.** The Solicitation Coordinator will calculate the sum of the Technical Response section scores and record the resulting number as the total score for the subject Response (refer to RFP Attachment 6.5., Score Summary Matrix).

5.3 Contract Award Process

5.3.1. The Solicitation Coordinator will submit the Proposal Evaluation Team determinations and scores to the head of the procuring agency for consideration along with any other relevant information that might be available and pertinent to the contract award.

5.3.2. The procuring agency head will determine the apparent best-evaluated Response. To effect a contract award to a Respondent other than the one receiving the highest evaluation process score, the head of the procuring agency must provide written justification and obtain the written approval of the Chief Procurement Officer and the Comptroller of the Treasury.

5.3.3. The State will issue a Notice of Intent to Award identifying the apparent best-evaluated response and make the RFP files available for public inspection at the time and date specified in the RFP Section 2, Schedule of Events.

NOTICE: The Notice of Intent to Award shall not create rights, interests, or claims of entitlement in either the apparent best-evaluated Respondent or any other Respondent.

5.3.4. The Respondent identified as offering the apparent best-evaluated response must sign a contract drawn by the State pursuant to this RFP. The Contract shall be substantially the same as the RFP Attachment 6.6., *Pro Forma* Contract. The Respondent must sign the contract by the Contractor Signature Deadline detailed in the RFP Section 2, Schedule of Events. If the Respondent fails to provide the signed Contract by this deadline, the State may determine that the Respondent is non-responsive to this RFP and reject the response.

5.3.5. Notwithstanding the foregoing, the State may, at its sole discretion, entertain limited negotiations prior to contract signing and, as a result, revise the *pro forma* contract terms and conditions or performance requirements in the State's best interests, PROVIDED THAT such revision of terms and conditions or performance requirements shall NOT materially affect the basis of response evaluations or negatively impact the competitive nature of the RFP and contractor selection process.

RFP Attachment 6.1.

RFP # 31865-00636 STATEMENT OF CERTIFICATIONS AND ASSURANCES

The Respondent must sign and complete the Statement of Certifications and Assurances below as required, and it must be included in the Technical Response (as required by RFP Attachment 6.2., Technical Response & Evaluation Guide, Section A, Item A.1.).

The Respondent does, hereby, expressly affirm, declare, confirm, certify, and assure ALL of the following:

1. The Respondent will comply with all of the provisions and requirements of the RFP.
2. The Respondent will provide all services as defined in the Scope of the RFP Attachment 6.6., *Pro Forma* Contract for the total Contract Term.
3. The Respondent, except as otherwise provided in this RFP, accepts and agrees to all terms and conditions set out in the RFP Attachment 6.6., *Pro Forma* Contract.
4. The Respondent acknowledges and agrees that a contract resulting from the RFP shall incorporate, by reference, all proposal responses as a part of the Contract.
5. The Respondent will comply with:
   (a) the laws of the State of Tennessee;
   (b) Title VI of the federal Civil Rights Act of 1964;
   (c) Title IX of the federal Education Amendments Act of 1972;
   (d) the Equal Employment Opportunity Act and the regulations issued there under by the federal government; and,
   (e) the Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government.
6. To the knowledge of the undersigned, the information detailed within the response submitted to this RFP is accurate.
7. The response submitted to this RFP was independently prepared, without collusion, under penalty of perjury.
8. 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, subcontractor, or consultant to the Respondent in connection with this RFP or any resulting contract.
9. Both the Technical Response and the Cost Proposal submitted in response to this RFP shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract pursuant to the RFP.
10. The Respondent affirms the following statement, as required by the Iran Divestment Act Tenn. Code Ann. § 12-12-111: “By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of its knowledge and belief that each bidder is not on the list created pursuant to §12-12-106.” For reference purposes, the list is currently available online at: https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/library-/public-information-library.html.

By signing this Statement of Certifications and Assurances, below, the signatory also certifies legal authority to bind the proposing entity to the provisions of this RFP and any contract awarded pursuant to it. If the signatory is not the Respondent (if an individual) or the Respondent’s company *President* or *Chief Executive Officer*, this document must attach evidence showing the individual’s authority to bind the Respondent.

DO NOT SIGN THIS DOCUMENT IF YOU ARE NOT LEGALLY AUTHORIZED TO BIND THE RESPONDENT

SIGNATURE: ____________________

PRINTED NAME & TITLE: ____________________

DATE: ____________________

RESPONDENT LEGAL ENTITY NAME: ____________________

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION A: MANDATORY REQUIREMENTS. The Respondent must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below. The Respondent should NOT exceed 15 pages in addressing items detailed below in Section A – Mandatory Requirement Items. The table of contents shall be excluded from the page limit.

The Solicitation Coordinator will review the response to determine if the Mandatory Requirement Items are addressed as required and mark each with pass or fail. For each item that is not addressed as required, the Proposal Evaluation Team must review the response and attach a written determination. In addition to the Mandatory Requirement Items, the Solicitation Coordinator will review each response for compliance with all RFP requirements.

RESPONDENT LEGAL ENTITY NAME:			
Response Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
		The Response must be delivered to the State no later than the Response Deadline specified in the RFP Section 2, Schedule of Events.	
		The Technical Response must be packaged separately as required (refer to RFP Section 3.2., et. seq.).	
		The Technical Response must NOT contain cost or pricing information of any type.	
		The Technical Response must NOT contain any restrictions of the rights of the State or other qualification of the response.	
		A Respondent must NOT submit alternate responses (refer to RFP Section 3.3.).	
		A Respondent must NOT submit multiple responses in different forms (as a prime and a subcontractor) (refer to RFP Section 3.3.).	
	A.1.	Provide the Statement of Certifications and Assurances (RFP Attachment 6.1.) completed and signed by an individual empowered to bind the Respondent to the provisions of this RFP and any resulting contract. The document must be signed without exception or qualification.	
	A.2.	Provide a statement, based upon reasonable inquiry, of whether the Respondent or any individual or subcontractor who shall cause to deliver goods or perform services under the contract has a possible conflict of interest (*e.g.*, employment by the State of Tennessee) and, if so, the nature of that conflict. This shall be inclusive of any proposed subcontractor(s) that hold current effective Contracts with the State of Tennessee. NOTE: Any questions of conflict of interest shall be solely within the discretion of the State, and the State reserves the right to cancel any award.	
	A.3.	Provide a current bank reference unequivocally indicating the current standing of the Respondent's business relationship with the financial institution. Such reference must be written in the form of a standard business letter, signed, and dated within the past three (3) months.	

RFP ATTACHMENT 6.2. — SECTION A (continued)

RESPONDENT LEGAL ENTITY NAME:			
Response Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
	A.4.	Provide an official document or letter indicating the Respondent's financial standing. Respondent's may submit one of the following four options: 1. Provide an official document or letter from an accredited credit bureau, verified and dated within the last three (3) months and indicating a satisfactory credit score for the Respondent (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive). 2. Provide documentation disclosing the amount of cash flows from operating activities for the Respondent's most current operating period. Said documentation must indicate whether the cash flows are positive or negative, and, if the cash flows are negative for the most recent operating period, the documentation must include a detailed explanation of the factors contributing to the negative cash flows. 3. Provide a consolidated current financial statement for the parent company of Respondent, if applicable. 4. Provide a financial guaranty from the parent company, if applicable.	
	A.5.	Provide an official document or letter from an accredited credit bureau, verified and dated within the last three (3) months and indicating a satisfactory credit rating for the Respondent (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive.)	
	A.6.	Provide written attestation that the Respondent does 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 and/or Medicaid programs pursuant to Sections 1128 of the Social Security Act.	
State Use – Solicitation Coordinator Signature, Printed Name & Date:			

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION B: GENERAL QUALIFICATIONS & EXPERIENCE. The Respondent must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below. Proposal Evaluation Team members will independently evaluate and assign one score for all responses to Section B – General Qualifications & Experience Items. The Respondent should NOT exceed 35 pages in addressing items detailed below in Section B – General Qualifications & Experience Items. The table of contents and resumes shall be excluded from the page limit.

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
	B.1.	Detail the name, e-mail address, mailing address, telephone number, and facsimile number, if applicable, of the person the State should contact regarding the response.
	B.2.	Describe the Respondent's form of business (*i.e.*, individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and business location (physical location or domicile).
	B.3.	Detail the number of years the Respondent has been in business.
	B.4.	Briefly describe how long the Respondent has been providing the goods or services required by this RFP.
	B.5.	Describe the Respondent's number of employees, client base, and location of offices.
	B.6.	Provide a statement of whether there have been any mergers, acquisitions, or change of control of the Respondent within the last ten (10) years. If so, include an explanation providing relevant details.
	B.7.	Provide a statement of whether the Respondent or, to the Respondent's knowledge, any of the Respondent's employees, agents, independent contractors, or subcontractors, involved in the delivery of goods or performance of services on a contract pursuant to this RFP, have been convicted of, pled guilty to, or pled *nolo contendere* to any felony. If so, include an explanation providing relevant details.
	B.8.	Provide a statement of whether, in the last ten (10) years, the Respondent has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, include an explanation providing relevant details.
	B.9.	Provide a statement of whether there is any material, pending litigation against the Respondent that the Respondent should reasonably believe could adversely affect its ability to meet contract requirements pursuant to this RFP or is likely to have a material adverse effect on the Respondent's financial condition. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it would impair the Respondent's performance in a contract pursuant to this RFP. NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Respondent must be properly licensed to render such opinions. The State may require the Respondent to submit proof of license for each person or entity that renders such opinions.
	B.10.	Provide a statement of whether there are any pending or in progress Securities Exchange Commission investigations involving the Respondent. If such exists, list each separately, explain

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		the relevant details, and attach the opinion of counsel addressing whether and to what extent it will impair the Respondent's performance in a contract pursuant to this RFP. NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Respondent must be properly licensed to render such opinions. The State may require the Respondent to submit proof of license for each person or entity that renders such opinions.
	B.11.	Provide a brief, descriptive statement detailing evidence of the Respondent's ability to deliver the goods or services sought under this RFP (*e.g.*, prior experience, training, certifications, resources, program and quality management systems, *etc*.).
	B.12.	Provide a narrative description of the proposed project team, its members, and organizational structure along with an organizational chart identifying the key people who will be assigned to deliver the goods or services required by this RFP.
	B.13.	Provide a personnel roster listing the names of key people who the Respondent will assign to meet the Respondent's requirements under this RFP along with the estimated number of hours that each individual will devote to that performance. Follow the personnel roster with a resume for each of the people listed. The resumes must detail the individual's title, education, current position with the Respondent, and employment history.
	B.14.	Provide a statement of whether the Respondent intends to use subcontractors to meet the Respondent's requirements of any contract awarded pursuant to this RFP, and if so, detail: (a) the names of the subcontractors along with the contact person, mailing address, telephone number, and e-mail address for each; (b) a description of the scope and portions of the goods, each subcontractor involved in the delivery of goods or performance of the services each subcontractor will perform; <u>and</u> (c) a statement specifying that each proposed subcontractor has expressly assented to being proposed as a subcontractor in the Respondent's response to this RFP.
	B.15.	Provide documentation of the Respondent's commitment to diversity as represented by the following: (a) <u>Business Strategy</u>. Provide a description of the Respondent's existing programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please also include a list of the Respondent's certifications as a diversity business, if applicable. (b) <u>Business Relationships</u>. Provide a listing of the Respondent's current contracts with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please include the following information: (i) contract description; (ii) contractor name and ownership characteristics (*i.e.*, ethnicity, gender, service-disabled veteran-owned or persons with disabilities); (iii) contractor contact name and telephone number. (c) <u>Estimated Participation</u>. Provide an estimated level of participation by business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises if a contract is awarded to the Respondent pursuant to this RFP. Please include the following information: (i) a percentage (%) indicating the participation estimate. (Express the estimated participation number as a percentage of the total estimated contract value that will be

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		dedicated to business with subcontractors and supply contractors having such ownership characteristics only and **DO <u>NOT</u> INCLUDE DOLLAR AMOUNTS**); (ii) anticipated goods or services contract descriptions; (iii) names and ownership characteristics (i.e., ethnicity, gender, service-disabled veterans, or disability) of anticipated subcontractors and supply contractors. NOTE: In order to claim status as a Diversity Business Enterprise under this contract, businesses must be certified by the Governor's Office of Diversity Business Enterprise (Go-DBE). Please visit the Go-DBE website at https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810 for more information. (d) <u>Workforce</u>. Provide the percentage of the Respondent's total current employees by ethnicity and gender. NOTE: Respondents that demonstrate a commitment to diversity will advance State efforts to expand opportunity to do business with the State as contractors and subcontractors. Response evaluations will recognize the positive qualifications and experience of a Respondent that does business with enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises and who offer a diverse workforce.
	B.16.	Provide a statement of whether or not the Respondent, including any proposed subcontractors, has any current contracts with the State of Tennessee or has completed any contracts with the State of Tennessee within the previous five (5) year period. If so, provide the following information for all of the current and completed contracts: (a) the name, title, telephone number and e-mail address of the State contact knowledgeable about the contract; (b) the procuring State agency name; (c) a brief description of the contract's scope of services; (d) the contract period; and (e) the contract number.
	B.17.	Provide customer references from individuals who are not current or former State employees for projects similar to the goods or services sought under this RFP and which represent: • two (2) accounts Respondent currently services that are similar in size to the State; and • three (3) completed projects. References from at least three (3) different individuals are required to satisfy the requirements above, e.g., an individual may provide a reference about a completed project and another reference about a currently serviced account. The standard reference questionnaire, which must be used and completed, is provided at RFP Attachment 6.4. References that are not completed as required may be deemed non-responsive and may not be considered. The Respondent will be solely responsible for obtaining fully completed reference questionnaires and including them in the sealed Technical Response. In order to obtain and submit the completed reference questionnaires follow the process below. (a) Add the Respondent's name to the standard reference questionnaire at RFP Attachment 6.4. and make a copy for each reference.

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		(b) Send a reference questionnaire and new, standard #10 envelope to each reference. (c) Instruct the reference to: (i) complete the reference questionnaire; (ii) sign and date the completed reference questionnaire; (iii) seal the completed, signed, and dated reference questionnaire within the envelope provided; (iv) sign his or her name in ink across the sealed portion of the envelope; and (v) return the sealed envelope directly to the Respondent (the Respondent may wish to give each reference a deadline, such that the Respondent will be able to collect all required references in time to include them within the sealed Technical Response). (d) Do NOT open the sealed references upon receipt. (e) Enclose all sealed reference envelopes within a larger, labeled envelope for inclusion in the Technical Response as required. NOTES: • The State will not accept late references or references submitted by any means other than that which is described above, and each reference questionnaire submitted must be completed as required. • The State will not review more than the number of required references indicated above. • While the State will base its reference check on the contents of the sealed reference envelopes included in the Technical Response package, the State reserves the right to confirm and clarify information detailed in the completed reference questionnaires, and may consider clarification responses in the evaluation of references. • The State is under no obligation to clarify any reference information.
	B.18.	Provide a statement and any relevant details addressing whether the Respondent is any of the following: (a) has within the past five (5) years been debarred, suspended, had regulatory action, sanction, proposal for debarment, or voluntarily excluded from covered transactions by any federal or state department or agency, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity. If so, identify and describe any letter of deficiency and/or any overview of findings issued by, as well as any corrective actions requested or required by, any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts; (b) has within the past three (3) years, been convicted of, indicted, criminally or civilly charged, or had a civil judgment rendered against the contracting party, including parent or subsidiary company, from commission of fraud (Medicaid- or Non-Medicaid-related), or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (c) is presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed above in (a) or

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		(b), Medicaid- or Non-Medicaid-related, including a parent or subsidiary company; and has within a three (3) year period preceding the contract had one or more public transactions (federal, state, or local) terminated for cause or default; and (d) has within a three (3) year period preceding the contract had one or more public transactions (federal, state, or local) terminated for cause or default.
	B.19.	Respondent shall describe how its background and experience will enable it to comply with the applicable federal and state civil rights laws. These laws prohibit discrimination based on a person's race, color, national origin, sex, age, religious, disability, or other status protected under federal and state laws. For example, describe Respondent's ability to ensure that network providers provide physical access, reasonable accommodations, and accessible equipment to TennCare members with physical or mental disabilities and provide language and communication assistance services to individuals who do not speak English or to individuals with disabilities.
SCORE ***(for <u>all</u> Section B—Qualifications & Experience Items above)*****:** *(maximum possible score =* ***20****)*		
State Use – Evaluator Identification:		

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH. The Respondent must address all items (below) and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below. Please Limit Response to Items in Section C to No More than Seventy-Five (75) Pages (excluding attachments)

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the response to each item. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The Solicitation Coordinator will multiply the Item Score by the associated Evaluation Factor (indicating the relative emphasis of the item in the overall evaluation). The resulting product will be the item's Raw Weighted Score for purposes of calculating the section score as indicated.

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
	C.1.	Describe the process whereby the Respondent will assure a seamless transition of the dental benefit. Include a project readiness plan and timeline that details the steps that will be taken from the contract signing date to the Go-Live date that will ensure the Respondent will be prepared to assume all responsibilities of the four (4) State DBM programs as described in the RFP scope of services. In developing your response Respondent should answer the following questions: (a) What are the key elements that are critical in developing your readiness and implementation plan? (b) List all critical documents that are required for the proforma contract and the anticipated completion date of such documents for review by TennCare (c) What detailed activities and work must be performed? (d) How often does Respondent anticipate meetings between it's transition team and TennCare? (e) How will Respondent track and depict completion of milestones and activities that must be performed as measured in units of days? (f) What is Respondent's anticipated completion date for hiring key staff for this proforma contract? (g) How often does Respondent anticipate updating the transition plan?		**15**	
	C.2.	Provide a detailed narrative that explains how the Respondent plans on building and maintaining an adequate dental provider network for each of the four (4) separate State DBM programs prior to the Go-Live date of July 1, 2025. What is Respondent's strategy for building a compliant network? How will Respondent build the networks in metropolitan counties versus rural counties? TennCare plans to provide utilization review data on providers currently participating in TennCare to the Health Plan/ DBM that is awarded the contract. How does Respondent plan to use that data in developing networks considering that Respondent are at full risk and that the DBM must ensure that members receive high quality, cost-effective dental care? Additionally, provide Respondent's strategy for ensuring that Respondent have compliant dental specialty networks with special consideration given to endodontists and specialists who historically may be reluctant to participate in a Medicaid program..		**15**	
	C.3.	Describe what steps the Respondent must take to comply with TennCare's benefit authorization and Enrollee Appeal processes in each of the following scenarios:		**9**	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		(a) When a contracted and treating dental provider has submitted a request for authorization of a procedure with sufficient documentation that meets written clinical criteria required for the DBM to determine medical necessity (b) When a contracted and treating dental provider has submitted an authorization request where insufficient information is available for the DBM to render a Medical Necessity (MN) determination, (c) When the DBM renders an adverse benefit determination. (d) When an enrollee files an appeal contesting a DBM-proposed adverse benefit determination and requests expedited resolution., (e) When an enrollee files an appeal contesting a DBM-proposed adverse benefit determination. (f) When contracted dental providers submit an excessive number of inappropriate appeals on behalf of their patient /enrollee, and the evidence suggests that greater than 90% of their previous appeals for the requested service are not overturned at fair hearing. (g) How does Respondent plan to make contracted providers aware of the benefit authorization and enrollee appeals processes?			
	C.4.	Describe in detail the Respondent's approach and processes for addressing provider fraud, waste, and abuse. Include: (a) Strategy and capability for identifying, investigating, and referring suspected cases of provider fraud and abuse including staffing and expertise necessary to effectively manage the considerable case load. (b) Capability for preventing and controlling provider fraud and abuse including: o a detailed explanation of the types of strategies, including utilization of new technologies Respondent will employ for combating existing types of fraud or abuse, as well as novel cases as they are encountered. o A detailed explanation of how Respondent will implement credible allegation of fraud suspensions. (c) For non-prior authorized dental procedures, the strategy for identifying and determining which participating providers are abusing the TennCare program by rendering and receiving reimbursement for dental services that are not medically necessary based upon TennCare rules and medical necessity guidelines provided in the Provider Office Reference Manual (d) Measures Respondent will employ and how Respondent will employ them for dealing with those providers identified in items a. through c. (above) to safeguard children, improve quality of care, and help maintain fiscal viability of the program.		**8**	
	C.5.	What is the Respondent's strategy for building a Patient Centered Dental Home (PCDH) in accordance with the requirements of the pro forma contract and TennCare's mission to maintain an exemplary system of high-quality healthcare for eligible Tennesseans within a sustainable and predictable budget. In developing your response, Respondent should answer the following questions: (a) How will Respondent use the PCDH to better engage members in order to improve quality of care?		**12**	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		(b) What metrics will Respondent develop in order to determine provider performance and evaluate effectiveness of the PCDH initiative and how will Respondent communicate this to providers? (c) How will Respondent use the PCDH in order to increase utilization of preventative services (Sealants and Topical Fluorides) as well as minimally invasive services like Silver Diamine Fluoride (SDF)? (d) How will Respondent use provider incentives as part of its PCDH strategy to improve oral health outcomes for TennCare members? (e) How will Respondent utilize the PCDH strategy to ensure low performing providers are remediated and members are reassigned to higher performing providers? (f) What other quality initiatives would Respondent implement, in order to improve oral health outcomes for members?			
	C.6.	What is the Respondent's strategy for meeting the requirements in the RFP specific to the implementation and operation of adult dental benefits under the TennCare ECF CHOICES and 1915(c) DBM Program? Please also provide a timeline of activities to address this need In developing your response, Respondent should answer the questions below. Please do not reiterate contract language requirements, but rather, explain how Respondent proposes implementing them: (a) How does Respondent plan to develop and sustain a network of providers that primarily treats the IDD population? (b) How does Respondent plan to collaborate with TennCare, DIDD, and the MCOs in coordinating dental benefits for these populations? Specifically, how will Respondent deal with requests for services that might be covered under either the adult dental program or the ECF CHOICES benefit. (c) How does Respondent plan to find staff that meet the contract qualifications, including the DBM-IDD Dental Director and IDD DBM-MCO Coordinator, with expertise in providing care for these populations? (d) How does Respondent plan to address known barriers to care for the IDD population?		8	
	C.7.	Provide a narrative describing how the Respondent would meet requirements in the RFP specific to the implementation and operation of the data exchange for TennCare eligibility and enrollment. Specifically, the Respondent must provide details regarding the following requirements: (a) No less than 60 days prior to the TennCare Programs Go-Live, as defined in Pro Forma Contract Sections A.4.1.1.1. and A.4.2.1.3., the Contractor must be prepared to receive and load a mass 834 file for the base TennCare member population with future eligibility begin dates, as required in Pro Forma Contract Section A.4.2.1.3. (b) 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, as required in Pro Forma Contract Section A.4.2.1.3.		8	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		(c) On and after the TennCare Programs Go-Live, the Contractor must be prepared to receive and load daily 834 files which will include new members whose eligibility begin dates could be prior to the TennCare Programs Go-Live date.			
	C.8.	What is the Respondent's strategy for meeting requirements in the RFP specific to the implementation and operation of encounter submissions to TennCare? Specifically, no less than 30 days prior to the TennCare Programs Go-Live date, the Contractor must be prepared to submit HIPAA compliant X12 837D encounter files to TennCare. TennCare will provide a detailed external test plan to the successful bidder during the implementation phase which will outline the planned timeline for 837D encounter testing with TennCare.		**8**	
	C.9.	What is the Respondent's strategy for collaboration with MCOs in order to coordinate care for members to ensure that enrollees receive covered services found to be medically necessary? In developing your response, Respondent should answer the following questions: (a) What steps would the DBM need to take to ensure that pediatric dentists with privileges at PAR MCO medical facilities have adequate OR time necessary to provide care for members who require treatment in such facilities? (b) How would the DBM coordinate with the MCO in resolving a pediatric dentist's inability to secure a time slot in a medical facility? (c) How would a DBM coordinate with the MCO in connecting an enrollee with appropriate resources when an enrollee is identified, during a routine dental visit as someone experiencing hardships in regard to food, housing, transportation, etc.? (d) How would a DBM collaborate with the MCO in coordinating mobile sedation in contracted dental offices?		**8**	
	C.10.	What is the Respondent's strategy for creatively outreaching and engaging members using existing and new technologies? In developing your response, Respondent should answer the following questions: (a) How will Respondent apply these technologies to encourage members to increase their utilization of dental benefits? (b) How will Respondent use these technologies to emphasize the importance of preventive dental services? (c) How will the DBM measure and evaluate the effectiveness of their member outreach initiatives? For example, did the member outreach result in a greater number of members making dental appointments versus those who did not receive such outreach		**9**	
The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.			**Total Raw Weighted Score:** *(sum of Raw Weighted Scores above)*		
Total Raw Weighted Score					

<table>
<tr><td colspan="3">RESPONDENT LEGAL ENTITY NAME:</td><td colspan="4"></td></tr>
<tr><th>Response Page # (Respondent completes)</th><th>Item Ref.</th><th colspan="2">Section C— Technical Qualifications, Experience & Approach Items</th><th>Item Score</th><th>Evaluation Factor</th><th>Raw Weighted Score</th></tr>
<tr><td colspan="3">Maximum Possible Raw Weighted Score
(i.e., 5 x the sum of item weights above)</td><td>X 80 (maximum possible score)</td><td colspan="2">= SCORE:</td><td></td></tr>
<tr><td colspan="7">State Use – Evaluator Identification:</td></tr>
<tr><td colspan="7">State Use – Solicitation Coordinator Signature, Printed Name & Date:</td></tr>
</table>

RFP ATTACHMENT 6.3.

Reserved

RFP ATTACHMENT 6.4.

REFERENCE QUESTIONNAIRE

The standard reference questionnaire provided on the following pages of this attachment should be completed by all individuals offering a reference for the Respondent.

The Respondent will be solely responsible for obtaining completed reference questionnaires as detailed below. Provide references from individuals who are not current State employees of the procuring State Agency for projects similar to the goods or services sought under this RFP and which represent:

- two (2) contracts Respondent currently services that are similar in size and scope to the services required by this RFP; and
- three (3) completed contracts that are similar in size and scope to the services required by this RFP.

References from at least three (3) different individuals are required to satisfy the requirements above, e.g., an individual may provide a reference about a completed project and another reference about a currently serviced account. The individual contact reference provided for each contract or project shall not be a current State employee of the procuring State agency. Procuring State agencies that accept references from another State agency shall document, in writing, a plan to ensure that no contact is made between the procuring State agency and a referring State agency. The standard reference questionnaire, should be used and completed, and is provided on the next page of this RFP Attachment 6.4.

In order to obtain and submit the completed reference questionnaires following one of the two processes below.

Written:

(a) Add the Respondent's name to the standard reference questionnaire at RFP Attachment 6.4. and make a copy for each reference.

(b) Send a reference questionnaire and new, standard #10 envelope to each reference.

(c) Instruct the reference to:

   (i) complete the reference questionnaire;

   (ii) sign and date the completed reference questionnaire;

   (iii) seal the completed, signed, and dated reference questionnaire within the envelope provided;

   (iv) sign his or her name in ink across the sealed portion of the envelope; and

   (v) return the sealed envelope directly to the Respondent (the Respondent may wish to give each reference a deadline, such that the Respondent will be able to collect all required references in time to include them within the sealed Technical Response).

(d) Do NOT open the sealed references upon receipt.

(e) Enclose all sealed reference envelopes within a larger, labeled envelope for inclusion in the Technical Response as required.

Email:

(a) Add the Respondent's name to the standard reference questionnaire at RFP Attachment 6.4. and make a copy for each reference.

(b) E-mail a reference questionnaire to each reference.

(c) Instruct the reference to:

   (i) complete the reference questionnaire;

   (ii) sign and date the completed reference questionnaire;

   (iii) E-mail the reference directly to the Solicitation Coordinator by the RFP Technical Response Deadline with the Subject line of the e-mail as "[Respondent's Name] Reference for RFP **# 31865-00636**".

NOTES:

- The State will not accept late references or references submitted by any means other than the two which are described above, and each reference questionnaire submitted must be completed as required.
- The State will not review more than the number of required references indicated above.
- While the State will base its reference check on the contents of the reference e-mails or sealed reference envelopes included in the Technical Response package, the State reserves the right to confirm and clarify information detailed in the completed reference questionnaires, and may consider clarification responses in the evaluation of references.
- The State is under no obligation to clarify any reference information.

RFP # 31865-00636 REFERENCE QUESTIONNAIRE

REFERENCE SUBJECT: RESPONDENT NAME (completed by Respondent before reference is requested)

The "reference subject" specified above, intends to submit a response to the State of Tennessee in response to the Request for Proposals (RFP) indicated. As a part of such response, the reference subject must include a number of completed and sealed reference questionnaires (using this form).

Each individual responding to this reference questionnaire is asked to follow these instructions:

- complete this questionnaire (either using the form provided or an exact duplicate of this document);
- sign and date the completed questionnaire and follow either process outlined below;

Physical:

- seal the completed, signed, and dated questionnaire in a new standard #10 envelope;
- sign in ink across the sealed portion of the envelope; and
- return the sealed envelope containing the completed questionnaire directly to the reference subject.

E-Mail:

- e-mail the completed questionnaire to:
  Solicitation Coordinator Name and E-Mail Address

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(1) What is the name of the individual, company, organization, or entity responding to this reference questionnaire?

(2) Please provide the following information about the individual completing this reference questionnaire on behalf of the above-named individual, company, organization, or entity.

NAME:	
TITLE:	
TELEPHONE #	
E-MAIL ADDRESS:	

(3) What goods or services does/did the reference subject provide to your company or organization?

(4) If the goods or services that the reference subject provided to your company or organization are completed, were the goods or services provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

(5) If the reference subject is still providing goods or services to your company or organization, are these goods or services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

(6) How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?

REFERENCE SIGNATURE:
(by the individual completing this request for reference information)

____
(must be the same as the signature across the envelope seal)

DATE: ____

SCORE SUMMARY MATRIX

The Score Summary Matrix for the DBM RFP is included below as an example of the DBM RFP scoresheet.

SCORE SUMMARY MATRIX

	RESPONDENT NAME		*RESPONDENT NAME*		*RESPONDENT NAME*	
GENERAL QUALIFICATIONS & EXPERIENCE (Section B) (maximum: 20)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH (Section C) (maximum: 80)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
TOTAL RESPONSE EVALUATION SCORE: (maximum: 100)						
Solicitation Coordinator Signature, Printed Name & Date:						

PRO FORMA CONTRACT ATTACHMENT

RFP #31865-00636 PRO FORMA CONTRACT

The pro forma contract detailed in following pages of this exhibit contains some “blanks” (signified by descriptions in capital letters) that will be completed with appropriate information in the final contract resulting from the RFP.

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

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Division of TennCare ("State" or "TennCare") and Contractor Legal Entity Name ("Contractor"), is for the provision of Dental Benefits Management (DBM) services for four (4) separate State DBM Programs (collectively referred to as the "State DBM Programs"), as further defined in the "SCOPE." State and Contractor may be referred to individually as a "Party" or collectively as the "Parties" to this Contract.

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

A. SCOPE

A.1. The Contractor shall provide all goods or Services and Deliverables as required, described, and detailed below and shall meet all service and delivery timelines as specified by this Contract.

A.2. Definitions. For the purposes of this Contract, definitions and abbreviations shall be as set forth in Attachment A, Definitions and Abbreviations.

A.3. General Requirements

A.3.1. The State administers five (5) separate dental benefit programs managed by the DBM. The following programs shall be a full risk-based contract: TennCare Children's DBM Program, TennCare Adult DBM Program, and CoverKids DBM Program. All other programs will be based on an administrative services fee arrangement. As further described below, four (4) of the five (5) dental benefit programs are "TennCare DBM programs", and one (1) of the five (5) dental benefit programs is considered to be the "CoverKids DBM program." Together, the five (5) separate DBM programs are collectively known as the "State DBM Programs." The four (4) TennCare DBM programs are described below in Sections A.3.1.1.1. through A.3.1.1.3. The one (1) CoverKids DBM program is described below in Section A.3.1.2. Each of these 5 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.3.1.1. 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 four (4) programs based upon each program's eligible enrollees:

A.3.1.1.1. 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.

A.3.1.1.2. TennCare ECF CHOICES DBM Program and 1915(c) DBM Program. The Contractor shall, pursuant to requirement set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols, administer covered adult dental benefits to approximately eleven thousand (11,000) 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 or Section 1915(c) Home and Community Based Services (HCBS) Waiver

A.3.1.1.3. 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 approximately six hundred thousand (600,000) eligible adults aged twenty-one (21) and older who are TennCare members.

A.3.1.2. 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 thirty-five thousand (35,000) 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).

A.3.1.3. 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.

A.3.1.4. The services, the 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 may adhere to its standard administrative policies and procedures, including without limitation dental policies, claims administration procedures, and provider reimbursement practices. Contractor shall modify its standard programs and procedures as needed to meet the requirements of the State DBM programs, at no cost to the State. Such modifications may be required before the go-live date of this Contract or during the term of this Contract as the program needs evolve. The Contractor shall use its network of Tennessee 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 in writing by the State.

A.4. State DBM Programs Implementation

A.4.1. General Requirements

A.4.1.1. 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.4.2.1.1. 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:

A.4.1.1.1. For the TennCare Children's DBM Program, TennCare Adult DBM Program, the TennCare ECF CHOICES DBM Program, TennCare 1915(c) DBM Program and the CoverKids DBM Program, the Contract Start Date will be July 1, 2024. The Contractor shall have a twelve (12) month readiness and implementation period, if applicable. Therefore, Contractor's services shall be fully implemented and operable on the Go-Live date for these programs, which is currently scheduled for July 1, 2025, if applicable (TennCare Programs Go-Live Date), or such later date as TennCare may specify in writing to the Contractor.

A.4.1.1.2. Currently most data exchanges between the DBM and TennCare are facilitated as delivery via Secure File Transfer Protocol (SFTP) directly to the legacy MMIS. However, as the MMIS Modular solutions progress over the next several years, these data exchanges will be facilitated through the TennCare ISL for routing and delivery between various MMPVP systems. The Contractor must have the capacity to create and maintain the required interfaces as directed by TennCare to enable data exchanges for both the existing and future systems and interface delivery methods.

A.4.1.1.3. The Contractor shall be responsible for establishing, controlling, maintaining, and ensuring data privacy and information security in coordination with the TennCare IS Security department, Data Privacy Office, and all other relevant stakeholders (i.e., other TennCare departments, IS vendors, other TN state agencies, etc.). These responsibilities include oversight of physical, technical, administrative, and organizational safeguards in accordance with TennCare security and data privacy policies, procedures, and standards.

A.4.1.1.4. The Contractor shall develop and provide to TennCare appropriate architectural models of the solution design, selected with TennCare's approval and modeled in accordance with the TennCare Enterprise Architecture Modeling Standard. TennCare will work with the Contractor to determine an appropriate timeline for the submission of the architectural models.

