



CONTRACT AMENDMENT COVER SHEET

Agency Tracking # 31865-00355	Edison ID 36736	Contract #	Amendment # 01
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Contractor Legal Entity Name DentaQuest USA Insurance Co., Inc.	Edison Vendor ID 0000008993
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Amendment Purpose & Effect(s)
Extends Term, Updates Scope, and Increases Maximum Liability

Amendment Changes Contract End Date: YES NO **End Date:** September 30, 2017

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **\$ 8,000,000.00**

Funding —					
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2014	\$1,012,500.00	\$1,012,500.00			\$2,025,000.00
2015	\$6,350,000.00	\$6,350,000.00			\$12,700,000.00
2016	\$6,350,000.00	\$6,350,000.00			\$12,700,000.00
2017	\$6,337,500.00	\$6,337,500.00			\$12,675,000.00
2018	\$3,000,000.00	\$3,000,000.00			\$6,000,000.00
TOTAL:	\$23,050,000.00	\$23,050,000.00			\$46,100,000.00

American Recovery and Reinvestment Act (ARRA) Funding: YES NO

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



CPO USE

Speed Chart (optional) TN0000000167	Account Code (optional) 70803000
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**AMENDMENT #1 TO CONTRACT NO. 36736
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
DENTAQUEST USA INSURANCE CO., INC.**

This Amendment ("Amendment #1") to that certain Contract (the "Contract") dated May 15, 2013 by and between Contractor (as defined below) and the State (as defined below) is made and entered by and between the State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Bureau of TennCare, hereinafter referred to as the "State" or "TennCare" and DentaQuest USA Insurance Company, Inc., hereinafter referred to as the "Contractor." All capitalized terms used herein and not otherwise defined herein shall have the meaning given to them in the Contract. For good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

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

A.3. Services. The Contractor agrees to administer TennCare dental benefits 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 and shall manage the program in a manner that ensures an adequate network of qualified dental providers for each population for whom the Contractor is responsible. These providers will render high quality, medically necessary, cost effective dental care. Furthermore, the Contractor shall exercise every available means through this Contract, provider agreements, office reference manual or Contractor's policies and procedures, to ensure that the program is managed in this manner.

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 21 and older who have an intellectual or developmental disability and are enrolled in the Employment and Community First ("ECF") CHOICES ("ECF CHOICES") program. This includes all applicable existing requirements set forth in this Contract pertaining to TennCare dental benefits for children under age 21.

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

A.5. Enrollee Cost Share Responsibilities. The Contractor and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TennCare in accordance with TennCare rules and regulations or TennCare approved policies and procedures for TennCare enrollees, nor may the Contractor and all providers and subcontractors charge enrollees for missed appointments. Enrollees may not be held liable for payments in the event of the Contractor's insolvency. Enrollees may not be held liable for payments in the event the State does not pay the Contractor, or the Contractor does not pay the provider.



Cost sharing responsibilities shall apply to services for children under age 21 years of age other than the preventive services described in Section A.3 and specified in the table below. Co-payments shall be applied on a sliding scale according to the enrollee's income. The procedure code listing for preventive services is as follows:

Preventive Dental Services for Children Under 21 Years of Age

D1110	Prophylaxis –adult (when billed for children over age 12 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

The current sliding scale schedule to be used in determining applicable cost sharing responsibilities for TennCare enrollees under age 21 years of age is described in the chart below.

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

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

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

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

The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service. A provider or a collection agency acting on the provider's behalf may not bill the enrollee for more than the allowable copay. If the Contractor discovers that the enrollee is being inappropriately billed, they 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 TBI.

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



- a. if the services are not covered by TennCare and the provider informed the enrollee the services were not covered prior to providing the service. This shall include any services provided to a Member who is an ECF CHOICES member ("ECF CHOICES Member") that exceed the amount approved in the ECF CHOICES Member's PCSP. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service; or
- b. if the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively; or
- c. if the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable cost share amounts must be refunded when a claim is submitted to the DBM if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim).

Dental services in the ECF CHOICES program shall be reimbursed only when the ECF CHOICES Member was enrolled in the ECF CHOICES program at the time the service was delivered, and subject to the amount approved for such services in the ECF CHOICES Member's PCSP.

3. The following is added as Contract Section A.16.i.:

A.16.i. The Contractor shall demonstrate good faith effort to include, among required and other staff or contractors, professionals who have expertise in providing and/or administering dental services to individuals with intellectual and developmental disabilities.

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

A.20. Transport Distance. The Contractor shall maintain under contract a statewide network of dental providers to provide the covered services specified in Sections A.3 and A.4, Obligations of the Contractor. The Contractor shall make services, service locations and service sites available and accessible so that transport distance to general dental providers will be the usual and customary, not to exceed an average of thirty (30) miles, as measured by GeoAccess Software, except in rural areas where community standards, as defined by TennCare, will be applied. Exceptions must be justified and documented to the State on the basis of community standards. 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 30 mile standard to access dental care. TennCare may grant an exception to transport distance requirements for ECF CHOICES Members based on the availability of ECF CHOICES Participating Dental Providers with expertise in serving individuals with intellectual and developmental disabilities.

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

A.26. Members Services Hotline. The Contractor shall provide a toll-free telephone service for all regular business days Monday through Friday. Since Tennessee spans two time zones, this service shall be operated from 7:00 a.m. Central Standard Time to 5:00 p.m. Central Standard Time and corresponding hours during periods of Daylight Savings Time. The member service lines shall be adequately staffed and individuals trained to



accurately respond to questions regarding covered services, to assist enrollees locate a participating dental provider, and other issues, including but not limited to EPSDT. Additionally, individuals shall be trained to accurately respond to questions and concerns regarding the ECF CHOICES program, including but not limited to, Covered Services and providing assistance locating an ECF CHOICES Participating Dental Provider.

6. Contract Section A.30 is deleted in its entirety and replaced with the following:
 - A.30. Provider Listing. The Contractor shall distribute information on how to access the provider directory, including the right to request a hard copy, to all enrollees (or heads of households), within thirty (30) days of initial enrollment, and upon request, such list shall include current provider address(es), telephone numbers, office hours, languages spoken, specialty and whether or not the provider is accepting new patients. The Contractor shall also be responsible for making available updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. The Contractor shall provide a separate listing of ECF CHOICES Participating Dental Providers. All provider directories shall be approved by TennCare prior to the Contractor's distribution.
7. The following is added as A.32.c.:
 - A.32.c. Policies specific to Covered Services provided pursuant to the ECF CHOICES Program.
8. Contract Section A.34 is deleted in its entirety and replaced with the following:
 - A.34. Reconsideration. If services, including those applicable to the ECF CHOICES program, are denied, the Contractor shall reconsider the denial of the service when the network provider submits additional information including but 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 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.
9. Contract Section A.35 is deleted in its entirety and replaced with the following:
 - A.35. Retrospective Utilization Review. The Contractor shall conduct retrospective treatment utilization review of Covered Services provided to Members under age 21 and to ECF CHOICES Members. This review will require the Contractor (DBM) to establish benchmarks for procedures that are prone to fraud or abuse but, don't require prior authorization. Examples would include pulpomies, stainless steel crowns or any other dental procedure highlighted by CMS, TennCare or identified by the DBM as prone to fraud and abuse. The DBM will evaluate the dental provider's treatment practice as compared with other in-network providers performing similar procedures based on provider specialty and identify those whose treatment utilization pattern deviates significantly from their peer's norm. The process will incorporate basic provider profiling, test edits, and Statistical Process Controls (SPC). SPC is a methodology of evaluating normal statistical variability or "noise" within any type of process. Normally the statistical limits are set at plus or minus three standard deviations so that any determination outside of these upper and lower control limits is expected to be a significant deviation from the network group being measured. Benchmarking analysis is mandatory as outlined above, and must be provided to TennCare upon request. All outlier reports will be submitted to TennCare quarterly through the Office of Program Integrity. If the type of finding elicited in the retrospective treatment utilization review process necessitates chart audit of a



dental provider, then the Contractor will draw a statistically valid random sample (SVRS) of dental records, utilizing a ninety five percent (95%) confidence interval consistent with US DHHS convention, specific to the procedure(s) where the provider is an outlier compared with the benchmark. The Contractor, utilizing dental expert(s) will perform an initial chart audit of the entire SVRS sample. If the initial audit findings reveal evidence of fraud, abuse, non compliance with medical necessity criteria or quality of care issues then the Contractor is required by this contract to present a convenience sample of at least 10% of the findings to be reviewed by its Provider Peer Review Committee for the purpose of agreement between reviewers. Utilization review by the Provider Peer Review Committee, must be conducted in a blinded manner.

The Contractor's Provider Peer Review Committee shall be made up of licensed Tennessee dentists in good standing with the Tennessee Board of Dentistry. Committee members must be familiar with the TennCare dental program and include at least one (1) ECF CHOICES Participating Dental Provider. The Contractor shall provide each member of its Provider Peer Review Committee with a copy of TennCare's Medicaid Rules, TennCare's Medical Necessity Rules as well as, the medical necessity guidelines presented in the Provider Office Reference Manual. The Contractor shall also provide orientation and medical necessity training for every member who serves on its Peer Review Committee before members are permitted to review case files. Section A.117 of this contract describes the DBM'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 Tennessee Peer Review Committee has completed its review and established written findings and recommendations, these are forwarded back to the Contractor for careful consideration and appropriate formal action. The Contractor shall forward to the TennCare Dental Director and Office of Program Integrity, a quarterly update including a summary of its investigations, Provider Peer Review Consensus findings and recommendations as well as, all formal actions taken.

- a. The Contractor's utilization review process intervention includes various options that safeguard children, improve quality of care, assure fiscal viability of the program and comport with TennCare's mission. These options include issuance of written corrective action plans, documentation of provider and staff education, recoupment of provider payments or any combination of these actions. Additionally, in accordance with its Provider Service Agreement, the Contractor may also choose to exercise its prerogative to terminate a dental provider with or without cause with thirty (30) days notice.
 - b. Utilization review of dental procedures, not requiring prior authorization which demonstrate that a provider is not adhering to TennCare's medical necessity criteria in the provision of a procedure(s), will necessitate that the Contractor initiate written corrective action for that provider which may include, but is not limited to, the following:
 1. Provider and staff education;
 2. Prior authorization for that procedure(s) and,
 3. Second opinion by a Contractor-designated dentist in cases involving "extensive" treatment plans and/or in cases where the dentist is requesting treatment in a medical facility (hospital operating room or ambulatory treatment center).
 - c. The Contractor is responsible for Retrospective Utilization Review activities specific to services provided in the ECF CHOICES program.
10. The following is added as Section A.43.f:



A.43.f. The Contractor shall provide a training program approved by TennCare that is specifically targeted to ECF CHOICES Participating Dental Providers. This training program shall be administered by a licensed dental professional with expertise in serving individuals with intellectual and developmental disabilities.

11. Contract Section A.44 is deleted in its entirety and replaced with the following:

A.44. Provider Manual. The Contractor shall produce and distribute a dental program criteria manual to assist Participating Dental Providers. The manual shall clearly define covered services, limitations, exclusions, and utilization management procedures, including, but not limited to: prior approval requirements, medical necessity guidelines for dental procedures, and special documentation requirements, including but not limited to Hospital readiness form, orthodontic readiness form, documentation of nutritional deficiencies (general pediatric records including growth data), and speech/hearing evaluations (may include school records) for treatment of enrollees. The manual shall include a detailed description of billing requirements for Participating Dental Providers and shall contain a copy of Contractor's paper billing form and electronic billing format. The Contractor shall ensure that the manual remains up-to-date and reflects changes in applicable law or revisions to TennCare or Contractor policy. The initial version of the manual and any subsequent revisions thereto must be submitted to TennCare and The TennCare Division, Tennessee Department of Commerce and Insurance (TDCI) for review and approval prior to distribution. Participating Dental Providers must be apprised of revisions to the manual by the Contractor, by means of written or electronic notice, to be sent thirty (30) days in advance of the implementation of the new policy or procedure. The Provider Manual shall include a supplement or manual component specific to ECF CHOICES Participating Dental Providers.

12. The first clause of Section A.45 shall be deleted and replaced in its entirety with the following:
"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:"

13. Contract section A.46 is deleted in its entirety and replaced with the following:

A.46. Providers Providing On-going Treatment. If an enrollee is in a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services to such enrollee and the Contractor is aware of such ongoing course of treatment, the Contractor shall immediately provide written notice immediately on the date that the Contractor becomes aware of such unavailability to such enrollee. Each notice shall include all components identified in the notice template to be provided by TennCare. The timing requirement for the provision of this notice shall be waived in instances where a provider becomes physically unable to care for 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, during the implementation of this Amendment #1.

14. Contract Section A.94 is deleted in its entirety and replaced with the following:

A.94. Standards of Care. The standards of care shall be taken from published recommendations of nationally recognized authorities, such as: the American Dental Association; the American Academy of Pediatric Dentistry, the American Academy of



Developmental Medicine and Dentistry, and the American Association of Oral and Maxillofacial Surgeons. The standard of care for the community shall be recognized. Participating Dental Providers shall not differentiate or discriminate in the treatment of any enrollee on the basis of race, color, sex, religion, national origin, age, handicap, health, economic status, or payment source. In the event of a conflict between a Providers 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.

15. The following is added as A.127.d:

A.127.d. Additional reporting requirements as may be established by TennCare in collaboration with the Contractor for Covered Services provided pursuant to the ECF CHOICES program.

16. Contract Section A.130 is deleted in its entirety and replaced with the following:

A.130. The Bureau of 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). TennCare shall be responsible for the enrollment of all ECF CHOICES members in the Contractor's plan, and no daily eligibility data for members of the ECF CHOICES program will come from other sources.

- a. The Contractor shall accept the enrollee in the health condition the enrollee is in at the time of enrollment.
- b. Enrollment shall begin at 12:01 a.m. on the effective date that the enrollee is enrolled in the Contractor's plan and shall end at 12:00 midnight on the date that the enrollee is disenrolled pursuant to the criteria in TennCare policy and/or TennCare rules and regulations. The Contractor shall be responsible for arranging for the provision of services and payment of all covered services during presumptive period of enrollment. In order to give children entering into DCS custody adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility, the Contractor shall accept notice from DCS and/or TennCare Select of TennCare "immediate" eligibility. If the child is not currently enrolled, the Contractor shall immediately build a forty-five (45) day eligibility record effective on the date the child was placed in state custody and identify the child as a child in state custody. The Contractor shall be responsible for arranging for the provision of services and payment of all covered services during immediate eligibility period of enrollment.
- c. In regards to EPSDT reporting, the Contractor shall continue to only report on those children whose TennCare eligibility status is permanent, who are assigned to the DBM. EPSDT reporting requirements shall not be applicable to ECF CHOICES Members.

17. The following is added as Contract Heading and new sections A.188 – A.215.

Dental Benefits in the ECF CHOICES Program

A.188. The Contractor shall, pursuant to requirements set forth in this Contract and in the approved TennCare waiver, rules, policies and protocols (each of which shall be delivered to Contractor in writing no more than five (5) business days following approval), administer covered adult dental benefits to eligible adults age 21 and older who have an intellectual or developmental disability and are enrolled in the ECF CHOICES program.



This includes all applicable existing requirements set forth in this Contract pertaining to TennCare dental benefits for children under age 21 unless specifically identified as non-applicable to the ECF CHOICES program in Section A.215.

- A.189. The State anticipates that enrollment in the ECF CHOICES program during FY 2017 will be approximately 1,700 members. Not all ECF CHOICES members are expected to receive dental services.
- A.190. A Member enrolled in ECF CHOICES shall receive covered dental services only as specified in the Member's approved person centered support plan ("PCSP"). The Contractor shall provide only the following covered dental benefits in the ECF CHOICES program:
- a. Adult dental services as provided under the State's Section 1915(c) waivers for individuals with intellectual disabilities, which include specific preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments as medically necessary to relieve pain and infection, as well as adjunctive sedation services, which may include medically necessary and appropriate deep sedation or general anesthesia, provided in the dentist's office by and billed by the dentist. Such services will be reimbursed in accordance with the maximum reimbursement rate listed in the TennCare ECF Dental Fee Schedule at the following link:
<http://tn.gov/assets/entities/tenncare/attachments/DentaQuestECFCHOICESDentalRates.pdf>.

Orthodontic services are excluded from coverage in the ECF CHOICES program.

- A.191. All Covered Services for children enrolled in the ECF CHOICES program are provided through the TennCare EPSDT program as provided in Contract Section A.3, A.4, and A.190. Dental services shall not be covered under the ECF CHOICES program for children under age 21 years, since it would duplicate TennCare EPSDT benefits.
- A.192. Covered Services in the ECF CHOICES 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.193. Adult dental services in the ECF CHOICES 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 do not exceed the limitations specified in A.192, except when the MCO elects to exceed such limit as a Cost-Effective Alternative Service. Upon inclusion of dental services in an ECF CHOICES member's PCSP, the Member's MCO support coordinator shall work with the Contractor to assist the Member in selecting a contracted ECF CHOICES Participating Dental Provider. A copy of the PCSP shall be provided to the ECF CHOICES Participating Dental Provider by the Member's MCO pursuant to a process approved by TennCare.
- A.194. Upon selection of an ECF CHOICES Participating Dental Provider and subject to the amount approved for dental services in the member's PCSP, each ECF CHOICES member must undergo a thorough dental evaluation prior to receiving Covered Services, unless the Member has had such an evaluation in the 90 days prior to such service



request. The results of that evaluation will be a proposed treatment plan that will include both short-term dental needs (i.e. cavities detected during the exam to be filled) and long-term dental services (i.e. cleaning every six months), which shall be incorporated into the Member's PCSP, as determined by the Member or his/her authorized representative. Notwithstanding the proposed treatment plan developed by the ECF CHOICES Participating Dental Provider, the total cost of ECF dental services that may be authorized are subject to the amount approved for ECF dental services in the member's PCSP.

- A.195 ECF CHOICES Participating Dental Providers may perform any Medically Necessary Covered Services determined to be needed after the dental evaluation referenced in Section A.194 above (or if an evaluation is not required—see A.194 above) even if the treatment plan has not yet been incorporated into the PCSP, unless such service is of a type that requires prior authorization under this Contract, subject to the amount authorized for dental services in the member's PCSP. If the total cost of services proposed in the treatment plan exceed the amount authorized for dental services in the Member's PCSP, the Participating Dental Provider shall not proceed to perform such services, except as specifically approved by the Member or his/her authorized representative, and with full disclosure that other services proposed in the treatment plan will not be provided based on the current amount approved for dental services in the Member's PCSP.
- A.196. The Contractor shall conduct utilization management and prior authorization for Covered Services under the ECF CHOICES program as may be required for the specific services included in the PCSP, including any dental services approved by the MCO as a Cost-Effective Alternative Service, subject to the amount approved for such services in the member's PCSP. This information shall be communicated to the Contractor by the member's MCO.
- A.197. The Contractor shall not authorize nor reimburse dental services for ECF CHOICES members that are not covered under the ECF CHOICES program, except for dental services approved by a Member's MCO as a Cost-Effective Alternative Service. The Contractor shall track dental expenditures for each ECF CHOICES member and shall not authorize nor reimburse dental services for an ECF CHOICES member that exceed the amount approved for such services in the member's PCSP. The Contractor shall also make available to ECF CHOICES Participating Dental Providers upon request the total dental expenditures that have been authorized and reimbursed for each ECF CHOICES Member served by the provider in order to ensure that dental services are not provided to the Member in excess of the amount approved for such services in the Member's PCSP.
- A.198. The Contractor shall also determine Medical Necessity for adjunctive sedation services, including Medically Necessary and appropriate deep sedation or general anesthesia provided in the dental office setting for individuals with intellectual and developmental disabilities enrolled in the ECF CHOICES program, and shall attempt to 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. Instances where sedation services may be appropriate include dental services for ECF CHOICES members:
- a. Who are extremely uncooperative, fearful, anxious, unmanageable, or physically resistant; and
 - b. Have dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain, infection, loss of teeth, or other increased oral or dental morbidity; and



- c. For which dental treatment under local anesthesia, and other alternative adjunctive techniques and modalities have not been successful in producing a successful result and which, under general anesthesia, can be expected to produce a superior result;
- A.199. 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 an ECF CHOICES member in the dental office setting unsuccessfully, and it is necessary to treat the patient in a medical facility.
- A.200. The Contractor shall establish medical necessity guidelines for authorization of dental treatment of individuals with intellectual and developmental disabilities in medical facilities including an ECF specific In-Patient and Out-Patient Hospital Readiness Pre-Admission Forms.
- A.201. The Contractor shall provide educational training/webinars and best practices information to contracted ECF CHOICES Participating Dental Providers about dental treatment for individuals with intellectual and developmental disabilities, 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 Member and not the convenience of the ECF CHOICES Participating Dental Provider.
- A.202. The Contractor shall be responsible for the submission of encounter data to TennCare regarding Covered Services provided under the Contract and the ECF CHOICES program, including Covered Services authorized by a Member's MCO as a Cost-Effective Alternative Service.
- A.203. The Contractor shall be responsible for establishing a special network of ECF CHOICES Participating Dental Providers who have experience and/or expertise in serving individuals with intellectual and developmental disabilities. This may include identifying and contracting with providers who have such expertise and/or experience. The Contractor may also assist dental providers in developing expertise in serving individuals with intellectual and developmental disabilities in order to participate in the ECF CHOICES program.
- A.204. TennCare shall deliver to the Contractor a listing of dental providers currently contracted with the Department of Intellectual and Developmental Disabilities and with TennCare to provide adult dental services in the existing Section 1915(c) home and community based services waiver programs, and a de-identified summary of utilization history of dental services provided to waiver program participants, including the number of members served by each such provider over a specified period, and the average annual per member and total annual cost of waiver dental services reimbursed by each such provider.
- A.205. This listing may be used by the Contractor to help identify potential providers for the ECF CHOICES program. However, the Contractor shall not be obligated to contract with any provider currently contracted with the Department of Intellectual and Developmental Disabilities and with TennCare to provide adult dental services in the existing Section 1915(c) home and community based services waiver programs. Nor is the Contractor required to include any provider currently contracted in the existing TennCare dental program in the network for the ECF CHOICES program. Current Participating Dental Providers have no entitlement to inclusion in the ECF CHOICES program. The Contractor may contract with any provider not currently contracted with the Department of



Intellectual and Developmental Disabilities or not currently in the existing TennCare dental program to provide services for the ECF CHOICES program as long as the provider is willing to register with the TennCare program as required by federal law.

- A.206. The Contractor shall only contract with dentists 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 network decisions are completely the responsibility of the Contractor.
- A.207. The Contractor shall be responsible to ensure the provider enrollment file will include the appropriate ECF CHOICES service code to designate those ECF CHOICES Participating Dental Providers contracted to provide services for ECF CHOICES members in the existing provider file layout.
- A.208. 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 program, which agreement shall be approved by TennCare and TDCI prior to contracting with ECF CHOICES Participating Dental Providers. These new or amended contracts must be signed by the ECF CHOICES Participating Dental Providers prior to the effective date of this Amendment #1 to the Contract unless an exception is granted by TennCare in writing.
- A.209. The Contractor shall be responsible for credentialing and contracting ECF CHOICES Participating Dental Providers sufficient in number to provide appointment availability for Covered Services to eligible ECF CHOICES members within the time frames specified in Section A.19. For both credentialing and recredentialing processes, the Contractor shall conduct a site visit for all ECF CHOICES Participating Dental Providers, which shall include observation of the provider's physical environment (to ensure accessibility), and review of the provider's practices with respect to serving individuals with intellectual or developmental disabilities.
- A.210. ECF CHOICES Participating Dental Providers shall render high quality, Medically Necessary, cost effective dental care for ECF CHOICES members. The Contractor shall exercise every available means through this Contract, provider agreements, office reference manual, policies and procedures, and training programs to ensure that dental benefits in the ECF CHOICES program are managed in this manner.
- A. 211. TennCare shall deliver the most current version of the ECF Dental Fee Schedule referenced in section A.190.a to the Contractor in writing promptly upon (and in no event more than 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.212. The Contractor shall not be responsible for administering any cost share responsibilities for dental services in the ECF CHOICES program. Collection of any Patient Liability amounts due from an ECF CHOICES member pursuant to federal post-eligibility provisions shall be the responsibility of the member's MCO.
- A.213. The Contractor shall establish processes for the timely and efficient exchange of data with each MCO administering the ECF CHOICES program.
- A.214. The Contractor shall participate in a readiness review prior to the implementation of the Contractor's management of dental benefits in the ECF CHOICES program. The State



may conduct an on-site review to assess the readiness of the Contractor to effectively administer the requirements set forth herein prior to a "go-live" date, and according to the implementation timeline agreed upon by TennCare and the Contractor. TennCare shall provide written confirmation of all aspects of readiness 20 business days prior to conducting such readiness review activities.

A.215. Requirements set forth in this Contract pertaining to TennCare dental benefits for children under age 21 that are not applicable to the Contractor's administration of dental benefits in the ECF CHOICES program are: A.2, A.4, A.8, A.9.f., A.36, A.37, A.39, A.41, A.42, A.49, A.50, A.91, A.93, A.96, A.97, A.98, A.142, and A.144.

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

B.1. This Contract shall be effective for the period beginning May 15, 2013 and ending on September 30, 2017. Actual delivery of services shall begin on October 1, 2013 after completion of transition, should one be necessary, and completion of readiness review. The Contractor hereby acknowledges and affirms that the State shall have no obligation for services rendered by the Contractor which were not performed within this specified contract period.