A.4.1.1.4.1. If there are significant changes made to the architecture throughout the contract period, the Contractor shall update the solution design models and present them for an As-Built Review, in accordance with the TennCare Enterprise Architecture Framework Standard located in Contract Attachment J, Procurement Library .

A.4.2. <u>Project Initiation and Requirements Definition Phase</u>

A.4.2.1. 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 meetings which shall be conducted on site at TennCare offices located in Nashville, Tennessee or virtually as indicated in the scheduling invite. 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 TennCare 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:

A.4.2.1.1. Project Plan. The Project Plan shall be created by the Contractor and submitted to TennCare for approval within 15 calendar days after the Contract Start 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 in writing to reflect adjustments to the detailed timelines and required services as implementation of the State DBM Programs progresses.

A.4.2.1.2. Functional and Informational Requirements (FIR) Document. This document shall include detailed requirements that meet at minimum the criteria for such as specified by the TennCare Requirements Management Standard 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 as detailed in Attachment B..

A.4.2.1.3. The Contractor shall be required to sync to Tennessee Eligibility Determination System (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 as detailed in Attachment B.

A.4.2.1.4. 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. The Contractor shall be required to meet all Contract requirements and deliverables regardless of whether TennCare determines to pursue Contractor's recommended modifications.

A.4.3. <u>System Analysis/General Design Phase</u>

A.4.3.1. 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:

A.4.3.1.1. 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.

A.4.3.1.2. A Detailed Conversion Plan that specifies plans for conversion of fifteen (15) months of MMIS and the previous DBM contractor/processor's claims history if applicable, and Prior Authorizations (PA) and reference data.

A.4.3.1.3. 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

A.4.4. <u>Technical Design Phase</u>

A.4.4.1. During this phase, detailed specifications shall be developed by the Contractor 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:

A.4.4.1.1. Unit test plan that includes test data, testing process, and expected results;

A.4.4.1.2. Back-up and recovery plan that includes processes for daily backup and recovery of system information;

A.4.4.1.3. Final disaster recovery plan;

A.4.4.1.4. 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

A.4.4.1.5. System, integration, and load and test plan

A.4.5. Development Phase

A.4.5.1. This phase includes activities that shall lead to implementation of the State DBM Programs. The Contractor shall develop and provide to TennCare test plans for all testing stages to include at minimum the specified criteria in the TennCare Test Management Standard. if requested by the State, the Contractor shall make necessary modifications to its standard programs and operations practices. 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. The Contractor shall perform testing on all phases and document programs. 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:

A.4.5.1.1. System testing to validate the appropriate adjudication of a claim which shall include a description of the test procedure, expected results, and actual results;

A.4.5.1.2. 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

A.4.5.1.3. 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.

A.4.6. Implementation/Operations Phase

A.4.6.1. 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. All remittance advices to the providers shall indicate whether the member is a Medicaid member or a CoverKids member. 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:

A.4.6.1.1. 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, PA operations/interfaces, check and remittance fulfillment and member notifications.

A.4.6.1.2. With the approval of TennCare, the Contractor shall develop production and report distribution schedules.

A.4.6.1.3. 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.

A.4.6.1.4. 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 PAs 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.

A.4.7. Readiness Review

A.4.7.1. 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 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:

A.4.7.1.1. Benefit plan designs loaded, operable and tested;

A.4.7.1.2. Perform comprehensive systems testing (including interface testing with all third parties) and quality assurance audits, with results reported to the TennCare prior to the Go-Live for the TennCare Children's DBM Program, TennCare Adult DBM Program, TennCare ECF CHOICES and 1915(c) DBM Program, and the CoverKids DBM Program.

A.4.7.1.3. Eligibility feed formats loaded and tested end to end;

A.4.7.1.4. Operable and tested toll-free numbers;

A.4.7.1.5. Account management, Help Desk and PA staff hired and trained;

A.4.7.1.6. Established billing/banking requirements;

A.4.7.1.7. Complete notifications to the outgoing State DBM contractor's dental providers regarding the upcoming change of State DBM contractor;

A.4.7.1.8. Each component shall be completed by thirty (30) days, 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 July 1, 2025, if applicable.

A.4.7.1.9. Claims history and existing PAs and overrides from the outgoing State DBM contractor shall be successfully migrated into the Contractor's system.

A.4.7.1.10. Satisfactory Completion of the requirements of Contract Section A.15.2.11.

A.4.7.1.11. No less than sixty (60) days prior to the TennCare Programs Go-Live, as defined in Contract Section A.4.1.1.1. the Contractor shall be prepared to receive and load a mass 834 file for the base TennCare member population with future eligibility begin dates.

A.4.7.1.12. After delivery from the State of the base line TennCare member population, the Contractor shall 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.

A.4.7.1.13. No less than thirty (30) days prior to the TennCare Programs Go-Live date, the Contractor shall be prepared to submit HIPAA complaint X12 837D encounter files to TennCare.

A.4.7.1.14. Thirty days prior to the start date of operations and any substantive program changes or amendments, as determined by TennCare, the Contractor shall demonstrate to TennCare's satisfaction that it is able to meet the requirements of this Contract.

A.4.7.1.15. The Contractor shall cooperate in a "readiness review" conducted by TennCare to review the Contractor's readiness to begin operations or to implement new program components or substantively modified program requirements, as applicable and determined by TennCare. This review may include, but is not limited to, desk and on-site review of documents provided by the Contractor, a walk-through of the Contractor operations, system demonstrations (including systems connectivity testing), network access benchmarking, interviews with Contractor's staff, and key milestone deliverables (including credentialing, contracting and authorizations, as applicable).

A.4.7.1.16. 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. At the sole discretion of the State, TennCare or CoverKids enrollees may not be enrolled with the Contractor or the Contractor may not be permitted to implement new program components or substantively modified program requirements until TennCare has determined that the Contractor is able to meet the requirements of this Contract and other actions may be taken by TennCare as determined necessary to ensure Contractor readiness to meet program requirements.

A.4.8. <u>TennCare ECF CHOICES DBM Program and 1915(c) DBM Program Readiness Review</u>

A.4.8.1. The Contractor shall participate in a readiness review, in coordination with TennCare, prior to the implementation of the Contractor's management of supplemental dental benefits in the TennCare ECF CHOICES DBM Program and 1915(c) DBM Program, in addition to any other readiness requirements under Section A.4.7. of this Contract. This readiness review specific to the TennCare ECF CHOICES DBM Program and 1915(c) 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 and 1915(c) DBM Program Participating Dental Provider network, requirements to develop and amend policies, procedures, and other documents related to this Contract such as the I/DD Dental Provider Office Reference Manual, the I/DD 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.

A.4.9. <u>TennCare Adult Dental DBM Program Readiness Review</u>

A.4.9.1. 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.4.7. of this Contract. This readiness review specific to the TennCare Adult Dental DBM Program will be conducted at a time 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.

A.4.10. <u>TennCare Children's DBM Program Readiness Review</u>

A.4.10.1. The Contractor shall participate in a readiness review prior to the implementation of the Contractor's management of dental benefits in the TennCare Children's DBM Program, in addition to any other readiness requirements under Section A.4.7. of this Contract. This

readiness review specific to the TennCare Children's DBM Program will be conducted at a time determined by TennCare, and will include, at a minimum, development of the Contractor's TennCare Children's 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.4.11. CoverKids DBM Program Readiness Review

A.4.11.1. The Contractor shall participate in a readiness review prior to the implementation of the Contractor's management of dental benefits in the TennCare CoverKids DBM Program, in addition to any other readiness requirements under Section A.4.7. of this Contract. This readiness review specific to the CoverKids DBM Program will be conducted at a time determined by TennCare, and will include, at a minimum, development of the Contractor's CoverKids 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.5. Services

A.5.1. The Contractor shall administer the dental benefit for the TennCare Children's DBM Program, TennCare ECF CHOICES DBM Program and 1915(c) DBM 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

A.5.2. 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.6. 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.6.1. 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:

A.6.1.1. 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).

A.6.1.2. 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.

A.6.1.3. Age twenty-one (21) and Older - When the Contractor denies a claim or PA request submitted by or on behalf of an individual age twenty-one (21) and older, despite the fact that the individual's age may render him/her ineligible for certain TennCare dental benefits, the Contractor shall render such denial in writing and in accordance with the appeals process set forth in Grievances and Appeals, Sections A.17. of this Contract.

A.6.2. <u>TennCare ECF CHOICES and 1915(c) DBM Program:</u> 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 and 1915(c) DBM Program. This includes all applicable requirements set forth in this Contract unless specifically identified as non-applicable to the TennCare ECF CHOICES and 1915(c) DBM Program..

A.6.2.1. The Contractor shall provide the following covered dental benefits in the TennCare ECF CHOICES and 1915(c) DBM Program:

A.6.2.1.1. Adult dental services as provided under the State's Section 1915(c) waivers for individuals with intellectual disabilities, which include specific diagnostic services, preventive dental services, fillings, crowns, root canals, extractions, periodontics, the provision of complete dentures and removable partial 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.

A.6.2.1.2. Such services will be reimbursed in accordance with the maximum reimbursement rate listed in the TennCare ECF CHOICES and 1915(c) DBM Program Dental Fee Schedule which shall be provided by TennCare. Orthodontic services are excluded from coverage in the TennCare ECF CHOICES and 1915(c) DBM Program.

A.6.2.2. All Covered Services for children under age 21 enrolled in the TennCare ECF CHOICES or the Section 1915(c) Home and Community Based Services (HCBS) Waiver are provided through the TennCare EPSDT program as provided in Contract Sections A.5. and A.6. Therefore, dental services shall not be covered under the TennCare ECF CHOICES and 1915(c) DBM Program for children under age 21 years since it would duplicate TennCare EPSDT benefits.

A.6.2.3. Covered dental services for eligible adults age 21 and older in the TennCare ECF CHOICES and 1915(c) 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.

A.6.2.4. ECF CHOICES members and 1915(c) members can access Adult Dental Benefits that are available to all TennCare members under the TennCare Adult DBM Program. Utilization of the TennCare Adult DBM Program will not change the supplemental/waiver-funded dental services available to ECF CHOICES members and 1915(c) members under the TennCare ECF CHOICES and 1915(c) members DBM Program. For these members, many of the dental services requested will be paid for by the DBM under the TennCare Adult DBM Dental Benefit and will not count against the member's waiver expenditure/cost cap.

A.6.2.5. Supplemental adult dental services offered in the TennCare ECF CHOICES and 1915(c) 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.6.2.3. except when the MCO elects to exceed such limit as a Cost-Effective Alternative Service. Upon inclusion of dental services in an ECF CHOICES or 1915(c) 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 and 1915(c) 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 and 1915(c) DBM Program Participating Dental Provider by the Member's MCO pursuant to a process approved by TennCare.

A.6.2.6. Coordination of TennCare ECF CHOICES and 1915(c) 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.

A.6.2.7. Upon selection of a TennCare ECF CHOICES and 1915(c) DBM Program Participating Dental Provider and subject to the amount approved for dental services in the member's PCSP, each TennCare ECF CHOICES or 1915(c) 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 dental 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). The dental provider will submit the treatment plan electronically, through an approved portal or clearinghouse, to the DBM for Medical Necessity Review under TennCare's Adult Dental DBM Program benefit coverage. After the DBM has reviewed the plan, the DBM shall issue a determination of "approved" or "denied" to the provider. The DBM shall also review any waiver-funded /supplemental dental services for medical necessity that are not covered under TennCare's Adult Dental DBM Program. Notwithstanding the proposed treatment plan developed by the participating Dental Provider, the total cost of dental services that may be authorized are subject to the amount of waiver approved dental services in the member's PCSP.

A.6.2.8. TennCare ECF CHOICES and 1915(c) DBM Program Participating Dental Providers may perform any Medically Necessary Covered Services determined to be needed after the dental evaluation referenced in Section A.6.2.7. above (or if an evaluation is not required, refer to A.6.2.7.) even if the treatment plan has not yet been incorporated into the PCSP, unless such service is of a type that requires PA 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 exceeds 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.

A.6.2.9. The Contractor shall not authorize nor reimburse dental services for ECF CHOICES or 1915(c) members that are not covered under the TennCare Adult Dental DBM Program or the TennCare ECF CHOICES and 1915(c) 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 or 1915(c) member and shall not authorize nor reimburse dental services for an ECF CHOICES or 1915(c) member that exceed the amount approved for such services in the member's PCSP. Upon written request, the Contractor shall also make available to TennCare ECF and 1915(c) CHOICES DBM Program Participating Dental Providers the total dental expenditures that have been authorized and reimbursed for each ECF CHOICES or 1915(c) member served by any other TennCare ECF CHOICES and 1915(c) DBM Program Participating Dental Providers 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 or 1915(c)

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.

A.6.2.10. 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 and 1915(c) DBM Program, including Covered Services authorized by a member's MCO as a Cost-Effective Alternative Service.

A.6.2.11. 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.

A.6.2.12. TennCare shall deliver the most current version of the TennCare ECF CHOICES and 1915(c) DBM Program Dental Fee Schedule referenced in section A.6.2.1.2. 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.

A.6.2.13. 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 and 1915(c) DBM Program are set forth in Contract Sections C.3.9.2., A.19.1.1.1.4., A.12.2.7., A.12.2.8., A.13.2.4., A.13.2.8., A.13.2.9., A.12.4.4., A.12.4.5., A.16.2., A.16.6., A.16.9., A.13.3.1., and A.13.3.2.

A.6.3. **Covered Services and Limitations**

A.6.3.1. The code set for the TennCare ECF CHOICES DBM Program and 1915(c) DBM Program are captured in the table below.

TennCare ECF CHOICES and 1915(c) DBM Program Code Set					
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	D3220	D3330	D3346	D3352	D3425

TennCare ECF CHOICES and 1915(c) DBM Program Code Set					
(D3000)	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	D5863	D6722
	D5120	D5511	D5730	D5864	D6740
	D5130	D5512	D5731	D5865	D6751
	D5140	D5520	D5740	D5866	D6752
	D5211	D5611	D5741	D5867	D6753
	D5212	D5612	D5750	D5876	D6781
	D5213	D5621	D5751	D6211	D6782
	D5214	D5622	D5760	D6212	D6783
	D5225	D5630	D5761	D6241	D6784
	D5226	D5640	D5765	D6242	D6791
	D5282	D5650	D5810	D6243	D6792
	D5283	D5660	D5811	D6245	D6920
	D5284	D5670	D5820	D6251	D6930
	D5286	D5671	D5821	D6552	D6940
	D5410	D5710	D5850	D6545	D6950
	D5411	D5711	D5851	D6548	D6980
	D5421	D5720	D5862	D6721	
Oral Surgery (D7000)	D7140	D7260	D7310	D7465	D7530
	D7210	D7270	D7311	D7471	D7540
	D7220	D7272	D7320	D7472	D7880
	D7230	D7280	D7410	D7473	D7970
	D7240	D7282	D7413	D7485	D7971
	D7241	D7285	D7440	D7510	D7972
	D7250	D7286	D7450	D7511	D7997
			D7460		
Adjunctive General Services (D9000)	D9110	D9215	D9239	D9630	D9944
	D9210	D9222	D9243	D9910	D9945
	D9211	D9223	D9248	D9911	D9946
	D9212	D9230	D9610	D9920	D9971

A.6.3.2. 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.

A.6.4. <u>TennCare Adult Dental DBM Program Benefits</u>

A.6.4.1. The Contractor shall provide enrollees in the TennCare Adult Dental DBM Program some of the following covered benefit services:

A.6.4.1.1. Diagnostic

A.6.4.1.2. Preventive – Fluoride treatments, Silver Diamine Fluoride (SDF), and teeth cleaning

A.6.4.1.3. Restorative – Fillings

A.6.4.1.4. Endodontics – Root canals

A.6.4.1.5. Periodontal – Scaling and Deep Cleaning

A.6.4.1.6. Prosthodontics – crowns and complete dentures

A.6.4.1.7. Oral Surgery – Extractions (simple, surgical, and soft tissue impacted), as well as

A.6.4.1.8. Adjunctive General Services – Emergency relief of pain and nitrous oxide inhalation analgesia.

A.6.4.2. Applicable current dental terminology codes for the TennCare Adult Dental DBM Program are listed below.

A.6.4.2.1.

Diagnostic, Preventive and Basic Restorative Services	
Procedure Code	**Procedure Code Description**
D0120	Periodic oral exam
D0140	Limited oral evaluation
D0150	Comprehensive oral evaluation
D0160	Detailed and extensive oral evaluation
D0210	Intraoral - complete series
D0220	Intraoral - periapical 1st film
D0230	Intraoral - periapical each additional
D0270	Bitewing - single film
D0272	Bitewing - two films
D0273	Bitewing - three films
D0274	Bitewing - four films
D0330	Panoramic film
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium
D1110	Prophylaxis – adult
D1206	Fluoride varnish
D1208	Topical Fluoride
D1354	Interim caries arresting medicament (Silver Diamine Fluoride) – per tooth
D2140	Amalgam - 1 surface
D2150	Amalgam - 2 surface
D2160	Amalgam - 3 surface
D2161	Amalgam - 4+ surface
D2330	Composite - 1 surf anterior
D2331	Composite - 2 surf anterior
D2332	Composite - 3 surf anterior
D2335	Composite - 4+ surf anterior
D2391	Composite - 1 surf posterior - permanent tooth
D2392	Composite - 2 surf posterior - permanent tooth
D2393	Composite - 3 surf posterior - permanent tooth
D2394	Composite - 4+ surf posterior - permanent tooth
D2721	Crown - resin/metal base
D2722	Crown - resin/metal noble
D2740	Crown - porcelain/ceramic
D2750	Crown-proc/metal high noble
D2751	Crown - porc/metal base
D2752	Crown - porc/metal noble
D2753	Crown – porc/titanium and titanium alloys
D2781	Crown - 3/4 metal base
D2782	Crown - 3/4/metal noble
D2783	Crown - 3/4 porc/ceramic
D2791	Crown - full metal base
D2792	Crown - full metal noble
D2920	Recement crown
D2931	Crown - stainless steel permanent
D3310	Endodontic therapy, anterior tooth
D3320	Endodontic therapy, premolar tooth
D3330	Endodontic therapy, molar tooth
D4341	Scaling and root planning - 4+ teeth per quad
D4342	Scaling and root planning - 1 to 3 teeth per quad
D4355	Full mouth debridement to enable a comprehensive oral evaluation
D4910	Periodontal Maintenance
D5110	Complete denture – max
D5120	Complete denture – mand
D5130	Immediate denture – max
D5140	Immediate denture – mand

D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)
D5212	mandibular partial denture – resin base (includingretentive/clasping materials, rests, and teeth)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular
D5284	removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant
D5286	removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant
D5611	repair resin partial denture base, mandibular
D5612	repair resin partial denture base, maxillary
D5621	repair - cast partial framework, mandibular
D5622	repair - cast partial framework, maxillary
D5630	repair - broken clasp partial denture
D5640	replace - missing/broken teeth - partial
D5650	add tooth - partial denture
D5660	add clasp - partial denture
D5730	Reline- complete denture max chairside (edits against 5750 and 5751)
D5731	Reline - complete denture mand chairside
D5750	Reline- complete denture max lab
D5751	Reline - complete denture mand lab
D7140	Extraction - erupted tooth or exposed root
D7210	Extraction – surgical
D7220	Impaction - soft tissue
D7250	Surgical removal of residual roots
D7310	alveoloplasty w/ extractions per quad
D7311	alveoloplasty w/ extractions - 1 - 3 teeth/spaces per quad
D7320	alveloplasty w/o extractions per quad
D7321	alveoloplasty w/o extractions - 1 - 3 teeth/spaces per quad
D7471	removal of lateral exostosis - max or mand
D7472	removal of torus palatinus
D7473	removal of torus mandibularis
D7485	surgical reduction of tuberosity
D9110	Palliative treatment
D9230	Inhalation of nitrous oxide/ analgesia

A.6.4.3. <u>Pregnancy Outreach for TennCare Adult Enrollees</u>

A.6.4.3.1. Once the Contractor is notified of the pregnancy status of an 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 to them. 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.

A.6.4.3.2. The Contractor shall provide education and outreach to pregnant 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 reminder notices to schedule appointments with their dental home, as well as providing additional strategies as options for supplemental outreach to increase access and utilization.

A.6.4.3.3. The Contractor shall mail letters, as approved by the State, to participating TennCare dentists and physicians that describe 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 their babies.

A.6.5. <u>CoverKids DBM Program Benefits.</u> 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).

A.6.5.1. 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.

A.6.5.2.

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

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**
		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**

A.6.5.3. The Contractor shall determine medical necessity based on the CDT Codes. The complete list of CoverKids DBM Program dental service categories by CDT Codes, is located in Contract Attachment D, CoverKids CDT Code Set.

A.6.5.4. 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.

A.6.5.5. 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.7. 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.7.1. TennCare Children’s DBM Program

A.7.1.1. 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.

A.7.1.1.1. 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 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:

A.7.1.1.1.1. **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

A.7.1.2. 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:

A.7.1.2.1.

Co-Pay	0 to 133% of Poverty	134-199% of Poverty	200% and Above Poverty
Dental visits	0	$5 per visit	$20 per visit

A.7.1.2.1.1. 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.

A.7.1.2.1.2. 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.

A.7.1.2.1.3. 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 Office of Program Integrity (OPI).

A.7.1.3. Providers or collection agencies acting on the Contractor'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 state and federal law.

A.7.1.4. Supplemental dental services offered in the TennCare ECF CHOICES DBM Program or TennCare 1915(c) DBM Program shall be reimbursed only when the TennCare ECF CHOICES DBM Program member or TennCare 1915(c) DBM Program member was enrolled in the TennCare ECF CHOICES DBM Program or TennCare 1915(c) DBM Program at the time the service was delivered, and subject to the amount approved for such services in the ECF CHOICES Member's or 1915(c) DBM Program member's PCSP. The preventive procedure codes listing for TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program are as follows:

A.7.1.4.1. **Preventive Services – TennCare ECF CHOICES DBM Program and TennCare 1915 (c) 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.7.2. <u>TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program Cost Sharing</u>

A.7.2.1. The Contractor is not responsible for administering any cost share responsibilities for dental services in the TennCare ECF CHOICES DBM Program or TennCare 1915(c) DBM Program. Collection of any Patient Liability amounts due from an ECF CHOICES member or 1915(c) member pursuant to federal post-eligibility provisions shall be the responsibility of the member's MCO.

A.7.3. <u>Adult Dental DBM Program Cost Sharing</u>

A.7.3.1. 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.

A.7.4. <u>CoverKids DBM Program Cost Sharing</u>

A.7.4.1. Contract Sections A.7.4.1. through A.7.4.4. 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 daily. 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 writing in advance by the State. The Medical Plan Administrator shall report to the Contractor daily 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.

A.7.4.2. 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.

A.7.4.3. 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.

A.7.4.4. The Contractor shall ensure that 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.8. <u>Adherence to Program Rules and Regulations</u>

A.8.1. 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.9. <u>Corrective Action Plans (CAP).</u> 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.9.1. <u>Contractor CAP.</u>

A.9.1.1. 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 which will be implemented via a Control Memorandum as defined in Section A.23.3 of this Contract;

A.9.1.1.1. <u>Notice of Deficiency:</u> 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.

A.9.1.1.2. <u>Proposed CAP:</u> 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.

A.9.1.1.3. 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.

A.9.1.1.4. 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.

A.9.2. Provider CAP.

A.9.2.1. 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.

A.10. **Staffing**

A.10.1. General Staffing Requirements. The Contractor shall have total responsibility for hiring and management of 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 (Key Staff) as identified below and corresponding job descriptions. For the purposes of this Contract, whenever Contractor's "staff" are referred to herein, it is understood to mean all staff employed by Contractor, including Key Staff, contractors and subcontractors. The Contractor's failure to provide and maintain Key Staff may result in liquidated damages as described in Section E.9 and Attachment B of this Contract. The Contractor shall limit personnel and data resources to US-based (onshore) resources only.

A.10.2. 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.10.4, with the exception of Provider Representatives and Provider Specialists, are required to be located in Metropolitan-Davidson County or a county contiguous to Metropolitan-Davidson County. However, the Contractor may assign at its discretion additional non-Key Staff members to the Tennessee local office.

A.10.3. Staff Requirements

A.10.3.1. The Contractor shall be responsible for assuring that all persons, whether they be Key Staff, employees, agents, subcontractors, providers, or anyone acting for or on behalf of the Contractor (hereinafter referred to collectively as "staff"), 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:

A.10.3.1.1. TennCare may refuse to approve or may rescind the approval of subcontracts with unlicensed persons;

A.10.3.1.2. TennCare may refer the matter to the appropriate licensing authority for action;

A.10.3.1.3. TennCare may assess liquidated damages provided by Attachment B of this Contract; and

A.10.3.1.4. TennCare may terminate this Contract for cause defined by Section D.6. of this Contract.

A.10.3.2. 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 15 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.

A.10.3.3. The Contractor shall provide TennCare with copies of resumes and job descriptions for all staff employed or planning to be 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 either not be hired for, or no longer be allowed to work on, matters arising under this Contract.

A.10.3.4. 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.

A.10.3.5. 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 Contractor staff and sub-contracted staff shall be approved by TennCare in advance.

A.10.3.6. The Contractor shall employ competent staff in all key positions listed below.

A.10.3.6.1. If any Key Staff position becomes vacant, the Contractor shall notify TennCare by completing an off-boarding request in writing within forty-eight (48) hours of receipt of notice of a Key Personnel's resignation/departure and notify TennCare immediately in the event of Key Personnel termination or departure without notice.

A.10.3.6.2. 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 such vacancies within sixty (60) days may result in liquidated damages as set forth in Attachment B.

A.10.3.7. The Contractor shall, at a minimum, have at least seventy percent (70%) 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.

A.10.3.8. 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.

A.10.3.9. In addition to dedicated staff as specified in Contract Section A.10.4. 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.10.4. <u>Key Staff</u>

A.10.4.1. The Contractor shall maintain sufficient levels of staff, including Key Staff, 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.

A.10.4.1.1. Key Staff shall be required to attend ad hoc meetings as requested by TennCare, in a format as directed by TennCare

A.10.4.1.2. Key Staff shall be assigned solely to work on matters arising under this Contract unless specific permission to the contrary is given by TennCare.

A.10.4.1.3. The Contractor shall provide the State with Curriculum Vitae of Key Staff candidates the Contractor is interested in hiring.

A.10.4.1.4. The Contractor shall request approval from the State for all Key Staff candidates prior to assigning them to work on this Contract.

A.10.4.1.5. The State may, in its sole discretion, require the Contractor's proposed Key Staff candidates to interview with the State.

A.10.4.1.6. 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 Key Staff, employee or subcontractor personnel found unacceptable to the State for work under this Contract only.

A.10.4.1.7. 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.

A.10.4.1.8. Unless specifically stated to the contrary in, Section A.10.4, Key Staff, with the exception of Provider Representatives and Provider Specialists, are required to be physically located in Metropolitan Davidson County, Tennessee or a county contiguous to Metropolitan Davidson County, Tennessee.

A.10.4.1.9. All key staff hired by the Contractor shall have a start date no later than sixty (60) calendar days prior to TennCare Programs Go-Live Date.

A.10.4.1.10. The Contractor shall provide to the State a crosswalk of Key Staff position titles, with a corresponding organizational chart, that is kept current. Any time Key Staffing changes occur, the updated organizational chart shall be shared with the State.

A.10.4.2. Key Staff shall include but are not limited to the following positions:

A.10.4.2.1. DBM Project Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Project Director who is one hundred percent (100%) dedicated to this Contract and 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.10.4.1.8.

A.10.4.2.1. DBM Chief Dental Officer (CDO) - The Contractor shall designate and maintain, subject to TennCare approval, a full-time DBM CDO who is one hundred percent (100%) dedicated to this Contract and who has day-to-day authority to manage all clinical aspects of the program. 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 the DBM CDO to oversee and be responsible for the proper provision of medically necessary covered services for enrollees. The DBM CDO 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 CDO shall serve on the Peer Review Committee as chairperson, and on the Quality Monitoring Program (QMP) Committee and Credentialing Committee. The DBM CDO 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. The DBM CDO will also be responsible for meeting or conversing with participating providers who request a peer-to-peer conversation or participating providers who TennCare has requested the DBM CDO or DBM Dental Director to personally outreach. The DBM CDO shall be physically located in the Contractor's Tennessee location as specified in Contract Section A.10.4.1.8.

A.10.4.2.2. Associate Dental Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Associate Dental Director who is one hundred percent (100%) dedicated to this Contract and who provides day-to-day support of the management of all clinical aspects of the TennCare Children's DBM program, Adult Dental DBM program, and CoverKids DBM program. The Associate Dental Director shall be a dentist who is licensed by the Tennessee Board of Dentistry, in good standing, and physically located in the State of Tennessee. The Associate Dental Director shall be responsible for supporting all clinical aspects of the program in conjunction with TennCare, such as the details associated with utilization review, electronic claims edits, appeals issues, support of the Patient Centered Dental Home (PCDH) and associated enhancement projects, greater utilization by dental providers of preventive and minimally invasive dental procedures and other initiatives as directed by TennCare or the DBM CDO. The Associate Dental Director shall also be responsible for meeting or conversing with participating providers who request a peer-to-peer conversation or participating providers who TennCare has requested to be outreached by the DBM to a dentist. The Associate Dental Director shall serve on the Peer Review Committee and on the Quality Monitoring Program (QMP) Committee and Credentialing Committee. The Associate 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. The Associate Dental Director shall be physically located in the Contractor's Tennessee location as specified in Contract Section A.10.4.1.8.

A.10.4.2.3. DBM I/DD Dental Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time DBM I/DD Dental Director who reports to the DBM CDO and is one hundred percent (100%) dedicated to this Contract. The DBM I/DD Dental Director shall be primarily focused on benefits provided under the TennCare ECF CHOICES 1915(c) DBM Program, but may also support the Children's DBM Program and CoverKids DBM Program as time permits. The DBM I/DD Dental Director shall be licensed by the Tennessee Board of Dentistry, be in good standing, and physically located in the State of Tennessee. The DBM I/DD Dental Director shall have at least four (4) 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 and 1915(c) DBM Program. The DBM I/DD Dental Director shall be responsible for the clinical oversight of adult dental services provided under the TennCare ECF CHOICES and 1915(c) DBM Program including, but not limited to, quality, utilization management and utilization review, site visits and credentialing of providers for the TennCare ECF CHOICES and 1915(c) DBM Program dental networks, development of clinical practice standards and clinical policies and procedures, PIPs pertaining to the TennCare ECF CHOICES and 1915(c) DBM Program, provider corrective actions, leadership in training and development of the TennCare ECF CHOICES and 1915(c) DBM Program dental provider networks, 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 DBM I/DD Dental Director shall be physically located in the Contractor's Tennessee location as specified in Contract Section A.10.4.1.8.

A.10.4.2.4. Children's DBM-MCO Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, two full-time employees (2 FTEs) to serve as Children's DBM-MCO Coordinators and are one hundred percent (100%) dedicated to this Contract and physically located in Metropolitan Davidson County, Tennessee or a county contiguous to Metropolitan Davidson County, Tennessee. The Children's DBM-MCO Coordinators 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. The Children's DBM-MCO Coordinators shall also coordinate with the MCO Coordinator any time the treating dental specialist with hospital privileges is having difficulty securing time in a medical facility for a child member who has received authorization to receive dental treatment in a medical facility. Additionally, the Children's DBM-MCO Coordinators shall interact with the MCO Coordinator to assist dental specialists who are having difficulty becoming credentialed at PAR medical facilities, with locating medical facilities in which they can secure hospital privileges. Additionally, the Children's DBM-MCO Coordinators shall be responsible for the requirements set forth in Section A.49.

A.10.4.2.5. Adult Dental DBM-MCO Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, one full-time employee (1 FTE) who is one hundred percent (100%) dedicated to this Contract and who is physically located in Metropolitan Davidson County, Tennessee or a county contiguous to Metropolitan Davidson County, Tennessee to coordinate adult dental services between the DBM and MCO specific to the TennCare Adult Dental DBM Program. The Adult Dental DBM-MCO Coordinator position shall not be filled with any person concurrently employed by the Contractor in the Children's DBM-MCO Coordinator position or I/DD DBM-MCO Coordinator position. Prior to program implementation and thereafter through the duration of this Contract, the Adult Dental DBM-MCO 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; positive findings from the Social Determinants of Health (SDOH) screening form, and other information as determined necessary by TennCare for the TennCare Adult Dental Program.

A.10.4.2.6. I/DD DBM-MCO Coordinator – The Contractor shall designate and maintain, subject to TennCare approval, one full-time employee (1 FTE) person who is one hundred percent (100%) dedicated to this Contract and physically located in Metropolitan Davidson County, Tennessee or a county contiguous to Metropolitan Davidson County, Tennessee to coordinate dental services between the DBM and MCO specific to the TennCare ECF CHOICES and 1915(c) DBM Program. The I/DD DBM-MCO Coordinator position shall not be filled with any person concurrently employed by the Contractor as the Children's DBM-MCO Coordinator or Adult DBM-MCO Coordinator. Prior to program implementation and thereafter through the duration of this Contract, the I/DD DBM-MCO 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 ECF CHOICES DBM Program and 1915(c) DBM Program.

A.10.4.2.7. Dental Case Management Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Dental Case Management Director who is one hundred percent (100%) dedicated to this Contract and physically located in Metropolitan Davidson County, Tennessee or a county contiguous to Metropolitan Davidson County, Tennessee, whose primary duties include development, submission and oversight of implementation by the Dental Case Managers of the Contractor's annual strategy, known as the Annual Outreach Plan, for increasing utilization of dental services by all TennCare enrollees with an emphasis on those under twenty-one (21) years of age. TennCare and the Contractor shall jointly design the scope of responsibilities and high-value activities that the Dental Case Management Director shall conduct in alignment with TennCare's goals. The Dental Case Management Director shall also provide supervision to each of the three (3)

Dental Case Managers. In addition, the Dental Case Management Director will be responsible for the compilation and submission of quarterly statewide reports and the Annual Outreach Plan to TennCare.

A.10.4.2.7.1. Additionally, the Dental Case Management Director shall be responsible for ensuring that all member materials developed by the Contractor, 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, , including materials specific to adult dental benefits in the TennCare ECF CHOICES - and TennCare 1915(c) DBM Program, are approved by TennCare and disseminated timely.

A.10.4.2.8. Dental Case Manager - The Contractor shall designate and maintain, subject to TennCare approval, three (3) full-time employees (3 FTEs), with one Dental Case Manager assigned to each of the three (3) grand divisions of the State. Each Dental Case Managers shall be one hundred percent (100%) dedicated to this Contract and physically located in Tennessee. The Dental Case Managers' primary duties shall include implementation of the Contractor's Annual Outreach Plan for increasing utilization of dental services by all TennCare enrollees with an emphasis on those under twenty-one (21) years of age. The Dental Case Managers shall target hard-to-reach populations, underutilizing and noncompliant TennCare enrollees who have not visited the dentist in the past six (6) months. The methods for member outreach shall include, but are not limited to, in-person events and screenings, Relay/SMS text messaging, written correspondence/letters and/or phone calls and other formats as requested by TennCare. Dental Case Managers shall also be responsible for the submission of quarterly reports detailing all outreach activities conducted across each of the respective Grand Divisions in accordance with the parameters outlined in A.13.3.2 Contractor's Outreach Activities.