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

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Forty-Six Million One Hundred Thousand Dollars (\$46,100,000.00). The payment rates in Section C.3 shall constitute the entire compensation due to the Contractor for the Services and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the payment rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

20. Contract Section C.3.b.(2) is deleted in its entirety and replaced with C.3.b.(2), C.3.b.(3) and C.3.b.(4):

C.3.b.(2) Should the term extension option set forth in Contract Section B.2 be utilized, for Services performed from October 1, 2016, through September 30, 2018, the following rates shall apply:

Service Description	Amount (per compensable increment)
Administrative Fee Per Child (Under Age 21) Eligible for Full Dental Benefit Package	\$ 0.30 per member per month



C.3.b.(3) ECF Choices program rates for period of July 1, 2016 through September 30, 2018
(should all contract extension options be utilized)

Service Description	Amount (per compensable increment)
Administrative Fee per Adult (Age 21 and Older) enrolled in ECF CHOICES program	\$ 0.75 per member per month

C.3.b.(4) In addition to the administrative payment for Covered Services provided to members enrolled in the ECF CHOICES program as specified in C.3.b(3) above, the Contractor shall be reimbursed for the actual cost of Covered Services provided pursuant to the ECF CHOICES program. Payments for such Covered Services provided to eligible Members enrolled in the ECF CHOICES program as specified in this section shall be paid based on a monthly invoice submitted by the Contractor. The invoice shall be submitted to TennCare in the form and format specified by TennCare. Risk levels in Section C.3.c. shall not be applicable to services provided under ECF CHOICES.

5. Attachment A to the Contract is deleted in its entirety and replaced with Revised Attachment A hereto.

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

Amendment Effective Date. The revisions set forth herein shall be effective June 30, 2016. All other terms and conditions of the Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

DENTAQUEST USA INSURANCE CO., INC.:



CONTRACTOR SIGNATURE

6-14-2016

DATE

Brett Bostrack, SVP Client & Provider Engagement

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE



Larry B. Martin / LD

LARRY B. MARTIN, COMMISSIONER

6/15/16

DATE



REVISED ATTACHMENT A

Terms and Definitions

1. Administrative Cost – All costs to the Contractor related to the administration of this Contract. Costs of subcontractors engaged solely to perform a non-medical administrative function for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract (including, but not limited to, claims processing, marketing, postage, personnel, rent) are considered to be an "administrative cost".
2. Administrative Services Fee - The per member per month amount that the Contractor will charge for provision of the services outlined in this Contract.
3. Adverse Action - Any action taken by the Contractor to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness or availability of such benefits.
4. Appeal Procedure - The process to resolve an enrollee's right to contest verbally or in writing, any adverse action taken by the Contractor to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by TennCare Rule 1200-13-13-.11 and any and all applicable court orders. Complaint shall mean an enrollee's right to contest any other action taken by the Contractor or service provider other than those that meet the definition of an adverse action.
5. Benefits - A schedule of health care services to be delivered to enrollees covered by the Contractor
6. Auxiliary Aids and Services - include, but are not limited to:
 - a. Qualified interpreters on-site or through video remote interpreting (VRI) services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;
 - b. Qualified readers; taped texts; audio recordings; Brailled materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;
 - c. Acquisition or modification of equipment or devices; and
 - d. Other similar services and actions as defined in 28 C.F.R. § 36.303.
7. Case Manager - An organization or a provider responsible for supervising or coordinating the provision of initial and primary care to enrollees; for initiating and/or authorizing referrals for specialty care; and for monitoring the continuity of patient care services.
8. CFR - Code of Federal Regulations



9. Clean Claim - A claim received by the Contractor for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the Contractor.
10. CMS - Centers for Medicare and Medicaid Services (formerly HCFA).
11. Community Service Area - Community Service Area (CSA) shall mean one (1) or more counties in a defined geographical area in which the Contractor is authorized to enroll providers and serve TennCare enrollees.

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

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



12. Corrective Action Plan (CAP) – The steps and timelines identified by the Contractor to correct, compensate for, and/or remedy each violation of the Contract.
13. Cost-effective Alternative Service – A service that is not a Covered Service but that is approved by TennCare and CMS and provided at an MCO's discretion. TennCare enrollees are not entitled to receive these services. Cost-effective alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in the MCO's judgment, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the MCO's judgment, would require more costly treatment in the future.
14. Covered Service - See Benefits at A.3, A.4, and A.190 of the Contract.
15. Cultural Competence - The level of knowledge-based skills required to provide effective clinical care to enrollees of particular ethnic or racial groups.
16. DBM – Dental Benefits Manager.
17. Dental Home -A dental practice that maintains an ongoing relationship between the dentist and the patient inclusive of all aspects of oral health care delivered in a comprehensive, medically necessary, continuously accessible, and coordinated way.
18. 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.
19. 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.
20. ECF CHOICES Participating Dental Provider –A Participating Dental Provider contracted to serve Members age 21 and older enrolled in the ECF CHOICES program,
20. 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 .
21. Eligible Person - Any person certified by TennCare as eligible to receive services and benefits under the TennCare Program.
22. 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.
23. Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.
24. 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. The ECF CHOICES program will begin implementation at a date to be determined by TennCare, but no sooner than July 1, 2016.

25. **Enrollee** - A Medicaid recipient or Medicaid Waiver recipient who is currently enrolled in an Managed Care Organization (MCO), Pre-paid Inpatient Health Plan (PIHP), Pre-aid Ambulatory Health Plan (PAHP) or Primary Case Care Management Program (PCCM) in a given managed care program.
26. **Enrollee Month** – A month of health care coverage for the TennCare eligible enrolled in a Dental Plan.
27. **Enrollment** - The process by which a person becomes a member of the Contractor's plan through the TennCare Bureau.
28. **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.
29. **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.
30. **Fee-for-Service** - A method of making payment for health services based on a fee schedule that specifies payment for defined services.
31. **FTE** - Full time equivalent position.
32. **Grand Region** – A defined geographical region that includes specified Community Service Areas in which a Contractor is authorized to enroll providers and serve TennCare enrollees. The following Community Service Areas constitute the three (3) Grand Regions in Tennessee:

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

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

- 34. Health Maintenance Organization (HMO) - An entity certified by the Department of Commerce and Insurance under applicable provisions of TCA Title 56, Chapter 32.
- 35. 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.
- 36. Managed Care Organization (“MCO”) - An HMO which participates in the TennCare Program.
- 37. 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.
- 38. 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.
- 39. Member - A person who is eligible for the Contractor's plan under the provisions of this Contract with TennCare. (See Enrollee, also).
- 40. NAIC – National Association of Insurance Commissioners.
- 41. Non-TennCare Provider – A provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.
- 42. Office of the Inspector General - A Unit established to help prevent, identify and investigate fraud and abuse within the healthcare system, most notably the TennCare system.
- 43. Out-of-Plan Services - Services provided by a non-TennCare provider.
- 44. 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, or to provide dental services to individuals in both populations.
- 45. 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.



46. 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).
47. 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.
48. 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.
49. 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.
50. 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.
51. Prior Authorization - The act of authorizing specific services or activities before they are rendered or activities before they occur.
52. 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.
53. Program Integrity - The Program Integrity unit is responsible for assisting with the prevention, identification and investigation of fraud and abuse within the health care system.
54. 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.
55. 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.
56. 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.



57. 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.
58. 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.
59. Service Site - The locations designated by the Contractor at which enrollees shall receive oral health treatment and preventive services.
60. Services - The benefits described in this Contract, including but not limited to, Section A.3.
61. Shall - Indicates a mandatory requirement or a condition to be met.
62. Specialty Services – Includes Endodontics, Oral Surgery, Orthodontics, Pediatric Dentistry, Periodontics, Prosthodontics
63. State - State of Tennessee.
64. 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.3 of this Contract shall be considered Provider Agreements and governed by Sections A.48–A.60 of this Contract. If a subcontractor will also be a Provider the requirements for Provider Agreements must also be met.
65. 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.
66. 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.
67. 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 Program and the terms of this Contract. Such entities include, but are not limited to, the Division of HealthCare Finance and Administration Bureau 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 Division within the Tennessee Department of Commerce and Insurance (C&I) and the Tennessee Bureau of Investigation (TBI), Medicaid Fraud Control Unit (MFCU).
68. TennCare Medicaid Enrollee – an enrollee who qualifies and has been determined eligible for benefits in the TennCare program through Medicaid eligibility criteria as described in the Medicaid/TennCare Rules and Regulations .(See also "Member")
69. TennCare Provider - A provider who accepts as payment in full for furnishing benefits to a TennCare 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.

70. 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”.
71. Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The State agency responsible for the investigation of provider fraud and abuse in the State Medicaid Program.
72. 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.
73. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party payor.
74. 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.
75. Utilization Rate – An adjusted proportion of enrollees, ages 2-20, with a minimum 90 days eligibility who have received any dental service during the past federal fiscal year.
76. Vital Documents – Consent and complaint forms, intake and application forms with the potential for important consequences, and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents shall be available in Spanish.



CONTRACT

(fee-for-service contract with an individual, business, non-profit, or governmental entity of another state)



Begin Date May 15, 2013	End Date September 30, 2016	Agency Tracking # 31865-00355	Edison Record ID 36736
Contractor Legal Entity Name DentaQuest USA Insurance Co., Inc.			Edison Vendor ID 8993

Service Caption (one line only)
TennCare Dental Administrative and Management Services

Subrecipient or Vendor <input type="checkbox"/> Subrecipient <input checked="" type="checkbox"/> Vendor	CFDA # 93.778 Dept of Health & Human Services/Title XIX
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Funding —					
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2014	\$1,012,500.00	\$1,012,500.00			\$2,025,000.00
2015	\$6,350,000.00	\$6,350,000.00			\$12,700,000.00
2016	\$6,350,000.00	\$6,350,000.00			\$12,700,000.00
2017	\$5,337,500.00	\$5,337,500.00			\$10,675,000.00
TOTAL:	\$19,050,000.00	\$19,050,000.00			\$38,100,000.00

American Recovery and Reinvestment Act (ARRA) Funding: YES NO

Ownership/Control

African American
 Asian
 Hispanic
 Native American
 Female
 Person w/Disability
 Small Business
 Government
 NOT Minority/Disadvantaged
 Other:

Selection Method & Process Summary (mark the correct response to confirm the associated summary)

<input checked="" type="checkbox"/> RFP	The procurement process was completed in accordance with the approved RFP document and associated regulations.
<input type="checkbox"/> Competitive Negotiation	The predefined, competitive, impartial, negotiation process was completed in accordance with the associated, approved procedures and evaluation criteria.
<input type="checkbox"/> Alternative Competitive Method	The predefined, competitive, impartial, procurement process was completed in accordance with the associated, approved procedures and evaluation criteria.
<input type="checkbox"/> Non-Competitive Negotiation	The non-competitive contractor selection was completed as approved, and the procurement process included a negotiation of best possible terms & price.
<input type="checkbox"/> Other	The contractor selection was directed by law, court order, settlement agreement, or resulted from the state making the same agreement with <u>all</u> interested parties or <u>all</u> parties in a predetermined "class."

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

Speed Chart (optional) TN00000167	Account Code (optional) 70803000
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CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
DENTAQUEST USA INSURANCE CO., INC.

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Bureau of TennCare, hereinafter referred to as the "State" or "TennCare" and DentaQuest USA Insurance Co., Inc., hereinafter referred to as the "Contractor", is for the provision of Dental Administrative and Management Services as further defined in the "SCOPE OF SERVICES."

The Contractor is a for-profit corporation.

Contractor Federal Employer Identification, Social Security, or Edison Registration ID # 8993

Contractor Place of Incorporation or Organization: Texas

A. SCOPE OF SERVICES

A.1. The Contractor shall provide all service and deliverables as required, described, and detailed herein and shall meet all service and delivery timelines as specified by this Contract. Refer to Attachment A for applicable terms and definitions located within this Contract.

A.2. Plan Implementation

A.2.1 Implementation of this TennCare dental benefits manager (DBM) Contract shall be conducted as series of defined phases described below. The benefit shall become fully effective and operable on October 1, 2013. The Contractor shall be required to complete all the tasks, obligations and responsibilities listed under each phase by the dates identified in the project plan. The project plan shall include a detailed timeline description of all work to be performed both by the Contractor and TennCare. The plan shall also include a description of the participants on the transition team and their roles and schedules of meetings between the transition team and TennCare. This plan shall require approval by TennCare.

A.2.2. Project Initiation and Requirements Definition Phase

TennCare shall conduct a project kick-off meeting. All key Contractor project staff shall attend. TennCare project staff shall provide access and orientation to the TennCare Dental Program and system documentation. TennCare technical staff shall provide an overview of the Tennessee TennCare Management Information System (TCMIS) emphasizing dental claims processing and adjudication, reference files, and payment processes. During this phase the Contractor shall develop the following documentation, for review and approval by TennCare:

a. Functional and Informational Requirements (FIR) Document. This document shall include detailed requirements for both internal and external interfaces and all TennCare functionalities required by the RFP and/or contained in the Contractor's proposal and/or this Contract. Eligibility interfaces with TennCare are critical and the Contractor must be in sync with the TCMIS eligibility data. All outbound 834 files from TennCare must be loaded to the Contractors data base within twenty four (24) hours of receipt from TennCare. This requirement includes any 834 transactions that must be handled manually by the Contractor. Failure to meet this performance standard may result in liquidated damages.



- b. Data Dictionary. For each data field this shall indicate content, size, values, structure, edit criteria and purpose.
- c. Data Mapping. This shall consist of a cross-reference map of required TCMIS data and TennCare data elements and data structures. A separate data structure map shall be required for each transaction and interface. A data conversion plan, that includes both automated and manual activities, shall be provided for each data structure map. TennCare shall make any necessary data formats available to the Contractor.
- d. Additionally, the Contractor shall recommend design modifications to the Tennessee TCMIS. Performing any maintenance and design enhancements to TCMIS shall be the decision and responsibility of TennCare.

A.2.3. System Analysis/General Design Phase

After approval of the documentation by TennCare required in the Project Initiation and Requirements Definition Phase, the Contractor shall develop the General System Design Document. The General System Design Document shall include the following information:

- a. An Operational Impact Analysis that details the procedures and infrastructure required to enable TCMIS and the Contractor's system used by dental providers to work effectively together.
- b. A Detailed Conversion Plan that specifies plans for conversion of fifteen (15) months of TCMIS and the previous DBM contractor/processor's claims history, prior authorization and reference data.
- c. 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 operations. It shall detail how TennCare and/or TCMIS software releases are tested and coordinated.

A.2.4. Technical Design Phase

During this phase, detailed specifications shall be developed for conversion and for the interface(s) between the TCMIS and the Contractor's system. The Contractor shall develop detailed plans that address back-up and recovery, information security and system testing. The Contractor shall develop the System Interface Design Overview Document (this document shall be completed after the Contractor has conducted a review of all previous design documents). In addition to the System Interface Design Overview, the Contractor shall provide the following system plan documents:

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

A.2.5. Development Phase

This phase includes activities that shall lead to the implementation. The Contractor shall develop interface and conversion programs, develop system documentation, and develop Unit Test Plans. Where manual data entry screens



are required, the Contractor shall develop these screens. Testing shall be performed on all phases and programs shall be documented. System testing shall require reports to substantiate and document the testing. These reports shall include 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. System test to validate the appropriate adjudication of a claim which shall include a description of the test procedure, expected results, and actual results;
- b. Integration testing shall test external system impacts, downstream TCMIS applications, and all interfaces. It shall include a description of the test procedure, expected results, and actual results; and
- c. Load and Stress testing shall include volume and efficiency to ensure that the system is able to process the volume of TennCare dental claims. It shall include a description of the test procedure, expected results, and actual results.

A.2.6. Implementation/Operations Phase

During this phase the Contractor and TennCare shall assess the operational readiness of all required system components. This shall result in the establishment of the operational production environment in which all TennCare dental claims shall be accurately and reliably processed, adjudicated and paid. TennCare shall have final approval for the elements of the operational production environment.

- a. The Contractor shall develop and prepare the operations documentation of all procedures of the Contractor's performance. This shall include, but may not be limited to: automated operations, data entry operations, prior authorization operations/interfaces, check and remittance fulfillment and member notifications.
- b. With the approval of TennCare, the Contractor shall develop production and report distribution schedules.
- c. 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 staff, dental providers, and other identified stakeholders.
- d. The Contractor and TennCare shall prepare a final conversion plan and perform final conversion activities that include procedures for testing the conversion data. The conversion plan shall include loading fifteen (15) months of claims history from the current system. The plan shall also include migrating current prior authorizations overrides with their end dates into the Contractor's system, running other conversion programs, performing manual functions, performing quality control, reporting on outcomes, and converting files in preparation for system operation.

A.2.7. Readiness Review

The State may conduct an on-site review to assess the readiness of the Contractor to effectively administer and provide the services as defined in this Contract. The Contractor shall complete all implementation actions prior to "go-live" date and according to the implementation timeline provided by the Contractor to TennCare. The Contractor shall receive TennCare's sign-off that each action has been completed successfully. Implementation action steps include the following minimum items:

- a. Benefit plan designs loaded, operable and tested;



- b. 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";
- c. Eligibility feed formats loaded and tested end to end;
- d. Operable and tested toll-free numbers;
- e. Account management, Help Desk and Prior Authorization staff hired and trained;
- f. Established billing/banking requirements;
- g. Complete notifications to dentists regarding contractor change;
- h. Each component shall be met by an agreed upon deadline in an implementation timeline provided by Contractor to TennCare. Implementation action requirements may include other items necessary to meet the claims processing commencement date of October 1, 2013, 1:00 a.m. CST ; and
- i. Claims history and existing prior authorizations and overrides shall be migrated Contractors system

OBLIGATIONS OF THE CONTRACTOR

- A.3. **Services.** The Contractor agrees to administer the TennCare dental benefit 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 and shall manage the program in a manner that ensures an adequate network of qualified dental providers for whom the Contractor is responsible. These providers will render high quality, medically necessary, cost effective dental care. Furthermore, the Contractor shall exercise every available means through this Contract, provider agreements, office reference manual or Contractor's policies and procedures, to ensure that the program is managed in this manner.
- A.4. **Benefit Packages.** The Contractor shall be responsible for ensuring that the following benefits are provided to eligible enrollees in accordance with TennCare rules, court orders and other applicable law.
 - a. 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).
 - b. Orthodontics - Orthodontic services must be prior authorized by the Dental Benefits Manager 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 following records are required to validate a handicapping malocclusion including but 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 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). TennCare reimbursement for orthodontic services begun before age twenty-one (21) will end on the individual's 21st birthday. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for TennCare.
 - c. Age twenty-one (21) and Older - When the Contractor denies a claim or prior authorization request submitted by or on behalf of an individual over age twenty-one (21),



despite the fact that the individual's age may render him/her ineligible for TennCare benefits, the Contractor nonetheless agrees to render such denial in writing and in accordance with the appeals process set forth in Complaints and Appeals, Sections A.99 - A.113 of this Contract.

- d. Non-Traditional Fluoride Varnish and Dental Screening Program - The Contractor shall implement a program that would allow non-traditional providers (such as Primary Care Physicians, Pediatricians, Physician Assistants, Nurse Practitioners and Public Health Nurses) to conduct dental screenings and apply fluoride varnish to the teeth of TennCare enrollees two (2) through four (4) years of age. Non-traditional providers would be reimbursed for such services within the age range of two (2) through four (4) years only if fluoride varnish application and dental screening are also conducted at the same visit. The Contractor would be responsible for non-traditional provider network development including provider credentialing, provider billing, provider reimbursement, provider training and applicable reporting to TennCare. Non-traditional providers shall submit current dental terminology (CDT) procedure codes D1206 (for fluoride varnish) and D0190 (for a dental screening) directly to the DBM utilizing a standard ADA claim form. Non-traditional providers would be reimbursed using maximum allowable rates of \$19.50 per fluoride varnish application and \$12.00 for a dental screening. Each enrollee is permitted two (2) visits per year. The Contractor shall be expected to have this program operational within three (3) months of contract start date; no later than January 1, 2014, or be subjected to damages under the liquidated damages provisions in Attachment B. The Contractor shall manage the encounter data files for TennCare enrollees receiving fluoride varnish and dental screenings by non-traditional providers in accordance with the specifications, format and timeframes outlined by the Bureau of TennCare.

A.5. Enrollee Cost Share Responsibilities. The Contractor and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TennCare in accordance with TennCare rules and regulations or TennCare approved policies and procedures for TennCare enrollees, nor may the Contractor and all providers and subcontractors charge enrollees for missed appointments. Enrollees may not be held liable for payments in the event of the Contractor's insolvency. Enrollees may not be held liable for payments in the event the State does not pay the Contractor, or the Contractor does not pay the provider.

Cost sharing responsibilities shall apply to services other than the preventive services described in Section A.3 and specified in the table below. Co-payments shall be applied on a sliding scale according to the enrollee's income. The procedure code listing for preventive services is as follows:

Preventive Dental Services for Children Under 21 Years of Age

D1110	Prophylaxis –adult (when billed for children over age 12 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



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

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

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

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

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

The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service. A provider or a collection agency acting on the provider's behalf may not bill the enrollee for more than the allowable copay. If the Contractor discovers that the enrollee is being inappropriately billed, they 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 TBI.

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

- a. if the services are not covered by TennCare and the provider informed the enrollee the services were not covered prior to providing the service. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service; or
- b. if the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively; or
- c. if the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable cost share amounts must be refunded when a claim is submitted to the DBM if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim).

A.6. Adherence to TennCare Rules and Regulations: The Contractor shall perform all services under this Contract and shall comply with all applicable administrative rules and TennCare written policies, protocols and procedures, as may be amended from time to time. It is the responsibility of the Contractor to keep up to date on enacted rules and TennCare policies, protocols and procedures.



A.7. Corrective Action Plans: A corrective action plan (CAP) is a plan to correct Contractor's noncompliance with the Contract that the Contractor prepares at TennCare's request and submits to TennCare for review and approval. A CAP can be requested by TennCare at any time and it is a requirement of this Contract that Contractor respond timely to the CAP request and take all CAP actions that have been approved by TennCare. Failure to comply with a CAP request or an approved CAP may result in Liquidated Damages as set forth on Attachment B. The various components of a CAP are as follows:

- a. **Notice of Deficiency:** If TennCare determines that the Contractor or Contractor's subcontractor or provider is not in compliance with a requirement of this Contract, TennCare will issue a notice of deficiency identifying the deficiency and request a CAP detailing how the Contractor intends to correct the deficiency. The Notice of Deficiency will also contain the deadline for the proposed CAP to be forwarded to TennCare for approval and may also contain recommendations or requirements the Contractor must include or address in the CAP.
- b. **Proposed CAP:** Upon receipt of a Notice of Deficiency, the Contractor shall prepare a proposed CAP and submit it to TennCare for approval within the time frame specified by TennCare. The proposed CAP shall comply with all recommendations and requirements of the Notice of Deficiency and contain a proposed time by which the noncompliance will be corrected.
- c. **Approved CAP Implementation:** TennCare will review the proposed CAP and work with the Contractor to revise it as needed. Once approved, the Contractor shall be responsible for ensuring that all actions and documentation required by the CAP are completed in compliance with the Contract and CAP, to TennCare's satisfaction.
- d. **Notice of Completed CAP:** Upon satisfactory completion of the implemented CAP, TennCare shall provide written notice to the Contractor. Until written approval is received by the Contractor, the approved CAP will be deemed to not have been satisfactorily completed.

A.8. The Contractor shall demonstrate to TennCare progressive increases in the dental utilization as determined by TennCare's dental utilization proportion as specified in A.144. In an effort to increase the number of TennCare children ages 1 – 20 who receive preventive dental services, the Contractor shall track providers' level of preventive services and rank them. These rankings shall be shared with providers who fall below the mean. Low ranking providers will be encouraged through education and behavior modification to improve their ranking.

EVIDENCE OF ENROLLEE COVERAGE AND ENROLLEE MATERIAL

A.9. Enrollee Materials. The Contractor shall distribute various types of enrollee materials within its entire service area as required by this Contract. These materials include, but may not be limited to member handbooks, provider directories, member newsletters, dental reminder notices, fact sheets, notices, or any other material necessary to provide information to enrollees as described herein. The Contractor may distribute additional materials and information, other than those required by this Section, to enrollees in order to promote health and/or educate enrollees. All materials sent to enrollees and enrollee communications including form letters, mass mailings and system generated letters, whether required or otherwise, shall require written approval by TennCare prior to dissemination as described herein and shall be designed and distributed in accordance with the minimum requirements as described in this Contract. Letters sent to enrollees in response to an individual query do not require prior approval. The required enrollee materials include the following:

- a. The Contractor shall develop and update their member handbook when major changes occur within the TennCare program, the DBM or upon request by TennCare. The member



handbooks shall contain the actual date it was printed either on the handbook or on the first page within the handbook. Member handbooks must be distributed to enrollee within thirty (30) days of receipt of notice of enrollment in the DBM plan. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the Contractor to mail one (1) member handbook to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to enrollee. Should a single individual be enrolled and be added into an existing case, a member handbook new or updated must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to enrollee in the existing case.