A.10.4.2.9. Regulatory Compliance Manager – The Contractor shall designate and maintain, subject to TennCare approval, a full-time Regulatory Compliance Manager who is one hundred percent (100%) dedicated to this Contract and physically located in Metropolitan Davidson County, Tennessee or a county contiguous to Metropolitan Davidson County, 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 generated from utilization review of dental claims data and related to inquiries from entities such as TennCare and TBI MFCD.

A.10.4.2.10. Provider Network Director – The Contractor shall designate and maintain, subject to TennCare approval, a full-time Provider Network Director one hundred percent (100%) dedicated to this Contract, physically located in Metropolitan Davidson County, Tennessee or a county contiguous to Metropolitan Davidson County, 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 for all State DBM programs 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, including for the TennCare ECF CHOICES DBM Program, TennCare 1915(c) DBM Program and the DBM Dental Directors for the ECF CHOICES DBM Program and 1915(c) DBM Program, respectively. The Provider Network Director shall 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 1915(c) 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 PA requests as described in this Contract.

A.10.4.2.11. PCDH Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Patient Centered Dental Home (PCDH) Coordinator who is one hundred percent (100%) dedicated to this Contract, and physically located in Metropolitan Davidson County, Tennessee or a county contiguous to Metropolitan Davidson County, 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 shall support outreach, coaching, and education to TennCare Patient Centered Dental Homes. TennCare and the Contractor shall jointly design the scope of responsibilities and high-value activities that the Coordinator shall conduct in alignment with the TennCare and Contractor's Dental strategy. The PCDH Coordinator shall enlist the support of the Provider Specialists in implementing the overall Dental Strategy. TennCare and the Contractor shall mutually agree upon the start date for this position but the start date shall be no later than six (6) months after go-live.

A.10.4.2.12. Provider Specialist – The Contractor shall designate and maintain, subject to TennCare approval, a minimum of three (3) full-time Provider Specialists, with one assigned to each of the three (3) grand divisions of the State and who are physically located in Tennessee. The Provider Specialists shall be responsible for network development and management to ensure that there is a statewide network of dentists adequate to provide services at service locations and service sites available and accessible for Child and Adult DBM programs in accordance with the terms and conditions for access and availability outlined in the Contract. The Provider Specialists shall coordinate with other areas of the Contractor's organization that may impact provider recruitment, retention or termination. Additionally, the Provider Specialists shall review Provider Performance Reports (PPRs) with providers, conduct in-person PCDH trainings and coaching regarding workflow best practices, and the importance of routine utilization of both minimally invasive and preventive modalities. Each Provider Specialist shall visit a minimum of one hundred (100) dental practice locations annually, with priority given to those practices treating the largest volume of TennCare members and/or has with the lowest provider performance based on provider metrics. Additionally, when a provider requests an office visit or TennCare directs the Contractor to conduct an office visit, a Provider Specialist shall schedule a visit with the provider within five (5) business days. This visit may count as an annual office visit.

A.10.4.2.13. Provider Representatives – The Contractor shall designate and maintain, subject to TennCare approval, a minimum of five (5) full-time Provider Representatives with a an acceptable dental background, and each of whom is one hundred percent (100%) dedicated to this Contract and physically located in Tennessee. The Provider Representatives shall 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, TennCare 1915(c) DBM Program benefit limits, CoverKids DBM Program benefits and benefit limits, and TennCare Adult Dental DBM Program benefits. The five (5) full-time Provider Representatives shall be evenly distributed within the state of Tennessee and shall be completely familiar with the operation of all State DBM Programs in their respective region. They shall also be required to visit all participating dental offices within their region once annually. They shall also support providers with non-billing related issues such as education and outreach to providers not routinely providing preventive services, at the direction of the PCDH Coordinator. For the TennCare ECF CHOICES DBM Program and the TennCare 1915(c) DBM Program, Provider Representatives shall educate and assist TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program participating dental providers in working with utilization management programs specific to TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program including, but not limited to, management of adult dental

benefits and benefit limits, PAs requests (including initial evaluation and treatment plan approval), electronic billing, compliance initiatives, and other program requirements as specified by TennCare.

A.10.4.2.14. Local Research Analyst – The Contractor shall designate and maintain, subject to TennCare approval, one (1) full-time Local Research Analyst who is one hundred percent (100%) dedicated to this Contract and who is physically located in Metropolitan Davidson County, Tennessee or a county contiguous to Metropolitan Davidson County, Tennessee to support local data needs with backup support from the corporate office for more complicated analytic requests. The Local Research Analyst shall be responsible but not limited to such things as 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 Local 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 Local 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 PA, 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.

A.10.4.2.15. System Liaison - The Contractor shall designate and maintain, subject to TennCare approval, one (1) full-time System Liaison who shall be responsible for the planning and timely coding of edits to the Contractor's system when requested by TennCare, as well as the quality control of such edits, ensure proper functioning within the system, and ensure that newly entered system changes and edits do not affect existing edits within Contractor's system which might cause 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 the State Dental Programs. The System Liaison position is not required to be located in the Tennessee office.

A.10.4.2.16. Fraud, Waste and Abuse Investigators – The Contractor shall designate and maintain, subject to TennCare approval, one (1) Fraud, Waste, and Abuse Investigator dedicated one hundred percent (100%) 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 support person, all of whom may be located in the Contractor's corporate offices and have full knowledge of provider investigations related to the State Dental Programs and shall work with the TennCare Office of Program Integrity (OPI). The Fraud, Waste, and Abuse 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 Fraud, Waste, and Abuse Investigators are required to be actively pursuing and/or currently have one (1) or more of the listed credentials/degrees;

A.10.4.2.16.1. Certified Fraud Examiner;

A.10.4.2.16.2. NHCAA Certified Anti-Fraud Investigator;

A.10.4.2.16.3. Degree in Statistics, Criminal Justice, Finance, Healthcare Management or any other related field that supports health care fraud investigations;

A.10.4.2.16.4. Certified Healthcare Coder;

A.10.4.2.16.5. Other nationally recognized healthcare certification.

A.10.4.2.17. 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 only be made within ten (10) business days after receipt of any required approvals from TennCare as outlined in A.10.3.6. The identity of each of the Key Staff persons listed above shall be disclosed on the Contractor's web site.

A.10.5. 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, PAs, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews. These full time Support Staff shall include:

A.10.5.1. Web Developer - The Contractor shall designate and maintain, subject to TennCare approval, one (1) Web Developer responsible for establishing an up-to-date website dedicated to TennCare to aid providers and enrollees in all aspects of the State Dental Programs. The Web Developer shall maintain the website in accordance with the specifications outlined in A.22.1 General Requirements. The Web Developer shall also ensure that the site is maintained so that all dated materials on the website are removed or updated timely, and that all current events, latest news and any relevant announcements shall be displayed in a clearly visible and readily accessible location on the homepage.

A.10.5.2. Appeals Support Staff (clerical and professional) to perform Contractor's obligations related to the TennCare Appeal Process;

A.10.5.3. 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 PA from the treating provider, and (ii) during the TennCare Appeal Process, in response to TennCare's request for Contractor to render a Reconsideration determination;

A.10.5.4. Non-discrimination Compliance Coordinator ("NCC") to be responsible for Contractor compliance with all applicable Federal and State civil rights laws and regulations. It is highly recommended that the NCC position is staffed by a licensed attorney. Compliance with the aforementioned federal and state laws and regulations is not required to be the sole function of the NCC, however, the Contractor shall identify by name the designated compliance staff member who will serve as the NCC. 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 during which the Contractor does not have a designated staff person to serve as the NCC. If the Contractor reassigns this function to a staff person other than the previously designated NCC, 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;

A.10.5.5. A sufficient number of Care Coordinators and Claim Coordinators (Care/Claim Coordinators) appointed by the Contractor to resolve issues related to MCO/DBM coordination, as described in Care Coordination Sections A.13.2.4 – A.13.2.9. 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 Care/Claim Coordinators and other staff shall be provided by the DBM to the MCO and TennCare;

A.10.5.6. 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 contact person who is available after hours for the "on-call" TennCare Solutions staff and enrollees to contact with service issues;

A.10.5.7. 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 and the TennCare 1915(c) DBM Program. The Contractor shall adequately staff the provider service lines 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 to and fielded by the Provider Network Director. Supervision of provider representatives as described in Section A.10.4.2.13 , is also the responsibility of the Provider Network Director, and

A.10.5.8. 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 to perform medical necessity and PA 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:

A.10.5.8.1. one (1) general dentist,

A.10.5.8.2. one (1) pediatric dentist,

A.10.5.8.3. one (1) oral surgeon, and

A.10.5.8.4. one (1) orthodontist.

A.11. **MEMBER AND ADMINISTRATIVE SERVICES**

A.11.1. Member Services Hotline

A.11.1.1. 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.

A.11.1.2. 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.

A.11.1.3. 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.

A.11.1.4. Additionally, individuals shall be trained to accurately respond to questions and concerns regarding the TennCare ECF CHOICES and 1915(c) DBM Program, including but not limited to, Covered Services and providing assistance locating a TennCare ECF CHOICES and 1915(c) DBM Program Participating Dental Provider.

A.11.1.5. 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.

A.11.1.6. During business 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.

A.11.1.7. The Contractor's Member Services Line and Provider Services Line shall be equipped with a Telecommunications Relay Service ("TRS") to service the hearing and speech impaired populations.

A.11.1.8. Service Level Agreement Standards. The Contractor shall provide sufficient staff for "live" answering services during business hours to meet the following performance standards for each queue within the Member Services Line and the Provider Services Line.

A.11.1.9. 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.11.1.9.1. 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.

A.11.1.9.2. 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.

A.11.1.9.3. 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.

A.11.1.9.4. Blocked Call Rate. The Service Center shall maintain a Blocked Call Rate of one percent (1 %) or less at all times without exception.

A.11.2. Interpreter and Translation Services

A.11.2.1. The Contractor shall develop written policies and procedures for the provision of language and communication assistance services, such as, interpreter and translation services and 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 or speech impaired. The Contractor shall provide cultural and linguistically appropriate service ("CLAS") training to subcontractors and contracted providers which shall include the potential impact of linguistic and cultural barriers on utilization, quality and satisfaction with care and how to deliver CLAS services appropriately during a service encounter.

A.11.2.2. The Contractor shall provide members and their representatives with free language and communication assistance services, including interpreter services in all languages and translation services as set forth in Section A.19.1.4 Written Material Guidelines, and auxiliary aids and services.

A.11.2.3. Language and communication assistance services shall ensure effective communication with enrollees. This assistance includes the Contractor having the ability to provide communication access realtime translation interpreters, speech-to-speech interpreters, deaf-blind interpreters, tactile interpreters, oral transliterators, cued-language transliterators, American and international sign language interpreters, and qualified mental health interpreters.

A.11.3. TRS/TDY

A.11.3.1. The Contractor shall make free of charge TRS to enrollees and their representatives. TRS allows 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.

A.11.4. Appointment Assistance

A.11.4.1. 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.11.5. Inquiries, Correspondence, Complaints, and Problems

A.11.5.1. 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.11.6. Revisions to Benefits

A.11.6.1. The State shall consult with Contractor on proposed revisions to the benefits. When so requested, the Contractor shall provide information regarding:

A.11.6.1.1. Industry practices;

A.11.6.1.2. The overall cost impact to the program;

A.11.6.1.3. Any cost impact to the Contractor's fee;

A.11.6.1.4. Impact upon utilization management performance standards;

A.11.6.1.5. Necessary changes in the Contractor's reporting requirements, and

A.11.6.1.6. System changes.

A.11.7. Meetings

A.11.7.1. Both parties of this Contract shall meet periodically, but no less than quarterly, in a format directed by TennCare, to discuss any problems and/or progress on matters outlined by either party.

A.11.7.1.1. 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.

A.11.7.1.2. 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.

A.11.7.2. 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.11.8. Member Satisfaction Survey

A.11.8.1. The Contractor shall perform, following review and approval of the proposed survey by the State, Participant member 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 adults and 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.11.8.1.1. 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.

A.11.8.1.2. 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 Liquidated Damages as listed in Attachment B.

A.11.9. Provider Satisfaction Survey

A.11.9.1. The Contractor shall conduct a provider satisfaction survey of the participating network dentists and dental specialists, following approval by the State of the survey instrument including but not limited to 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.

A.12. **PROVIDER MANAGEMENT**

A.12.1. **PROVIDER NETWORK, ACCESS, AND AVAILABILITY OF CARE**

A.12.1.1. General Requirements

A.12.1.1.1. 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 DBM Programs Go-Live and CoverKids DBM Program Go-Live dates 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.12.1.2. 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.12.1.1.2. *Minimum Provider Requirements.* Prior to the effective date of the Contractor's Provider Agreement with a dental provider, the Contractor shall ensure said dental provider meets the following requirements:

A.12.1.1.2.1. Provider must be a currently licensed dentist in the State of Tennessee;

A.12.1.1.2.2. Provider must complete the TennCare electronic provider registration process;

A.12.1.1.2.3. Provider must provide proof of a current and valid Medicaid Provider number; and

A.12.1.1.2.4. Provider must meet such other standards developed by TennCare that are provided to the Contractor in writing.

A.12.1.2. Access to Care

A.12.1.2.1. 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.

A.12.1.2.2. For the TennCare Children' DBM Program, the Contractor will maintain the Primary Care Dental Network (general dentists and pediatric dentists), so that there is a member to dentist ratio of no greater than one thousand five hundred (1,500) to one (1).

A.12.1.2.3. For the TennCare Adult DBM program, the Contractor will maintain 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 two (2) for Medicaid enrollees.

A.12.1.2.4. TennCare reserves the right to reevaluate one (1) year post go-live and in subsequent year to determine if these network ratios are adequate to meet the needs

of the members and adjust 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. If the Contractor does not maintain network sufficiency in accordance with these provisions, then TennCare reserves the right to require the Contractor create and implement a mitigation plan subject to the approval of TennCare to ensure network adequacy and capacity.

A.12.1.2.5. The Contractor has entered a full risk-based contract for the following programs: TennCare Children's DBM Program, TennCare Adult DBM Program, and CoverKids DBM Program. All other programs will be based on an administrative services fee arrangement.

A.12.1.2.6. The Contractor is required to negotiate fee schedule rates with dental providers as needed, to ensure adequate provider networks to serve Members in each of these programs including those with limited English proficiency or physical or mental disabilities. Built into the capitation rates are funds, expressly for this purpose.

A.12.1.2.7. 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.

A.12.1.2.8. 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).

A.12.1.2.9. The Contractor shall consider the following when establishing its networks:

A.12.1.2.9.1. The anticipated TennCare and CoverKids enrollment;

A.12.1.2.9.2. The expected utilization of services, taking into consideration the characteristics and health care needs of specific TennCare and CoverKids populations represented;

A.12.1.2.9.3. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted TennCare and CoverKids services;

A.12.1.2.9.4. The numbers of network providers who are not accepting new TennCare and CoverKids patients;

A.12.1.2.9.5. The geographic location of providers and TennCare and CoverKids enrollees, considering distance, travel time, the means of transportation ordinarily used by TennCare and CoverKids enrollees, and whether the location provides physical access for Tenncare and CoverKids enrollees with disabilities, and

A.12.1.2.9.6. After consultation with the Contractor and at the direction of the State the Contractor shall be required to provide Mobile dental clinic services for patients who cannot leave nursing facilities. Mobile dental clinics shall not be considered in determining sufficient network access.

A.12.1.3. <u>Network for TennCare ECF CHOICES DBM and TennCare 1915(c) DBM Program Providers</u>

A.12.1.3.1. The Contractor shall be responsible for establishing a TennCare ECF CHOICES DBM Program and TennCare 1915(c) 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.

A.12.1.3.1.1. The TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program network shall meet the Access to Care and

Transport Distance requirements in Sections A.12.1.1., A.12.1.2., and A.12.1.5. of this Contract. TennCare requires that the TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program network of dental providers meet the following requirements, unless the Contractor seeks an exception to the following requirements from TennCare:

A.12.1.3.1.1.1. 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;

A.12.1.3.1.1.2. 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;

A.12.1.3.1.1.3. 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

A.12.1.3.1.1.4. Such other standards as may be developed or approved by TennCare.

A.12.1.3.1.2. If the Contractor cannot meet the Access to Care and Transport Distance requirements in Sections A.12.1.1., A.12.1.2., and A.12.1.5. of this Contract for the TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program network with dental providers that meet the TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program Dental Provider Requirements, then the Contractor shall not be required to have a network of dental providers that consists of providers, all of whom meet the TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program Dental Provider Requirements

A.12.1.3.1.2.1. However, the Contractor shall demonstrate to TennCare that these Provider Requirements are being thoughtfully considered in developing these networks by reporting information, if any, about the number of dental providers in the TennCare ECF CHOICES DBM Program network and TennCare 1915(c) DBM Program that meet the TennCare Dental Provider Requirements. Development of the TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program networks 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.

A.12.1.4. <u>Provider Enrollment File for TennCare ECF CHOICES and 1915(c) DBM Program</u>

A.12.1.4.1. The Contractor shall include in the provider enrollment file the appropriate TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program service code

to designate those TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program Participating Dental Providers contracted to provide services for TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program members in the existing provider file layout.

A.12.1.5. Transport Distance and Time

A.12.1.5.1. The Contractor shall maintain under contract a statewide network of dental providers for each of the aforementioned programs to provide the covered services specified in Sections A.5. and A.6.

A.12.1.5.2. The Contractor shall make services, service locations and service sites available and accessible so that transport distance and time to participating general dentists and dental specialists shall not exceed an average of thirty (30) miles or forty-five (45) minutes for general dentists; sixty (60) miles or sixty (60) minutes for oral surgery services; sixty (60) miles or sixty (60) minutes for orthodontic services; seventy (70) miles or seventy (70) minutes for pediatric dental services, and one hundred (100) miles or one hundred twenty (120) minutes for endodontists as measured by geographic access software. If these standards cannot be met for a given area, the standard needs to be the community standard for that area for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

A.12.1.5.3. 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.

A.12.1.5.4. The Contractor shall maintain under contract a network of TennCare ECF CHOICES DBM Program and TennCare 1915(c) DBM Program Participating Dental Providers who have experience and/or expertise in serving individuals with intellectual and developmental disabilities with required contracting standards as defined in Section A.12.1.3. 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. If these standards cannot be met for a given area, the standard needs to be the community standard in that area for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

A.12.1.6. Office Wait Time. The Contractor shall ensure that the office waiting time shall not exceed forty-five (45) minutes.

A.12.1.7. 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.12.1.8. 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 it would be if the services were furnished within the network.

A.12.1.9. 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 ensuring that

network providers have the capabilities to ensure physical access, reasonable accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities.

A.12.1.10. 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.

A.12.2. **UTILIZATION MANAGEMENT**

A.12.2.1. Policies and Procedures

A.12.2.1.1. 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 clinical criteria 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).

A.12.2.1.2. 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.

A.12.2.1.3. The policies and procedures shall contain the following elements:

A.12.2.1.3.1. The policies and procedures shall contain mechanisms to detect both underutilization and overutilization.

A.12.2.1.3.2. Prior Authorization (PA) and Concurrent Review Requirements

A.12.2.1.3.2.1. 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.

A.12.2.1.3.2.2. PA and concurrent review decisions shall be supervised by qualified dental professionals.

A.12.2.1.3.2.3. Documented efforts shall be made to obtain all necessary information (including pertinent clinical information), and to consult with the treating dentists as appropriate.

A.12.2.1.3.2.4. The reasons for decisions shall be clearly documented and available to the enrollees.

A.12.2.1.3.2.5. There shall be well publicized and readily available appeals mechanisms for both providers and enrollees.

A.12.2.1.3.2.6. PA and service appeal-related decisions shall be made in a timely manner as required by the exigencies of the situation.

A.12.2.1.3.2.7. There shall be mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.

A.12.2.1.3.2.8. If the Contractor delegates responsibility for utilization management, it shall have mechanisms to ensure that these standards are met by the delegate.

A.12.2.1.3.2.9. 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.

A.12.2.1.3.3. 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.16.3.

A.12.2.2. Utilization Management for the TennCare ECF CHOICES and 1915(c) DBM Program

A.12.2.2.1. The Contractor shall conduct utilization management and PA for Covered Services under the TennCare ECF CHOICES and 1915(c) 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.

A.12.2.2.2. 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.

A.12.2.2.3. 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.

A.12.2.3. Utilization Management of Anesthesia for TennCare ECF CHOICES and 1915(c) DBM Program

A.12.2.3.1. 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 or TennCare 1915(c) DBM Program or in the dental office setting unsuccessfully, and it is necessary to treat the patient in a medical facility.

A.12.2.4. Prior Authorization (PA)

A.12.2.4.1. 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.

A.12.2.4.2. 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.17.

A.12.2.4.2.1. 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 Section A.17 of this Contract.

A.12.2.4.2.2. 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.

A.12.2.4.2.3. All adult benefits provided under the TennCare ECF CHOICES and1915(c) DBM Program shall be prior-authorized by the Contractor.

A.12.2.5. Provider's Submission of Additional Information

A.12.2.5.1. 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.12.2.6. Retrospective Utilization Review

A.12.2.6.1. The Contractor shall conduct retrospective treatment utilization review of Covered Services provided to members of all State DBM Programs. This review shall require the Contractor to establish benchmarks for procedures that do not require PA, but which are susceptible to fraud or abuse. Examples of procedures that do not require PA, 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, waste and abuse.

A.12.2.6.2. 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.

A.12.2.6.3. 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.

A.12.2.6.4. 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.

A.12.2.6.5. 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 United States Department of Health and Human Services (US DHHS) convention, specific to the procedure(s) where the provider is an outlier compared with the benchmark.

A.12.2.6.6. 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.

A.12.2.6.7. The Contractor's Provider Peer Review Committee shall be made up of licensed Tennessee participating 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.

A.12.2.6.8. 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.13.4.4. 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.

A.12.2.6.9. 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.12.2.6.9.1. 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, extrapolation, when indicated (See A.21.10.), and 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' written notice.

A.12.2.6.9.2. Contractor's utilization review process shall include review of procedures that do not require PA. 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

as outlined in Section A.21.11.12. Corrective action may include, but is not limited to, requiring any of the following:

A.12.2.6.9.2.1. Provider and staff education;

A.12.2.6.9.2.2. PA for that specific procedure(s) and,

A.12.2.6.9.2.3. 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).

A.12.2.7. Emergent and Urgent Care

A.12.2.7.1. The Contractor shall ensure access to services for emergent and urgent dental and oral conditions or injuries based on 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.12.2.7.1.1. 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.

A.12.2.7.1.2. The Contractor may not deny payment for treatment obtained when an eligible enrollee had an emergency dental or oral condition or injury, where it is the Contractor's responsibility to pay, including cases in which the absence of immediate treatment 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.12.2.8. Continuity of Care

A.12.2.8.1. 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.12.2.9. Referral Requirements

A.12.2.9.1. 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.12.2.9.1.1. 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

A.12.2.9.1.2. have a mechanism in place to allow special needs enrollees and enrollees determined to require an ongoing course of treatment direct access to specialists as appropriate.

A.12.3. **PROVIDER SERVICES**

A.12.3.1. Informational Sessions

A.12.3.1.1. The Contractor shall provide continuing informational sessions for participating Dental Providers throughout the State.

A.12.3.1.1.1. 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 (scope of services) and limits of all TennCare dental programs. Informational sessions shall also address 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.

A.12.3.1.1.2. 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.

A.12.3.1.1.3. The Contractor shall handle the day-to-day management of the Provider network(s) 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.

A.12.3.1.1.4. 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 accessible to all dental providers on the Contractor's webpage, to participating Dental Providers addressing claims submission

requirements, and thirty (30) days' notice for updates to submissions requirements The Contractor shall confer participating Dental Providers with any assistance reasonably necessary to ensure provider compliance with applicable claims payment policy. Contractor shall monitor multiple claims denials for all providers and provide education to the provider(s) with multiple denials, in how to properly submit claims. When the Contractor contracts with providers, the Contractor shall:

A.12.3.1.1.4.1. Consider: the anticipated TennCare enrollment; the expected utilization of services, taking into consideration the characteristics of specific TennCare populations included in this Contract; the number and types of providers required to furnish TennCare services; the number of contract providers who are not accepting new members; and the geographic location of providers and TennCare members, considering distance, travel time, the means of transportation ordinarily used by TennCare members, and whether the location provides physical access for members with disabilities;

A.12.3.1.1.5. On a quarterly basis, the Contractor shall provide TennCare with documentation substantiating its compliance with the obligations addressed in this section.

A.12.3.1.1.6. The Contractor shall collaborate with the TennCare Provider Services' Provider Experience team regarding provider engagement to improve the relationship between dental providers, the Contractor and TennCare on a schedule mutually agreed upon by both parties.

A.12.3.2. Education for ECF CHOICES and 1915(c) Participating Dental Providers

A.12.3.2.1. 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 and 1915(c) 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 or 1915(c) Participating Dental Provider. The Contractor shall further identify subject matter experts on dentistry for individuals with I/DD and facilitate presentation to ECF CHOICES and 1915(c) 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 and 1915(c) 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 or 1915(c) dental network.

A.12.3.3. ECF CHOICES and 1915(c) Participating Dental Providers

A.12.3.3.1. ECF CHOICES and 1915(c) Participating Dental Providers shall render high quality, Medically Necessary, cost-effective dental care for ECF CHOICES and 1915(c) members. The Contractor shall exercise every available means through this Contract, Provider Agreements, ORM, policies and procedures, and educational programs to ensure that dental benefits in these programs are managed in this manner.

A.12.3.4. Provider Manual/Office Reference Manual (ORM).

A.12.3.4.1. The Contractor shall produce and distribute a dental program criteria manual, ORM for each specific TennCare DBM dental Program to assist Participating Dental Providers. The ORM(s) shall be incorporated by reference in the Network Provider Agreement. The ORM(s) shall clearly define covered services, limitations, exclusions, and utilization management procedures, including, but not limited to: PA 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 depending on the dental program being administered . The ORM(s) 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(s) remains up-to-date and reflects changes in applicable law or revisions to TennCare or Contractor policy. The initial version of the ORM(s) and any subsequent revisions thereto shall be submitted to TennCare and the Tennessee Department of Commerce and Insurance (TDCI) TennCare Oversight Division for review and approval prior to distribution. Participating Dental Providers shall be apprised of revisions to the ORM(s) 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 the TennCare ECF CHOICES DBM program and TennCare 1915(c) DBM program Participating Dental Providers.

A.12.3.5. <u>Practice Guidelines</u>

A.12.3.5.1. 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.12.3.5.1.1. Must comply fully with TennCare Medical necessity rule found at 1200-13-16, as applicable;

A.12.3.5.1.2. 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;

A.12.3.5.1.3. Consider the needs of the enrollees;

A.12.3.5.1.4. Are adopted in consultation with contracting health care professionals;

A.12.3.5.1.5. Are reviewed and updated periodically as appropriate; and

A.12.3.5.1.6. Are disseminated to all affected providers and, upon request, to enrollees and potential enrollees.

A.12.4. **<u>NETWORK DEVELOPMENT AND MANAGEMENT</u>**

A.12.4.1. <u>Providers Providing On-Going Treatment.</u>

A.12.4.1.1. 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.12.4.2. Other Provider Termination.

A.12.4.2.1. 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 within the previous two (2) years by the terminated provider.

A.12.4.3. Notice of Network Deficiency

A.12.4.3.1. 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.12.4.4. Notice of Subcontractor Termination

A.12.4.4.1. 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 TDCI TennCare Oversight Division. Said notices shall include, at a minimum; the Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed 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 PA requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees, etc.

A.12.4.5. Provider Terminations

A.12.4.5.1. The Contractor shall notify TennCare of any provider termination (to include Name, Address, NPI, Medicaid ID, TennCare ID) and submit a template copy of the enrollee notice sent as well as an electronic listing identifying each enrollee to whom a notice was sent. The Contractor shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TennCare. If the termination was initiated by the provider, said notice shall include a copy of the provider's notification to the Contractor.

A.12.5. **PROVIDER AGREEMENTS**

A.12.5.1. General Requirements

A.12.5.1.1. 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 TennCare Oversight Division 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.

A.12.5.1.2. The Contractor shall design a Provider Agreement that would allow the provider a choice to participate in one or more of the following programs: TennCare Children's DBM Program, TennCare Adult DBM Program, TennCare ECF CHOICES DBM Program, TennCare 1915(c) DBM Program and CoverKids DBM Program.

A.12.5.1.3. The Contractor shall not use "opt out" provisions to Provider Agreements or amendments to Provider Agreements when building provider networks for existing or new DBM dental programs. All Contractor Provider Agreements and amendments to such agreements must be "opt in".

A.12.5.1.4. 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.

A.12.5.1.5. 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.12.5.2. for enrollees in the TennCare Children's DBM Program, CoverKids DBM Program and the 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.

A.12.5.2. Patient-Centered Dental Home (PCDH)

A.12.5.2.1. 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 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.

A.12.5.2.2. The Contractor must establish a PCDH in order to ensure that enrollees in the TennCare Children's DBM Program, CoverKids 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.

A.12.5.2.3. Individual primary care dentists must be able to access their roster of dental home assignments through their provider web portal established by the Contractor.

A.12.5.2.4. Reserved.

A.12.5.2.5. 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.

A.12.5.2.6. 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 oral disease prevention strategy must include engagement of both members and providers by the DBM, and must be updated quarterly. The strategy must be submitted to TennCare for approval, one quarter prior to implementation of the strategy.

A.12.5.2.7. The Contractor shall also develop an individual confidential provider performance report (PPR) for the TennCare Children's DBM program that is sent to participating primary care dentists (general dentists and pediatric 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 Silver Diamine Fluoride (SDF) network benchmark and topical fluoride network benchmark. It is anticipated that sharing confidential feedback with primary care 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 -effectiveness, 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.9, as well as A.12.2.6., and A.12.2.6.9.2. 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.

A.12.5.2.8. 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. See Section C.3.9.2 for more detail regarding provider incentive structure.

A.12.5.2.9. For the TennCare Children's DBM Program, the Contractor will be assigned a panel of members based on the following considerations: member satisfaction, utilization of services, quality of care, and relocation of a member to a different part of the state. Members shall be allowed to change their PCDH annually, during the open enrollment period, or for cause.

A.12.5.2.10. The PCDH Provider Manual must be updated as necessary, but at least annually.

A.12.5.2.11. The DBM must submit quarterly reports (in a format approved by TennCare) about the PCDH to TennCare that track provider assignment of new members and provider reassignment of existing members, as well as outreach and corrective action plans to providers.

A.12.5.2.12. The Contractor shall provide technical and training assistance services for primary care dentists (PCDs) to assist them in participating in TennCare's Patient-Centered Dental Home program. The Contractor shall comply with the following general requirements:

A.12.5.2.12.1. Prepare participating dental practices to design, execute, and track improvements in practice management, care delivery, workflow, and care team effectiveness to achieve PCDH goals,

partnering with the provider in a manner least disruptive to the operations of the individual dental practice;

A.12.5.2.12.2. Prepare dental practices to proactively coordinate activities and facilitate collaboration with other healthcare stakeholders;

A.12.5.2.12.3. Assist dental practices in monitoring and improving performances on select quality measures for the PCDH. The Contractor shall assist dental practices in avoiding underutilization and overutilization of dental services to assure that TennCare Members receive the right care, in the right amount, and at the appropriate age.

A.12.5.2.13. The Contractor shall design and implement a gold card program, in which providers are able to bypass certain prior authorization requirements, for select general dentists who provide comprehensive care and either meet or exceed the agreed upon threshold of preventive and minimally invasive services, as approved by TennCare, and any other conditions or qualifications as determined by the DBM as found in C.3.9.2.2.. Gold card providers as identified by the DBM should be in good standing (be high performing providers with no evidence of overutilization of services).

A.12.5.2.14. 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:

A.12.5.2.14.1. 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.

A.12.5.2.14.2. Contractor may remove the Provider from the network as long as network adequacy can be maintained.

A.12.5.2.14.3. Contractor may choose not to contract with providers who do not routinely use SDF or sealants in their practice.

A.12.5.3. Provider Agreement Execution

A.12.5.3.1. 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 TennCare Oversight Division. 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.12.5.4. Provider Medical ID Required

A.12.5.4.1. 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.

A.12.5.4.2. 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.12.6. and A.12.7. 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.12.5.5. Required Provider Agreement Provisions

A.12.5.5.1. All Provider Agreements executed by the Contractor, and all Provider Agreements executed by subcontracting entities or organizations which cover delivering services to enrollees, pursuant to this Section A.12.5.5. 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.12.5.5.1.1. All new Provider Agreements and existing Provider Agreements as they are renewed, must include an electronic signature page that contains Contractor and provider names, which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties;

A.12.5.5.1.2. Specify the effective dates of the Provider Agreement;

A.12.5.5.1.3. Specify in the provider agreement that the Provider Agreement and its attachments contain all the terms and conditions agreed upon by the parties;

A.12.5.5.1.4. Identify the population covered by the Provider Agreement;

A.12.5.5.1.5. 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;

A.12.5.5.1.6. Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;

A.12.5.5.1.7. 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;

A.12.5.5.1.8. Provide that emergency services for eligible enrollees be rendered without the requirement of PA. However, the required documentation if requested must be submitted post-treatment for retro authorizations in order for the dentist to receive payment.

A.12.5.5.1.9. 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;

A.12.5.5.1.10. 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.

A.12.5.5.1.11. Require that all records be maintained for a period not less than ten(10) 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;

A.12.5.5.1.12. Enrollee Records-Consent. As a condition of participation in any of the TennCare DBM Programs or CoverKids DBM Program, enrollees have given 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, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately at no cost to the requesting party upon request to 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 MFCD, the DHHS OIG and the DOJ.

A.12.5.5.1.13. 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 ten (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.