- b. Upon notice by TennCare of benefit changes, the Contractor shall make the appropriate revisions to the member handbook, including two (2) separate versions of the Contractor's TennCare Member Handbook if necessary for the specific population being serviced for the purpose of describing Medicaid Benefits to the Medicaid populations and Standard benefits to the Standard population. All revisions must be approved by TennCare prior to dissemination.
- c. Once materials are approved by TennCare, the Contractor shall submit an electronic version (pdf) of the final product, unless otherwise specified by TennCare, within thirty (30) calendar days from the print date. If the print date exceeds thirty (30) calendar days from the date of approval, the Contractor shall submit a written notification to the TennCare Member Materials Coordinator to specify a print date. Should TennCare request original prints be submitted in hard copy, photo copies may not be submitted as a final product. Upon request, the Contractor shall provide additional original prints of the final product to TennCare. When large distributions of the member handbook occur, the Contractor must submit to TennCare the date the information was mailed to the enrollees along with an invoice or a specific document to indicate the date and volume of handbooks mailed. Each member handbook shall, at a minimum, be in accordance with the following guidelines:
 - (1) Must be in accordance with all applicable requirements as described in this contract.
 - (2) Shall include a table of contents;
 - (3) Shall include an explanation on how enrollees will be notified of member specific information such as effective date of enrollment.
 - (4) Shall include a description of services provided including limitations, exclusions and out-of-plan use;
 - (5) Shall include a description of cost share responsibilities for non Medicaid eligible individuals including an explanation that providers and/or the DBM may utilize whatever legal actions that are available to collect these amounts;
 - (6) Shall include information about preventive services for children under age twenty-one (21), to include a listing of preventive services and notice that preventive services are at no cost and without cost share responsibilities.
 - (7) Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to providers outside of the plan. The handbook should advise 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;



- (8) Shall explain that prior authorization is required for some services, including non-emergency services provided by a non-contract provider, that such services will be covered and reimbursed only if such prior authorization/service authorization is received before the service is provided; that all prior authorizations/service authorizations are null and void upon expiration of a member's TennCare eligibility; and that the member shall be responsible for payment for any services provided after the member's eligibility has expired;
- (9) 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;
- (10) Shall include appeal procedures as described in Section A.99 – A.113 of the Contract;
- (11) Shall include notice to the enrollee that in addition to the enrollee's right to file an appeal for actions taken by the Contractor, the enrollee shall have the right to request reassessment of eligibility related decisions directly to the Department of Human Services.
- (12) Shall include written policies on enrollee rights and responsibilities.
- (13) 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);
- (14) Shall include notice to the member that it is the member's responsibility to notify the Contractor, TennCare, and DHS (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify DHS (or for SSI eligibles, SSA) could result in the member not receiving important eligibility and/or benefit information
- (15) Shall include the toll free telephone number for TennCare with a statement that the enrollee may contact the plan or TennCare regarding questions about TennCare. The TennCare Family Assistance Service Center number is 1-866-311-4287.
- (16) Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;
- (17) Shall include information educating enrollees of their rights and necessary steps to amend their data in accordance with HIPAA regulations.
- (18) 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.
- (19) Shall include notice to the enrollee of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and 42 U.S.C.A. § 18116 and a complaint form on which to do so.



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

- (1) The Contractor shall include the following information, in each newsletter:
 - i. Specific articles or other specific information as described when requested by TennCare. Such requests by TennCare shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;
 - ii. the procedures on how to obtain auxiliary aids or services in order to achieve effective communication and how to access language interpretation and translation services which will include a statement that these services are free; and
 - iii. ~~for TennCare Medicaid enrollees, EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services.~~
- (2) The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the Contractor shall also submit to TennCare, five (5) final printed originals, unless otherwise specified by TennCare, of the newsletters and documentation from the DBM's mail room or outside vendor indicating the quantity and date mailed to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in this Contract.
- (3) The Contractor shall also include in the newsletter notice to the enrollee the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, , Title IX of the Education Amendments of 1972, and 42 U.S.C.A. § 18116 and a Contractor contact phone number for doing so. The notice shall be in English and Spanish.

A.9.e. The Contractor shall be responsible for providing information on how to access the provider directory, including the right to request a hard copy, how to contact member services, and how to access the searchable version of the provider directory on the Contractor's website to new enrollees within thirty (30) calendar days of receipt of notification of enrollment in the plan. The Contractor shall also be responsible for redistribution of updated provider information on a regular basis and shall make available a complete and updated provider directory at least on an annual basis.

- (1) The provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network providers, and identification of providers accepting new patients.
- (2) Enrollee provider directories, and any revisions thereto, shall be submitted to TennCare for approval prior to distribution to enrollees. The text of the directory shall be in Microsoft Word or Adobe (pdf) format. In addition, the provider information used to populate the enrollee provider directory shall be submitted as a TXT file or such



format as otherwise approved by TennCare and be produced using the same extract process as the actual enrollee provider directory.

- (3) In situations where there is more than one (1) enrollee in a TennCare case, it shall be acceptable for the Contractor to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.
 - (4) The Contractor may choose to provide a modified provider listing to enrollees who are only eligible for the limited Dental Benefits as described in Section A.4 of this Contract. However, all provider directories shall be approved by TennCare prior to the Contractor's distribution.
- f. 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.10. Permissible Communication Activities. The following enrollee communication activities shall be permitted under this Contract pending approval of a communication/outreach/access plan describing the time(s), place(s), intent, audience and other relevant information requested by TennCare.
- a. Distribution of general information through mass media;
 - b. Telephone calls, mailings and home visits to current enrollees of the Contractor only for the sole purpose of educating current enrollees about services offered by or available through the Contractor;
 - c. General activities that benefit the entire community (e.g., health fairs, school activity sponsorships, and health education programs)
- A.11. Prohibited Communication Activities. The following information and activities are prohibited. Failure to to comply with prohibited communication activities may result in the imposition by TennCare of one or more sanctions as provided in Section E.4 and Attachment B of this Contract.
- a. Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers. Further, the Contractor shall adhere to all requirements contained in this Contract for written materials to assure that such material is accurate and does not mislead, confuse or defraud the enrollees or the state agency and materials shall be subject to review by TennCare;
 - b. Overly aggressive solicitation, such as repeated telephoning;
 - c. Gifts and offers of material gain or financial gain as incentives;
 - d. Compensation arrangements that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;
 - e. Direct solicitation of potential enrollees;



- f. ~~Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;~~
- g. Assertions or statements (whether oral or written) that the enrollee must enroll with the Contractor in order to obtain benefits or in order not to lose benefits;
- h. Assertions or statements (whether written or oral) that the Contractor is endorsed by CMS, the federal or state government or similar entity;
- i. In accordance with federal requirements, independent marketing agents shall not be used in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions; and
- j. Seeking to influence enrollment in conjunction with the sale or offering of any private insurance.

A.12. Written Material Guidelines

- a. All materials shall be worded at a 6th grade reading level, unless TennCare approves otherwise.
- b. All written materials shall be clearly legible with a minimum font size of 12pt. with the exception of enrollee I.D. cards, unless otherwise approved by TennCare.
- c. All written materials shall be printed with an assurance of non-discrimination that has been preapproved by TennCare.
- d. The following shall not be used on communication material without the written approval of TennCare:
 - (1) The Seal of the State of Tennessee;
 - (2) The TennCareSM name unless the initials "SM" denoting a service mark, are superscripted to the right of the name;
 - (3) The word "free" can only be used if the service is no cost to all enrollees;
 - (4) The TENNderCare name and logo, unless permission is given by the State.
- e. All vital documents, including but not limited to, the member handbook must be translated and available in Spanish. Within ninety (90) days of notification from TennCare, all vital documents must be translated and available to each Limited English Proficiency group identified by TennCare that constitutes five percent (5%) of the TennCare population or 1,000 enrollees, whichever is less.
- f. All written member materials shall notify enrollees that auxiliary aids or services and language interpretation and translation services are available at no expense to the member and how to access those services.
- g. All written member materials shall ensure effective communication with disabled/handicapped persons at no expense to the member. Effective Communication may be achieved by providing auxiliary aids or services, including, but may not be limited to: Braille, large print, and audio and shall be based on the needs of the individual



enrollee. The Contractor and its providers and direct service subcontractors shall be required to comply with Title III of the Americans with Disabilities Act of 1990 in the provision of auxiliary aids and services to enrollees to achieve effective communication. In the event that the provision of auxiliary aids and services to an enrollee is not readily achievable by the Contractor's providers or direct service subcontractors, the Contractor shall provide the enrollee with the auxiliary aid or service that would result in effective communication with the enrollee.

- h. The Contractor shall provide written notice of any changes in policies or procedures described in written materials previously sent to enrollees at least thirty (30) days before the effective date of the change to provide TennCare an opportunity to review prior to the changes take effect.
- i. The Contractor shall be responsible for postage on all mailings sent out by the Contractor.
- j. The Contractor shall use the TennCare approved glossary of required Spanish terms in the Spanish translation of all member materials.

A.13. Failure to Comply with Enrollee Material Requirements. All services listed in A.4 must be provided as described and the materials must adhere to the requirements as described and must not mislead, confuse, or defraud the enrollees or the State. Failure to comply with the communication limitations contained in this Contract, including but not limited to the use of unapproved and/or disapproved communication material, may result in the imposition by TennCare of one or more sanctions as provided in Section E.4 and Attachment B. of this Contract.

STAFFING

A.14. The Contractor shall have total responsibility for hiring and management of any and all Contractor staff as determined necessary to perform the services in accordance with the terms of this Contract and shall provide a proposed staffing plan for review and approval by TennCare. The Plan shall include at a minimum, key staff identified below and corresponding job descriptions. The Contractor's failure to provide and maintain key staff may result in liquidated damages as described in Section E.4 and Attachment B of this Contract.

A.15. Office Location. The Contractor must maintain a physical office in Metropolitan-Davidson County, Tennessee, or counties contiguous to Metropolitan-Davidson County.

A.16. Staff Requirements

- a. The Contractor shall be responsible for assuring that all persons, whether they be employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render services under applicable state law and/or regulations. Failure to adhere to this provision may result in one (1) or more of the following sanctions that shall remain in effect until the deficiency is corrected:
 - (1) TennCare may refuse to approve or may rescind the approval of subcontracts with unlicensed persons;
 - (2) TennCare may refer the matter to the appropriate licensing authority for action;
 - (3) TennCare may assess liquidated damages provided by Attachment B of this Contract; and
 - (4) TennCare may terminate this Contract for cause defined by Section D.4. of this Contract.



- b. The Contractor shall provide to TennCare documentation verifying that all staff employed by the Contractor or employed as a sub-contractor are licensed to practice in his or her area of specialty. This documentation shall be supplied at the execution of this Contract and annually thereafter, due 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.
 - c. The Contractor shall provide TennCare with copies of resumes and job descriptions for all persons employed under this Contract. TennCare reserves the right, at its sole discretion, to request dismissal of Contractor staff and sub-contracted staff based on performance deficiencies and/or lack of knowledge, skills or demonstrated expertise necessary to perform contracted activities.
 - d. The Contractor shall ensure that all Contractor staff and sub-contracted staff are trained and knowledgeable regarding all applicable aspects of the TennCare Dental Program.
 - e. A training plan shall be submitted and approved by TennCare within ten (10) business days of the execution of this Contract. Contractor shall be responsible for providing training to any newly hired Contractor staff and sub-contracted staff prior to those individuals performing any reviews. Training for newly hired Contracted staff and sub- contracted staff shall be approved by TennCare in advance.
 - f. The Contractor shall employ competent staff in all key positions listed below. If any key position becomes vacant, the Contractor shall employ an adequate replacement within sixty (60) days of the vacancy unless TennCare grants an exception in writing to this requirement. Failure to fill vacancies within sixty (60) days may result in liquidated damages as set forth in Attachment B.
 - g. The Contractor shall 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 dental benefits.
 - h. The Contractor shall, at a minimum, have at least fifty percent (50%) of its staff in the core disciplines 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.17. Staff Dedicated to TennCare - The Contractor shall maintain sufficient levels of staff, including supervisory and support staff, with appropriate training, work experience, and expertise to perform all contract requirements on an ongoing basis and be available to attend meetings as requested by TennCare. The Contractor staff shall include but is not limited to the following personnel:
- a. DBM Project Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Project Director dedicated to this Contract who has day-to-day authority to manage the total project. The Project Director shall be readily available to TennCare staff during regular working hours. The Project Director shall be physically located in Tennessee.
 - b. DBM Dental Director - The Contractor shall designate and maintain, subject to TennCare approval, a full-time Dental Director dedicated to this Contract who has day-to-day authority to manage the clinical aspects of the project. A dentist who is licensed by the Tennessee Board of Dentistry, in good standing, and physically located in the State of Tennessee shall serve as full-time DBM Dental Director to oversee and be responsible for the proper provision of medically necessary covered services for enrollees. The DBM Dental Director



shall be closely involved in the monitoring of program integrity, quality, utilization management and utilization review, provider corrective action, site visits, credentialing processes, and Performance Improvement Projects (PIPs). The DBM Dental Director shall serve on the Peer Review Committee (chairperson), Quality Monitoring Program (QMP) Committee and Credentialing Committee. The DBM Dental Director shall attend all TennCare Dental Advisory Committee (TDAC) meetings and be on the quarterly meeting agenda when indicated to present recommendations regarding changes to clinical guidelines.

- c. EPSDT Outreach Coordinator - The Contractor shall designate and maintain, subject to TennCare approval, a full-time EPSDT Outreach Coordinator, physically located in Tennessee, whose primary duties include development and implementation of the Contractor's strategy to increase enrollee utilization of dental services by TennCare enrollees under the age of twenty-one (21) years of age.
- d. Regulatory Compliance Manager – The Contractor shall designate and maintain, subject to TennCare approval, a full-time Regulatory Compliance Manager, physically located in Tennessee. The Regulatory Compliance Manager shall possess a thorough knowledge regarding investigations related to provider fraud and abuse in the TennCare program and will be the key staff handling day-to-day provider investigation related to inquiries from TennCare and TBI MFCU.
- e. Provider Network Director – The Contractor shall designate and maintain, subject to TennCare approval, a Provider Network Director, physically located in Tennessee, responsible for network development and management to ensure that there is a statewide dental network adequate to make services, service locations and service sites available and accessible in accordance with the terms and conditions for access and availability outlined in the contract. The Provider Network Director shall coordinate with other areas of the Contractor's organization that may impact provider recruitment, retention or termination. The Provider Network Director will also ensure that the provider enrollment file and the Insure Kids Now (IKN) files are accurate and delivered to TennCare timely. The Provider Network Director shall have a provider service line staffed adequately to respond to providers' questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in this Contract. The provider service lines shall be adequately staffed and trained to accurately respond to questions regarding the TennCare program, including but not limited to, EPSDT. The Contractor shall adequately staff the provider service line to assure that the average wait time for assistance does not exceed ten (10) minutes. Difficult provider network questions and or complaints should be referred and fielded by the Provider Network Director. Supervision of provider representatives as described below, is also the responsibility of the Provider Network Director.
- f. Provider Representatives – The Contractor shall designate and maintain, subject to TennCare approval, a minimum of two (2) full-time Provider Representatives physically located in Tennessee to educate and assist participating dental providers in working with utilization management programs including, but not limited to, prior authorization requests, electronic billing, compliance initiatives, or other program requirements.
- g. Complaint and Appeals Coordinator – The Contractor shall designate and maintain, subject to TennCare approval, one (1) Complaint and Appeals Coordinator to process enrollee complaints and appeals within specified time frames and in accordance with TennCare requirements. The Complaint and Appeals Coordinator shall ensure compliance with all enrollee notice requirements and notice content requirements specified in applicable state and federal law.