A.12.5.5.1.14. 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;

A.12.5.5.1.15. Whether announced or unannounced, provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and appeal procedures established by the Contractor and/or TennCare;

A.12.5.5.1.16. 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;

A.12.5.5.1.16.1. Specify that the Contractor initiate corrective action if a participating provider is not complying with state and federal laws and regulations and TennCare policies

A.12.5.5.1.16.2. Require that the provider comply with corrective action plans initiated by the Contractor in addition to other possible actions as determined by TennCare

A.12.5.5.1.17. Provide for submission of all reports and clinical information required by the Contractor;

A.12.5.5.1.18. 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;

A.12.5.5.1.19. Provide the name and address of the official payee to whom payment shall be made;

A.12.5.5.1.20. Make full disclosure of the method and amount of compensation or other consideration to be received from the Contractor;

A.12.5.5.1.21. Provide for prompt submission of information needed to make payment;

A.12.5.5.1.22. 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.15.1.4. of this Contract;

A.12.5.5.1.23. 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;

A.12.5.5.1.24. 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;

A.12.5.5.1.25. Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the Plan's enrollees and the Contractor under the agreement. The provider shall provide such insurance coverage at all times during the agreement and upon execution of the Provider Agreement furnish the Contractor with written verification of the existence of such coverage;

A.12.5.5.1.26. 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;

A.12.5.5.1.27. 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. If changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the Contractor and provider agree to negotiate further any amendment as may be necessary to correct any inequities;

A.12.5.5.1.28. 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.);

A.12.5.5.1.29. 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;

A.12.5.5.1.30. 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);

A.12.5.5.1.31. 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;

A.12.5.5.1.32. 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;

A.12.5.5.1.33. 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;

A.12.5.5.1.34. Specify that the dental provider shall comply with the appeal process and PA 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;

A.12.5.5.1.35. 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;

A.12.5.5.1.36. Require that if any requirement in the Provider Agreement is determined by TennCare to conflict with the Contract between TennCare and the Contractor, such requirement shall be null and void and all other provisions shall remain in full force and effect;

A.12.5.5.1.37. 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.13.3.1. and A.13.3.2. of this Contract, or includes language that states those requirements;

A.12.5.5.1.38. 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;

A.12.5.5.1.39. Specify that if TennCare deems the Contractor unable to timely process and reimburse claims and requires the Contractor to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the Contractor's contracted reimbursement rate or the rate established by TennCare, whichever is greater;

A.12.5.5.1.40. Specify that the provider warrants that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractors, or consultant to the provider in connection with any work contemplated or performed relative to the agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration;

A.12.5.5.1.41. The Provider Agreements shall include the following nondiscrimination provisions:

A.12.5.5.1.41.1. No person on the grounds of disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with the Contractor or in the employment practices of the provider. The provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees and enrollees.

A.12.5.5.1.41.2. The provider shall be interacting with individuals from diverse cultural backgrounds including, individuals with LEP, individuals with low literacy, individuals with disabilities, including individuals with vision, cognitive, hearing, and speech disabilities, therefore, the provider shall have policies and procedures for delivering services in a nondiscriminatory and cultural competent manner, providing free language and communication assistance services to individuals, providing individuals with reasonable accommodations, discrimination complaint procedures and for regularly inspecting assessment methods and any data algorithms, such as clinical algorithms, to promote equity and eliminate bias with generating assessment results.. The provider's staff members carrying out the terms of the Provider Agreement shall receive annual training on the provider entity's: policies on how to deliver services in a nondiscriminatory and culturally competent manner, complaint procedures, process to obtain free language assistance services for LEP individuals, process for providing free effective communication services (auxiliary aids or services) to individuals with disabilities, and process for providing reasonable accommodations for individuals with disabilities. The provider entity's new hires carrying out the terms of the Provider Agreement shall receive this training within thirty (30) days of joining the entity's workforce.

A.12.5.5.1.41.3. The provider shall provide any discrimination complaint received relating to TennCare's services and activities within in two (2) days of receipt to TennCare's Office of Civil Rights Compliance ("OCRC") at HCFA.Fairtment@tn.gov. The provider agrees to cooperate with OCRC and other federal and state authorities during discrimination complaint investigations and to assist individuals in obtaining information on how they can report a complaint or get assistance for a disability related need that involves TennCare's services or activities by contacting OCRC. To satisfy this obligation the provider may direct the individual to OCRC's webpage at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html or to call TennCare Connect at 855-259-0701 if they need assistance with filing a complaint.

A.12.5.5.1.41.4. To the extent that the provider is using electronic and information technology to fulfill its obligations under this Contract, 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 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 Section 508 standards: https://www.access-board.gov/ict/).

A.12.5.5.1.41.5. For Provider Agreement that include Ethical and Religious Directives provisions, include the following requirements:

A.12.5.5.41.5.1. The Provider shall provide a list of the services it does not deliver due to the Ethical and Religious Directives to the CONTRACTOR. The CONTRACTOR shall furnish this list to TENNCARE, notating those services that are TennCare covered services. This list shall be used by the CONTRACTOR and TENNCARE to provide information to TennCare members about where and how the members can obtain the services that are not being delivered by the Provider due to Ethical and Religious Directives.

A.12.5.5.41.5.2. Should a medical issue arise at the time of service, the Provider shall inform TennCare members that the member's MCO has additional information on providers and procedures that are covered by TENNCARE. The Provider is not required to make specific recommendations or referrals.

A.12.5.5.1.42. 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,

A.12.5.5.1.43. 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

A.12.5.5.1.44. 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.

A.12.5.5.1.45. Provider understands that payment 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.

A.12.5.5.1.46. 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.12.5.6. <u>Provider Discrimination Prohibited</u>

A.12.5.6.1. 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.12.5.6.2. 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. In addition, as a participant in a program receiving federal funds, providers shall not be subjected to discrimination because of their race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law.

A.12.5.7. 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 a written notice within thirty (30) days of the reason for its decision.

A.12.5.8. Provider Advocacy for Enrollee

A.12.5.8.1. 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.12.5.8.1.1. for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

A.12.5.8.1.2. for any information the enrollee needs in order to decide among all relevant treatment options;

A.12.5.8.1.3. for the risks, benefits, and consequences of treatment or non-treatment; and

A.12.5.8.1.4. 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.12.5.9. Provider Identification of Third-Part Liability (TPL)

A.12.5.9.1. The TennCare program shall be the payer of last resort for all covered services in accordance with federal regulations. The Contractor shall exercise assignment rights as applicable and shall be responsible for making every reasonable effort to determine the liability of third parties to pay for services rendered to enrollees under this Contract and cost avoid and/or recover any such liability from the third party. The Contractor shall develop and implement policies and procedures to meet its obligations regarding third party liability when the third party (e.g., long-term care insurance) pays a cash benefit to the Member, regardless of services used or does not allow the Member to assign his/her benefits. The Contractor shall comply with all requirements included in this Contract, TennCare policies, TennCare Plan and any other written directives from TennCare.

A.12.5.9.2. 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. 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.12.5.10. 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.12.5.11. Notification of Claims Against Contractor. The Contractor shall give TennCare and TDCI TennCare Oversight Division immediate notification in writing by Certified Mail of any administrative or legal action or complaint filed regarding any claim made against the Contractor by a provider or enrollee which is related to the Contractor's responsibilities under this Contract, including but not limited to notice of any arbitration proceedings instituted between a provider and the Contractor. The Contractor shall ensure that all tasks related to the Provider Agreement are performed in accordance with the terms of this Contract.

A.12.5.12. Dentists Majority Ownership/Control. 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 or majority partnership interests 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. This requirement does not apply to the Federally Qualified Health Center (FQHC) and Rural Health Centers (RHC) classes of providers.

A.12.5.13. TennCare ECF CHOICES and 1915(c) DBM Program. 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 and 1915(c) DBM Programs, which agreement shall be approved by TennCare and TDCI TennCare Oversight Division prior to contracting with any ECF CHOICES or 1915(c) Participating Dental Provider. The dental Provider Agreement or amendment specific to the dental benefits provided under the TennCare ECF CHOICES and 1915(c) DBM Program shall incorporate, at a minimum, the coverage criteria in Contract Sections A.16.3. and A.16.4.

A.12.6. **CREDENTIALING AND RE-CREDENTIALING**

A.12.6.1. 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.12.6.1.1. 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 fully completed clean application, including all necessary documentation and attachments, a Medicaid ID number and signed Provider Agreement/contract.

A.12.6.1.2. Written Policies and –Procedures - The Contractor shall have 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.

A.12.6.1.3. 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.

A.12.6.1.4. 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.

A.12.6.1.5. Process - The Contractor's initial credentialing process shall obtain and review verification of the following information, at a minimum:

A.12.6.1.5.1. Primary Verification:

A.12.6.1.5.1.1. the practitioner holds a current valid license to practice Dentistry within the State;

A.12.6.1.5.1.2. valid Drug Enforcement Agency (DEA) certificate, as applicable.

A.12.6.1.5.1.3. confirmation of highest level of education and training received;

A.12.6.1.5.1.4. professional liability claims history (past five (5) years) from the national practitioner data bank and the state board of dentistry; and

A.12.6.1.5.1.5. any sanctions imposed by Medicare, Medicaid, TennCare, the Tennessee Board of Dentistry or any other state board of Dentistry if available.

A.12.6.1.5.1.6. 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.)

A.12.6.1.5.1.7. any revocation or suspension of a state license or DEA number.

A.12.6.1.5.2. Secondary Verification (Self-reported):

A.12.6.1.5.2.1. work history – past five (5) years. Verbal explanation for gaps greater than six (6) months, written explanation for gaps greater than one (1) year;

A.12.6.1.5.2.2. the practitioner holds current, adequate malpractice insurance according to the plan's policy;

A.12.6.1.5.2.3. any curtailment or suspension of medical staff privileges (other than for incomplete medical records);

A.12.6.1.5.2.4. the application process includes a statement by the applicant and an investigation of said statement regarding:

A.12.6.1.2.4.1. any physical or mental health problems that may affect current ability to provide dental care;

A.12.6.1.2.4.2. any history of chemical dependency/substance abuse;

A.12.6.1.2.4.3. history of loss of dental license and/or felony convictions;

A.12.6.1.2.4.4. history of loss or limitation of privileges or disciplinary activity;

A.12.6.1.2.4.5. current malpractice coverage and limits;

A.12.6.1.2.4.6. an attestation to correctness/completeness of the application;

A.12.6.1.2.4.7. current or former listing on the national sex offender registry; and

A.12.6.1.2.4.8. current or former listing on the Tennessee Sex Offender Registry.

A.12.6.1.5.3. The Contractor must verify licensure and valid DEA certificate, as applicable, within one hundred eighty (180) calendar days prior to the credentialing date.

A.12.6.1.5.4. 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.

A.12.6.1.5.5. A site review shall be required by the Contractor for a dentist's office for which the Contractor receives a grievance from an enrollee that the facility does not meet acceptable standards such as infection control standards or standards for accessibility for individuals with disabilities.

A.12.6.1.6. Recredentialing - A process for the periodic reverification of clinical credentials (recredentialing, reappointment, or recertification) shall be described in the Contractor's policies and procedures and contain at a minimum the following requirements.

A.12.6.1.6.1. There is evidence that the procedure is implemented at least every three (3) years.

A.12.6.1.6.2. There is verification of State licensure at least every three (3) years,

A.12.6.1.6.3. 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 A.12.6.1.6.1. through A.12.6.1.6.2. above.

A.12.6.1.6.4. The recredentialing, recertification or reappointment process shall also include review of data from:

A.12.6.1.6.4.1. enrollee grievances;

A.12.6.1.6.4.2. results of quality reviews;

A.12.6.1.6.4.3. utilization management;

A.12.6.1.6.4.4. member satisfaction surveys; and

A.12.6.1.6.4.5. reverification of hospital privileges and current licensure.

A.12.6.1.7. 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.

A.12.6.1.8. 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.

A.12.6.1.9. If credentialing is denied, the provider must be notified in writing by the Contractor and the reason for the denial must be specified.

A.12.6.1.10. 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 that considers 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.12.7. Credentialing for ECF CHOICES and 1915(c) Participating Dental Providers

A.12.7.1. The Contractor shall be responsible for credentialing and contracting ECF CHOICES and 1915(c) Participating Dental Providers sufficient in number to provide appointment availability for Covered Services to eligible ECF CHOICES and 1915(c) 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 and 1915(c) 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.12.8. Dental Record Standards

A.12.8.1. Accessibility and Availability of Dental Records

A.12.8.1.1. 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 of the U.S. Department of Health and Human Services, TennCare agencies, or agents thereof

A.12.8.2. 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:

A.12.8.2.1. Dental Record Standards - The Contractor sets standards for dental records. These standards shall, at a minimum, include requirements for:

A.12.8.2.1.1. Enrollee Identification Information - Each page in the record contains the enrollee's name or enrollee ID number;

A.12.8.2.1.2. Personal/biographical Data - Personal/biographical data includes: age; sex; race; primary language; disability status; address; employer; home and work telephone numbers; and marital status;

A.12.8.2.1.3. Entry Date - All entries –are dated;

A.12.8.2.1.4. Entry Submission - Written submission of treatment for every date of service;

A.12.8.2.1.5. Provider Identification - All entries are– identified as to author;

A.12.8.2.1.6. 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;

A.12.8.2.1.7. 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;

A.12.8.2.1.8. 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;

A.12.8.2.1.9. Immunizations - (for pediatric records ages 12 and under) There is a completed immunization record or a notation that immunizations are up to date;

A.12.8.2.1.10. Diagnostic information;

A.12.8.2.1.10.1. The Contractor shall ensure that participating providers properly identify and label patient radiographs, including the patient's name and date of birth, as well as spatial orientation, left/right

A.12.8.2.1.11. Medication information;

A.12.8.2.1.12. Identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record;

A.12.8.2.1.13. 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;

A.12.8.2.1.14. Referrals and Results Thereof, and

A.12.8.2.1.15. Emergency Care.

A.12.8.2.2. 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.12.8.2.2.1. History and Physical Examination - Appropriate subjective and objective information is obtained for the presenting grievance;

A.12.8.2.2.2. Plan of Treatment;

A.12.8.2.2.3. Diagnostic Tests;

A.12.8.2.2.4. Treatment rendered, medications by dosage, dispensed or prescribed;

A.12.8.2.2.5. 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 oxide;

A.12.8.2.2.6. Appropriate charting of conditions and treatment;

A.12.8.2.2.7. 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;

A.12.8.2.2.8. 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

A.12.8.2.2.9. All other aspects of patient care, including ancillary services.

A.12.8.2.2.10. Signature of rendering provider

A.12.8.3. Record Review Process

A.12.8.3.1. The Contractor shall have a record review process to assess the content of dental records for legibility, organization, completion and conformance to its standards.

A.12.8.3.2. The record assessment system must address documentation of the items listed in Section A.145.b above.

A.12.9. **PROVIDER PAYMENT**

A.12.9.1. Dental Service Payments

A.12.9.1.1. The Contractor shall be considered to be at financial risk for the provision of covered benefits to enrollees in the following DBM Programs: TennCare Children's DBM Program, TennCare Adult DBM Program, and the CoverKids DBM Program. For the TennCare ECF CHOICES and 1915(c) DBM Program, The Contractor shall not be considered to be at financial risk for the provision of covered benefits to TennCare ECF CHOICES and 1915(c) DBM Program enrollees. For the non at risk population, 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.12.9.2. Interest

A.12.9.2.1. 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.12.9.3. Service Dates

A.12.9.3.1. 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.12.9.4. Covered Services

A.12.9.4.1. The State shall only assume responsibility for payment of providers for the provision of covered services as specified in Section A.6 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.12.9.5. <u>Allowable Rates</u>

A.12.9.5.1. The Contractor shall negotiate rates with providers to meet contractual requirements.

A.12.9.6. <u>Non-Discrimination Compliance Requirements</u>

A.12.9.6.1. No person on the grounds of disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state civil rights laws 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. The Contractor agrees to cooperate with the Division of TennCare's Office of Civil Rights ("OCRC") in carrying out its federal and state nondiscrimination compliance obligations, which include and are not limited to: the Title VI of the Civil Rights Act of 1964, Section 504 and 508 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) and Section D.9 of this Contract. The Contractor shall provide OCRC with the name and contact information for a Nondiscrimination Compliance Coordinator who will work with OCRC to fulfill the nondiscrimination compliance activities related to the terms of this Contract.

A.12.9.6.1.1. Policies and Procedures and Training. The Contractor shall be interacting with individuals from diverse cultural backgrounds including, individuals with Limited English Proficiency ("LEP"), individuals with low literacy, individuals with disabilities, including individuals with vision, cognitive, hearing, and speech disabilities, therefore, the Contractor shall have policies and procedures for providing services in a nondiscriminatory and cultural competent manner, providing free language and communication assistance services to individuals, providing individuals with reasonable accommodations, discrimination complaint procedures, and for regularly inspecting assessment methods and any data algorithms, such as clinical algorithms, to promote equity and eliminate bias with generating assessment results. The Contractor's staff members carrying out the terms of this Contract shall receive annual training on the entity's: policies on how to provide services in a nondiscriminatory and culturally competent manner, complaint procedures, process to obtain free language assistance services for LEP individuals, process for providing free effective communication services (auxiliary aids or services) to individuals with disabilities, and process for providing reasonable accommodations for individuals with disabilities. The Contractor's new hires carrying out the terms of this Contract shall receive this training within thirty (30) days of joining the Contractor's workforce.

A.12.9.6.1.2. Ethical and Religious Directives. Should the Contractor not provide certain services covered under this Contract due to their sincerely held ethical/moral beliefs and/or religious directives the Contractor shall comply with the following requirements:

A.12.9.6.1.2.1. The Contractor shall provide a list of the services it does not deliver due to the Ethical/Moral and Religious Directives 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 by the Contractor due to their sincerely held ethical/moral beliefs and/or religious directives.

A.12.9.6.1.2.2. Should an issue arise at the time of a service interaction, the Contractor shall inform TennCare members that TennCare can assist them with that issue. The Contractor is not required to make specific treatment recommendations or referrals.

A.12.9.6.1.3. Electronic and Information Technology Accessibility Requirements. To the extent that the Contractor is using electronic and information communication 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 Section 508 standards: https://www.access-board.gov/ict/). Additionally, the Contractor agrees to comply with Title VI of the Civil Rights Act of 1964, by adding 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 a machine translate tool or translating the page into non-English languages as directed by TennCare.

A.12.9.6.1.3.1. 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.

A.12.9.6.1.4. Discrimination Complaints and Assistance. The Contractor shall provide any discrimination complaint received relating to this Contract's services and activities within in two (2) days of receipt to OCRC at HCFA.Fairtment@tn.gov. The Contractor agrees to cooperate with OCRC and other federal and state authorities during discrimination complaint investigations and to assist individuals in obtaining information on how they can report a complaint or get assistance for a disability related need that involves TennCare's services or activities by contacting OCRC. To satisfy this obligation the Contractor may direct the individual to OCRC's webpage at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html or to call TennCare Connect at 855-259-0701 if they need assistance with filing a complaint. If a member asks for assistance with filing complaint or making a disability related request to TennCare, the Contractor shall assist the member. In addition, the Contractor shall inform its employees, providers, and subcontractors how to assist members with reporting discrimination complaints and making requests for disability related assistance to TennCare and the Contractor.

A.12.9.6.1.5. Readiness Review. Prior to the contract start date, the Contractor's designated staff member shall participate in a nondiscrimination/civil rights readiness review phase. This process is to assist the Contractor with implementing the Contract's nondiscrimination requirements.

A.12.9.6.1.6. Nondiscrimination Compliance Reports. The Contractor shall submit the following nondiscrimination compliance deliverables to OCRC using TennCare's Office of Compliance Management Oversight Processing System ("TOPS") as follows:

A.12.9.6.1.6.1. Annual Compliance Questionnaire. On an annual basis, using TOPS, OCRC shall provide the Contractor with a Nondiscrimination Compliance Questionnaire. The Contractor shall answer the applicable questions and submit the completed questionnaire to OCRC within sixty (60) days of receipt of the questionnaire with any requested documentation, which shall include, the Contractor's: Assurance of Nondiscrimination, nondiscrimination policies, data capturing the amount of language and communication assistance services provided to individuals, and a civil rights and cultural compliance training report.

A.12.9.6.1.6.2. Quarterly Compliance Reports. The Contractor shall submit a quarterly Non-discrimination Compliance Report which shall include the following:

A.12.9.6.6.2.1. A civil rights and cultural compliance training report;

A.12.9.6.6.2.2. 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 the services provided under the scope of this Contract.

A.12.9.6.6.2.3. 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; large print; Sign Language) and the methods used to provide those services.

A.12.9.6.1.7. Nondiscrimination Notice and Taglines. Should the Contractor create materials (flyers, emails, text messages), the Contractor shall ensure that communications critical to obtaining services and vital documents that are targeted to participants, enrollees, applicants, and members of the public shall be printed with the notice of nondiscrimination and taglines required by TennCare. Written materials specific to TennCare program members shall be approved by TennCare prior to the materials being sent to these individuals and at a minimum vital documents shall be translated and available in Spanish and Arabic.

A.13. <u>QUALITY IMPROVEMENT/QUALITY MANAGEMENT (QI/QM)</u>

A.13.1. <u>Reserved</u>

A.13.2. <u>DENTAL POPULATON HEALTH AND CARE COORDINATION</u>

A.13.2.1. The Contractor shall be responsible for the management, coordination, and continuity of care for all its TennCare members and shall develop and maintain policies and procedures to address this responsibility.

A.13.2.2. The Contractor shall evaluate the entire member population and identify members for education, outreach, and intervention purposes, according to risk level, and provide targeted education, outreach, and interventions to members, according to their identified risk levels. Education, outreach, and interventions shall vary, with increasing engagement and intensity as level of risk increases. Member outreach shall include the provisions of clinical reminders.

A.13.2.3. For all eligible members, the Contractor shall establish and maintain a care coordination and member outreach program designed to help members who are at highest risk, have not had a dental appointment within the past twelve (12) months, or have dental needs which need immediate attention. The goal of the Care Coordination and Member Outreach program is to assure members get the urgent dental services they need timely to prevent or reduce an adverse health outcome. Services provided are short-term and time limited in nature and may include assistance in making and keeping needed dental appointments and referrals related to the members' immediate dental needs, PCDH reconnection and offering other resources or materials related to oral health and prevention.

A.13.2.4. <u>Transition Period</u>

A.13.2.4.1. 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 PA and regardless of whether the services are being provided by a provider within or outside the Contractor's provider network. 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 PAs 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 PAs as outlined in Section A.12.2.4 of this Contract, the Contractor will accept and honor those PAs 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, if applicable, are redirected to the Contractor.

A.13.2.5. <u>Web Portal</u>

A.13.2.5.1. The Contractor shall develop, prior to program implementation and maintain thereafter through the duration of this Contract, a web portal that allows sharing of specific information such as member treatment plans and budget statuses between the Contractor and MCOs for members receiving dental care in the TennCare ECF CHOICES and 1915(c) DBM Program. The web portal also allows sharing of specific treatment information between the Contractor and MCOs for enrollees in other TennCare DBM Programs and the CoverKids DBM Program receiving dental services. Additionally, the web portal shall allow for exchange of information between the Contractor and participating dental providers such as authorizations and claims, review of Explanation of Benefits (EOBs) or remittances for applicable denial reasons, checking member eligibility, viewing status of dental home patients, submitting inquiries or supporting documents and other information as determined necessary by TennCare.

A.13.2.6. <u>Coordination Between MCO and Contractor</u>

A.13.2.6.1. 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.13.2.6. 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.

A.13.2.6.2. The Contractor shall coordinate dental and medical services in accordance with the provisions in this Section A.13.2.6.

A.13.2.6.2.1. The MCO bears responsibility for providing enrollee with transportation to obtain Contractor-covered services. For example, if the Contractor approves a PA request for orthodontic treatment, the MCO is responsible for providing transportation to and from the treatment location if requested by the enrollee.

A.13.2.6.2.2. The Contractor shall be responsible for covering medically necessary, authorized dental services. The Contractor or MCC bears responsibility for covering the attendant medical, facility, and anesthesia services depending on where such anesthesia services are administered and who administers them.

A.13.2.6.2.2.1. 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

A.13.2.6.2.2.2. 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.

A.13.2.6.2.3. 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 (except for 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.

A.13.2.6.2.4. Services and Responsibilities - Coordination of dental services, shall at a minimum, include:

A.13.2.6.2.4.1. Means for referral which assures immediate access for emergency care and a provision of urgent and routine care according to TennCare guidelines;

A.13.2.6.2.4.2. Means for the transfer of information (to include items before and after the visit);

A.13.2.6.2.4.3. Maintenance of confidentiality;

A.13.2.6.2.4.4. Cooperation with the MCO regarding training activities provided by the MCO.

A.13.2.6.2.4.5. 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;

A.13.2.6.2.4.6. 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

A.13.2.6.2.4.7. 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

A.13.2.6.2.5. 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 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. If such issues cannot be resolved, the MCO and the Contractor shall meet with TennCare to reach final resolution of matters involved. Final resolution of system issues shall occur within ninety (90) days from referral to TennCare.

A.13.2.6.2.6. 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 PA 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) where 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 PA. The receiving party shall immediately inform the requesting provider that receiving party is responsible for rendering a decision to the PA request. In accordance with applicable law, this PA 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 PA, 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.

A.13.2.6.2.7. Claim Resolution Authorization

A.13.2.6.2.7.1. 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 PA 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.

A.13.2.6.2.7.2. 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.

A.13.2.6.2.7.3. 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.

A.13.2.6.2.7.4. 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.

A.13.2.6.2.7.5. 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.

A.13.2.6.2.7.6. 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.

A.13.2.6.2.7.7. 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.

A.13.2.6.2.7.8. The State, or its designee, shall decide 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.

A.13.2.6.2.7.9. 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).

A.13.2.6.2.7.10. Emergencies - PA 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.

A.13.2.6.2.8. 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.

A.13.2.6.2.9. 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.

A.13.2.6.2.10. 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.

A.13.2.6.2.11. 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 D.34. 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.

A.13.2.6.2.12. 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.13.2.6.2.13. Access to Medical Facilities – The Contractor shall work with the MCOs to develop a protocol, approved by TennCare, that will assist dental specialists needing facility time or credentialing, such as time in an operating room or Ambulatory Surgery Center, to ensure that children who have been authorized for dental treatment in a medical facility are able to receive timely treatment. The Children's DBM-MCO Coordinator shall adhere to all steps in the developed protocol by working closely with their counterpart at the MCO and notify TennCare when escalation to the MCOs fails to result in timely care for the member.

A.13.2.7. <u>Social Determinants of Health (SDOH)</u>

A.13.2.7.1. The Contractor shall establish a TennCare approved uniform SDOH screening form. This form will be available to dental providers to screen members for unmet social and health needs. The form shall be downloadable from the Contractor's website for use by participating dental providers. Positive findings for acute unmet social needs such as food, housing, or transportation identified on the screening form reported to the Contractor by the participating dental provider must be shared by the Contractor, with the member's MCO through the DBM-MCO Coordinators to assist with connecting the member to community resources.

A.13.2.8. <u>Tracking System</u>

A.13.2.8.1. 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.13.2.9. <u>Provider Listing for MCO Primary Care Providers</u>

A.13.2.9.1. The Contractor shall prepare updated provider listings to be provided to the MCOs for the purpose of distribution to MCO primary care providers. This listing must be provided to MCOs on a quarterly basis in accordance with a form, format and schedule as determined by TennCare

A.13.3. **<u>EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT</u>**

A.13.3.1. <u>EPSDT and CoverKids Dental Services</u>

A.13.3.1.1. Contractor shall require Dental Providers to follow practice guidelines for preventive health services and minimally invasive services identified by TennCare including

EPSDT and CoverKids. This includes timely provision of exams, cleaning, fluoride treatment, silver diamine fluoride treatments, sealants and referral for treatment of Child Enrollees. Performance Guarantees have been established for providing EPSDT and CoverKids services. The Contractor shall be evaluated based on its performance of the following measures: member utilization or Partial Enrollment Adjusted Ratio (PEAR), Dental Screening Percentage (DSP) ages 3-20, Sealant Percentage for members ages 6-15, SDF Percentage and SDF OR Diversion, which requires dentists to attempt to use SDF as a caries arresting medicament as an alternative to requesting authorization for the member to receive dental treatment in a medical facility setting, when applicable. This is measured by the number of hospital treatment requests denied by the DBM due to lack of attempted use of SDF by the provider as reported on the hospital readiness form by the provider divided by the total number of hospital requests during the measurement period (See A.23.2. EPSDT and CoverKids Monitoring).

A.13.3.2. <u>Contractor's Outreach Activities for the TennCare Children's DBM Program and CoverKids DBM Program and Pregnant and Postpartum Members</u>

A.13.3.2.1. The Contractor shall conduct regularly scheduled outreach activities designed to educate enrollees about the availability of EPSDT and CoverKids dental services and to increase the number of children receiving such services.

A.13.3.2.1.1. Within forty-five (45) days of TennCare Programs Start Date, the Contractor shall submit a proposed outreach plan.

A.13.3.2.1.1.1. The Contractor's plan shall identify the target populations, service areas, specific outreach activities, including numbers of dental screenings to be conducted, schedule for completion and include copies of any material to be released to enrollees.

A.13.3.2.1.1.2. 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.

A.13.3.2.1.1.3. 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 Grand Divisions of the state. 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 Dental Screening Percentage (DSP) see Attachment F as well as county demographics must be utilized in determining counties for targeted activities and in developing strategies for specific populations.

A.13.3.2.1.1.4. 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.

A.13.3.2.1.1.5. The Contractor shall utilize a Short Message Service (SMS) to outreach enrollees regarding noncompliant appointments, value of keeping appointments and receiving oral disease preventive services such as fluoride

varnishes, dental sealants and Silver Diamine Fluoride (SDF). The frequency of such outreach should be a minimum of six (6) texting campaigns spread throughout the year.

A.13.3.2.1.1.6. 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.

A.13.3.2.1.1.7. The Contractor shall be responsible for distributing annual notices to enrollees of their dental benefit encouraging them to schedule a dental appointment.

A.13.3.2.1.2. 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.

A.13.3.2.1.3. 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.

A.13.3.2.1.4. If the Contractor's CMS 416 Dental Screening Percentage (DSP) 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.

A.13.3.2.1.5. The Contractor may provide member incentives that have received prior written approval by TennCare. For example, TennCare may approve the use of incentives given to enrollees to encourage participation in Social Determinants of Health (SDOH) and Population Health programs or to promote compliance with dental visits.

A.13.3.2.2. Failure to comply with the requirements of this Section may result in the application of liquidated damages as provided in Section E.9 and Attachment B of this Contract.

A.13.4. **QUALITY OF CARE**

A.13.4.1. Quality and Appropriateness of Care

A.13.4.1.1. The Contractor shall prepare for TennCare approval a written description of a Quality Monitoring Program (QMP) as described in Section A.13.4.8., 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.13.4.2. Committee Meeting Requirements

A.13.4.2.1. The Contractor shall provide the TennCare' s Chief Dental Officer 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 Chief Dental Officer of TennCare, or his/her designee, may attend the committee meetings at his/her option. The Contractor shall provide TennCare a copy of the written minutes for each meeting per Sections A.13.4.3.6. and A.13.4.4.1.7. of this Contract.

A.13.4.3. Quality Monitoring Program (QMP) Committee

A.13.4.3.1. 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.

A.13.4.3.2. 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.

A.13.4.3.3. The QMP Committee shall review and approve the written QMP and associated work plan (as described in Section A.13.4.8. of this Contract) prior to submission to TennCare.

A.13.4.3.4. 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:

A.13.4.3.4.1. Oversight of QMP - There is documentation that the Governing Body has approved the overall QMP and the annual QMP work plan.

A.13.4.3.4.2. 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.

A.13.4.3.4.3. 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.

A.13.4.3.5. 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.

A.13.4.3.6. 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.

A.13.4.3.7. The Contractor shall provide the Chief Dental Officer 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 Chief Dental Officer of TennCare, or his/her designee, may attend the QMP Committee meetings at his/her option.

A.13.4.4. Provider Peer Review Committee

A.13.4.4.1. The Contractor shall establish a Tennessee 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.13.4.4.1.1. The Committee shall review and provide detailed written findings, recommendations and appropriate corrective action for any participating dental provider who has provided inappropriate care.

A.13.4.4.1.2. The Contractor shall manage the network and inform TennCare's Office of Program Integrity and TennCare's Dental Division 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.

A.13.4.4.1.3. Suspected cases of fraud or abuse shall be referred to TennCare OPI and the TBI as appropriate.

A.13.4.4.1.4. The Contractor shall coordinate with TennCare in regard to issues involving fraud or abuse by any participating dental provider.

A.13.4.4.1.5. The Contractor shall coordinate with TennCare regarding extrapolation when indicated (See A.21.10.) and recoupment related to fraud, waste, and abuse.

A.13.4.4.1.6. 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.

A.13.4.4.1.7. 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 by TennCare and during the annual on-site EQRO review.

A.13.4.5. <u>Advisory Committee</u>

A.13.4.5.1. 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 stakeholders interested in improving oral health care in Tennessee. There should be provider representation on the committee for each of the State DBM programs . The TennCare Chief Dental Officer shall serve as the committee chairperson. The Committee shall review and make recommendations

regarding other policies of the Contractor relative to services provided under this Contract.

A.13.4.6. Standards for Facilities

A.13.4.6.1. The Contractor shall maintain standards for dental 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.13.4.6.1.1. Compliance with existing State and local laws regarding safety and accessibility;

A.13.4.6.1.2. Availability of emergency equipment;

A.13.4.6.1.3. Storage of drugs, and

A.13.4.6.1.4. Inventory control for expired medications

A.13.4.7. Performance Reviews

A.13.4.7.1. 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.13.4.8. Quality Monitoring Program

A.13.4.8.1. 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.13.4.8.1.1. At a minimum the Contractor shall adhere to the following requirements for the QMP:

A.13.4.8.1.1.1. Have a QMP Committee that oversees the QMP functions as described in Section A.13.4.3. of this Contract.

A.13.4.8.1.1.2. 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.

A.13.4.8.1.1.3. 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.

A.13.4.8.1.1.4. Evaluate the QMP annually and updated as appropriate.

A.13.4.8.1.2. 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:

A.13.4.8.1.2.1. Specification of the types of problems requiring remedial/corrective action;

A.13.4.8.1.2.2. Specification of the person(s) or body responsible for making the final determinations regarding quality problems;

A.13.4.8.1.2.3. Specific actions to be taken;

A.13.4.8.1.2.4. Provision of feedback to appropriate dental professionals and staff;

A.13.4.8.1.2.5. The schedule and accountability for implementing corrective actions;

A.13.4.8.1.2.6. The approach to modifying the corrective action if improvements do not occur; and

A.13.4.8.1.2.7. Procedures for terminating the affiliation with the dental professional.

A.13.4.8.1.3. The Contractor shall use the results of QMP activities to improve the quality of dental health with appropriate input from providers and members.

A.13.4.8.1.4. 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.

A.13.4.8.1.5. 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.

A.13.4.8.1.6. 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.13.4.9. Performance Improvement Projects (PIPs)

A.13.4.9.1. The Contractor shall perform at least one (1) clinical and one (1) non-clinical PIP in a format specified by TennCare.

A.13.4.9.2. The Contractor shall ensure that CMS protocols for PIPs are adhered to and that the following are documented for each activity:

A.13.4.9.2.1. Rationale for selection as a quality improvement activity;

A.13.4.9.2.2. Specific population targeted, include sampling methodology if relevant;

A.13.4.9.2.3. Metrics to determine meaningful improvement and baseline measurement;

A.13.4.9.2.4. Specific interventions (enrollee and/or provider);

A.13.4.9.2.5. Relevant clinical practice guidelines; and

A.13.4.9.2.6. Date of re-measurement.

A.13.4.9.3. 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.

A.13.4.9.4. The Contractor shall identify benchmarks and set achievable performance goals for each of its PIPs. In addition, the Contractor shall indicate the current measurement year (Baseline, Y1, Y2, Y3, Extension Y4, or Extension Y5) for each PIP. The Contractor shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.

A.13.4.9.5. 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. The Contractor shall also include the rationale for selection of each new PIP topic.

A.13.4.10. Enrollee Rights and Responsibilities

A.13.4.10.1. Reserved.

A.13.4.10.2. 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:

A.13.4.10.2.1. to be treated with respect, and recognition of their dignity and need for privacy;

A.13.4.10.2.2. to be provided with information about the organization, its services, the practitioners providing care, and enrollees' rights and responsibilities;

A.13.4.10.2.3. to participate in decision making regarding their dental care;

A.13.4.10.2.4. to voice grievances or appeals about the organization or care provided;

A.13.4.10.2.5. to be guaranteed the right to request and receive a copy of his or her dental records;

A.13.4.10.2.6. to request that his or her dental records be amended or corrected as specified in 45 CFR part 164;

A.13.4.10.2.7. 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;

A.13.4.10.2.8. to be free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the DBM and its providers or the State agency treat the enrollee;

A.13.4.10.2.9. 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

A.13.4.10.2.10. to exercise an advance directive, and include information about state law.

A.13.4.10.3. 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:

A.13.4.10.3.1. providing, to the extent possible, information needed by professional staff in caring for the enrollee; and

A.13.4.10.3.2. following instructions and guidelines given by those providing dental care services.

A.13.4.10.4. 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.

A.13.4.10.5. Communication of Policies and Procedures to Enrollees - Upon enrollment, Contractor shall provide enrollees a written statement that includes information on the following:

A.13.4.10.5.1. rights and responsibilities of enrollees;

A.13.4.10.5.2. benefits and services included and excluded as a condition of membership, and how to obtain them, including a description of:

A.13.4.10.5.2.1. any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to services obtained outside the system; and

A.13.4.10.5.2.2. the procedures for obtaining out of area coverage;

A.13.4.10.5.3. provisions for emergency coverage;

A.13.4.10.5.4. the organization's policy on referrals for specialty care;

A.13.4.10.5.5. charges to enrollees, if applicable, including:

A.13.4.10.5.5.1. policy on payment of charges; and

A.13.4.10.5.5.2. Co-payment and fees for which the enrollee is responsible;

A.13.4.10.5.6. procedures for notifying those enrollees affected by the termination or change in any benefits, services, or service delivery office/site;

A.13.4.10.5.7. procedures for appealing decisions adversely affecting the enrollee's coverage, benefits, or relationship to the organization;

A.13.4.10.5.8. procedures for changing practitioners; and

A.13.4.10.5.9. procedures for voicing grievances and/or appeals and for recommending changes in policies and services.

A.13.4.10.6. 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:

A.13.4.10.6.1. procedures for registering and responding to grievances and appeals in a timely fashion (organizations should establish and monitor standards for timeliness);

A.13.4.10.6.2. documentation of the substance of grievances or appeals, and actions taken;

A.13.4.10.6.3. procedures to ensure a resolution of the grievance or appeal;

A.13.4.10.6.4. aggregation and analysis of grievance and appeal data and use of the data for quality improvement; and

A.13.4.10.6.5. an appeal process for adverse actions.

A.13.4.10.7. Steps to Assure – Accessibility of Services - The Contractor shall take steps to promote accessibility of services offered to enrollees. These steps include:

A.13.4.10.7.1. the points of access to dental services, specialty care, and hospital or ambulatory surgical center services are identified for enrollees; and

A.13.4.10.7.2. at a minimum, enrollees are given information about:

A.13.4.10.7.2.1. how to obtain services during regular hours of operations;

A.13.4.10.7.2.2. how to obtain emergency care, and

A.13.4.10.7.2.3. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care.

A.13.4.10.8. Written Information for Enrollees shall comply with the requirements of this Contract, which includes, but is not limited to:

A.13.4.10.8.1. Enrollee information (for example, subscriber brochures, announcements, handbooks) is written in plain language in a manner that is readable and easily understood by individuals with low literacy levels.

A.13.4.10.8.2. Written information is available as set forth in Contract Section A.19.1.4., Written Material Guidelines.

A.13.4.10.9. Confidentiality of Enrollee Information - The organization acts to ensure that the confidentiality of specified patient information and records is protected.

A.13.4.10.9.1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records.

A.13.4.10.9.2. 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.

A.13.4.10.9.3. 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.13.4.10.9.3.1. it is required by law;

A.13.4.10.9.3.2. it is necessary to coordinate the enrollee's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matter pertaining to payment, or

A.13.4.10.9.3.3. it is necessary in compelling circumstances to protect the health or safety of an individual.

A.13.4.10.9.4. Any release of information in response to a court order is reported to the enrollee in a timely manner.

A.13.4.10.9.5. 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.

A.13.4.10.10. Treatment of Minors - The Contractor shall have written policies regarding the appropriate treatment of minors.

A.13.4.10.11. Assessment of Enrollee Satisfaction - The Contractor shall conduct periodic surveys of enrollee satisfaction with its services.

A.13.4.10.11.1. The surveys shall include content on perceived problems in the quality, availability, and accessibility of care.

A.13.4.10.11.2. As a result of the surveys, the Contractor shall:

A.13.4.10.11.2.1. identify and investigate sources of dissatisfaction;

A.13.4.10.11.2.2. outline action steps to follow up on the findings, and

A.13.4.10.11.2.3. inform providers of assessment results.

A.13.4.10.11.3. 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.14. **SUBCONTRACTORS**

A.14.1. Legal Responsibility

A.14.1.1. 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 Attachment A. 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.

A.14.1.2. 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.

A.14.1.3. 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.

A.14.1.4. 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.14.2. Prior Approval

A.14.2.1. 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 pursuant to Contract Section D.7. 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.14.3. Subcontractor Nondiscrimination Provisions

A.14.3.1. If the Contractor delegates its responsibilities under this Agreement to subcontractors, the Contractor shall require the subcontractors to comply with the nondiscrimination requirements set forth in Section A.12.5.5.1.41 Provider Agreement Nondiscrimination Requirements.

A.14.4. Assignability of Subcontracts

A.14.4.1. 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.14.5. Claims Processing

A.14.5.1. 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 subcontractor that is approved for a claims processing function must comply with the requirements for disclosure of ownership and control information found in 42CFR455.101 et seq

A.14.6. Notice of Subcontractor Termination

A.14.6.1. 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 TDCI TennCare Oversight Division. 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 PA requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees. 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.14.7. Notice of Approval

A.14.7.1. Approval of subcontracts shall not be considered granted unless TennCare issues its approval in writing.

A.14.8. Subcontract Relationship and Delegation

A.14.8.1. In addition to any other requirements for subcontracting set forth in this Contract, if the Contractor delegates responsibilities to a subcontractor, 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.14.8.1.1. The Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

A.14.8.1.2. The Contractor shall require that the agreement be in writing and specifies the activities and report responsibilities delegated to the subcontractors and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

A.14.8.1.3. The Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review consistent with industry standards or State MCO laws and regulations.

A.14.8.1.4. The Contractor shall identify deficiencies or areas for improvement and the Contractor and the subcontractors shall take corrective action as necessary.

A.15. **Systems**

A.15.1. **CLAIMS PROCESSING REQUIREMENTS**

A.15.1.1. General Requirements

A.15.1.1.1. 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.15.1.2. Electronic Billing System

A.15.1.2.1. 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

A.15.1.2.2. 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.15.1.3. HIPAA

A.15.1.3.1. 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, at no cost to the State.

A.15.1.4. Timeliness and Accuracy of Payment

A.15.1.4.1. 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.

A.15.1.4.2. 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. The remittance advice or other written notice must designate which program (TennCare or CHIP) the enrollee is a member of.)

A.15.1.4.3. 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.

A.15.1.4.4. 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.

A.15.1.4.5. 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.

A.15.1.4.6. 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.9 and Attachment B of this Contract.

A.15.1.5. Enrollee Eligibility

A.15.1.5.1. 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. CST on the effective date of eligibility in the Contractor plan.

A.15.1.6. Payment in Full

A.15.1.6.1. 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.12.9.1. 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.

A.15.2. MANAGEMENT INFORMATION SYSTEMS REQUIREMENTS

A.15.2.1. Data Mapping

A.15.2.1.1. 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, CoverKids data elements and data structures, and Contractor system 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 will make any necessary data formats available to the Contractor.

A.15.2.2. <u>Daily Enrollment Updates</u>

A.15.2.2.1. The Contractor must have a procedure to maintain and update enrollee profiles that is capable of processing daily updates.

A.15.2.3. <u>Contractor Interface Requirements</u>

A.15.2.3.1. 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 Virtual Private Network (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.15.2.4. <u>Requirements Prior to Operations</u>

A.15.2.4.1. Licensure

A.15.2.4.1.1. 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) TennCare Oversight Division. 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 TennCare Oversight Division to obtain such licensure.

A.15.2.4.1.2. Prior to the start date of operations, the Contractor shall ensure that its staff, all subcontractors and providers, and their staff are appropriately licensed.

A.15.2.4.1.3. The Contractor shall ensure that the Contractor and its staff, all subcontractors and staff, and all providers and staff retain at all times during the period of this Contract a valid license, as appropriate, and comply with all applicable licensure requirements.

A.15.2.4.2. Readiness Review

A.15.2.4.2.1. 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.

A.15.2.4.2.2. The Contractor shall cooperate in a readiness review(s) conducted by TennCare to review the Contractor's readiness to begin operations. This review(s) 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(s) may include any and all requirements of this Contract as determined by TennCare.

A.15.2.4.2.3. 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.

A.15.2.4.2.4. 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.

A.15.2.4.2.5. 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.15.2.5. Provider Assistance

A.15.2.5.1. 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 PA requests and claims status.

A.15.2.6. Help desk for prior approval operations

A.15.2.6.1. The Contractor shall develop a provider portal that allow dental providers to file dental claims electronically and maintain a toll-free telephone access to support the PA process, available between the hours of 7:00 a.m. and 5:00 pm, Central Standard Time, Monday through Friday to respond to questions about PA requests.

A.15.2.6.2. Service Level Performance Standards. The Contractor shall provide sufficient staff for “live" answering services during business 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.

A.15.2.6.2.1. 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.

A.15.2.6.2.2. 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.

A.15.2.6.2.3. 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.

A.15.2.6.2.4. Blocked Call Rate. The Service Center shall maintain a blocked call rate of one percent (1%) or less at all times without exception.

A.15.2.6.3. Failure by the Contractor to meet the aforementioned Service Level Agreement Standards may result in Liquidated Damages as set out in Attachment B.

A.15.2.7. Data validation edits and audits

A.15.2.7.1. The Contractor's claims processing system shall perform the following validation edits and audits:

A.15.2.7.1.1. Prior Authorization (PA) - The system shall determine whether a covered service requires PA, and if so, whether approval was granted by the Contractor;

A.15.2.7.1.2. 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 PA, if such PA 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;

A.15.2.7.1.3. 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;

A.15.2.7.1.4. 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;

A.15.2.7.1.5. 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;

A.15.2.7.1.6. 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;

A.15.2.7.1.7. Eligibility Validation – The system shall confirm the enrollee for whom a service was provided was eligible on the date the service was incurred;

A.15.2.7.1.8. Quantity of Service - The system shall validate claims to assure that the quantity of services is consistent with TennCare rules and policy;

A.15.2.7.1.9. 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,

A.15.2.7.1.10. 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.15.2.8. Data exchange with managed care organizations and pharmacy benefits manager

A.15.2.8.1. 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.13.2.5.

A.15.2.9. Prior approval request tracking

A.15.2.9.1. Each PA 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.15.2.10. System security

A.15.2.10.1. 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.15.2.10.1.1. Computer hardware controls that ensure acceptance of data from authorized networks and providers only;

A.15.2.10.1.2. At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes;

A.15.2.10.1.3. Manual procedures that provide secure access to the system with minimal risk;

A.15.2.10.1.4. Multilevel passwords, identification codes or other security procedures that shall be used by State agency or Contractor personnel;

A.15.2.10.1.5. All Contractor MIS software changes are subject to TennCare approval prior to implementation, and

A.15.2.10.1.6. System operation functions shall be segregated from systems development duties.

A.15.2.10.2. System requirements.

A.15.2.10.2.1. 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 ongoing and continuous support and maintenance of the of the website so that it stays current, accurate and guarantees that 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.

A.15.2.11. Disaster preparedness and recovery at the automated claims processing site

A.15.2.11.1. The Contractor shall submit evidence that they have a Business Continuity/Disaster Recovery plan as required in Section A.18.6.3.7. 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.15.2.11.1.1. Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation 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 if the central site is rendered inoperable;

A.15.2.11.1.2. Employees at the site shall be familiar with the emergency procedures;

A.15.2.11.1.3. Smoking shall be prohibited at the site;

A.15.2.11.1.4. 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;

A.15.2.11.1.5. Portable fire extinguishers shall be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested;

A.15.2.11.1.6. The site shall be protected by an automatic fire suppression system; and

A.15.2.11.1.7. The site shall be backed up by an uninterruptible power source system.

A.15.2.12. Transition upon termination requirements

A.15.2.12.1. 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.10, 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.15.2.13. Additional system requirements

A.15.2.13.1. 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.

A.15.2.13.2. 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.

A.15.2.13.3. 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.

A.15.2.13.4. The Contractor's DBM system send X12 compliant data as outlined in the Tennessee 837D Companion Guide.

A.15.2.13.5. The DBM system must be capable of providing data to TennCare's Fraud, Waste and Abuse reporting department.

A.15.2.14. Tennessee Eligibility Determination System (TEDS)

A.15.2.14.1. The Contractor shall maintain 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.

A.15.2.14.2. The Contractor shall report address changes, other TPL resource and PCP assignments for their Members in the daily 834 inbound files within twenty-four (24) hours or within the next 834 inbound file submission to TennCare. If the Contractor has reason to believe they may not meet this requirement based on unusual circumstances, the Contractor must notify TennCare and TennCare may make an exception without requiring a Corrective Action Plan.

A.15.2.14.3. Within five (5) business days of receipt of notice from TennCare of the occurrence of a problem with the provision and/or intake of an encounter or outbound 834 enrollment file or submission of an inbound 834 file, the Contractor shall provide TennCare with full written documentation that includes acknowledgement of receipt of the notice, a corrective action plan describing how the Contractor has addressed or will address the immediate problem and how the Contractor shall prevent the problem from recurring. In the event the Contractor fails to correct errors which prevent processing of encounter or enrollment data in a timely manner as required by TennCare or fails to submit a corrective action plan as required, TennCare may assess liquidated damages as specified in Attachment B. Continued or repeated failure to submit clean encounter data may result in the application of additional damages or sanctions or be considered a breach of the Contract.

A.16. **COVERED BENEFITS**

A.16.1. 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.6 of this Contract.

A.16.2. Medically Necessity Determination

A.16.2.1. 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, 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. 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.16.3. <u>Coverage criteria determinations for Sedation for TennCare ECF CHOICES and 1915(c) DBM program members</u>

A.16.3.1. 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 TennCare ECF CHOICES program and 1915(c) DBM 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 TennCare ECF CHOICES and 1915(c) members:

A.16.3.1.1. Who are extremely uncooperative, fearful, anxious, unmanageable, or physically resistant; and

A.16.3.1.2. 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

A.16.3.1.3. 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.16.4. <u>Coverage Criteria Determinations for TennCare ECF CHOICES and 1915(c) Members</u>

A.16.4.1. 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.16.5. <u>Prior Authorization (PA) for Covered Services</u>

A.16.5.1. 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.

A.16.5.2. If PA 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 PA was granted. PA shall not be required for emergency services.

A.16.5.3. PA 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.

A.16.5.4. 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.16.5.4.1. Adverse PA 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.17.5.

A.16.5.4.1.1. 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.

A.16.5.4.1.2. Enrollee Notice. Contractor shall abide by the notice provisions in TennCare Rule 1200-13-13-.11 and 1200-13-14-.11.

A.16.5.4.2. Appeals Related to PA/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.

A.16.5.4.3. 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 to impose appropriate financial penalties against the provider.

A.16.6. <u>EPSDT</u>

A.16.6.1. 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.16.7. <u>Standards of Care</u>

A.16.7.1. 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, disability, health, economic status, payment source, or other statuses protected under the applicable federal and state civil rights laws. 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.16.8. Transportation

A.16.8.1. 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.16.9. Coordination with and Management of Public Health's School Based Dental Encounter Data Files

A.16.9.1. 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.12.1.5. 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.

A.17. TENNCARE ENROLLEE GRIEVANCES AND ADVERSE BENEFIT DETERMINATION APPEALS

A.17.1. The provisions contained in the Grievances and Appeals Section shall apply to each of the programs listed in paragraph A.3 of this contract.

A.17.2. TennCare Member Medical Appeal Process

A.17.2.1. 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 to contest Contractor's proposed adverse benefit determination.

A.17.2.2. As permitted under federal and state law, TennCare, at its sole discretion, may delegate back to itself any portion of this Appeals Section (Contract Sections A.17.2 through A.17.17) 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.

A.17.2.3. 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.

A.17.2.4. Contractor Appeals Staff.

A.17.2.4.1. 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.

A.17.2.4.2. The Contractor shall provide general and targeted education to Contractor's Appeal Unit staff and to its TennCare providers regarding the Grievance and the SFH process. This training shall cover the TennCare provider's rights and obligations concerning the Grievance and the SFH Process, including but not limited to, provider's obligation to timely supply medical or other records necessary for resolving the Grievance or the SFH. Additionally, the provider training must include training on the requirements related to PA; 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.

A.17.2.4.3. The Contractor must provide written notice and written instruction to its contracted providers regarding provider responsibility in the Appeal process.

A.17.3. <u>Enrollee Grievance and State Fair Hearing (SFH) Process.</u>

A.17.3.1. <u>Grievance System</u>. 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).

A.17.3.2. <u>TennCare SFH System</u>. 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.

A.17.3.3. <u>Prior Authorization (PA) Determination Timeframes</u>. In accordance with 42 CFR § 438.210(d)(1), Contractor shall respond to the requesting provider within fourteen (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.

A.17.3.4. <u>Adverse Prior Authorizations (PAs) Determinations</u>. 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 fourteen (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]

A.17.3.4.1. When Contractor is required to provide written notice to enrollee, Contractor shall do so using TennCare-approved notice templates.

A.17.3.5. Reasonable Assistance with Grievance and Request for SFH.

A.17.3.6. In accordance with 42 CFR §438.406(a) and 42 CFR §438.228(a), Contractor shall provide enrollees reasonable assistance with the grievance and appeal process. Reasonable assistance includes providing staff to orally explain how to file complaints (that is, "grievances") with the Contractor versus how to contest adverse benefit determinations by calling in oral, or by filing written appeal requests for a SFH with TennCare. Reasonable assistance also includes informing enrollees that free language and communication assistance services are available. These free services include auxiliary aids, interpreter services, and TRS as required in Sections A. 11.2. and A. 11.3.

A.17.3.7. 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 five (5) business days. TennCare will send enrollee an acknowledgement letter and inform enrollee that matter will be treated as a request for a SFH.

A.17.4. Decision-Makers.

A.17.4.1. 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.17.4.1.1. Involved in any previous level of review or decision-making; or

A.17.4.1.2. Subordinates of any individual who was involved in a previous level of review or decision-making.

A.17.4.2. 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.17.4.2.1. the Reconsideration phase of a SFH request involving a denial based on lack of medical necessity;

A.17.4.2.2. grievance regarding denial of expedited resolution of a request for SFH; or

A.17.4.2.3. grievance or SFH request involving clinical issues.

A.17.4.3. Decision-makers shall consider 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.17.5. Notice of Adverse Benefit Determination Requirements

A.17.5.1. 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.

A.17.5.2. 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).

A.17.5.3. 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.

A.17.5.4. 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.

A.17.5.5. 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.

A.17.5.6. 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.17.6. Notice of Adverse Benefit Determination Timing

A.17.6.1. 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 prior to the date of action. See 42 CFR §438.404(c)(1); 42 CFR §431.211.

A.17.6.2. 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.

A.17.6.3. 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).

A.17.6.4. 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)]

A.17.6.5. 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 reimbursement of benefits enrollee paid for out-of-pocket.

A.17.6.6. The Contractor may extend the fourteen (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).

A.17.6.7. The Contractor may extend the fourteen (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.

A.17.6.8. If the Contractor extends the fourteen (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).

A.17.6.9. If the Contractor extends the fourteen (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).

A.17.6.10. If the Contractor determines that following the standard authorization timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor 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).

A.17.6.11. The Contractor may extend the seventy-two (72) hour expedited service authorization decision time 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.

A.17.7. Who May File Appeals and Grievances

A.17.7.1. Grievances. The Contractor shall allow enrollees to file grievances.

A.17.7.2. Appeal requests filed with Contractor instead of with TennCare. Contractor shall, within one (1) business day 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]

A.17.7.3. 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. but the enrollee's provider may serve as an authorized representative, although (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) - (ii); 42 CFR §438.408]

A.17.8. 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.17.9. Process for Filing a Standard or Expedited SFH Request

A.17.9.1. Enrollee may request a SFH either orally or in writing. [42 CFR 438.402(c)(3)(ii)]

A.17.9.2. 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)]

A.17.9.3. 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)]

A.17.9.4. 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)]

A.17.9.5. 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.

A.17.9.5.1. 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.

A.17.9.5.2. 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.

A.17.9.5.3. 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)]

A.17.9.5.4. Contractor's Reconsideration response to TennCare must contain the following:

A.17.9.5.4.1. complete case file,

A.17.9.5.4.2. medical records and history pertaining to the benefit under dispute,

A.17.9.5.4.3. NABD issued to enrollee,

A.17.9.5.4.4. PA Decision issued to requesting provider.

A.17.9.5.4.5. written medical necessity review substantiating Contractor's PA decision,

A.17.9.5.4.6. written Reconsideration medical necessity review upholding or reversing original PA decision, and

A.17.9.5.4.7. any additional information requested by TennCare or pertaining to the matter under dispute.

A.17.10. 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 three (3) business days of TennCare's receipt of Contractor's Reconsideration Response.

A.17.11. Required Content for Notice of SFH Resolution

A.17.11.1. 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.

A.17.11.2. 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.17.12. Continuation of Benefits

A.17.12.1. 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:

A.17.12.1.1. The enrollee files the request for SFH within sixty (60) calendar days following the date on the Adverse Benefit Determination notice.

A.17.12.1.2. The contested issue at the SFH involves the termination, suspension, or reduction of a previously authorized Medicaid service.

A.17.12.1.3. The enrollee's services were ordered by an authorized provider.

A.17.12.1.4. The period covered by the original authorization has not expired.

A.17.12.1.5. 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).

A.17.12.2. 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:

A.17.12.2.1. The enrollee withdraws the request for State Fair Hearing: or

A.17.12.2.2. 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).

A.17.12.3. 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.17.13. <u>TennCare Directives</u>

A.17.13.1. 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)]

A.17.13.2. 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)]

A.17.13.3. 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.

A.17.13.4. 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.17.14. <u>Grievances</u>

A.17.14.1. 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)(i).

A.17.14.2. 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).

A.17.14.3. 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.

A.17.14.4. 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.17.15. <u>Grievance and SFH-Related Recordkeeping Requirements</u>

A.17.15.1. 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).

A.17.15.2. The Contractor's record of Grievance or SFH request must include:

A.17.15.2.1. A general description of the reason for the Grievance or SFH request;

A.17.15.2.2. The date received;

A.17.15.2.3. The date of each review or, if applicable, review meeting;

A.17.15.2.4. The date of resolution and how it was resolved; and

A.17.15.2.5. The identity of the enrollee for whom the SFH request or Grievance was filed. See 42 CFR §438.416(b)(1)-(6).

A.17.16. Provision of Information about Enrollee Grievance and Appeal Rights

A.17.16.1. 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

A.17.16.2. The Contractor must include information about the enrollee's Grievance, and State Fair Hearing rights in the following materials:

A.17.16.2.1. Notice of Adverse Benefit Determination;

A.17.16.2.2. Provider and subcontractor contracts with Contractor;

A.17.16.2.3. Member Handbook and Provider Manual;

A.17.16.2.4. Provider training materials; and

A.17.16.2.5. Contractor website.

A.17.17. Corrective Action by Contractor

A.17.17.1. 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.

A.17.17.2. 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.17.18. CoverKids Enrollee Grievance and Appeal System.

A.17.18.1. This Contract Section A.17.18. 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.17.1 through A.17.17. 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.

A.17.18.2. 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.17.18.2.1. 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.

A.17.18.2.2. 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.

A.17.18.2.3. 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.

A.17.18.2.4. 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.

A.17.18.2.5. 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.

A.18. DATA AND REPORTING REQUIREMENTS

A.18.1. Data Base

A.18.1.1. 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. The Contractor shall limit personnel and data resources to US-based (onshore) resources only. At a minimum, the database shall include the following data:

A.18.1.1.1. Enrollee Name;

A.18.1.1.2. Enrollee Identification Number (SSN);

A.18.1.1.3. Enrollee MCO;

A.18.1.1.4. Dates of Service;

A.18.1.1.5. Specific service provided by procedure using Code on Dental Procedures and Nomenclature/Current Dental Terminology (CDT) as published by the American Dental Association;

A.18.1.1.6. Servicing Provider Number (Medicaid #);

A.18.1.1.7. Participating Dental Provider Name;

A.18.1.1.8. Payment status;

A.18.1.1.9. Billed Charge Amount;

A.18.1.1.10. Allowed Amount;

A.18.1.1.11. Payment Amount;

A.18.1.1.12. Received Date;

A.18.1.1.13. Payment Date; and

A.18.1.1.14. Any other data element required by common dental practice, ADA Guidelines, federal or state law

A.18.2. Reporting Requirements

A.18.2.1. 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.18.2.1.1. 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.

A.18.2.1.2. The Contractor shall furnish to TennCare an electronic Decision Support System (DSS) described as a data gathering and storage system that allows the TennCare user the ability to submit specific queries and obtain in real time, answers to help drive decision-making and better program oversight. .

A.18.2.1.3. The Contractor shall also furnish specified TennCare staff with sufficient training, permission, and 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 concerns that would normally be requested in an ORR. The capability shall not diminish the Contractors responsibility for responding to requests for ORRs.

A.18.2.1.4. The Contractor shall be responsible for offering assistance to TennCare associates using the Contractor's DSS as needed, including both dental staff and other departmental staff users.

A.18.2.1.5. Additional reporting requirements as established by TennCare in collaboration with the Contractor for Covered Services provided pursuant to the TennCare ECF CHOICES and 1915(c) DBM Program, including, but not limited to, ECF CHOICES and 1915(c) 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 the ECF CHOICES DBM Program and 1915(c) DBM Program, and as well as ECF CHOICES and 1915(c) network training and development.

A.18.2.1.6. Additional reporting requirements regarding the Patient-Centered Dental Home as requested by TennCare such as, but not limited to, reporting the number of lower performing dental practice locations outreached by the Provider Specialists each year.

A.18.2.2. TennCare may impose liquidated damages under Section E.9 and Attachment B of the Contract based upon Contractor's failure to timely submit Standard Reports in the required format and medium.

A.18.3. Reports

A.18.3.1. At a minimum, the Contractor will provide the following reports, however, the DBM Deliverables Requirement, Attachment C, may contain a more comprehensive list of required reports, along with scheduled due dates.

A.18.3.2. The Contractor shall provide the following reports every month: :

A.18.3.2.1. Monthly Program Integrity TIPs

A.18.3.2.2. Encounter data report (837D)

A.18.3.2.3. Provider Enrollment File

A.18.3.2.4. Program Integrity Exception List

A.18.3.2.5. Monthly Provider Office Visit Response Time Report

A.18.3.2.6. Monthly Recovery and Cost Avoidance Report

A.18.3.3. The Contractor shall provide the following reports every quarter:

A.18.3.3.1. "Insure Kids Now" (IKN) File

A.18.3.3.2. DBM Quarterly TennCare Kids Report

A.18.3.3.3. Program Integrity Quarterly Utilization by Std Dev

A.18.3.3.4. Program Integrity Denied Provider Credentialing Summary

A.18.3.3.5. Enrollee cost-sharing liabilities

A.18.3.3.6. Adult Dental Program Report

A.18.3.3.6.1. Number of Unique Members 21 years of age and older who received a dental service

A.18.3.3.6.2. Number of Paid and Denied Dental Claims for members 21 years of age and older

A.18.3.3.6.3. Number of Dental Services provided for members 21 years of age and older, differentiated by service category

A.18.3.3.6.4. Dental Expenditures for members 21 years of age and older, differentiated by service category

A.18.3.3.6.5. Number of General Dentists contracted in the TennCare Adult Dental network

A.18.3.3.6.6. 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)

A.18.3.3.6.7. % Member Utilization – Number of unique eligible adult members who received a covered dental service in the measurement year divided by the number of unique eligible adult members that have been continuously enrolled for a minimum of ninety (90) days during the same period.

A.18.3.3.6.8. Quarterly DBM CAPs Report

A.18.3.3.6.9. Quarterly PCDH Reports (including provider assignment of new members and provider reassignment of existing members, as well as outreach and corrective action plans to providers

A.18.3.3.6.10. Quarterly Opioid Dental Prescriptions Report (number of prescriptions provided to child and adult members written by participating dentists)

A.18.3.3.6.11. Quarterly Dental Provider Opioid Outlier Report

A.18.3.3.6.12. Quarterly Dental Provider Outreach Report for Opioid Outliers, including CAPs

A.18.3.3.7. Outreach Attempts Report - Number of outreach attempts (telephonic, text, mailers, etc) to eligible pregnant members age 21 and older to connect to dental services

A.18.3.3.8. Quarterly Dental Provider Extrapolation Report

A.18.3.3.9. Program Integrity Non-Registered Provider Payments

A.18.3.3.10. Program Integrity Fraud, Waste, and Abuse Activities

A.18.3.3.11. Program Integrity Cost Savings Report

A.18.3.3.12. Encounter/MLR Reconciliation Report

A.18.3.3.13. Quarterly Provider Remediation, CAP, and Reassignments Report

A.18.3.3.14. Quarterly Opioid Dental Prescriptions Report (number of prescriptions provided to child and adult members written by participating dentists)

A.18.3.3.15. Quarterly Dental Provider Opioid Outlier Report

A.18.3.3.16. Quarterly Dental Provider Outreach Report for Opioid Outliers, including CAPs

A.18.3.3.17. Quarterly Recovery and Cost Avoidance Report

A.18.3.4. The Contractor shall provide the following reports once a year:

A.18.3.4.1. Annual Outreach Plan

A.18.3.4.2. Annual Access Report

A.18.3.4.3. DBM Community Outreach Plan Annual Evaluation

A.18.3.4.4. Annual Disclosure Form

A.18.3.4.5. Annual Opioid Dental Prescriptions Report (number of prescriptions provided to child and adult members written by participating dentists)

A.18.3.4.6. Annual Dental Provider Opioid Outlier Report

A.18.3.4.7. Annual Compliance Plan for Program Integrity

A.18.3.4.8. Annual policies for employees, contractors, and agents that comply with 1902(a)(68) SSA (Deficit Reduction Act) for Internal Audit

A.18.3.4.9. Program Integrity Annual Recoveries

A.18.3.4.10. Systems Refresh Plan

A.18.3.4.11. HEDIS Measures Report by June 15

A.18.3.4.12. Annual Recovery and Cost Avoidance Report

A.18.3.5. The Contractor shall provide ad hoc reports, as requested by TennCare. The time intervals/schedule of such reports shall be determined by TennCare

A.18.4. 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.18.5. 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.18.6. Management and Information Systems Reports

A.18.6.1. 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.

A.18.6.2. 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.

A.18.6.3. Information Systems Reports.

A.18.6.3.1. 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 ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

A.18.6.3.2. The Contractor shall submit Encounter Data Report in a standardized format as specified by TennCare (see Section A.15.2.13.) and transmitted electronically to TennCare on a weekly basis.

A.18.6.3.3. 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.3.6.). 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. If TennCare requires further detail of the variances listed, the Contractor shall provide any other data as requested by TennCare. This s information shall be submitted with the MLR report.

A.18.6.3.4. 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.18.6.3.4.1. The companion data file shall be in an Excel format and shall represent a claim triangle report in terms of claim counts and total payment based on all encounter batch files submitted to TennCare EDI during the prior quarter with delineations by 'paid month', 'incurred month', 'claim types (as it is defined in the MLR Triangle report)', and 'encounter batch file ID'.

A.18.6.3.4.2. The reconciliation report shall include an overall assessment of reporting integrities between the two Claim Triangle reports in terms of counts and amount based on the common delineations. When the two reports are not reconciling under the common delineations, the Contractor shall address the root causes of the gaps with proposed corrective action plans

A.18.6.3.5. 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.

A.18.6.3.6. 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.

A.18.6.3.7. The Contractor shall submit a baseline Business Continuity and Disaster Recovery (BC-DR) plan for review and written approval as specified by TennCare. Thereafter, the Contractor shall submit, at a minimum, an annual update to their BC-DR. The Contractor shall communicate proposed modifications to the BC-DR plan at least

fifteen (15) calendar days prior to their proposed incorporation. Such updates and/or modifications shall be subject to review and written approval by TennCare.

A.19. **ENROLLMENT AND ELIGIBILITY**

A.19.1. **Enrollee Materials**

A.19.1.1. Enrollee Materials Requirements

A.19.1.1.1. 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 to promote health and/or educate enrollees. All materials sent to enrollees and enrollee communications including form letters, mass mailings and system generated letters, Short Messaging Service (SMS) notifications 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 PA. The required enrollee materials include the following:

A.19.1.1.1.1. Member Handbook

A.19.1.1.1.1.1. 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 the 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 a member handbook has been previously mailed to another enrollee in the existing case.

A.19.1.1.1.1.2. 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.

A.19.1.1.1.1.3. 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.19.1.1.1.3.1. Must be in accordance with all applicable requirements as described in this Contract.

A.19.1.1.1.3.2. Shall include a table of contents.

A.19.1.1.1.3.3. Shall include an explanation on how enrollees will be notified of member specific information such as effective date of enrollment.

A.19.1.1.1.3.4. Shall include a description of services provided including limitations, exclusions and out-of-plan use.

A.19.1.1.1.3.5. 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.

A.19.1.1.1.3.6. 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.

A.19.1.1.1.3.7. Shall explain that PA 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 PA/service authorization is received before the service is provided; that all PAs/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;

A.19.1.1.1.3.8. Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the Contractor's service area.

A.19.1.1.1.3.9. Shall include grievance/appeal procedures as described in Sections A.17.1. through A.17.18. of the Contract.