- h. ~~Data Research Analyst~~ – The Contractor shall designate and maintain, subject to TennCare approval, ~~one (1) Data Research Analyst~~ responsible for generating daily, weekly, monthly, quarterly and yearly reports required by the Contract, in addition to all ad hoc requests made by TennCare, in formats requested by TennCare. The ~~Data Research Analyst~~ shall be expert in data that is warehoused by Contractor on behalf of TennCare and shall be available to assist TennCare staff with Contractor's decision support systems. The ~~Data Research Analyst~~ shall provide expertise and assistance in provider post utilization review, establishing benchmarks for procedures prone to provider fraud and abuse that don't require prior authorization, evaluation of provider's treatment patterns, identification of provider outliers, and drawing statistically valid random sample (SVRS) of dental records, utilizing a ninety five percent (95%) confidence interval, specific to the procedure(s) where the provider is an outlier;
- i. System Liaison- The Contractor shall designate and maintain, subject to TennCare approval, one (1) system liaison responsible for, but not limited to the planning and timely coding of edits to the Contractor's system when requested by TennCare, the quality control of such edits to ensure proper functioning within the system, and to ensure that newly entered system changes and edits do not affect existing edits within Contractor's system causing unanticipated adverse system events affecting TennCare's claims, enrollees and providers. The System Liaison shall be responsible for all testing of new programs or modules to be used by Contractor to manage TennCare's business. The System Liaison shall also be responsible for the maintenance and management of Contractor's website, including updating.
- j. Member Materials and Marketing Coordinator – The Contractor shall designate and maintain, subject to TennCare approval, one (1) Member Materials and Marketing Coordinator responsible for ensuring that all member materials including, but not limited to, member handbooks, provider directories, member newsletters, dental reminder notices, fact sheets, notices or any other materials necessary to provide information to enrollees as developed by the Contractor is approved by TennCare and disseminated timely.
- k. Support Staff - Sufficient support staff to conduct daily business in an orderly manner, including such functions as administration, accounting and finance, prior authorizations, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews;
- (1) Appeals Support Staff (clerical and professional) to process enrollee appeals related to adverse actions effecting enrollees as defined in *Grier*.
 - (2) Dentist Consultants including at a minimum, general dentist(s), pediatric dentist(s), oral surgeon(s), and orthodontist(s), whose primary duties are medical necessity determinations for authorization of dental services;
 - (3) Non-discrimination Compliance Coordinator to be responsible for Contractor compliance with all applicable Federal and State civil rights laws and regulations, which may include, but are not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and Title IX of the Education Amendments of 1972, 42 U.S.C.A § 18116, the Church Amendments (42 U.S.C. 300 a-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. G., Section 508(d), 123 Stat. 3034, 3279-80). The Contractor does not have to require that compliance with the aforementioned federal and state laws and regulations be the sole function of the designated staff member. However, the Contractor shall identify the designated compliance staff member to TennCare by name. The Contractor shall report to TennCare in



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

- (4) Care Coordinators and Claim Coordinators appointed by the Contractor in order to coordinate and resolve issues related to MCO/DBM coordination issues as described in Care Coordination Sections A.39 – A.42 of this Contract. Further, the Contractor shall appoint a Care Coordination Committee and a Claims Coordination Committee made up of the Care/Claim Coordinators and other staff as appropriate. A list with the names and phone numbers of said representatives shall be provided by the DBM to the MCO and TennCare.
 - (5) The Contractor shall provide a twenty-four (24) hour toll-free telephone line accessible to enrollees that provides information to enrollees about how to access needed services. In addition, the Contractor shall appoint and identify in writing to TennCare a responsible contact available after hours for the “on-call” TennCare Solutions staff and enrollees to contact with service issues
- I. The Contractor shall identify in writing the name and contact information for the Key contact persons within thirty (30) days of Contract award. Any changes in staff persons listed in this section during the term of this Contract must be made in writing within ten (10) business days after receipt of any required approvals from TennCare. The identity of each of the persons listed above shall be disclosed on the Contractor’s web site.

ACCESS AND AVAILABILITY TO CARE

- A.18. The Contractor shall arrange for the provision of all services described as covered 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 below. Nothing in this Contract shall be construed to preclude the Contractor from closing portions of the network to new providers when all conditions of access and availability are met.
- A.19. Access to Care. The Contractor shall maintain a network of dental providers with a sufficient number of providers who accept new TennCare enrollees in accordance with the geo access standards required under this Contract so that appointment waiting times do not exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care. The Contractor shall ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. Services must be available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. Performance on access to care shall be monitored by the Contractor. Additional monitoring of the standards may be conducted by TennCare and/or the External Quality Review Organization (EQRO). The Contractor shall consider the following:
- a. The anticipated Medicaid enrollment;
 - b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the DBM;
 - c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services;
 - d. The numbers of network providers who are not accepting new Medicaid patients;
 - e. The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities, and



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

- A.20. Transport Distance. The Contractor shall maintain under contract a statewide network of dental providers to provide the covered services specified in Sections A.3 and A.4, Obligations of the Contractor. The Contractor shall make services, service locations and service sites available and accessible so that transport distance to general dental providers will be the usual and customary, not to exceed an average of thirty (30) miles, as measured by GeoAccess Software, except in rural areas where community standards, as defined by TennCare, will be applied. Exceptions must be justified and documented to the State on the basis of community standards. 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 30 mile standard to access dental care.
- A.21. Office Wait Time. The Contractor shall ensure that the office waiting time shall not exceed forty-five (45) minutes.
- A.22. 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.23. Out of Network Providers. If the Contractor's network is unable to provide necessary, medical services covered under the contract to a particular enrollee, the Contractor must adequately and timely cover these services out of network for the enrollee, for as long as the Contractor is unable to provide them. Out of network providers must coordinate with the Contractor with respect to payment. The Contractor must ensure that cost to the enrollee is no greater than it would be if the services were furnished within the network.
- A.24. The Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
- A.25. 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 be able to 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 them. Documentation assuring adequate network capacity and services as specified by the State must be submitted by the Contractor.

MEMBER SERVICES

- A.26. Members Services Hotline. The Contractor shall provide a toll-free telephone service for all regular business days Monday through Friday. Since Tennessee spans two time zones, this service shall be operated from 7:00 a.m. Central Standard Time to 5:00 p.m. Central Standard Time and corresponding hours during periods of Daylight Savings Time. The member service lines shall be adequately staffed and individuals trained to accurately respond to questions regarding covered services, to assist enrollees locate a participating dental provider, and other issues, including but not limited to EPSDT.
- A. 27. Interpreter and Translation Services
- a. The Contractor shall develop written policies and procedures for the provision of language interpreter and translation services, including providing auxiliary aids and services to any member who needs such services, including but not limited to, members with Limited English Proficiency and members who are hearing impaired.



- b. The Contractor shall provide language interpreter and translation services including auxiliary aids and services free of charge to members.
- c. Language interpreter and translation services shall ensure effective communication with enrollees. This assistance should be available in the form of auxiliary aids, which include, but are not limited to in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.
- A.28. TDD/TDY. The Contractor shall make free of charge TDD/TDY services available to enrollee.
- A.29. Appointment Assistance. The Contractor shall assist enrollees in obtaining appointments for covered services, including facilitation of enrollee contact with a Participating Dental Provider who will establish an appointment. The Contractor shall track the number of requests for assistance to obtain an appointment, including the service area in which the enrollee required assistance.
- A.30. Provider Listing. The Contractor shall distribute information on how to access the provider directory, including the right to request a hard copy, to all enrollees (or heads of households), within thirty (30) days of initial enrollment, and upon request, such list shall include current provider address(es), telephone numbers, office hours, languages spoken, specialty and whether or not the provider is accepting new patients. The Contractor shall also be responsible for making available updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. All provider directories shall be approved by TennCare prior to the Contractor's distribution.
- A.31. I.D. Card. The Contractor shall not be required to provide identification cards to TennCare enrollees; however, the Contractor shall provide TennCare with a written process detailing how enrollees and providers will access information, including but not limited to, pertinent phone numbers for enrollee services, provider identification of eligible individuals and access to prior authorization procedures, etc.

UTILIZATION MANAGEMENT

- A.32. Policies and Procedures. The Contractor shall have written policies and procedures for utilization management and review, which include, at minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of medical services. The Contractor shall provide an electronic copy and two written copies of its dental management policies and procedures to TennCare for approval during Readiness Review and at any time the policies or procedures are updated or changed.

The policies and procedures shall contain the following elements:

- a. Scope - The program has mechanisms to detect underutilization as well as overutilization.
- b. Prior Authorization and Concurrent Review Requirements.
 1. The Contractor shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or defacto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her history.
 2. Prior authorization and concurrent review decisions are supervised by qualified dental professionals.
 3. Documented efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating dentists as appropriate.
 4. The reasons for decisions are clearly documented and available to the enrollees.
 5. There are well-publicized and readily available appeals mechanisms for both



providers and enrollees.

6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
7. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.
8. If the Contractor delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

A.33. Prior Authorization. Policies and procedures must clearly identify any services for which the Contractor will require network providers to obtain authorization prior to the provision of the service as well as any additional submissions (such as radiographs) that may be required for approval of a service. TennCare shall have thirty (30) days to review and approve or request modifications to the policies and procedures. Should TennCare not respond in the required amount of time, the Contractor shall not be penalized as a result of implementing the policies and procedures. However, failure to respond timely shall not preclude the State from requiring the Contractor to respond or modify the policy or operating guideline prospectively. Dental management policies and procedures must be consistent with the following requirements:

- a. Requests for prior approvals that are denied by the Contractor must be denied in writing within fourteen (14) days of receipt.
- b. Prior approval shall not be required for referrals from the Public Health Screening Program, Primary Care Physicians, and for preventive services as defined in A.3.
- c. Utilization management activities may 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.34. Reconsideration. If services are denied, the Contractor shall reconsider the denial of the service when the network provider submits additional information including but 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 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.35. Retrospective Utilization Review. The Contractor shall conduct retrospective treatment utilization review. This review will require the Contractor (DBM) to establish benchmarks for procedures that are prone to fraud or abuse but, don't require prior authorization. Examples would include pulpotomies, stainless steel crowns or any other dental procedure highlighted by CMS, TennCare or identified by the DBM as prone to fraud and abuse. The DBM will evaluate the dental provider's treatment practice as compared with other in-network providers performing similar procedures based on provider specialty and identify those whose treatment utilization pattern deviates significantly from their peer's norm. The process will incorporate basic provider profiling, test edits, and Statistical Process Controls (SPC). SPC is a methodology of evaluating normal statistical variability or "noise" within any type of process. Normally the statistical limits are set at plus or minus three standard deviations so that any determination outside of these upper and lower control limits is expected to be a significant deviation from the network group being measured. Benchmarking analysis is mandatory as outlined above, and must be provided to TennCare upon request. All outlier reports will be submitted to TennCare quarterly through the Office of Program Integrity. If the type of finding elicited in the retrospective treatment utilization review process necessitates chart audit of a dental provider, then the Contractor will draw a statistically valid random sample (SVRS) of dental records, utilizing a ninety five percent (95%) confidence interval consistent with US DHHS convention, specific to the procedure(s) where the provider is an outlier compared with the benchmark. The Contractor, utilizing dental expert(s) will



perform an initial chart audit of the entire SVRS sample. If the initial audit findings reveal evidence of fraud, abuse, non-compliance with medical necessity criteria or quality of care issues then the Contractor is required by this contract to present a convenience sample of at least 10% of the findings to be reviewed by its Provider Peer Review Committee for the purpose of agreement between reviewers. Utilization review by the Provider Peer Review Committee, must be conducted in a blinded manner.