A.19.1.1.1.3.10. Shall include written policies on enrollee rights and responsibilities as described in Section A.13.4.10.

A.19.1.1.1.3.11. 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).

A.19.1.1.1.3.12. Shall include notice to the member that it is the member's responsibility to notify the Contractor, TennCare, and for SSI eligibles, SSA, every time the member moves to a new address and that failure to notify SSA for SSI eligibles could result in the member not receiving important eligibility and/or benefit information.

A.19.1.1.1.3.13. Shall include the toll-free telephone number for TennCare with a statement that the enrollee may contact the plan or TennCare regarding questions about TennCare. The TennCare Connect number is 855-259-0701.

A.19.1.1.1.3.14. 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 interpretation and written translation services.

A.19.1.1.1.3.15. Shall include information educating enrollees of their rights and necessary steps to amend their data in accordance with HIPAA regulations.

A.19.1.1.1.3.16. 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;

A.19.1.1.1.3.17. Shall include a copy of TennCare's discrimination complaint forms.

A.19.1.1.1.3.18. Shall include information about preventive services; and

A.19.1.1.1.3.19. Shall include information about the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and how to access component services.

A.19.1.1.1.2. Member Newsletter

A.19.1.1.1.2.1. 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.

A.19.1.1.2.1.1. The Contractor shall include the following information, in each newsletter:

A.19.1.1.1.2.1.1.1. Specific articles or other specific information as described when requested by TennCare. Such requests by TennCare shall be limited to two hundred (200) words and shall include sufficient notification of information to be included.

A.19.1.1.1.2.1.1.2. 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 the full language tagline as it is readily available to members on the DBM's website This information shall comply with the Contract requirements set forth in A. 19.1.4. Written Material Guidelines and at a minimum be available in the English, Arabic and Spanish newsletters.

A.19.1.1.2.1.2. TennCare Information on how to report fraud, waste, or abuse:

A.19.1.1.1.2.1.2.1. To report member fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to Program Integrity (tn.gov). To report provider fraud or patient abuse to the TBI Medicaid Fraud Control Division, call toll-free 1-800-433-5454.

A.19.1.1.2.1.3. The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. 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 PA 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.

A.19.1.1.1.3. Provider Directory

A.19.1.1.1.3.1. 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.

A.19.1.1.3.1.1. The provider directories shall include the following: names, locations, telephone numbers, office hours, a provider's cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, whether the provider has completed cultural competence training, whether offices/facilities have accommodations for people with physical and mental disabilities including offices, exam room(s) and equipment, specialties as appropriate by current network providers, and identification of providers accepting new patients.

A.19.1.1.3.1.2. 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.

A.19.1.1.3.1.3. 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 a provider directory has been previously mailed to enrollees in the existing case.

A.19.1.1.3.1.4. The Contractor shall furnish a Provider Directory/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.

A.19.1.1.1.4. <u>Dental Notices</u>

A.19.1.1.1.4.1. 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.19.1.2. <u>Permissible Communication Activities</u>

A.19.1.2.1. 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.19.1.2.1.1. Distribution of general information through mass media;

A.19.1.2.1.2. 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;

A.19.1.2.1.3. General activities that benefit the entire community (e.g., health fairs, school activity sponsorships, and health education programs).

A.19.1.3. <u>Prohibited Communication Activities</u>

A.19.1.3.1. 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.9 and Attachment B of this Contract.

A.19.1.3.1.1. Materials and/or activities that mislead, confuse, 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 material to assure that such material is accurate and does not mislead, confuse or defraud the enrollees or the state agency. These materials shall be subject to review by TennCare;

A.19.1.3.1.2. Overly aggressive solicitation, such as repeated telephoning;

A.19.1.3.1.3. Gifts and offers of material gain or financial gain as incentives;

A.19.1.3.1.4. Compensation arrangements that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;

A.19.1.3.1.5. Direct solicitation of potential enrollees;

A.19.1.3.1.6. Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;

A.19.1.3.1.7. Assertions or statements (whether oral or written) that the enrollee must enroll with the Contractor in order to obtain benefits or in order not to lose benefits;

A.19.1.3.1.8. Assertions or statements (whether written or oral) that the Contractor is endorsed by CMS, the federal or state government or similar entity;

A.19.1.3.1.9. 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

A.19.1.3.1.10. Seeking to influence enrollment in conjunction with the sale or offering of any private insurance.

A.19.1.4. <u>Written Material Guidelines</u>

A.19.1.4.1. All materials shall be worded at a 6th grade reading level, unless TennCare approves otherwise. All materials shall also be submitted to TennCare in the format specified by TennCare, for review and written approval prior to distribution.

A.19.1.4.2. All written materials shall be clearly legible with a minimum font size of 12pt. except for enrollee I.D. cards, unless otherwise approved by TennCare.

A.19.1.4.3. 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.12.9.6 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.12.9.6. Nondiscrimination Compliance Requirements the nondiscrimination section of this Contract;

A.19.1.4.4. The following shall not be used on communication material without the written approval of TennCare:

A.19.1.4.4.1. The Seal of the State of Tennessee;

A.19.1.4.4.2. The TennCare name unless the initials "SM" denoting a service mark, are superscripted to the right of the name;

A.19.1.4.4.3. The CoverKids name unless the initials "SM" denoting a service mark, are superscripted to the right of the name;

A.19.1.4.4.4. The word "free" can only be used if the service is no cost to all enrollees;

A.19.1.4.4.5. Any of the Program names and logos unless permission is given by the State.

A.19.1.4.5. 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.19.1.4.5.1. 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

A.19.1.4.5.2. If there are fewer than fifty (50) individuals in a language group that is part of 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.

A.19.1.4.5.3. At a minimum, all vital Contractor documents shall be translated and available in the Arabic and Spanish languages.

A.19.1.4.6. All written member materials shall notify enrollees that free language and communication assistance services like oral interpretation for any language, telecommunication relay services, or auxiliary aids or services are available to the member and how to access those services.

A.19.1.4.7. 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: accessible electronic documents, Braille, large print, and audio and shall be based on the needs of the individual enrollee and/ or the enrollee's representative. 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 the provision of language and communication assistance services to enrollees to achieve effective communication. If the enrollee's requested language or communication assistance services 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 service that would result in effective communication with the enrollee.

A.19.1.4.8. 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.

A.19.1.4.9. The Contractor shall be responsible for postage on all mailings sent out by the Contractor.

A.19.1.4.10. The Contractor shall use a language service vendor that is certified with the international quality standards for translation and interpretation ISO 9001:2015 and ISO 17100:2015 for all member materials.

A.19.2. **ENROLLMENT AND DISENROLLMENT**

A.19.2.1. General Requirements

A.19.2.1.1. 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.19.2.1.1.1. 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 against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

A.19.2.1.1.2. Enrollment shall begin at 12:01 a.m. CST 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.

A.19.2.1.1.3. 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.19.2.2. <u>Disenrollment</u>

A.19.2.2.1. 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.19.2.2.1.1. 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.

A.19.2.2.1.2. The Contractor's responsibility for disenrollment shall be to inform TennCare promptly when the Contractor knows or has reason to believe that an enrollee may satisfy any of the conditions for disenrollment described in TennCare policy and/or TennCare rules and regulations. Actions taken by TennCare cannot be grieved by the Contractor.

A.20. <u>**THIRD PARTY LIABILITY**</u>

A.20.1. The Contractor will comply with all items listed below:

A.20.1.1. If third party liability (TPL) exists for part or all of the services provided directly by the Contractor to an enrollee, the Contractor will make

reasonable efforts to recover from TPL sources the value of services rendered.

A.20.1.2. If TPL exists for part or all of the services provided to an enrollee by a subcontractor or a provider, and the third party will make payment within a reasonable time, the Contractor may pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount of TPL.

A.20.1.3. If the probable existence of TPL has been established at the time the claim is filed, the Contractor may reject the claim and return it to the provider for a determination of the amount of any TPL, unless the claim is for services described in TennCare policy, including the State Medicaid Manual, Section 3904.4.

A.20.2. The claims specified in Section A.20.1. will be paid at the time presented for payment by the provider and the Contractor will bill the responsible third party.

A.20.3. The Contractor will deny payment on a claim that has been denied by a third party payer when the reason for denial is the provider or enrollee's failure to follow prescribed procedures, including but not limited to, failure to obtain PA, timely filing, etc.

A.20.4. The Contractor will treat funds recovered from third parties as offsets to claims payments. The Contractor will report all cost avoidance values to TennCare in accordance with federal guidelines and as described in the Contract.

A.20.5. The Contractor will post all third-party payments to claim level detail by enrollee.

A.20.6. TennCare cost sharing and patient liability responsibilities permitted pursuant to Section A.7. of the Contract will not be considered TPL.

A.20.7. The Contractor will provide TPL data to any provider having a claim denied by the Contractor based upon TPL.

A.20.8. The Contractor will provide to TennCare any third party resource information necessary in a format and media described by TennCare and will cooperate in any manner necessary, as requested by TennCare, with TennCare and/or a cost recovery vendor.

A.20.9. TennCare may require a TennCare contracted TPL vendor to review paid claims that are over one hundred eighty (180) calendar days old and pursue TPL for those claims that do not indicate recovery amounts in the Contractor's reported encounter data. The Contractor shall only be responsible for TPL for the at-risk portion of the Contract.

A.20.10. If the Contractor operates or administers any non-Medicaid HMO, health plan or other lines of business, the Contractor will assist TennCare with the identification of enrollees with access to other insurance.

A.20.11. The Contractor will demonstrate, upon request, to TennCare that reasonable effort has been made to seek, collect and/or report third party recoveries. TennCare will have the sole responsibility for determining whether reasonable efforts have been demonstrated. Said determination will take into account reasonable industry standards and practices.

A.20.12. TennCare will be solely responsible for estate recovery activities and will retain any and all funds recovered through these activities.

A.20.13. Third Party Liability (TPL) Resources Reports

A.20.13.1. The Contractor will submit a monthly, quarterly and annual Recovery and Cost Avoidance Report that includes any recoveries for third party resources as well as funds for which the Contractor does not pay a claim due to TPL coverage or Medicare coverage. The Contractor will calculate cost savings in categories described by TennCare.

A.21. **<u>Program Integrity</u>**

A.21.1. Contracting with Excluded Providers Prohibited

A.21.1.1. 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 or who have been terminated with the TennCare or CoverKids programs. All Provider Agreements executed by the Contractor shall:

A.21.1.1.1. Require that an adequate record system be maintained and that all records be maintained for ten (10) years from the termination of the Provider Agreement or retained until all evaluations, audits, reviews or investigations or prosecutions are completed. Records should contain the following information: 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);

A.21.1.1.2. 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 the Tennessee Office of Inspector General (OIG), the Tennessee Bureau of Investigation Medicaid Fraud Control Division (TBI MFCD), 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 in either paper or electronic form, at no cost to the requesting party, for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the Contractor, TennCare or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCD, the DHHS OIG and the DOJ;

A.21.1.1.3. Provide that TennCare, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCD, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Contract including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Such records are to be provided at no charge to the requesting agency. Record requests shall be filled as required by Tennessee Code Annotated Section 63-2-101(i) or related provisions. In addition, the TBI MFCD/OIG/TennCare Office of Program Integrity (OPI) 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 MFCD/OIG/OPI. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCD, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TennCare, OIG, TBI MFCD, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions;

A.21.1.1.4. Require the provider to comply with fraud, waste and abuse requirements of this Contract; and

A.21.1.1.5. 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.21.2. Requirement for Medicaid provider ID Number

A.21.2.1. 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.21.3. OIG Statement

A.21.3.1. 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 Division, call toll-free 1-800-433-5454 or email TBI.MedicaidFraudTips@tn.gov ."

A.21.4. Explanation of Benefits (EOBs) and Related Functions

A.21.4.1. The Contractor shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TennCare. The EOB shall indicate which State DBM program that the enrollee is a member of. 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.21.5. Return of Overpayments

A.21.5.1. In accordance with the Affordable Care Act and TennCare policy and procedures, including the terms and conditions of the MCPIM, the Contractor and its subcontractors and providers shall report overpayments, 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 or other financial sanction pursuant to state or federal law or policy.

A.21.6. False Claims Act

A.21.6.1. 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 of the False Claims Act and whistleblower protections.

A.21.7. Fraud, Waste, and Abuse Requirements

A.21.7.1. General

A.21.7.1.1. The Tennessee Bureau of Investigation, Medicaid Fraud Control Division is the state agency responsible for the investigation of provider fraud, waste, and abuse (FWA) in the TennCare program.

A.21.7.1.2. OIG has the primary responsibility to investigate TennCare enrollee fraud, waste, and abuse.

A.21.7.1.3. The Attorney General's Medicaid Fraud and Integrity Division (AG/MFID) works with TennCare, TBI MFCD, and OIG in combating medical provider fraud in the TennCare/Medicaid program.

A.21.7.1.4. The Division of TennCare, Managed Care Operations, Office of Program Integrity 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 Manual (MCPIM) for Fraud, Waste, and Abuse. The MCPIM is incorporated by reference and shall be utilized to implement and maintain compliance with TennCare's FWA policies and procedures. .

A.21.7.1.5. 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

A.21.7.1.6. 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. For providers, this requirement may be satisfied through TennCare's provider registration process. Annually, the Contractor shall confirm with TennCare that reminders are sent to providers to comply with 42 C.F.R. Part 455, Subpart B.

A.21.7.1.7. 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.

A.21.7.1.7.1. For providers, this requirement may be satisfied through TennCare's provider registration process. Annually, the Contractor shall confirm with TennCare that reminders are sent to providers to comply with 42 C.F.R. Part 455, Subpart B.

A.21.7.1.8. 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.

A.21.7.1.9. 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.

A.21.7.1.10. 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.

A.21.7.1.11. 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, office reference guide, or any other guidance manuals information on FWA, including how to identify and report FWA, and a description of the laws and the rights of employees to be protected as whistleblowers. Billing and Incentive instructions and/or notifications, announcements shall include the following:

A.21.7.1.11.1. Fraud is an intentional deception or misrepresentation of services that an individual knows to be false and could result in an unauthorized reimbursement to a practice. To report provider billing fraud to TennCare call (833)687-9611 or report online at https://stateoftennessee.formstack.com/forms/tenncare_provider_fraud_report or mail information to TennCare – OPI, 310 Great Circle Road, Nashville, TN 37243."

A.21.7.1.12. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the State Medicaid Program Integrity Unit and to the State Medicaid Fraud Control Division as directed by TennCare.

A.21.7.1.13. 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 when applicable.

A.21.7.1.14. 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.

A.21.7.1.15. The Contractor may recoup and retain overpayments made to providers within timeframes determined by the State.

A.21.7.1.16. The Contractor shall report to TennCare OPI all non-administrative over payments, both identified and recovered, on a quarterly basis.

A.21.7.1.17. 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:

A.21.7.1.17.1. 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

A.21.7.1.17.2. When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Tennessee or are the subject of pending Federal or State litigation or investigation,

A.21.7.1.17.3. The prohibition described in this section shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims.

A.21.7.1.18. The Contractor shall determine if the prohibition to recoup or withhold improperly paid funds is applicable utilizing methods as directed by TennCare OPI.

A.21.7.1.19. In the event that Contractor recoups or otherwise obtains funds in cases where overpayment recovery is prohibited, under this section or as otherwise directed by TennCare, the Contractor shall notify the Director of TennCare OPI and take action in accordance with written instructions from the Director of TennCare OPI or his designee.

A.21.7.1.20. The Contractor shall report quarterly on FWA cost savings information to TennCare OPI via TOPS.

A.21.7.1.21. 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.

A.21.7.1.22. 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, and TennCare's Terminated Provider List. 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.

A.21.7.1.23. 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.

A.21.7.1.24. 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.

A.21.7.1.25. The Contractor shall comply with all written direction provided by TennCare OPI regarding fraud, waste, and abuse investigations, overpayments, and any other program integrity related activities and reporting.

A.21.7.1.26. Reporting and Investigating Suspected Fraud, Waste, and Abuse

A.21.7.1.27. 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 Division (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.

A.21.7.1.28. The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases.

A.21.7.1.29. The Contractor shall notify TennCare OPI and TBI MFCD simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining

outliers, audit concerns, critical incidences, and external (such as hotline calls) tips with potential implications to TennCare providers' billing anomalies and/or to safety of TennCare enrollees Along with notification, the Contractor shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to TennCare OPI and TBI MFCD when the concerns and/or allegations of any tips are authenticated.

A.21.7.1.30. The Contractor shall report all tips, confirmed or suspected fraud, waste, and abuse to TennCare OPI and the appropriate agency as follows:

A.21.7.1.30.1. All tips shall be reported monthly to TennCare OPI and TBI MFCD;

A.21.7.1.30.2. Suspected fraud, waste, and abuse in the administration of the program shall be reported to TennCare OPI, TBI MFCD and/or OIG;

A.21.7.1.30.3. All confirmed or suspected provider fraud, waste, and abuse s hall immediately be reported to TennCare OPI and TBI MFCD; and

A.21.7.1.30.4. All confirmed or suspected enrollee fraud, waste, and abuse shall be reported immediately to OIG.

A.21.7.1.31. 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.

A.21.8. Penalty for Failure to report

A.21.8.1. 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, waste and abuse by recipients, enrollees, applicants, or providers to OIG, the TennCare Office of Program Integrity, or TBI MFCD, as appropriate.

A.21.9. Preliminary Investigation

A.21.9.1. 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:

A.21.9.1.1. Contact the subject of the investigation about any matters related to the investigation;

A.21.9.1.2. Enter into or attempt to negotiate any recoupment, settlement or agreement regarding the incident; or

A.21.9.1.3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

A.21.9.2. The Contractor shall immediately contact the TennCare OPI for guidance if, during an audit, it is determined the provider is already under review by the State.

A.21.9.3. 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.21.9.4. The Contractor shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or in clinical questions or in any matter related to an investigation.

A.21.9.5. The Contractor shall suspend payment to a provider upon notification from TennCare OPI of the determination of a credible allegation of fraud.

A.21.9.6. The State shall not transfer its law enforcement functions to the Contractor.

A.21.9.7. 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 MFCD, 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. Such records will be made available at no cost to the requesting agency. In addition, the TennCare Office of Program Integrity, TBI MFCD, 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 MFCD, 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.21.9.8. The Contractor shall notify the Director of 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 provider s to participate in the program for program integrity reasons.

A.21.9.9. 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.

A.21.10. <u>Program Integrity Requirements for Extrapolation of Provider Claims</u>

A.21.10.1. When extrapolating provider claims, as defined in TennCare rules and regulations, the Contractor shall utilize the following process:

A.21.10.1.1. 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.

A.21.10.1.2. 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.

A.21.10.1.3. 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.

A.21.10.1.3.1. 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.

A.21.10.1.4. 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.

A.21.10.1.5. 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

A.21.10.1.6. 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.

A.21.10.1.7. 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).

A.21.10.1.8. The Contractor will report the final overpayment amounts to be recouped to TennCare OPI either:

A.21.10.1.8.1. after the final findings letter is issued to the Provider and the Provider has not elected to use the Peer review process; or

A.21.10.1.8.2. after the Peer review process has been completed and any necessary adjustments to the overpayment amounts have been made.

A.21.10.1.9. 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.

A.21.10.1.9.1. The provisions of A.21.9.7. 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.21.11. Fraud, Waste, and Abuse Reporting Requirements

A.21.11.1. All Fraud, Waste and Abuse deliverables shall follow the guidance outlined in the Managed Care Program Integrity Manual provided by TennCare OPI. These guidelines are incorporated by reference and shall be utilized.

A.21.11.2. The Contractor shall submit a quarterly Fraud, Waste, and Abuse Activities Report. This report shall summarize the results of its fraud, waste, and abuse compliance and other fraud, waste, and abuse prevention, detection, reporting, and investigation measures.

A.21.11.3. 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. The Contractor shall provide the compiled information to OPI upon request.

A.21.11.4. On an annual basis the Contractor shall submit to TennCare Internal Audit and Investigations 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.21.11.5. The Contractor shall submit a quarterly Non-Registered Provider Payment Report identifying payments made to providers without a Medicaid ID.

A.21.11.6. The Contractor shall submit a monthly Program Integrity Exception List Report that identifies employees or contractors (as defined in Section A.21.1.1) 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

A.21.11.7. The Contractor shall submit a monthly List of Involuntary Terminations Report (including providers termed due to sanctions, invalid licenses, services and billing concerns, etc.) due to program integrity concerns to TennCare.

A.21.11.8. The Contractor shall submit an annual Recoveries Report detailing all administrative and non-administrative recovery activities conducted by the Contractor during the previous calendar year

A.21.11.9. The Contractor shall submit a monthly Tips Report of all tips of potential or suspected fraud, waste or abuse received during the previous month, including tips that have not yet been assigned, have been screened out, and /or have been closed with no action.

A.21.11.10. 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.

A.21.11.11. 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.

A.21.11.12. 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.

A.21.11.13. The CONTRACTOR shall submit annually an attestation that providers are reminded to submit disclosure changes within the guidelines of 42 C.F.R. Part 455, Subpart B.

A.21.12. Report Monitoring

A.21.12.1. 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 potential liquidated damages 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 potential liquidated damages. At the State's option, such notices will be sent to the Contractor via electronic means or certified U.S. Mail.

A.22. **Website**

A.22.1. General Requirements

A.22.1.1. Pursuant to Section A.12.9.6.1.3. Electronic and Information Technology Accessibility 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. Up to date means that all dated materials on the website will be removed or updated, all current events, latest news and any relevant announcements shall be displayed in a clearly visible and readily accessible location on the homepage. 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, most questions that each group would ask. This shall include, but is not limited to:

A.22.1.1.1. Home Page, which includes:

A.22.1.1.1.1. General information related to dental benefits, announcements and recent changes occurring within the State DBM Programs, including pertinent fact sheets, and

A.22.1.1.1.2. Navigation tool bar that links to enrollee information, provider information, finding a dentist, as well as policy and guidelines.

A.22.1.1.2. Provider Page, which includes:

A.22.1.1.2.1. Applying to become a participating dental provider;

A.22.1.1.2.2. Provider credentialing and recredentialing;

A.22.1.1.2.3. Provider Office Reference Manual;

A.22.1.1.2.4. Current Dental Fee Schedules;

A.22.1.1.2.5. Program policies and procedures;

A.22.1.1.2.6. Procedures for obtaining PAs;

A.22.1.1.2.7. Printable provider education materials;

A.22.1.1.2.8. Provider newsletters including archived newsletters;

A.22.1.1.2.9. Procedures for electronic billing;

A.22.1.1.2.10. Information on Patient Centered Dental Homes (PCDH)

A.22.1.1.2.11. PCDH Operations Manual

A.22.1.1.2.12. Information about Tennessee's Peer Review Committee, and

A.22.1.1.2.13. Call Center hours of operation and contact numbers.

A.22.1.1.2.14. Contact information for assigned Dental Provider Representative

A.22.1.1.2.15. All training sessions and live webinars shall be recorded and posted on the website for those practices unable to attend.

A.22.1.1.2.16. Information, including policies and procedures and educational resources on complying with the civil rights laws and delivering services in a culturally competent manner that is free of discrimination.

A.22.1.1.3. Enrollee Page, which includes:

A.22.1.1.3.1. A description of oral health services provided including limitations, exclusions and out-of-network use;

A.22.1.1.3.2. Member Handbook including provider directory;

A.22.1.1.3.3. Find A Dentist (FAD) Tool for locating a dentist close to where you live

A.22.1.1.3.4. Call Center hours of operation and contact numbers;

A.22.1.1.3.5. Copay information;

A.22.1.1.3.6. Transportation assistance;

A.22.1.1.3.7. How to access language and communication assistance services;

A.22.1.1.3.8. Viewable and printable education material specific to enrollees, and

A.22.1.1.3.9. On-line search, by address or zip code, to locate the network dentists nearest to the enrollee.

A.22.1.1.3.10. Privacy and Security information regarding enrollee records;

A.22.1.1.3.11. Privacy Assistance for individuals with disabilities, and

A.22.1.1.3.12. Discrimination complaint forms and the Civil Rights Notice, including how individuals with disabilities can request help.

A.23. Performance Guarantees

A.23.1. Administration and Management

A.23.1.1. 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 and/or application of liquidated damages as specified in Section E.9 and Attachment B of this Contract. Utilization benchmarks may be established by TennCare after discussion with Contractor for specific EPSDT services or procedures. The State may, in its sole discretion and upon thirty (30) days prior written notice, select any other services or deliverables required in the Contract to use as performance indicators. In addition to selecting different performance metrics, the State may also use this thirty (30) day notice to change the weight of the selected performance metrics to be higher or lower than the weights currently shown in A.23.1.2 or A.23.2.2.

A.23.1.2.

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
Annual Provider Office Visits by Provider Specialist	Monthly Provider Office Visit Response Time Report	# of office visits conducted by Provider Specialists annually	100%	One hundred (100) provider office visits annually per Provider Specialist
Ad hoc Provider Office Visit Request by Provider Specialist	Monthly Provider Office Visit Response Time Report	Response times where scheduling exceeds five (5) business days	100%	Provider office visit scheduled within five (5) business days of the provider request
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

Performance Indicator	Data Sources	Measure	Target	Benchmark
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.23.2. EPSDT and CoverKids Monitoring

A.23.2.1. The following performance indicators related to EPSDT (TennCare Children's DBM Program) and the CoverKids DBM Program 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.9.1. and liquidated damages in Attachment B. Utilization benchmarks may be established by TennCare after discussion with Contractor for specific EPSDT services or procedures. The State may, in its sole discretion and upon thirty (30) days prior written notice, select any other services or deliverables required in the Contract to use as performance indicators. In addition to selecting different performance metrics, the State may also use this thirty (30) day notice to change the weight of the selected performance metrics to be higher or lower than the weights currently shown in A.23.1.2 or A.23.2.2.

A.23.2.2.

Performance Indicator	**Data Sources**	**Measure**	**Benchmark**
Annual EPSDT Dental Screening For TennCare's Children DBM Program only	Claims encounter data; TennCare enrollment data	Dental Screening Percentage (DSP) (Refer to Attachment F)	≥ 80%
Member Utilization for members age 2-20	Claims encounter data; TennCare enrollment data	Annual Partial Enrollment Adjusted Ratio (PEAR); Refer to Attachment E	≥ 58%

Performance Indicator	Data Sources	Measure	Benchmark
% Member Utilization for members age 21 and older	Claims encounter data; TennCare enrollment data	Number of unique eligible adult members who received a covered dental service in the measurement year divided by the number of adults that have been continuously enrolled for a minimum of ninety (90) days during the same period	≥ 20%
Disease Prevention	Claims encounter data; TennCare enrollment data	Annual Dental Sealant Percentage for Members ages 6-15 (Refer to Attachment H)	≥ 15%
Minimally Invasive Therapy	Claims encounter data TennCare enrollment data;	Annual SDF Percentage; (Refer to Attachment H)	≥ 1.4%
Hospital Diversion	Claims encounter data TennCare enrollment data;	Annual SDF OR Diversion	≥ 25%
Preventive CAPs	Quarterly DBM CAPs Report	Percentage of Providers who fall below established thresholds for sealant or SDF utilization who are issued Preventive CAPs	≥20%

A.23.3. Control Memorandum Process

A.23.3.1. 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.

A.23.3.2. A CM may include one (1) or more of the five (5) components of the CM process described below:

A.23.3.2.1. On Request Report – a request directing the Contractor to provide information by the time and date set out in the CM.

A.23.3.2.2. 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 incorporation into this Contract.

A.23.3.2.3. 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.

A.23.3.2.4. 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.

A.23.3.2.5. 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.

A.23.3.3. 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.9, including Liquidated Damages as listed in Contract Attachment B, a corrective action plan, and/or termination of the Contract.

A.23.3.4. 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.23.4. <u>Non-Disclosure and Contractors</u>

A.23.4.1. 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.

A.23.4.2. 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.

A.23.4.3. 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.

A.24. Obligations of the State

A.24.1. 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.24.2. 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.24.3. 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.

B. TERM OF CONTRACT:

B.1. This Contract shall be effective on July 1, 2024 ("Effective Date") and extend for a period of Sixty (60) months after the Effective Date ("Term"). The State shall have no obligation for goods 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 each 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-six (96) months.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Written Dollar Amount ($Number) ("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 as 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:

C.3.1. **General**

C.3.1.1. For the transition period occurring during the first year from the Contract effective date, there shall be no cost to the State.

C.3.1.2. For TennCare ECF CHOICES and 1915(c) DBM Program services performed from Year 2 through Year 5 of the initial Contract term, the following rates shall apply:

Cost Item Description	**Amount** (per compensable increment)
Year 2 through Year 5 **TennCare ECF CHOICES DBM Program** **Year 2 through Year 5** Administrative Fee Per Eligible Adult Enrolled in the TennCare ECF CHOICES DBM Program (per member per month)AND **TennCare 1915 (c) DBM Program** **Year 2 through Year 5** Administrative Fee Per Eligible Adult Enrolled in the TennCare 1915(c) Home and Community Based Services (HCBS) Waiver	$0.47 per member per month

C.3.1.3. For the TennCare Adult Dental DBM Program, TennCare Children's DBM Program and CoverKids DBM Program, services performed from July 1, 2025 (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. There shall be no cost to the State for TennCare Adult Dental DBM Program services prior to Go Live Date of July 1, 2025. The rate categories and the specific rates associated with each rate category are specified below.

Children Rate Cells (under 21)

Aid Category	Age Group	East Minimum	East Maximum	Middle Minimum	Middle Maximum	West Minimum	West Maximum
Medicaid (TANF & Related)							
	Ages 0 – 1	$1.17	$1.56	$1.59	$2.11	$0.96	$1.28
	Ages 2 – 3	$7.41	$9.85	$9.53	$12.67	$6.28	$8.34
	Ages 4 – 9	$15.22	$20.23	$17.56	$23.33	$12.20	$16.21
	Ages 10 + Female	$15.95	$21.19	$16.99	$22.58	$12.10	$16.08
	Ages 10 + Male	$13.52	$17.96	$14.75	$19.60	$10.13	$13.46
Uninsured/Uninsurable*							
	Ages 0 – 1	$1.17	$1.56	$1.59	$2.11	$0.96	$1.28
	Ages 2 – 3	$7.41	$9.85	$9.53	$12.67	$6.28	$8.34
	Ages 4 – 9	$15.22	$20.23	$17.56	$23.33	$12.20	$16.21
	Ages 10 + Female	$15.95	$21.19	$16.99	$22.58	$12.10	$16.08
	Ages 10 + Male	$13.52	$17.96	$14.75	$19.60	$10.13	$13.46
Disabled/Duals/Waiver Duals							
	Ages 0 – 1	$0.97	$1.29	$1.14	$1.52	$0.85	$1.13
	Ages 2 – 3	$5.89	$7.83	$9.08	$12.06	$4.54	$6.03
	Ages 4 – 9	$13.08	$17.38	$15.00	$19.94	$9.59	$12.74
	Ages 10 + Female	$13.83	$18.38	$15.14	$20.12	$9.78	$13.00
	Ages 10 + Male	$13.04	$17.33	$12.50	$16.61	$8.44	$11.22
CoverKids							
	Ages 0 – 1	$0.78	$1.04	$1.37	$1.82	$0.88	$1.17
	Ages 2 – 3	$4.99	$6.63	$8.06	$10.71	$5.22	$6.93
	Ages 4 – 9	$15.53	$20.64	$18.96	$25.20	$14.50	$19.27
	Ages 10 + Female	$12.81	$17.02	$14.45	$19.20	$10.53	$13.99
	Ages 10 + Male	$11.92	$15.84	$14.71	$19.55	$9.20	$12.23

* Set equal to Medicaid (TANF & Related) rate due to low volume

Adult Rate Cells (21 +)

Aid Category	Age Group	East Minimum	East Maximum	Middle Minimum	Middle Maximum	West Minimum	West Maximum
Medicaid (TANF & Related)							
	Ages 21 - 44: Female	$8.28	$10.49	$8.99	$11.38	$6.81	$8.62
	Ages 21 - 44: Male	$6.79	$8.59	$7.46	$9.45	$5.38	$6.81
	Ages 45 - 64	$9.07	$11.49	$9.91	$12.55	$7.35	$9.31
	Ages 65+	$4.08	$5.17	$4.46	$5.65	$3.31	$4.19

Disabled						
All Ages	$7.89	$9.99	$8.62	$10.92	$6.39	$8.10
Duals/Wavier Duals						
All Ages	$7.08	$8.96	$7.73	$9.79	$5.73	$7.26

C.3.1.3.1. The Contractor shall ensure that no payment is made to a network provider by the Contractor other than for the services covered under the Contract between the state and the Contractor, except when these payments are specifically required to be made by the state in Title XIX of the Social Security Act, in 42 CFR 438.60, or when the state agency makes direct payments to network providers for graduate medical education costs approved under the state plan.

C.3.1.3.2. In accordance with TCA 71-5-188, the State will retain a qualified actuary to conduct an annual actuarial study of the TennCare program. The Contractor shall provide any information requested and cooperate in any manner necessary as requested by TennCare in order to assist the State's actuary with completion of the annual actuarial study.

C.3.1.3.3. The Contractor and TennCare agree that the capitation rates described in Section C.3.1.3. of this Contract may be adjusted periodically.

C.3.1.3.4. 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. 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:

C.3.1.3.4.1. 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,

C.3.1.3.4.2. 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

C.3.1.3.5. In addition to other adjustments specified in Section C.3.1.3.4. of this Contract, the capitation rates shall be adjusted annually for inflation in accordance with the recommendation of the State's actuary.

C.3.1.3.6. 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.3.1.3., as determined by TennCare, TennCare shall have its independent actuary review the required change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TennCare's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

C.3.1.3.7. 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.3.1.3., as determined by TennCare, TennCare shall have its independent actuary review the proposed change and determine whether the change would impact the actuarial soundness of the capitation rate(s). If TennCare's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

C.3.1.3.8. With respect to Post Eligibility Treatment of Income (PETI), TennCare will perform a review of patient liability experience to determine remaining liability that had not been addressed in the managed care rate setting process. If additional adjustments are necessary, the adjustments will be made on a periodic basis to assure the correct application of federal funds.

C.3.1.3.9. Any rate adjustments shall be subject to the availability of state appropriations.

C.3.1.3.9.1. 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.

C.3.2. CAPITATION PAYMENT CALCULATION

C.3.2.1. When eligibility has been established by the State for enrollees, the amount owed to the Contractor shall be calculated as described herein.

C.3.2.2. 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.

C.3.2.3. The capitation rates stated above in this Section C.3.1.3. will be the amounts used to determine the amount of the monthly capitation payment.

C.3.2.4. The actual amount owed the Contractor for each member shall be determined by dividing the appropriate monthly capitation rate(s) by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the member was enrolled in the Contractor's plan.

C.3.2.5. The amount paid to the Contractor shall equal the total of the amount owed for all enrollees determined pursuant to Section C.3.1.3. less capitation payment adjustments made pursuant to this Section C.3.1.3., and any other adjustments, which may include, damages, liquidated damages, or adjustments based upon a change of enrollee status.