The Contractor's Provider Peer Review Committee shall be made up of licensed Tennessee dentists in good standing with the Tennessee Board of Dentistry. Committee members must be familiar with the TennCare dental program, The Contractor shall provide each member of its Provider Peer Review Committee with a copy of TennCare's Medicaid Rules, TennCare's Medical Necessity Rules as well as, the medical necessity guidelines presented in the Provider Office Reference Manual. The Contractor shall also provide orientation and medical necessity training for every member who serves on its Peer Review Committee before members are permitted to review case files. Section A.117 of this contract describes the DBM'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 Tennessee Peer Review Committee has completed its review and established written findings and recommendations, these are forwarded back to the Contractor for careful consideration and appropriate formal action. The Contractor shall forward to the TennCare Dental Director and Office of Program Integrity, a quarterly update including a summary of its investigations, Provider Peer Review Consensus findings and recommendations as well as, all formal actions taken.

- a. The Contractor's utilization review process intervention includes various options that safeguard children, improve quality of care, assure fiscal viability of the program and comport with TennCare's mission. These options include issuance of written corrective action plans, documentation of provider and staff education, recoupment of provider payments or any combination of these actions. Additionally, in accordance with its Provider Service Agreement, the Contractor may also choose to exercise its prerogative to terminate a dental provider with or without cause with thirty (30) days notice.
- b. Utilization review of dental procedures, not requiring prior authorization which demonstrate that a provider is not adhering to TennCare's medical necessity criteria in the provision of a procedure(s), will necessitate that the Contractor initiate written corrective action for that provider which may include, but is not limited to, the following:
 1. Provider and staff education;
 2. Prior authorization for that procedure(s) and,
 3. Second opinion by a Contractor-designated dentist in cases involving "extensive" treatment plans and/or in cases where the dentist is requesting treatment in a medical facility (hospital operating room or ambulatory treatment center).

A.36. Emergent and Urgent Care. The Contractor shall ensure access to services for emergent and urgent dental and oral conditions or injuries on the basis of the professional judgment of the enrollee's treating dentist, other dental professional, primary care provider or a triage nurse who is trained in dental care and oral health care.

- a. The Contractor may not deny payment for treatment obtained when a representative of the Contractor instructs the eligible enrollee (under age 21) 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. Under the terms of this Contract and the TennCare MCO Contractor Risk Agreement, the MCO is responsible for the provision of treatment for emergency medical



conditions and is also responsible for the facilities and physician charges for dental services provided in a hospital emergency room.

- b. The Contractor may not deny payment for treatment obtained when an eligible enrollee (under age 21) had an emergency medical condition, where it is the Contractor's responsibility to pay, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 § CFR 438.114 (a) of the definition of emergency medical conditions. Under the terms of this Contract and the TennCare MCO Contractor Risk Agreement, the MCO is responsible for the provision of treatment for emergency medical conditions and is also responsible for the facilities and physician charges for dental services provided in a hospital emergency room.
- A.37. Continuity of Care. The Contractor shall accept claims and authorize reimbursement for Covered Services that were approved or were part of a course of treatment that started prior to the Effective Date of this Contract.
- A.38. Referral Requirements. A patient must be referred by a general dentist or pediatric dentist to a dental specialist (e.g., endodontist, oral surgeon, orthodontist, periodontist, prosthodontist) for the initial visit for services requiring specialized expertise. Subsequent visits to the same specialist in a course of treatment do not require separate referrals. The Contractor shall:
- a. provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain one outside the network, at no cost to the enrollee, and
- b. have a mechanism in place to allow special needs enrollees and enrollees determined to require an ongoing course of treatment direct access to specialists as appropriate.

CARE COORDINATION

- A.39. Transition Period. In the event a TennCare enrollee is receiving medically necessary covered dental services the day before the effective date of this Contract, the Contractor shall authorize the continuation of said services without any form or prior approval and regardless of whether the services are being provided by a provider within or outside the Contractor's provider network. In order to ensure uninterrupted service delivery, the Contractor shall accept authorization files from the previous DBM and/or TennCare as directed to identify enrollees for whom prior approvals were issued prior to the effective date of this Contract. To the extent that the approvals are for covered services and are within the parameters of the TennCare approved policies and procedures for prior approvals as outlined in Section A.33 of this Contract, the Contractor will accept and honor those prior approvals for the first ninety days of this Contract. The Contractor shall coordinate with the previous DBM so that dental inquiries received after January 1, 2014 are redirected to the Contractor.
- A.40. Coordination Between MCO and Contractor (DBM). The provision of Dental services are the responsibility of the Contractor, however, the provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service (with the exception of anesthesia services administered by a dental provider or in a dentist office) shall remain with the MCO. The Contractor shall remain responsible for anesthesia services that are appropriately provided by a dental provider or in a dentist's office. The Contractor shall agree to coordinate dental and medical services in accordance with the following provisions. The Contractor shall be responsible for: (1) authorizing dental services for which they have the responsibility to pay; and (2) arranging services that are not covered under this Contract to be provided, when appropriate, with providers that are contracted in the MCO's plan. The MCO shall be responsible for authorizing said services that require transportation, anesthesia (with the exception of anesthesia services administered by a dental provider or in a dentist office), and/or medical services related to the



dental service; however, the MCO may waive authorization of said services based on authorization of the dental services by the Contractor. The Contractor and the MCO may develop policies and procedures to further clarify responsibilities of the DBM 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. Services and Responsibilities - Coordination of dental services, shall at a minimum, include:
 1. Means for referral which assures immediate access for emergency care and a provision of urgent and routine care according to TennCare guidelines;
 2. Means for the transfer of information (to include items before and after the visit);
 3. Maintenance of confidentiality;
 4. Cooperation with the MCO regarding training activities provided by the MCO.
 5. Results of any identification and assessment of any enrollee with special health care needs (as defined by the State) so that those activities need not be duplicated;
 6. Mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals, and
 7. If applicable, the development of treatment plans for enrollees with special health care needs that are developed by the enrollee's primary care provider with enrollee participation and in consultation with any specialists caring for the enrollee. These treatment plans must be approved by the Contractor in a timely manner, if approval is required, and be in accord with any applicable State quality assurance and utilization review standards.

- b. Coordination Processes - Coordinating the delivery of dental services to TennCare 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 the Bureau of TennCare of the name, title, telephone number and other means of communicating with that coordinator. The Contractor shall be responsible for communicating the MCO provider services and/or claim coordinator contact information to all of its providers. With respect to specific enrollee services, resolution of problems shall be carried out between the MCO coordinator and the DBM coordinator. Should systemic issues arise, the MCO and the Contractor agree to meet and resolve these issues. In the event that such issues cannot be resolved, the MCO and the Contractor shall meet with TennCare to reach final resolution of matters involved. Final resolution of system issues shall occur within ninety (90) days from referral to TennCare.

- c. Resolution of Requests for Authorization - The Contractor agrees and recognizes that the MCO shall agree through its contractual arrangement with the State, that any dispute concerning which party should respond to a request for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a TennCare enrollee. DBM and MCO agree that Care Coordinators will, in addition to their responsibilities for care coordination, deal with issues related to requests for authorization which require coordination between DBM and MCO. The DBM and MCO shall provide the other party with a list of its Care Coordinators and telephone number(s) at which each Care Coordinator may be contacted. When either party receives a request for authorization from a provider for a enrollee and the party believes care is the responsibility of the other party, the Care Coordinator for the receiving party will contact the respective Care Coordinator of the other party by the next business day after receiving the request for prior authorization. The receiving party shall respond with an



acknowledgement of receipt of the authorization request to the enrollee or enrollee's provider on routine requests within fourteen (14) days or less of the provider's request for prior authorization. The receiving party shall respond to the provider's prior authorization request immediately after receiving the request for prior authorization for urgent requests. Requests for urgent prior authorization will be evaluated by the receiving party. The Contractor and the MCO shall establish a coordination committee to address all issues of care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Contract. The parties shall attempt in good faith to resolve any dispute and communicate the decision to the provider requesting authorization of a service. In the event the parties cannot agree within fifteen (15) days of the provider's request for prior authorization, the party who first received the request from the provider will be responsible for authorization and payment to their contracted provider within the time frames designated by the Bureau of TennCare. Both parties are responsible for enforcing hold harmless protection for the enrollee. The parties agree that any response to a request for authorization shall not exceed fourteen (14) days and shall comply with the Grier Revised Consent Decree (modified) and the TennCare Rules.

d. Claim Resolution Authorization

1. The Contractor agrees and recognizes that the MCO shall agree through its contractual arrangement with the State, to designate one or more Claim Coordinators to deal with issues related to claims and payment issues that require coordination between the Contractor and MCO (parties). The Contractor and MCO shall provide the other party, and TennCare with a list of its Claim Coordinators and telephone number(s) at which each Claim Coordinator may be contacted.
2. When either party receives a disputed claim for payment from a provider for a enrollee and the party believes care is the responsibility of the other party, the Claims Coordinator for that party will contact the respective Claims Coordinator of the other party within four (4) business days of receiving such claim for payment. If the Claims Coordinators are unable to reach agreement on which party is responsible for payment of the claim, the claim shall be referred to the Claims Coordination Committee for review.
3. The Contractor and the MCO shall establish a Claim Coordination Committee made up of Claims Coordinators and other representatives, as needed, from each party. The number of members serving on the Claim Coordination Committee shall be determined by the mutual agreement of the parties from time to time during the term of this Contract, or, if the parties fail to agree within ten (10) calendar days of the execution of this Contract, the Claim Coordination Committee shall consist of two (2) representatives of each party. The Claim Coordination Committee shall review any disputes and negotiate responsibility among the parties. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party will reimburse and abide by the prior decisions of that party. Reimbursement will be made within ten (10) business days of the Claim Coordination Committee's decision.
4. If the Claim Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) business days of the initial referral to the Claim Coordination Committee, said claim shall be referred to the



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

5. If the meeting between the CEOs, or their designee(s), of the Contractor and the MCO does not successfully resolve the dispute within ten (10) days, the parties shall, within fourteen (14) days after the meeting among the CEOs or their designee(s), submit a request for resolution of the dispute to the State or the State's designee for a decision on responsibility after the service has been delivered.
6. The process as described above shall be completed within thirty (30) days of receiving the claim for payment. In the event the parties cannot agree within thirty (30) days of receiving the claim for payment, both parties will be responsible for enforcing hold harmless protection for the member and the party who first received the request or claim from the provider will be responsible for authorization and payment to the provider within the following time frames designated by the Bureau of TennCare: claims must be processed in accordance with the requirements of the MCO's and DBM's respective Agreements with the State of Tennessee. Moreover, the party that first received the request or claim from the provider must also make written request of all requisite documentation for payment and must provide written reasons for any denial.
7. The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable contract provisions, and position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party. The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of the Request for Resolution. The Response shall contain the same information required of the Request for Resolution. Failure to timely file a Response or obtain an extension from the state shall be deemed a waiver of any objections to the Request for Resolution.
8. The state, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) days of the receipt of the required information. The decision may reflect a split payment responsibility that will designate specific proportions to be shared by the MCO and the DBM which shall be determined solely by the State, or its designee based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the state, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars (\$1000) for each request for resolution. The amount of the Contractor's payment responsibility shall be contained in the state's Decision. These payments may be made with reservation of rights regarding any such judicial resolution. If a party fails to pay the state for the Contractor's payment responsibility as described in this section within thirty (30) calendar days of the date of the state's Decision, the state may deduct amounts of the Contractor's payment responsibility from any current or future amount owed the party.



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 TennCare enrollee under age 21. 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 must be approved or disapproved based on the definition of emergency medical condition specified in this Contract.
10. Emergencies - Prior authorization shall not be required for emergency services prior to stabilization. Federal law requires the emergency screenings be provided at the Emergency Department. The enrollee's MCO is responsible for payment for the screening or any medical care required to stabilize the patient. If the screening reveals that a dental problem exists, the Contractor shall be notified and is responsible for providing any necessary emergency services.
- e. Claims Processing Requirements - All claims must be processed in accordance with the requirements of the MCO's and DBM's respective Contracts with the State of Tennessee.
- f. 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.
- g. 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.
- h. 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 DBM and MCO standards. These standards will apply to both DBM's and MCO's providers and staff. If either party believes that the standards require updating, or operational changes are needed to enforce the standards, the parties agree to meet and resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the enrollees. The DBM and MCO shall assure all materials and information directly or indirectly identifying any current or former enrollee which is provided to or obtained by or through the MCO's or DBM's performance of this Contract, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, Section E.7 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 the Bureau of 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.
- i. Access to Service - The Contractor is required to 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.41. Tracking System. The Contractor shall develop and maintain a tracking system with the capability to identify the current screening status, pending preventive services, and screening due dates, referrals for corrective treatment, whether corrective treatment was provided, and dates of service for corrective treatment for each enrollee.
- A.42. Provider Listing for MCO PCP's. The Contractor shall prepare updated provider listings to be provided to the MCOs for the purpose of distribution to MCO primary care providers. This listing must be provided to MCOs on a quarterly basis in accordance with a form, format and schedule as determined by TennCare.