C.3.3. CAPITATION PAYMENT ADJUSTMENTS

C.3.3.1. The State has the discretion to retroactively adjust the capitation payment for any enrollee if TennCare determines an incorrect payment was made to the Contractor; provided, however:

C.3.3.1.1. 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.

C.3.3.1.2. 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.3.1.3.

C.3.3.1.3. 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 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..

C.3.3.1.4. 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.

C.3.3.1.5. 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:

C.3.3.1.6. 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.

C.3.3.1.7. 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.3.3.1.8. TennCare and the Contractor agree that the retroactive capitation payment limitation described in this Section C.3.3. 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.

C.3.3.1.9. 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.

C.3.4. Pursuant to 42 CFR 438.6, any incentive arrangements shall comply with the following:

C.3.4.1. The total of all payments made to the Contractor for a measurement year shall not exceed one hundred and five percent (105%) of capitation payments made to the Contractor.

C.3.4.2. 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;

C.3.4.3. Are not renewed automatically;

C.3.4.4. Are made available to both public and private contractors under the same terms of performance;

C.3.4.5. Do not condition Contractor's participation in the incentive arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.

C.3.5. Effect of Disenrollment on Capitation Payments

C.3.5.1. Payment of capitation payments shall cease effective the date of the member's disenrollment from the Contractor's MCO, and the Contractor shall have no further responsibility for the care of the enrollee. Disenrollment from TennCare shall not be made retroactively with the exception of the following situations:

C.3.5.1.1. Fraudulent applications;

C.3.5.1.2. Fraudulent Enrollment

C.3.5.1.2.1. In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the Contractor, at TennCare's discretion, shall refund to TennCare all capitation payments made on behalf of persons who obtained enrollment in TennCare through such means and the Contractor shall pursue full restitution for all payments made on behalf of the individual while the person was inappropriately enrolled in the Contractor's plan.

C.3.5.1.2.2. In the event of enrollment obtained by fraud, misrepresentation or deception by the Contractor's staff, officers, employees, providers, volunteers, subcontractors, or anyone acting for or on behalf of the Contractor, TennCare may retroactively recover capitation amounts plus interest, as allowed by TCA 47-14-103, and any other monies paid to the Contractor for the enrollment of that individual. The refund of capitation payments plus interest will not preclude the State from exercising its right to criminal prosecution, civil penalties, trebled damages and/or other remedial measures.

C.3.5.1.3. Member's death;

C.3.5.1.4. TennCare and/or OIG determines the member moved out of state and failed to inform TennCare within a timely manner;

C.3.5.1.5. An appeal by the member to disenroll with a retroactive effective date is decided by TennCare in favor of the member.

C.3.6. **Medical Loss Ratio**

C.3.6.1. 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 provisions of 42CFR438.8

C.3.6.1.1. 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:

C.3.6.1.1.1. Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense shall be prorated between types of expenses.

C.3.6.1.1.2. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on pro rata basis.

C.3.6.1.1.3. Expense allocation shall be based on a generally accepted accounting method that is expected to yield the most accurate results.

C.3.6.1.1.4. Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense.

C.3.6.1.1.5. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to the other entities.

C.3.6.1.1.6. The Contractor shall use an MLR template that is provided by TennCare.

C.3.6.2. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

C.3.6.2.1. The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the state.

C.3.6.2.2. The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

C.3.6.2.3. If a Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

C.3.6.3. The MLR calculation in a MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

C.3.6.4. The Contractor shall aggregate data for all Medicaid eligibility groups covered under the Contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

C.3.6.5. 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:

C.3.6.5.1. Total incurred claims.

C.3.6.5.2. Expenditures on quality improving activities.

C.3.6.5.3. Expenditures related to activities compliant with program integrity requirements.

C.3.6.5.4. Non-claims costs.

C.3.6.5.5. Premium revenue.

C.3.6.5.6. Taxes.

C.3.6.5.7. Licensing fees.

C.3.6.5.8. Regulatory fees.

C.3.6.5.9. Methodology(ies) for allocation of expenditures.

C.3.6.5.10. Any credibility adjustment applied.

C.3.6.5.11. The calculated MLR.

C.3.6.5.12. Any remittance owed to the state, if applicable.

C.3.6.5.13. A comparison of the information reported with the audited financial report.

C.3.6.5.14. A description of the aggregation method used to calculate total incurred claims.

C.3.6.5.15. The number of member months.

C.3.6.6. The Contractor shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within One Hundred Eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

C.3.6.7. In any instance where TennCare makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the Contractor shall:

C.3.6.7.1. Re-calculate the MLR for all MLR reporting years affected by the change.

C.3.6.7.2. Submit a new MLR report meeting the applicable requirements.

C.3.6.8. This report shall be accompanied by a letter from an actuary, who may be an employee of the Contractor, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy.

C.3.6.9. The Contractor shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

C.3.6.10. The Contractor shall also file this report with its NAIC filings due in March and August of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary.

C.3.6.10.1. This report shall reconcile to NAIC filings including the supplemental TennCare income statement.

C.3.6.11. The Contractor shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the Contractor's encounter file submission as specified in Sections A.18.3 and A.18.6.1.

C.3.7. **Risk Corridor**

C.3.7.1. In each capitation year, TennCare has the option to, but is not required to, implement a risk corridor in the rates.

C.3.7.2. For purposes of risk corridor calculations, the MLR shall be calculated as follows:

C.3.7.2.1. 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.

C.3.7.2.2. The denominator shall include State revenues, including the impacts of risk sharing mechanisms and withholds, but excluding state premium tax. Additional accruals, taxes, or fees shall be approved for inclusion or exclusion by the State on a case by case basis.

C.3.7.3. 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.

C.3.7.4. 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%.

C.3.7.5. 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.

C.3.7.6. 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.

C.3.7.7. 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.

C.3.7.8. 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.

C.3.7.9. 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.

C.3.8. 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)
ECF CHOICES and 1915(c) waiver Administrative Fee Per Individual Eligible for Full Dental Benefit Package (per member per month)	$0.47 Per Member Per Month

C.3.9. Pay-For-Performance Quality Incentive Payments

C.3.9.1. DBM Performance Measures. TennCare may make incentive payments to the Contractor pursuant to 42 CFR 438.6, where all incentive arrangements are necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state's quality strategy and shall comply with the following:

C.3.9.1.1. The total of any and all incentive payments made to the Contractor for a measurement year shall not exceed five percent (5%) of the capitation payments made annually to the Contractor.

C.3.9.1.2. 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;

C.3.9.1.3. Are not renewed automatically;

C.3.9.1.4. Are made available to both public and private contractors under the same terms of performance;

C.3.9.1.5. Do not condition DBM participation in the incentive arrangement on the DBM entering into or adhering to intergovernmental transfer agreements.

C.3.9.1.6. At such time and in a manner described by TennCare, TennCare will partner with the Contractor to implement pay-for-performance (P4P) initiatives with the goal of improving TennCare members' lives.

C.3.9.2. Provider Performance Measures & Incentive Payment Opportunities

C.3.9.2.1. With input and direction from TennCare, the Contractor shall employ various metrics for evaluating provider performance. The Contractor shall create a provider performance report (PPR) /report card and a provider ranking process for measuring individual provider performance as compared to a network of participating peers for one (1) or more selected performance measures, for one (1) or all of the State DBM Programs. These rankings shall be shared with all providers, and the Contractor's role shall be to encourage providers who fall below the mean through education and behavior modification to improve their ranking and hence their performance.

C.3.9.2.2. The Contractor shall also establish a methodology, as approved by TennCare, on how high performing providers participating in the TennCare Children's DBM Program can receive Contractor incentives, including participation in a provider gold card program.

C.3.9.2.2.1. Examples of such conduct might include compliance with mandatory provider trainings, including PCDH training, and attestation to training completion

C.3.9.2.2.2. Providers' participation in lunch and learns, as hosted by provider specialists

C.3.9.2.2.3. Meeting TennCare approved thresholds for certain preventive services, such as silver diamine fluoride and dental sealants

C.3.9.2.2.4. Active participation in the TennCare dental program, as measured by treating more than one hundred (100) members annually

C.3.9.2.2.5. Seventy-five percent (75%) member engagement (75% of assigned members visited the dental office on an annual basis)

C.3.9.2.3. For the TennCare Children's DBM Program, emphasis will be placed on member engagement and utilization of oral disease prevention measures, such as dental sealants, silver diamine fluoride, and fluoride varnish with threshold(s) established, as approved by TennCare

C.3.9.2.4. Pending state and federal approval, the State may choose to mandate that the Contractor provide annual P4P incentive payments to high performing providers whose activities align with TennCare goals. Providers shall only qualify for incentive payments if they meet the aforementioned criteria in C.3.9.2.2.

C.3.9.2.5. Once approved by TennCare, the Contractor shall share the approved general parameters with all of their primary care dentists (general dentists and pediatric dentists). The Contractor shall provide the specific methodology sixty (60) days prior to making the incentive payments to recipient providers, to TennCare for approval, to include the following components:

C.3.9.3. communication strategy to Providers;

C.3.9.4. a method for calculating payment amount to individual providers; and

C.3.10. timelines for making the payment to Providers.

C.4. **Withhold of the Capitation Rate**

C.4.1. A withhold of the aggregate capitation payment shall be applied to ensure Contractor compliance with the requirements of this Contract and to provide an agreed incentive for assuring Contractor compliance with the requirements of this Contract. The withhold as described herein may be retained by Grand Region or statewide based upon specific deficiencies as determined by TennCare.

C.4.2. The amount due for the first monthly payment, and for each month thereafter, calculated pursuant to Section C.3.1.2 and C.3.1.3 shall be reduced by the appropriate cash flow withhold percentage amount and set aside for distribution to the Contractor in the next regular monthly payment, unless retained as provided below.

C.4.2.1. Except as further provided below, the applicable capitation payment withhold amount will be equivalent to ten percent (10%) of the monthly capitation payment for the first six months following the start date of operations, for any consecutive six (6) month period following the Contractor's cure of a deficiency as determined by TennCare, and for the final month of operations of this Contract;

C.4.2.1.1. The ten percent (10%) withhold of the monthly capitation payment during the final month of operations of this Contract shall be retained during the run-out period as described in the termination procedures in this Contract.

C.4.2.1.1.1. Upon TennCare's written acknowledgement that the Contractor has completed and satisfied the termination procedures, TennCare shall return the ten percent (10%) withhold of the final month's capitation payment.

C.4.2.1.1.2. Should TennCare determine that the termination procedures were not completed to TennCare's satisfaction, TennCare shall permanently retain the ten percent (10%) withhold of the final month's capitation payment;

C.4.2.2. If, during any consecutive six (6) month period following the start date of operations, TennCare determines that the Contractor has no deficiencies and has not issued a notice of deficiency, the monthly withhold amount will be reduced to five percent (5%) of the monthly capitation payment.

C.4.2.3. If, during any consecutive six (6) month period following a reduction of the monthly withhold amount to five percent (5%) of the monthly capitation payment, TennCare determines that the Contractor has no deficiencies and has not issued a notice of deficiency, the monthly withhold amount will be reduced to two and one half percent (2.5%) of the monthly capitation payment.

C.4.2.4. If the Contractor is notified by TennCare of a minor deficiency and the Contractor cures the minor deficiency to the satisfaction of TennCare within a reasonable time prior to the next regularly scheduled capitation payment cycle, TennCare may disregard the minor deficiency for purposes of determining the withhold.

C.4.2.5. If TennCare has determined the Contractor is not in compliance with a requirement of this Contract in any given month, TennCare may issue a written notice of deficiency and TennCare may retain the amount withheld for the month prior to TennCare identifying the compliance deficiencies.

C.4.2.6. The withhold amounts for subsequent months thereafter in which the Contractor has not cured the deficiencies may at TennCare's discretion be applied in accordance with Section C.4.2.1 as described above. If the Contractor has attained a five percent (5%) withhold or a two and one half percent (2.5%) withhold and TennCare subsequently determines the Contractor is not in compliance with a requirement of this Contract, TennCare may provide written notice of such determination and TennCare may, at the discretion of TennCare, re-institute the retention of the ten percent (10%) withhold as described in Section C.4.2.1 at the next capitation payment cycle. Monthly retention of the withhold amount may continue for each subsequent month so long as the identified deficiencies have not been corrected.

C.4.2.6.1. These funds may not be distributed to the Contractor unless it is determined by TennCare the Contractor has come into compliance with the Contract requirement(s) within six (6) months of TennCare identifying these deficiencies. For example, if a specified deficiency(s) is corrected within four (4) months and there are no other identified deficiencies which the Contractor has been given written notice of by TennCare, the withhold for the four (4) consecutive months will be paid to the Contractor upon TennCare determination that the deficiency(s) was corrected. However, any amounts withheld by TennCare for six (6) consecutive months (i.e., six (6) consecutive capitation payment cycles) for the same or similar compliance deficiency(s) may be permanently retained by TennCare on the first day after the sixth consecutive month period and may not be paid to the Contractor. For purposes of permanent retention of the withhold amount, six (6) consecutive months shall be calculated from the date the withhold amount was initially retained and shall not be based on the date of the notice of deficiency or the date of notification of the withhold retention. If the same or similar specified deficiency(s) continues beyond six (6) consecutive months, TennCare may declare the Contractor ineligible for future distribution of the ten percent (10%) incentive withhold and may continue to permanently retain any amounts withheld by TennCare for six (6) consecutive months. Such ineligibility will continue for each month TennCare determines the same or similar specified deficiency(s) continues to exist. Once a Contractor corrects the deficiency(s), TennCare may reinstate the Contractor's eligibility for distribution of the ten percent (10%) compliance incentive payment of future withholds. If TennCare determines that distribution of the ten percent (10%) withhold is appropriate, distribution of the ten percent (10%) shall be made at the time of the next scheduled monthly check write which includes all other payments due the Contractor.

C.4.3. No interest shall be due to the Contractor on any sums withheld or retained under this Section. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract or applicable law.

C.4.4. If TennCare has not identified Contractor deficiencies, TennCare will pay to the Contractor the withhold of the Contractor's payments withheld in the month subsequent to the withhold.

C.5. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel time, travel expenses, meals, or lodging.

C.6. 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 TennCare;

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.6.

C.7. 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.8. 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.9. 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.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, as directed by TennCare in writing, must stop 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.

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 # 615-507-6443

The Contractor:

Contractor Contact Name & Title
Contractor Name
Address
Email Address
Telephone # Number
FAX # Number

All instructions, notices, consents, demands, or other communications shall be considered 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.12.9.6. (Nondiscrimination Compliance Requirements) and Section D.9 shall not be deemed to limit or abridge any requirement set forth in Section A.12.9.7.

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 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 by submitting to the State a completed Attestation (accessible through the Edison Supplier Portal) and included 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 ten (10) 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 from 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. For clarity, except as otherwise expressly set forth in this Section, Contractor's indemnification obligations and other remedies available under this Contract are subject to the limitations on liability set forth in this Section.

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' fees, court costs, expert witness fees, and other litigation expenses 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, 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 for the affected obligations 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 State and federal laws and regulations applicable to Contractor in the Contractor's performance of this Contract.

D.26. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee, without regard to its conflict or choice of law rules. 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 - 408.

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:
    1. Attachment A – Definitions and Abbreviations;
    2. Attachment B – Service Level Agreements and Liquidated Damages;
    3. Attachment C – DBM Deliverable Requirements;
    4. Attachment D – CoverKids CDT Code Set;
    5. Attachment E – Annual Dental Participation Ratio

6. Attachment F – Dental Screening Percentage
7. Attachment G – Attestation RE: Personnel Used in Contract Performance
8. Attachment H – Silver Diamine Fluoride (SDT) Percentage and Dental Percentage
9. Attachment I – Annual Adult Dental Participation Percentage
10. Attachment J – Procurement Library;
    a) 834 Enrollment Outbound Companion Guide and accompanying 2300 Loop Definitions Cloud Security Questionnaire
    b) 837D Companion Guide
    c) TennCare Data Policies and Standards
    d) TennCare Enterprise Architecture Framework Standard
    e) TennCare Enterprise Architecture Modeling Standard
    f) TennCare Requirements Management Standard
    g) TennCare Test Management Standard
    h) MCC Tagline Notice Templates
11. Attachment K – HIPAA Business Associate Agreement; and

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 Tenn. Code Ann. §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 reserves the right to require complete copies of all required insurance policies, including endorsements required by these specifications, at any time.

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. Automobile Liability Insurance

1) The Contractor shall maintain automobile liability insurance which shall cover liability arising out of any automobile (including owned, leased, hired, and non-owned automobiles).

2) The Contractor shall maintain bodily injury/property damage with a limit not less than one million dollars ($1,000,000) per occurrence or combined single limit.

d. Technology Professional Liability (Errors & Omissions)/Cyber Liability Insurance

1) The Contractor shall maintain technology professional liability (errors & omissions)/cyber liability insurance appropriate to the Contractor's profession 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, claims, errors, omissions, negligence, infringement of intellectual property (including copyright, patent and trade secret); network security and privacy risks, including but not limited to unauthorized access, failure of security, information theft, damage to destruction of or alteration of electronic information, breach of privacy perils, wrongful disclosure and release of private information, collection, or other negligence in the handling of confidential 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 and expenses in the performance of services for the State or on behalf of the State hereunder.

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. The policy must allow for reporting of circumstances or incidents that may give rise to future claims, include an extended reporting period of no less than two (2) years with respect to events which occurred but were not reported during the term of the policy, and 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). 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. Professional Liability

i. 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.

ii. 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.

iii. 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.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.

D.34. 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. The Contractor shall only use Confidential Information for activities pursuant to and related to the performance of the Contract, including limited disclosures of information to subcontractors to satisfy the requirements of the Contract. 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.

D.35. Equal Opportunity. The Contractor agrees as follows:

a. The Contractor will not discriminate against any employee or applicant for employment because of disability, race, color, religion, sex, sexual orientation, gender identity, or national origin. The Contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their disability, race, color, religion, sex, sexual orientation, gender identity, or national origin. Such action shall include, but not be limited to the following:

(1) Employment, upgrading, demotion, or transfer, recruitment or recruitment advertising;

(2) Layoff or termination;

(3) Rates of pay or other forms of compensation; and

(4) Selection for training, including apprenticeship.

The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

b. The Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive considerations for employment without regard to disability, race, color, religion, sex, sexual orientation, gender identity, or national origin.

c. If the State approves any subcontract, the subcontract shall include paragraphs (a) and (b) above.

d. In addition, to the extent applicable the Contractor agrees to comply with 41 C.F. R. § 60-1.4, as that section is amended from time to time during the term.

D.36. Boycott of Israel. The Contractor certifies that it is not currently engaged in, and covenants that it will not, for the duration of the Contract, engage in a Boycott of Israel, as that term is defined in Tenn. Code Ann. § 12-4-119.

D.37. Prohibited Contract Terms. The prohibited contract terms and conditions enumerated
Tenn. Code Ann. §12-3-515.
, shall be a material provision of this Contract. The Contractor acknowledges, understands, and agrees that the inclusion of a term or condition prohibited by
Tenn. Code Ann. §12-3-515.
, shall be null and void and the Contract shall be enforceable as if the Contract did not contain such term or condition.

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. 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 #31865-00636 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, 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.3. 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.4. Contractor Hosted Services Confidential Data, Audit, and Other Requirements

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 or 140-3 (current applicable version) validated encryption technologies. The State shall control all access to encryption keys. The Contractor shall provide installation and maintenance support at no cost to the State.

(3) The Contractor and the Contractor's processing environment containing Confidential State Data shall either (1) 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 (2) be subject to an annual engagement by a CPA firm in accordance with the standards of the American Institute of Certified Public Accountants ("AICPA") for a System and Organization Controls for service organizations ("SOC") Type II audit. The State shall approve the SOC audit control objectives. The Contractor shall provide proof of current ISO certification or FedRAMP authorization for the Contractor and Subcontractor(s), or provide the State with the Contractor's and Subcontractor's annual SOC Type II audit report within 30 days from when the CPA firm provides the audit report to the Contractor or Subcontractor. The Contractor shall submit corrective action plans to the State for any issues included in the audit report within 30 days after the CPA firm provides the audit report to the Contractor or Subcontractor.

If the scope of the most recent SOC audit report does not include all of the current State fiscal year, upon request from the State, the Contractor must provide to the State a letter from the Contractor or Subcontractor stating whether the Contractor or Subcontractor made any material changes to their control environment since the prior audit and, if so, whether the changes, in the opinion of the Contractor or

Subcontractor, would negatively affect the auditor's opinion in the most recent audit report.

No additional funding shall be allocated for these certifications, authorizations, or audits as these are included in the Maximum Liability of this Contract.

(4) 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. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. "Penetration Tests" shall be in the form of attacks on the Contractor's computer system, with the purpose of discovering security weaknesses which have the potential to gain access to the Processing Environment's features and data. The "Vulnerability Assessment" shall be designed and executed to define, identify, and classify the security holes (vulnerabilities) in the Processing Environment. The Contractor shall allow the State, at its option, to perform Penetration Tests and Vulnerability Assessments on the Processing Environment.

(5) 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

(6) 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.

(7) Contractor must enter into a Business Associate Agreement (BAA) with the State. See Contract Section E.17. and Contract Attachment K.

b. Minimum Requirements

(1) The Contractor and all data centers used by the Contractor to host State data, including those of all Subcontractors, must comply with the State's Enterprise Information Security Policies as amended periodically. The State's Enterprise Information Security Policies document is found at the following URL: https://www.tn.gov/finance/strategic-technology-solutions/strategic-technology-solutions/sts-security-policies.html.

(2) The Contractor agrees to maintain the Application so that it will run on a current, manufacturer-supported Operating System. "Operating System" shall mean the software that supports a computer's basic functions, such as scheduling tasks, executing applications, and controlling peripherals.

(3) 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.

c. Comptroller Audit Requirements

Upon reasonable notice and at any reasonable time, the Contractor and Subcontractor(s) agree to allow the State, the Comptroller of the Treasury, or their duly appointed representatives to perform information technology control

audits of the Contractor and all Subcontractors used by the Contractor. Contractor will maintain and cause its Subcontractors to maintain a complete audit trail of all transactions and activities in connection with this Contract. Contractor will provide to the State, the Comptroller of the Treasury, or their duly appointed representatives access to Contractor and Subcontractor(s) personnel for the purpose of performing the information technology control audit.

The information technology control audit may include a review of general controls and application controls. General controls are the policies and procedures that apply to all or a large segment of the Contractor's or Subcontractor's information systems and applications and include controls over security management, access controls, configuration management, segregation of duties, and contingency planning. Application controls are directly related to the application and help ensure that transactions are complete, accurate, valid, confidential, and available. The audit shall include the Contractor's and Subcontractor's compliance with the State's Enterprise Information Security Policies and all applicable requirements, laws, regulations or policies.

The audit may include interviews with technical and management personnel, physical inspection of controls, and review of paper or electronic documentation.

For any audit issues identified, the Contractor and Subcontractor(s) shall provide a corrective action plan to the State within 30 days from the Contractor or Subcontractor receiving the audit report.

Each party shall bear its own expenses incurred while conducting the information technology controls audit.

d. 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 and the Subcontractor(s) 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 actual State Data Sets that mirror 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 Recovery Test that its Disaster Recovery Capabilities meet the RPO and RTO requirements.

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 Advertisement 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 USC § 1352.

E.9. 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 failure and/or assess damages ("Liquidated Damages") in accordance with Attachment B, Service Level Agreement and Liquidated Damages 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.23.3. 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 Contract 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, Service Level Agreements and Liquidated Damages 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 reasonable estimates 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 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.10. Patrial 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 sixty (60) days prior written notice of a Partial Takeover. The notice shall 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.11. 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.12. 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. The obligations set forth in this Section shall survive the termination of this Contract.

E.13. 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 USC 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. § 229.402I(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 Unique Entity Identifier (UEI) number and maintain its UEI number for the term of this Contract. More information about obtaining a UEI Number can be found at: the System for Award Management (SAM.gov).

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.14. Drug-Free Workplace. The Contractor shall provide a drug-free workplace pursuant to the Drug-Free Workplace Act of 1988, Title 41 U.S.C. §§ 701, et seq., and the regulations in Title 41 U.S.C.A. §§ 8101 through 8106.

E.15. Survival. The terms, provisions, representations, and warranties contained in this Contract which by their sense and context are intended to survive the performance and termination of this Contract, shall so survive the completion of performance and termination of this Contract.

E.16. Applicable Legal Authority. The Contractor agrees to comply with all applicable legal authority, including federal and State laws, rules, regulations, policies, sub-regulatory guidance, the State Medicaid Manual, executive orders, TennCare waivers, and all current, modified or future Court decrees, orders or judgments applicable to the State's TennCare and CHIP programs. 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 any further responsibilities set forth in the Business Associate Agreement (See Attachment K) between the Parties.

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, Personal Digital Assistants (PDAs), Blackberry devices (or other Smartphones), Universal Serial Bus (USB) drives, thumb drives, flash drives, Compact Discs (CDs), and/or hard disks.

E.19. Termination

E.19.1. In the event of a termination pursuant to Contract Sections D.5 (Termination for Convenience), D.6 (Termination for Cause), E.10 (Partial Takeover), or E.19.2 (Termination by Contractor), both parties agree to comply with the termination procedures set forth in Contract Section E.19.3. It is agreed that neither party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred during the course of this Contract.

E.19.2. Termination by Contractor

E.19.2.1. The Contractor shall have the option to provide TennCare with a six (6) months notice of termination on or by July 1 of each calendar year after receipt of notice of the capitation payment rates to become effective in July. Said notice shall terminate the Contract on the following December 31st.

E.19.3. TERMINATION PROCEDURES

E.19.3.1. Upon receipt of notice of termination, and subject to the provisions of this Section, on the date and to the extent specified in the notice of termination, the Contractor shall:

E.19.3.1.1. Stop work under the Contract, but not before the termination date;

E.19.3.1.2. At the point of termination, assign to TennCare in the manner and extent directed by TennCare, all the rights, title and interest of the Contractor for the performance of the subcontracts to be determined at need in which case TennCare shall have the right, in its discretion, to settle or pay any of the claims arising out of the termination of such agreements and subcontracts;

E.19.3.1.3. Complete the performance of such part of the Contract that shall have not been terminated under the notice of termination;

E.19.3.1.4. Take such action as may be necessary, or as a contracting officer may direct, for the protection of property related to this Contract which is in possession of the Contractor and in which TennCare has or may acquire an interest;

E.19.3.1.5. In the event the Contract is terminated by TennCare, continue to serve or arrange for provision of services to enrollees for up to forty-five (45) calendar days from the Contract termination date or until the Members can be transferred to another DBM, whichever is longer. During this transition period, TennCare shall continue to make payment as specified in Section C;

E.19.3.1.6. Promptly make available to TennCare, or another DBM acting on behalf of TennCare, any and all records related to the Contractor's activities undertaken pursuant to this Contract. Such records shall be in a usable form and shall be provided at no expense to TennCare or the successor DBM;

E.19.3.1.7. Promptly make available all signed Provider Agreements/contracts, including historical agreements/contracts, to TennCare in PDF format. (The Contractor shall have the option to submit said agreements on an on-going basis during the term of this Contract rather than at the end of this Contract). Upon termination of this Contract and completion of the Contractor's continuing obligations, the State will reserve all rights to pursue improper payments and false claims with the Contractor and/or directly with the Contractor's subcontractors and providers;

E.19.3.1.8. Promptly supply all information necessary to TennCare or another DBM acting on behalf of TennCare for reimbursement of any outstanding claims at the time of termination;

E.19.3.1.9. Submit a termination plan to TennCare for review, which is subject to TennCare written approval. This plan shall, at a minimum, contain the provisions in Sections E.19.3.1.10 through E.19.3.1.15 below. The Contractor shall agree to make revisions to the plan as necessary in order to obtain approval by TennCare. Failure to submit a termination plan, obtain written approval of the termination plan by TennCare and obtain written acknowledgement by TennCare that all termination procedures have been satisfied shall result in the retention of the withhold of ten percent (10%) of the Contractor's monthly capitation payment as described in Section C.4. of this Contract.

E.19.3.1.10. Agree to maintain claims processing functions as necessary for a minimum of nine (9) months (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims;

E.19.3.1.11. Agree to comply with all duties and/or obligations incurred prior to the actual termination date of the Contract, including but not limited to, the appeal process as described in Section A.2.17;

E.19.3.1.12. File all reports concerning the Contractor's operations during the term of the Contract in the manner described in this Contract;

E.19.3.1.13. Take whatever other actions are necessary in order to ensure the efficient and orderly transition of Members from coverage under this Contract to coverage under any new arrangement developed by TennCare;

E.19.3.1.14. In order to ensure that the Contractor fulfills its continuing obligations both before and after termination, maintain the financial requirements (as described in this Contract as of the Contractor's date of termination notice), fidelity bonds and insurance set forth in this Contract until the State provides the Contractor written notice that all continuing obligations of this Contract have been fulfilled; and

E.19.3.1.15. Upon expiration or termination of this Contract, submit reports to TennCare every thirty (30) calendar days detailing the Contractor's progress in completing its continuing obligations under this Contract. The Contractor, upon completion of these continuing obligations, shall submit a final report to TennCare describing how the Contractor has completed its continuing obligations. TennCare shall within twenty (20) calendar days of receipt of this report advise in writing whether TennCare agrees that the Contractor has fulfilled its continuing obligations. If TennCare finds that the final report does not evidence that the Contractor has fulfilled its continuing obligations, then TennCare shall require the Contractor to submit a revised final report. TennCare shall in writing notify the Contractor once the Contractor has submitted a revised final report evidencing to the satisfaction of TennCare that the Contractor has fulfilled its continuing obligations.

E.20. 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 in Contract Attachment B – Service Level Agreements and Liquidated Damages.

E.21. Social Security Administration (SSA) Required Provisions for Data Security.

a. Definitions.

1. "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.

b. 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, 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. In addition, the Contractor shall have in place administrative, physical, and technical safeguards for data. The Contractor shall also comply with Section 1106(a) of the Act (42 U.S.C. 1306) and the regulations promulgated pursuant to that section (20 C.F.R. Part 401).

c. 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.

d. The Contractor shall not duplicate in a separate file or disseminate, without prior written permission from TennCare, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the TennCare program. Should the Contractor propose a redisclosure of said data, the Contractor must specify in writing to TennCare the data the Contractor proposes to redisclose, to whom, and the reasons that justify the redisclosure. TennCare will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.

e. The Contractor agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.

f. The Contractor shall maintain a current list of the employees of such contractor with access to SSA data and provide such lists to TennCare upon request and at any time there are changes.

g. 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.

h. The Contractor shall ensure that its employees:

1. Properly safeguard SSA-supplied data furnished by TennCare under this Contract from loss, theft, or inadvertent disclosure;
2. Receive regular, relevant, and sufficient SSA data-related training, including use, access, and disclosure safeguards and information regarding penalties for misuse of information;
3. Understand and acknowledge that they are responsible for safeguarding this information at all times, regardless of whether or not the Contractor employee is at his or her regular duty station;

4. Ensure that laptops and other electronic devices/ media containing SSA-supplied data are encrypted and/or password-protected;
5. Send emails containing SSA-supplied data only if the information is encrypted or if the transmittal is secure; and,
6. Limit disclosure of the information and details relating to a SSA-supplied data loss only to those with a need to know.

i. 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.

j. 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 notify TennCare immediately upon becoming aware to report the actual or suspected loss. The Contractor must provide TennCare with timely updates as any additional information about the loss of SSA-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.

k. 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) otherwise violated or failed to follow the terms and conditions of this Contract.

E.22. Medicaid and CHIP. The Contractor must provide safeguards that restrict the use or disclosure of information concerning Medicaid and Children's Health Insurance Plan (CHIP) 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

2) Information received under the Internal Revenue Code (Title 26 of the United States Code (USC)) is exchanged only with parties authorized to receive that information under that section of the United States 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 minimum, the following:

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 the Social Security Administration (SSA) or the Internal Revenue Service (IRS);

7) Income information received from SSA or the IRS 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) Conditions for release and use of information about applicants and beneficiaries;

2) Access to information concerning applicants or beneficiaries must be restricted to Contractor representatives or other individuals 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; or 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.

5) The Contractor's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.

6) 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.23. 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 the Social Security Act, Section 1128 (Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs).

E.24. 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, CMS, 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.25. 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 TennCare 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 TennCare 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 TennCare and, upon request, to the IRS reviewing office.

10) TennCare 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 USC 552a. Specifically, 5 USC 552a(i)(1), which is made applicable to contractors by 5 USC 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 (see Publication 1075 Exhibit 6, IRC Sec. 7431 Civil Damages for Unauthorized Disclosure of Returns and Return Information and Publication 1075 Exhibit 5, IRC Sec. 7213 Unauthorized Disclosure of Information). 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. (See Publication 1075 Section 10) 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.

c) Inspection – The IRS and TennCare, with twenty-four (24) hours' 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 TennCare'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 safe.

E.26. Discovery and Litigation. TennCare is frequently involved in litigation as either a party or a non-party with relevant information. If any such litigation should arise, the Contractor shall cooperate fully and timely with any State attorneys or paralegals at no additional cost to the State, which shall include the following responsibilities:

a. **Litigation Support**. The Contractor shall make its personnel available to testify in Tennessee, whether in person before a tribunal or by deposition. The Contractor agrees to waive any objections to any subpoena issued by a Tennessee tribunal, in any case relating to this Contract.

b. **Discovery and Litigation Hold Requirements**. The Contractor shall cooperate with all TennCare requests to aid in data and document retention and collection, as required for litigation. The Contractor shall promptly provide the State with all information within the Contractor's control if required to do so by a discovery demand or court order. The State will exert its best effort to narrow the scope of any discovery request.

The obligation to meet the requirements listed above shall survive the termination of this Contract and shall extend to any subcontractor hired by the Contractor to provide goods or perform services on its behalf as required herein.

E.27. Public Accountability. If the Contractor is subject to Tenn. Code Ann. §§ 8-4-401, *et seq.*, or if this Contract involves the provision of services to citizens by the Contractor on behalf of the State, the Contractor agrees to establish a system through which recipients of services may present grievances about Contractor's operation of the service program. The Contractor shall also display in a prominent place, located near the passageway through which the public

enters in order to receive contract-supported services, a sign at least eleven inches (11") in height and seventeen inches (17") in width stating the following:

NOTICE: THIS AGENCY IS A RECIPIENT OF TAXPAYER FUNDING. IF YOU OBSERVE AN AGENCY DIRECTOR OR EMPLOYEE ENGAGING IN ANY ACTIVITY THAT YOU CONSIDER TO BE ILLEGAL, IMPROPER, OR WASTEFUL, PLEASE CALL THE STATE COMPTROLLER'S TOLL-FREE HOTLINE: 1-800-232-5454

The sign shall be of the form prescribed by the Comptroller of the Treasury. The contracting state agency shall request copies of the sign from the Comptroller of the Treasury and provide signs to contractors.

E.28. Extraneous Terms and Conditions. Contractor shall fill all orders submitted by the State under this Contract. No purchase order, invoice, or other documents associated with any sales, orders, or supply of any good or service under this Contract shall contain any terms or conditions other than as set forth in the Contract. Any such extraneous terms and conditions shall be void, invalid and unenforceable against the State. Any refusal by Contractor to supply any goods or services under this Contract conditioned upon the State submitting to any extraneous terms and conditions shall be a material breach of the Contract and constitute an act of bad faith by Contractor.

IN WITNESS WHEREOF,

CONTRACTOR LEGAL ENTITY NAME:

____

CONTRACTOR SIGNATURE **DATE**

____

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE:

JIM BRYSON, COMMISSIONER **DATE**

DEFINITIONS AND ABBREVIATIONS

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. Appeal - or "State Fair Hearing request" refers to an enrollee's request to contest a DBM-proposed adverse benefit determination.

6. ARRA – American Recovery and Reinvestment Act of 2009

7. As-Built Review - Final design models for the solution submitted by the contractor to TennCare for review. This includes any models, diagrams, tables, and narrative, which together translate the complexities of the solution into a meaningful representation of how it will operate. Additionally, this should include both a description of logical terms (e.g., business processes, rules, information needs and flows, users, locations) and technical terms (e.g., hardware, software, data, communications, and security standards and protocols).

8. 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.

9. Average Speed of Answer (ASA) - 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.

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

11. Business Days - Monday through Friday from 8:00 AM – 5:00 PM Central Standard Time (CST); TennCare holidays are excluded. A list of TennCare Holidays is located at https://www.tn.gov/about-tn/state-holidays.html

12. Calendar Days – Each day shown on the calendar beginning at 12:00 Midnight, including Saturdays, Sundays and Holidays.

13. CFR - Code of Federal Regulations

14. Claim Coordination Committee - made up of Claims Coordinators and other representatives, as needed, from each party who shall review any disputes and negotiate responsibility among the parties.

15. 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.

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

17. 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

18. Corrective Action Plan - A written step by step plan of action that is developed to achieve targeted outcomes for resolution of identified errors.

19. 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, nor can they be required to use a CEA in lieu of a standard covered service.. 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.

20. Covered Service - See Benefits at Contract Sections A.5, A.6, and A.16.1.

21. CoverKids Enrollee – Defined as:

    a. 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.

    b. 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.

    c. 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.

22. CoverKids Member – Shall have the same meaning as the term 'CoverKids Enrollee'.

23. Cultural Competence - Is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

24. Culturally and Linguistically Appropriate Services ("CLAS") - means the ability to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of the individuals being served. The national CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities and are located at: https://thinkculturalhealth.hhs.gov/clas/standards.

25. DBM – Dental Benefits Manager. A contractor that manages and delivers dental benefits and services to eligible TennCare/Medicaid and CoverKids/CHIP members.

26. 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.

27. 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.

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

29. 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.

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

31. 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.

32. 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.

33. 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.

34. Enrollee-Authorized Representative - For purposes of Enrollee Benefit Appeals, and the Enrollee-Benefit Appeal-related provisions in Section A.17. 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.

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

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

37. 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.

38. 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.

39. 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.

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

41. 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).

42. 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.10.4.2. 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.

43. Governing Body – an organization's 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

44. 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		

45. Grievance - synonymous with a complaint. An expression of dissatisfaction (other than an organization determination) with any aspect of the operations, activities, or behavior of a Medicare health plan, its providers, regardless of whether remedial action is requested.

46. 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.

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

48. 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.

49. 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.

50. Integration Service Layer (ISL) - The ISL provides integration and orchestration for all MMIS modules in the MMP.

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

52. 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.

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

54. Medical Loss Ratio (MLR) – The percentage of capitation payment received from TennCare that is paid for medical expenses (covered medical services).

55. Medicaid Management Information System (MMIS) - The MMIS is a mechanized claims processing and information retrieval system that State Medicaid programs must have to be eligible for Federal funding. For Title XIX purposes, "systems mechanization" and "mechanized claims processing and information retrieval systems" is identified in section 1903(a)(3) of the Act and defined in regulation at 42 CFR 433.111. The objectives of this system and its enhancements include the Title XIX program control and administrative costs; service to recipients, providers and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.

56. Medicaid Modernization Program Vendors and Partners (MMPVP) - include but are not limited to the following TennCare vendors and partners:
    — Technical Advisory Services (TAS): TAS supports and advises TennCare in completing the TennCare Information Services Portfolio by offering organizational change management and training, operations & maintenance planning, lifecycle advisory services, quality management, and enterprise architecture services.
    — Strategic Program Management Office (SPMO): The SPMO provides program and project management support to TennCare IS.
    — MMIS Module Vendor(s): The modular vendor partners who design, implement, test and maintain the systems, applications and business and technology services that support the enterprise. MMIS modules use the ISL to consume or provide services or data across solutions and modules throughout the TennCare enterprise.
    — Business Support Services (BSS): Assists with strategic planning and development of business enterprise architecture strategy, providing subject-matter expertise supporting certification, testing, MITA, and Advanced Planning Documents (APD). BSS assists TennCare in preparing for and coordinating project reviews, including documentation of existing processes and recommendations for future process improvements.

57. 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.

58. 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.

59. NAIC – National Association of Insurance Commissioners.

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

61. 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.

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

63. Office Reference Manual – A dental program criteria manual specific to each separate dental benefit program, to assist participating dental providers.

64. 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 TennCare Adult Dental DBM Program, and CoverKids enrollees or to provide dental services to individuals in all populations.

65. 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.

66. 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).

67. 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.

68. 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.

69. 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.

70. Primary Care Dental Network – A group of general and pediatric dentists that will provide dental services under this Contract.

71. 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.

72. 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.

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

74. 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.

75. 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.

76. 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.

77. 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.

78. Provider Peer Review Committee – A committee of dental providers appointed by a state or local or specialty dental society or appointed by the governing board or any other organization formed pursuant to state or federal law and engaged for the purpose of evaluating the quality of provider services or the competence of providers and suggest improvements in provider systems to enhance patient care.

79. 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.

80. 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.

81. Readiness Review - A review to ensure the Contractor's readiness to begin operations or implement new program components or substantively modified program requirements, as applicable and determined by TennCare.

82. SDF OR Diversion – limiting members' dental treatment in medical facilities by use of Silver Diamine Fluoride (SDF), a caries arresting medicament, when appropriate. This is measured by the number of hospital treatment requests denied by the DBM for lack of attempted use of SDF by the provider as reported on the hospital readiness form divided by the total number of hospital requests made during the measurement period.

83. Secure File Transfer Protocol (SFTP) - a network protocol for securely accessing, transferring and managing large files and sensitive data.

84. 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.

85. Service Oriented Architecture (SOA) - A software design strategy that packages common functionality and capabilities (services) with standard, well-defined service interfaces to produce formally described functionality invoked using a published service contract.

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

87. Services - The benefits described in this Contract, including but not limited to, Section A.4.

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

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

90. State - State of Tennessee.

91. 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.5 of this Contract shall be considered Provider Agreements and governed by Section A.12.5. of this Contract. If a subcontractor will also be a Provider the requirements for Provider Agreements must also be met.

92. 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.

93. 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.

94. Telecommunications Relay Service (TRS) - A service that allows persons with hearing or speech disabilities to place and receive telephone calls.

95. 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).

96. 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.7.1.4.1.), 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.

97. 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.7.1.4.1.), 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.

98. TennCare Member – Shall have the same meaning as the term 'Enrollee'

99. 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.

100. 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".

101. Tennessee Board of Dentistry – an agency of state government created by the Tennessee state legislature, whose mission is to safeguard the health, safety, and welfare of Tennesseans by requiring those who practice as dentists, dental hygienists, or dental assistant within the state be qualified.

102. 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.

103. Tennessee Eligibility Determination System (TEDS) - the TennCare solution that establishes whether or not an applicant is eligible for Medicaid or eligible for other insurance affordability programs, such as the Children's Health Insurance Program (CHIP).

104. 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.

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

106. 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.

107. 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.

108. Vital Documents – May include and are not limited to 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, certain critical outreach documents, and any other documents designated by the State. All vital documents shall be at a minimum available in the Arabic and Spanish languages.

109. 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.

SERVICE LEVEL AGREEMENTS AND LIQUIDATED DAMAGES

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 D. 34. 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.)		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.12 and Business Associate Agreement.)		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 See E.18 and the 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.	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.6.2.9.		The damage that may be assessed shall be five hundred dollars ($500) per occurrence.
6.	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.
7.	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 law, plus, the amount paid to the staff/provider/agent/ subcontractor during that period.
8.	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, per staffing requirement, for each day that staffing requirements are not met.
9.	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 fifty thousand dollars ($50,000) for each failure to meet a listed requirement, either individually or in combination on a monthly basis. The liquidated damage may be lowered to ten thousand dollars ($10,000) if the Contractor timely provides a corrective action plan that is accepted by TennCare
10.	Failure of the Contractor to maintain an accurate listing of providers that truly reflects those who participate in a specific TennCare Dental Program.		$500 per calendar day for each inaccurate instance in which the Contractor fails to maintain an accurate provider listing per specific dental program.
11.	TennCare-related Enrollee Appeals. Failure to confer a timely response to a request for PA in accordance with 42 CFR §438.210 and Section A.17.3 of this Contract.		TennCare may assess damages amounting to $500 for each occurrence and for each day DBM is in default.
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.17.3., A.17.5., and A.17.6 of this Contract.		TennCare may assess damages amounting to $500 for each Enrollee Appeal 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		$500 per calendar day, per untimely or incomplete response, that Contractor is in default.

	notices issued to enrollee, dental records, PA requests and decisions.		
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, per untimely or incomplete response, that 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, per Enrollee Benefit Appeal, that Contractor is in default.
16.	Enrollee Benefit Appeals. Failure to submit an expedited appeal/SFH request to TennCare within one (1) business day of receipt by Contractor.		$500 per calendar day, per Enrollee Benefit Appeals, that 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 Section A.15.1. of this Contract and the performance requirements in Section A.23.1.		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.15.1. and A.23.1.
19.	Maintain an average daily abandonment rate of five percent (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.11.1. and A.15.2.6.		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 sixty (60) seconds or less as specified in Sections A.11.1. and A.15.2.6. 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 sixty-one (61) seconds up to one hundred eighty (180) seconds. A maximum of one thousand five hundred dollars ($1,500) per queue per operating day for an ASA of one hundred eighty-one (181) seconds or more.
21.	Maintain a daily blocked call rate of 1% or less as specified in Sections A.11.1. and A.15.2.6.		A maximum of one thousand dollars ($1,000) for each percentage point above one percent (1%).
22.	The Contractor's shall answer one hundred percent (100%) of calls each day within three hundred (300) seconds as specified in Section A.11.1. and A.15.2.6..		A maximum of five hundred dollars ($500) for each instance of each call answered within three hundred one (301) seconds to six hundred (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 six hundred one (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 Section A.17 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.19.2.1. 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.21. of this Contract.		The damage that may be assessed is five hundred dollars ($500) per calendar day, per occurrence, for each day that the Contractor does not comply with the program integrity provisions
26.	Failure by the Contractor to maintain a Dental Screening Percentage (DSP) (Refer to Attachment F) greater than or equal to 80% as required in Section A.23.2. for the TennCare Children's DBM Program only.		Liquidated Damages of up to twenty-five thousand dollars ($25,000) may be assessed for every one percent (1%) decrease in DSP below eight percent (80%).
27.	Failure by the Contractor to maintain the PEAR for the CoverKids Program above fifty percent (>50%) on an annual basis as required by Contract Section A.23.2.		A maximum of up to one hundred thousand dollars ($100,000) in liquidated damages may be assessed for failure to have the PEAR for the CoverKids Program above fifty percent (>50%) on an annual basis.
28.	Failure by the Contractor to maintain the PEAR for the TennCare DBM Program above fifty-eight percent (>58%) on an annual basis as required by Contract Section A.23.2.		Annual Dental Participation Ratio as calculated in Attachment E: 50% or below: $500,000 Between 51-54%: $200,000 Between 55% - 56%: $125,000 Between 57-58%: $75,000
29.	Failure by the Contractor to maintain % member utilization for the TennCare DBM Adult Dental Program above twenty percent (>20%) on an annual basis as required by the Contract in Section A.23.2.		A maximum of up to twenty-five thousand dollars ($25,000) in liquidated damages may be assessed for failure to have the member utilization for the TennCare Adult Dental DBM Program above twenty percent (>20%) on an annual basis.
30.	Failure by the Contractor to maintain the Dental Sealant Percentage for the TennCare DBM Program at or above fifteen percent (≥15%) on an annual basis as required by Contract Section A.23.2.		A maximum of up to fifty thousand dollars ($50,000) in liquidated damages may be assessed for failure to have the Dental Sealant Percentage for the TennCare Children's DBM Program at or above fifteen percent (≥ 15%) on an annual basis.

31.	Failure by the Contractor to maintain the Dental Sealant Percentage for the CoverKids DBM Program at or above fifteen percent (≥15%) on an annual basis as required by Contract Section A.23.2.		A maximum of up to fifty thousand dollars ($50,000) in liquidated damages may be assessed for failure to have the Dental Sealant Percentage for the CoverKids DBM Program at or above fifteen percent (≥ 15%) on an annual basis.
32.	Failure by the Contractor to maintain the SDF Percentage for the CoverKids DBM Program at or above 1.4 percent (≥1.4%) on an annual basis as required by Contract Section A.23.2.		A maximum of up to fifty thousand dollars ($50,000) in liquidated damages may be assessed for failure to have the SDF for the CoverKids DBM Program at or above 1.4 percent (≥ 1.4%) on an annual basis.
33.	Failure by the Contractor to maintain the SDF Percentage for the TennCare Children's DBM Program at or above 1.4 percent (≥1.4%) on an annual basis as required by Contract Section A.23.2.		A maximum of up to fifty thousand dollars ($50,000) in liquidated damages may be assessed for failure to have the SDF for the TennCare Children's DBM Program at or above 1.4 percent (≥ 1.4%) on an annual basis.
34.	Failure by the Contractor to maintain the SDF- OR Diversion for the TennCare Children's DBM Program at or above twenty-five percent (≥25%) on an annual basis as required by Contract Section A.23.2.		A maximum of up to fifty thousand dollars ($50,000) in liquidated damages may be assessed for failure to have the SDF-OR Diversion for the TennCare Children's DBM Program at or above twenty-five Percent (≥ 25%) on an annual basis.
35.	Failure by the Contractor to maintain the SDF- OR Diversion for the CoverKids DBM Program at or above twenty-five percent (≥25%) on an annual basis as required by Contract Section A.23.2.		A maximum of up to fifty thousand dollars ($50,000) in liquidated damages may be assessed for failure to have the SDF-OR Diversion for the CoverKids DBM Program at or above twenty-five Percent (≥ 25%) on an annual basis.
36.	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.
37.	Failure to comply with distribution timeframes for providing Member Handbooks, Provider Directories, and Newsletters, as required by Contract Section A.19.1.		The damage that may be assessed shall be five thousand dollars ($5000) for each occurrence.
38.	Failure to complete or comply with Corrective Action Plans as required by TennCare in Contract A.9.		The damage that may be assessed shall be five hundred dollars ($500) per calendar day, per occurrence, for each day the corrective action is not completed or complied with as required.
39.	Failure to completely process a clean 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.12.6.		Five thousand dollars ($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. One thousand ($1,000) per application per calendar day for each day beyond

			thirty (30) calendar days that a completed credentialing application has not been processed.
40.	Failure to report provider notice of termination of participation in the Contractor's Plan as required by Contract Section A.12.4.2.		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.
41.	Failure to submit a Provider Enrollment File that meets TennCare's specifications as required by Contract Sections A.12.1.4. and A.18.3.2.		Five hundred dollars ($500) per day after the due date that the Provider Enrollment File fails to meet TennCare's specifications.
42.	The level of overall customer satisfaction, as measured annually by a State approved Enrollee Satisfaction survey(s), shall 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 as required by Contract Section A.11.8.		Three thousand dollars ($3000) per Enrollee Satisfaction survey(s), less than eighty-five percent (85%) in the first year of the Contract, and ninety percent (90%) in all subsequent year(s) within the Term.
43.	Failure to disclose Lobbying Activities as specified in Contract Section E.8.		The damage that may be assessed shall be one thousand dollars ($1000) per calendar day that disclosure is late.
44.	Failure to comply with overpayment reporting as outlined in Contract Section A.21.5.		The damage that may be assessed shall be one thousand dollars ($1000) per calendar day that disclosure is late.
45.	Failure to coordinate with TennCare for the timely and effective completion of the readiness review process and implementation relating to the TennCare ECF CHOICES and 1915(c) DBM Program (see Contract Section A.4.8.).		One thousand dollars ($1,000) per readiness review deliverable (e.g., documents and demonstrations) that is not provided by the Contractor pursuant to TennCare expectations and timeframes.
46.	Failure to ensure each TennCare ECF CHOICES and 1915(c) Dental Program member receives a timely and proper evaluation prior to receiving covered services (see Contract Section A.6.2.7).		One thousand dollars ($1,000) per member that does not receive a timely and proper evaluation
47.	Failure to ensure that only covered services are rendered to TennCare ECF CHOICES and 1915(c) Dental program members		One thousand dollar ($1,000) per improper authorization and/or reimbursement of dental services for TennCare 1915(c) Dental Program members.
48.	Failure of the Contractor's TennCare ECF CHOICES and 1915(c) Dental Program provider network to meet Access to Care and Transport Distance requirements (see Contract Sections A.12.1.2. and A.12.1.5.) without a TennCare-approved waiver.		A maximum of one hundred thousand dollars ($100,000) may be assessed 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 fifty thousand dollars ($50,000) in the event that the Contractor timely provides a corrective action plan that is accepted by TennCare.

49.	Dental Network Access Readiness Benchmarking *DATE* – 50% network access standards are met. *DATE* – 75% network access standards met. *DATE* – 90% network access standards met. *DATE* – Dental network access standards to be 100% met. Utilizing the Provider Enrollment File. Definition of In-Network Provider – signed executed Provider Agreement with a fully credentialed provider to participate in the Contractor's network as a contract provider.		A maximum of one hundred thousand dollars ($100,000) may be assessed if ANY of the listed standards are not met, either individually or in combination on a monthly basis. The liquidated damage may be lowered to fifty thousand dollars ($50,000) in the event the Contractor provides a corrective action plan that is accepted by TennCare. The liquidated damage may be waived if the Contractor provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of Dental providers in the area.
50.	Failure of the Contractor to meet the requirement for visiting one hundred (100) provider offices on an annual basis, per Provider Specialist, as required in Contract Section A.23.1.2.		A maximum of up to twenty-five thousand dollars ($25,000) in liquidated damages may be assessed for failure of a Provider Specialist to visit one hundred (100) offices on an annual basis.
51	Failure of the Contractor to meet the requirement for scheduling provider requested ad hoc office visits, or TennCare directed office visits within five (5) business days of the request, as required in Contract Section A.23.1.2.		Five hundred dollars ($500) per business day in liquidated damages may be assessed for failure of a Provider Specialist to schedule an ad hoc provider requested visit, or TennCare directed visit after five (5) business days.
52.	Failure of the Contractor to issue Preventive CAPs to 20% of PCDs who fall below the established threshold for sealant or SDF utilization, per quarter, as required in Contract Section A.23.2.2.		The damage that may be assessed shall be five thousand dollars ($5,000) for each quarter the issuance of CAPs does not meet the required percentage.
53.	Failure to provide a timely and/or acceptable response to any On Request Report (ORR) as requested by TennCare		Two hundred fifty dollars ($250) per calendar day, per untimely and/or unacceptable response, may be assessed for each day the On Request Report is late, or for each day the Contractor fails to comply with an On Request Report action as required by TennCare
54.	Failure to provide a timely and/or acceptable response to any Corrective Action Plan (CAP) as requested by TennCare		Five Hundred ($500) per calendar day may be assessed for each day the Corrective Action Plan is late, or for each day the Contractor fails to comply with the Corrective Action Plan as required by TennCare.
55.	Failure of the Contractor to ensure that dental evidence submitted by providers are properly identified and labeled		The damage that may be assessed shall be one thousand dollars ($1,000) per occurrence.

56.	Provider Information Accuracy – Provider Enrollment File Benchmark: Data for no more than ten percent (10%) of listed providers is incorrect for each data element Definition: Data for no more than ten percent (10%) of a statistically valid sample of participating providers on the most recent monthly provider enrollment is incorrect for each element as determined by TennCare. Frequency: Quarterly		Five thousand dollars ($5,000) per quarter if data for more than ten percent (10%) but fewer than thirty-one percent (31%) of providers is incorrect for each data element. Twenty-five thousand ($25,000) per quarter if data for more than thirty percent (30%) of providers is incorrect for each data element The twenty-five thousand dollar ($25,000) liquidated damage may be lowered to five thousand dollars ($5,000) in the event that the Contractor provides a corrective action plan that is accepted by TennCare, or may be waived by TennCare if the Contractor submits sufficient documentation.
57.	Failure to comply with required program integrity-related plans and reports as outlined in Contract Section A.21.12		The damage that may be assessed shall be one thousand dollars ($1000) per calendar day that disclosure is late.
58.	For each day that a report or Deliverable is incorrect, incomplete, or deficient, the Contractor shall be liable to TennCare for liquidated damages per day per report or Deliverable unless specified otherwise in this Section. Liquidated damages for late reports/Deliverables shall begin on the first day the report/Deliverable is late.		The damage that may be assessed shall be five hundred dollars ($500) per calendar day per report or Deliverable.

DBM Deliverables Requirement

ATTACHMENT C

DBM Deliverables Requirement

DBM Dental Deliverables	Scheduled Due Dates
Monthly Reports:	**Thirty (30) calendar days after the end of each calendar month unless otherwise noted.**
• Batch Claims operation	
• 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	
• Claims Lag Triangle	**20th of the month – submit to OPI**
• 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 (PEF)☼	
• Systems Availability and Performance Report	By fifth business day each month for the TennCare PEF and by the tenth day of each month for the CoverKids PEF after receiving notice that the TennCare PEF was accepted
• Monthly Provider Office Visit Response Time Report	
• Monthly Recovery and Cost Avoidance Report	

Quarterly Reports:
• PI 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
• Encounter/MLR Reconciliation Report
• DBM Quarterly TennCare Kids Report
	Thirty (30) days after the end of each Federal Fiscal Year quarter (unless noted)

• Quarterly Provider Remediation, CAP, and Reassignments Report • QMP Committee Meeting Minutes • Quality Indicator • PI Referral ¥ • Quarterly FWA Activities Report • "Insure Kids Now" (IKN) File☼ • PI Disclosure Rate Report • Quarterly Member Newsletter • PI Utilization by Standard Deviation • PI Cost Savings Report • Quarterly PCDH Reports (including provider assignment of new members and provider reassignment of existing members, as well as outreach and corrective action plans to providers) • Quarterly DBM CAPs Report • Quarterly Recovery and Cost Avoidance Report	**<u>PI referrals should be submitted as soon as the FWA is suspected or confirmed</u>** Ten (10) days after the end of <u>each federal quarter</u> <u>Submit to TC OPI</u> 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 • <u>Two (2) PIPs Dental Studies†</u> • 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)	**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

• Annual Recovery and Cost Avoidance Report • HEDIS Measures Report	**By February 15 each year** By June 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 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 • 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	Thirty (30) days after the end of each Federal Fiscal Year quarter (unless noted) Within five (5) days of end of each quarter Within five (5) days of end of each quarter

Annual Reports/ Plans/Studies:	Ninety (90) days after end of Federal Year (unless noted)
• Enrollee Satisfaction Survey	By March 30 each year
• Provider Satisfaction Survey	By March 30 each year
• Non-Discrimination Policy	By August 16 each year
• Non-Discrimination Policy Compliance Plan	By August 16 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

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.18.6.1. (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:

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

CoverKids CDT Code Set

COVERKIDS CODE SET

Code	Description
D0120	periodic oral exam
D0140	limited oral evaluation
D0150	comprehensive oral evaluation
D0160	detailed & extensive oral evaluation
D0170	re-evaluation
D0180	comprehensive periodontal evaluation
D0210	intraoral - complete series
D0220	intraoral - periapical 1st film
D0230	intraoral - periapical each additional
D0240	intraoral - occlusal film
D0270	bitewing - single film
D0272	bitewing - two films
D0274	bitewing - four films
D0277	vertical bitewings - 7 to 8 films
D0321	other tmj films - by report
D0330	panoramic film
D0340	cephalometric film
D0350	oral/facial images
D0367	cone beam CT capture and interpretation with field of view of both jaws, with or without cranium
D0415	bacteriologic studies
D0431	adjunctive pre-diagnostic test for mucosal abnormalities
D0460	pulp vitality tests
D0470	diagnostic casts
D1110	prophylaxis – adult
D1120	prophylaxis – child
D1206	fluoride varnish
D1208	topical application of fluoride
D1351	sealant - per tooth
D1354	interim caries arresting medicament application - per tooth
D1510	space maintainer - fixed - unilateral
D1516	space maintainer - fixed - bilateral, maxillary
D1517	space maintainer - fixed - bilateral, mandibular
D1526	space maintainer - removable - bilateral, maxillary
D1527	space maintainer - removable - bilateral, mandibular
D1551	recement/rebond bilateral space main maxillary
D1552	recement/rebond bilateral space main mandibular
D1553	recement/rebond bilateral space main per quadrant
D2140	amalgam - 1 surface
D2150	amalgam - 2 surface
D2160	amalgam - 3 surface
D2161	amalgam - 4+ surface
D2330	composite - 1 surface anterior
D2331	composite - 2 surface anterior
D2332	composite - 3 surface anterior
D2335	composite - 4+ surface anterior
D2390	composite crown - anterior
D2391	composite - 1 surface posterior
D2392	composite - 2 surface posterior
D2393	composite - 3 surface posterior
D2394	composite - 4+ surface posterior
D2740	crown - porc/ceramic
D2750	crown - porc/metal high noble

Code	Description
D2751	crown - porc/metal base
D2752	crown - porc/metal noble
D2790	crown - full metal high noble
D2791	crown - full metal base
D2792	crown - full metal noble
D2799	provisional crown
D2910	recement inlay
D2920	recement crown
D2928	prefabricated porcelain/ceramic crown – permanent tooth
D2930	crown - stainless steel primary
D2931	crown - stainless steel permanent
D2932	crown - prefab resin
D2933	crown - stainless steel w/ window
D2940	sedative filling
D2941	interim therapeutic restoration – primary dentition
D2950	core buildup w/ pins
D2951	pin retention - per tooth
D2952	cast post & core
D2954	prefab post & core
D2980	crown repair
D2999	unspecified procedure - by report
D3110	pulp cap - direct
D3120	pulp cap - indirect
D3220	pulpotomy
D3221	gross pulpal debridement
D3230	pulpal therapy anterior primary
D3240	pulpal therapy posterior primary
D3310	root canal - anterior
D3320	root canal - bicuspid
D3330	root canal - molar
D3332	incomplete endodontic therapy
D3346	retreatment - anterior
D3347	retreatment - bicuspid
D3348	retreatment - molar
D3351	apexification - initial
D3352	apexification - interim
D3353	apexification - final including rt canal-fill
D3410	apicoectomy - anterior
D3421	apicoectomy - bicuspid - first root
D3425	apicoectomy - molar - first root
D3426	apicoectomy (each additional root)
D3430	retrograde filling - per root
D3471	surgical repair of root resorption - anterior
D3472	surgical repair of root resorption - premolar
D3473	surgical repair of root resorption - molar
D4210	gingivectomy - per quad - 4+ teeth
D4211	gingivectomy - per quad - 1-3 teeth
D4249	crown lengthening - hard tissue
D4260	osseous surgery - 4+ teeth per quad
D4261	osseous surgery - 1 to 3 teeth per quad
D4263	bone replacement graft - 1st site in quad
D4264	bone replacement graft
D4265	biologic materials - regeneration
D4266	tissue regeneration - resorbable - per site
D4273	subepithelial tissue graft
D4322	splint – intra-coronal, natural teeth or prosthetic crowns
D4323	splint – extra-coronal, natural teeth or prosthetic crowns
D4341	periodontal scaling and root planing – per quad

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Code	Description
D4342	scaling and root planing - 1 to 3 teeth per quad
D4355	full mouth debridement
D4381	localized delivery of antimicrobial agents
D4910	periodontal maintenance
D4999	unspecified procedure - by report
D5110	complete denture - max
D5120	complete denture - mand
D5130	immediate denture - max
D5140	immediate denture - mand
D5211	partial denture - resin max
D5212	partial denture - resin mand
D5213	partial denture - metal max
D5214	partial denture - metal mand
D5225	partial denture - flexible base - max
D5226	partial denture - flexible base – mand
D5227	immediate maxillary partial denture – flexible base (incl. clasps, rests and teeth)
D5228	immediate mandibular partial denture – flexible base (incl. clasps, rests and teeth
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary
D5283	removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular
D5511	repair broken complete denture base, mandibular
D5512	repair broken complete denture base, maxillary
D5520	repair - missing/broken teeth
D5611	repair resin partial denture base, mand.
D5612	repair resin partial denture base, maxillary
D5621	repair cast partial framework, mandibular
D5622	repair cast partial framework, maxillary
D5630	repair - broken clasp
D5640	replace broken teeth
D5650	add tooth - partial
D5660	add clasp - partial
D5725	rebase hybrid prosthesis
D5730	reline- complete dent max chair
D5731	reline - complete dent mand chair
D5740	reline - partial dent max chair
D5741	reline - partial dent mand chair
D5750	reline- complete dent max lab
D5751	reline - complete dent mand lab
D5760	reline - partial dent max lab
D5761	reline - partial dent mand lab
D5765	soft liner for complete or partial removable denture - indirect
D5820	interim partial denture - max
D5821	interim partial denture - mand
D5850	tissue conditioning - max
D5862	precision attachment
D6010	surgical placement implant body - endosteal
D6056	prefabricated abutment
D6057	custom abutment
D6059	abutment supported crown - porc/metal high noble
D6065	implant supported crown - porc/ceramic
D6066	implant supported crown - porc/metal high noble
D6069	abutment supported retainer - crown - porc/metal high noble
D6191	semi – precision abutment - placement
D6192	semi – precision attachment - placement
D6240	pontic crown - porc/metal high noble
D6241	pontic crown - porc/metal base
D6242	pontic crown - porc metal noble
D6545	retainer - met for resin bonded
D6740	crown - porc/ceramic

Code	Description
D6750	crown - porc/metal high noble
D6751	crown - porc/metal base
D6752	crown - porc/metal noble
D6930	recement bridge
D6950	precision attachment
D7140	extraction - erupted tooth or exposed root
D7210	extraction - surgical
D7220	impaction - soft tissue
D7230	impaction - partially bony
D7240	impaction - completely bony
D7241	impaction - completely bony - surgical complications
D7250	surgical removal of residual roots
D7270	tooth reimplantation
D7280	surgical access of unerupted tooth for orthodontics
D7283	placement of device to facilitate eruption of impacted tooth
D7285	biopsy-hard
D7286	biopsy - soft
D7310	alveoloplasty w/ extractions
D7311	alveoloplasty w/ extractions - 1 -3 teeth/spaces per quad
D7320	alveoloplasty w/o extractions
D7410	excision benign lesion - 1.25 cm
D7510	incision & drainage - intraoral
D7520	Incision and drainage of abscess - extraoral soft tissue
D7880	occlusal orthotic device - by report
D7953	bone replacement graft for ridge preservation - per site
D7961	buccal / labial frenectomy(frenulectomy)
D7962	lingual frenectomy(frenulectomy)
D8020	limited ortho treatment-transitional
D8030	limited ortho treatment of adolescent dentition
D8080	comprehensive ortho treatment-adolescent
D8210	removable appliance therapy-minor habit control
D8220	fixed appliance therapy-minor habit control
D8660	pre-orthodontic treatment visit
D8670	periodic ortho tx. visit (part of contract)
D8680	orthodontic retention
D8999	unspecified orthodontic procedure
D9110	palliative treatment
D9222	deep sedation/general anesthesia – first 15 minutes
D9223	deep sed/gen anesthesia - each 15 minute
D9230	nitrous oxide/analgesia, anoxiolysis
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes
D9243	Intravenous moderate (conscious) sedation - each 15 min
D9248	non-intravenous conscious sedation
D9420	hospital call
D9430	office visit for observation
D9610	therapeutic drug injection - by report
D9612	Therapeutic drug injection – 2 or more meds by report
D9630	other drugs/medications - by report
D9910	desensitizing medicament
D9911	desensitizing resin - per tooth
D9930	treatment of complications - post surgical - by report
D9944	occlusal guard - hard appliance, full arch
D9945	occlusal guard - soft appliance, full arch
D9951	occlusal adjustment - limited
D9971	odontoplasty- 1-2 teeth
D9999	unspecified adjunctive procedure, by report

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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**

$\mathbf{W}_i = \boldsymbol{Fte} / \sum_{i=1}^{I} \boldsymbol{Fte};$ Where $\boldsymbol{I}$ equals the total qualifying eligibles

Where $\sum_{i=1}^{I} \mathbf{W}_i = \mathbf{1}$

ii. Qualifying Service Indicator

$f(s) = \{ 1, \text{ if received qualifying service} \quad 0, \text{ if not}$

iii. Participation Ratio for Individual i

$PR_i = W_i * f(s)$

iv. Overall Participant Ratio

$PR = \sum_{i=1}^{I} PRi$

Dental Screening Percentage

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 2026		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:***								
	CDT 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

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

ANNUAL ADULT DENTAL PARTICIPATION PERCENTAGE

ATTACHMENT I

Annual Adult Dental Participation Percentage

Description

Number of unique eligible adult members who received a covered dental service in the measurement year divided by the number of adults that have been continuously enrolled for a minimum of ninety (90) days during the same period

Eligible Population

Members age 21 or older with a minimum 90 days of continuously enrollment. Age is determined at the mid-point of the reporting period

Qualifying Services

Claims with a qualifying paid service

Codes: Adult Dental Code Set covered by TennCare, see Section A.6.4.2.1)

Metric Formulation

Numerator – Number of unique eligible adult members who received a covered dental service in the measurement year

Denominator – the number of adults that have been continuously enrolled for a minimum of ninety (90) days during the same period

FTE equals the number of days eligible divided by 365.25

CONTRACT ATTACHMENT J

PROCUREMENT LIBRARY

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, 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:

____
____
____
____
____
____
____

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:	BUSINESS ASSOCIATE:
Stephen Smith, 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: ______________________________

Stephen Smith, Director

Date: ______________________________

Division of TennCare
310 Great Circle Road
Nashville, TN 37243
Fax: (615) 253-5607

BUSINESS ASSOCIATE

By: ______________________________

____

Date: ______________________________

On behalf of:

Name: ______________________________

Address:

____

____

Fax/Email:

____