PROVIDER SERVICES

- A.43. Training. The Contractor shall provide continuing training for participating Dental Providers throughout the State.
- a. The Contractor shall hold at least two training sessions per year for each Grand Region in the state. Such training sessions shall address state and federal law pertaining to the provision of TennCare benefits. At a minimum, such training sessions shall address (i) the extent and limits of TennCare dental and orthodontic treatment coverage rules (i.e., handicapping malocclusion, orthodontic readiness form, documentation of nutritional problems [pediatric growth records], speech/hearing evaluations [may include school records]), and medical necessity rule and (ii) those requirements that must be satisfied by dental providers in order to ensure compliance with federal EPSDT law, Children and Youth with Special Needs (CYSHCN), and services under the Grier Consent Decree and TennCare Rules . The Contractor shall submit all proposed training material to TennCare for approval at least sixty (60) days prior to the training session. TennCare shall have fifteen (15) days to review and request changes, if necessary. If changes are requested, the Contractor must resubmit the training material within ten (10) days of receipt of TennCare's comments.
 - b. The Contractor shall monitor provider compliance with TennCare coverage rules, medical necessity rules, TennCare policies and with requirements of EPSDT and clinical criteria guidelines presented in TennCare's Office Reference Manual. The Contractor shall promptly address compliance deficiencies, other than fraud, 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 must be reported to the TBI and TennCare's Director of Program Integrity . If the appropriate authority determines that the conduct in question does not constitute fraud then the Contractor may impose the corrective measure mentioned in this section.
 - c. The Contractor shall handle the day to day management of the Provider network so as to insure the provision of safe and effective dental care. The State must be able to protect its enrollees from unsafe medical care. Therefore, the State reserves the right in extreme and unusual cases, at its sole discretion, to disapprove certain corrective actions recommended by the Contractor for a given Provider.
 - d. The Contractor shall require that participating Dental Providers file TennCare-associated claims directly with the Contractor, or its subcontractors. The Contractor shall provide written instructions to participating Dental Providers addressing claims submission requirements. The Contractor shall confer participating Dental Providers with any assistance reasonably necessary to ensure provider compliance with applicable claims payment policy.



- e. On a quarterly basis, the Contractor shall provide TennCare with documentation substantiating its compliance with the obligations addressed in this section.
- A.44. Provider Manual. The Contractor shall produce and distribute a dental program criteria manual to assist Participating Dental Providers. The manual shall clearly define covered services, limitations, exclusions, and utilization management procedures, including, but not limited to: prior approval requirements, medical necessity guidelines for dental procedures, and special documentation requirements, including but not limited to Hospital readiness form, orthodontic readiness form, documentation of nutritional deficiencies (general pediatric records including growth data), and speech/hearing evaluations (may include school records) for treatment of enrollees. The manual shall include a detailed description of billing requirements for Participating Dental Providers and shall contain a copy of Contractor's paper billing form and electronic billing format. The Contractor shall ensure that the manual remains up-to-date and reflects changes in applicable law or revisions to TennCare or Contractor policy. The initial version of the manual and any subsequent revisions thereto must be submitted to TennCare and The TennCare Division, Tennessee Department of Commerce and Insurance (TDCI) for review and approval prior to distribution. Participating Dental Providers must be apprised of revisions to the manual by the Contractor, by means of written or electronic notice, to be sent thirty (30) days in advance of the implementation of the new policy or procedure.
- A.45. Practice Guidelines: The Contractor shall adopt practice guidelines that meet the following requirements:
- a. Must comply fully with TennCare Medical necessity rule found at 1200-13-16;
 - b. Are based on valid and reliable clinical evidence or a consensus of health care professional in a particular field;
 - c. Consider the needs of the enrollees;
 - d. Are adopted in consultation with contracting health care professionals;
 - e. Are reviewed and updated periodically as appropriate; and
 - f. Are disseminated to all affected providers and, upon request, to enrollees and potential enrollees.

NETWORK DEVELOPMENT AND MANAGEMENT

- A.46. Providers Providing On-going Treatment. If an enrollee is in a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services to such enrollee and the Contractor is aware of such ongoing course of treatment, the Contractor shall immediately provide written notice immediately on the date that the Contractor becomes aware of such unavailability to such enrollee. Each notice shall include all components identified in the notice template to be provided by TennCare. The timing requirement for the provision of this notice shall be waived in instances where a provider becomes physically unable to care for 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.
- A.47. Other Provider Termination: If a provider ceases participation in the DBM, the Contractor shall make a good faith effort to give a thirty (30) day written notice of termination of a contracted provider immediately after receipt or issuance of termination notice to each enrollee who received his/her primary care from or was seen on a regular basis by the terminated provider.
- A.48. Network Deficiency. Upon final notification from TennCare of a network 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. The notice content shall be reviewed and approved by TennCare prior to distribution.



- A.49. Notice of Subcontractor Termination. When a subcontract that relates to the provision of services to enrollees or claims processing is being terminated between the Contractor and a subcontractor, the Contractor shall give at least thirty (30) days prior written notice of the termination to TennCare and the TennCare Division, TDCI. Said notices shall include, at a minimum; a Contractor's intent to change to a new subcontractors for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed to access services. In addition to prior written notice, the Contractor shall also provide TennCare with a transition plan, when requested, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees, etc.
- A.50. Provider Terminations. The Contractor shall notify TennCare of any provider termination and submit a template copy of the enrollee notice sent as well as an electronic listing identifying each enrollee to whom a notice was sent. The Contractor shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TennCare. If the termination was initiated by the provider, said notice shall include a copy of the provider's notification to the Contractor.

PROVIDER AGREEMENTS

- A.51. The Contractor shall assure that medically necessary, covered services as specified in this Contract are provided. The Contractor shall enter into agreements with providers and/or provider subcontracting entities or organizations which will provide medically necessary services to the enrollees in exchange for payment from the Contractor for services rendered. The Contractor shall ensure that the Provider Agreement remains up-to-date and reflects applicable law or revisions to TennCare rules and Contractor policy. The initial provider template and revisions thereto must be submitted to TennCare and the TDCI for review and approval prior to distribution. Participating providers shall be apprised of revisions to the Provider Agreement by the Contractor through written notice thirty (30) days in advance of the implementation of the new template.

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 make every effort to enter into provider agreements that promote the concept of a true "dental Home" defined here as a dental practice that maintains an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, medically necessary, continuously accessible and coordinated way. Mobile clinic providers should only be utilized in areas underserved by community providers willing to provide a dental home for TennCare members. 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.

Credentialing of providers with multiple service locations - Except for public health or accredited schools of dentistry in Tennessee, no entity owning or operating multiple practice locations nor any individual provider nor group of providers operating multiple practice locations, may be credentialed by the Contractor at more than one location at the time of the initial credentialing by the Contractor. All requests for satellite office credentialing will be based upon proven delivery of good quality dental care at the initial location and subject to careful individual review of the new location's dentist, dental associates and entire dental staff. The requirement of one initial location may be waived, at the sole discretion of the Contractor, only for providers in good standing who are current TennCare providers, with a proven record of delivery of quality dental care, at the time of the Contract start date. Prior to credentialing satellite offices, the Contractor must conduct a thorough and documented site visit which takes into account the impact of the satellite on existing



TennCare dental provider network in that community. Such documentation must be made available to TennCare on request.

- A.52. 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 TennCare 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
- A.53. 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.54. The Contractor shall not execute a Provider Agreement with any Provider Person or Provider Entity that does not have a valid TennCare Provider ID number. The Contractor shall verify each individual and group TennCare Provider ID with TennCare electronically utilizing a means specified by TennCare. TennCare will provide demographic and other data for each individual and group provider authorized by TennCare to be used by the Contractor. Providers without a TennCare Provider ID number should be directed to the TennCare Provider Portal through which the provider can provide the necessary information to receive a valid TennCare ID number. The Contractor shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who do not meet all the parameters of the credentialing process as outlined in Section A.119. 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.55. All provider agreements executed by the Contractor, and all provider agreements executed by subcontracting entities or organizations, pursuant to this Section shall, at a minimum, meet the following requirements: (No other terms or conditions agreed to by the Contractor and provider shall negate or supersede the following requirements.)
- a. Be in writing. All new provider agreements and existing provider agreements as they are renewed, must include a signature page that contains Contractor and provider names, which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties;
 - b. Specify the effective dates of the provider agreement;
 - c. Specify in the provider agreement that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;
 - d. Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without approval of the Contractor and state that any claims submitted or paid under such unapproved contracts are considered to be false claims and subject to recoupment by either Contractor or the Bureau of TennCare;
 - e. Identify the population covered by the provider agreement;
 - f. Specify that provider may not refuse to provide medically necessary or covered services to a TennCare 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 TennCare cost share responsibilities prior to receiving non-emergency services. However, the provider shall not be required to accept or continue treatment of an enrollee with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

- g. Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;
- h. Specify the amount, duration and scope of services to be provided by the provider; specify that the provider comply with TennCare medical necessity rules listed at 1200-13-16;
- i. Provide that emergency services for eligible enrollees under age 21 be rendered without the requirement of prior authorization. However, the required documentation must be submitted post-treatment for retro authorizations in order for the dentist to receive payment.
- j. If the provider performs laboratory services, the provider must meet all applicable requirements of the Clinical Laboratory Improvement Act (CLIA) of 1988 at such time that the Center for Medicare and Medicaid Services (CMS) mandates the enforcement of the provisions of CLIA;
- k. Require that an adequate record system be maintained for recording services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement). Such records must be legible and appropriately signed by the rendering provider. Enrollees and their representatives shall be given access to the enrollees' dental records, to the extent and in the manner provided by T.C.A. §§ 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When a patient-provider relationship with a TennCare provider ends and the enrollee requests that dental records be sent to a second TennCare provider who will be the enrollee's primary dentist, the first provider shall not charge the enrollee or the second provider for providing the dental records;
- l. Require that any and all records be maintained for a period not less than five (5) years from the close of the agreement and retained further if the records are under review or audit until the review or audit is complete. Said records shall be made available and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of authorized representative of the Contractor or TennCare and other authorized federal and state personnel;
- m. Provide that TennCare, U.S. Department of Health and Human Services, Tennessee State Board of Dentistry, Tennessee Bureau of Investigation (TBI) State auditors, and other agencies as designated by TennCare, shall have the right to evaluate through inspection, whether announced or unannounced, or other means any records pertinent to this Contract including quality, appropriateness and timeliness of services and such evaluation, and when performed, shall be performed with the cooperation of the dental provider. Upon request, the dental provider shall assist in such reviews including the provision of complete copies of records, reports or any other media whether electronic or hardcopy. ;
- n. Provide for monitoring, whether announced or unannounced, of services rendered to enrollees pursuant to the agreement between the provider and the Contractor and that



services are compliant with all current, modified or future decrees, court orders, or judgments that are required of TennCare;

- o. Whether announced or unannounced, provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and appeal procedures established by the Contractor and/or TennCare;
- p. Specify that the Contractor shall monitor the quality of services delivered under the agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TennCare. In the event of a conflict between a Providers opinion as to the appropriate level of care and the TennCare medical necessity rules in 1200-13-16, the TennCare medical necessity rules shall prevail as the controlling standard;
 - 1. Specify that the Contractor initiate corrective action if a participating provider is not complying with state and federal laws and regulations and TennCare policies;
 - 2. Require that the provider comply with corrective action plans initiated by the Contractor or be subject to recoupment of funds, termination or other penalties determined by TennCare;
- q. Provide for submission of all reports and clinical information required by the Contractor;
- r. Require dental providers safeguard information about enrollees according to applicable state and federal laws and all HIPAA regulations including, but not limited to, 42 C.F.R. § 431, Subpart F, and all applicable Tennessee statutes and TennCare rules and regulations;
- s. Provide the name and address of the official payee to whom payment shall be made;
- t. Make full disclosure of the method and amount of compensation or other consideration to be received from the Contractor;
- u. Provide for prompt submission of information needed to make payment;
- v. 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.76 of this Contract;
- w. 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;
- x. 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;



- y. 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;
- z. 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;
- aa. Provide that any changes in applicable federal and state laws and regulations, TennCare rules and policies and Contractor policies or revisions to the Provider Manual or current or future court orders, and revisions of such laws or regulations shall be followed as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the Contractor and provider agree to negotiate further any amendment as may be necessary to correct any inequities;
- bb. Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc);
- cc. Specify that both parties recognize that in the event of termination of this Contract between the Contractor and TennCare for any of the reasons described in Section E.4 of this Contract, the provider shall immediately make available to TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the Contractor/provider agreement. The provision of such records shall be at no expense to TennCare;
- dd. 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);
- ee. 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;
- ff. 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;
- gg. 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;

- hh. Specify that the dental provider shall comply with the appeal process by providing all required records and documentation in a timely fashion as provided in the *Grier* Revised Consent Decree including but not limited to assisting an enrollee by providing appeal forms and contact information including the appropriate address for submitting appeals for state level review;
- ii. 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;
- jj. 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;
- kk. 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.97 – A.98 of this Contract, or includes language that states those requirements;
- ll. 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 ;
- mm. Specify that in the event that TennCare deems the Contractor unable to timely process and reimburse claims and requires the Contractor to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the Contractor's contracted reimbursement rate or the rate established by TennCare, whichever is greater;
- nn. 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;
- oo. The provider agreements shall include the following nondiscrimination provisions: Specify that the provider agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the provider on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal and, State laws and regulations;
 - 1. Specify that the provider have written procedures and policies for the provision of free language interpretation and translation services including auxiliary aids and services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;



2. Require the provider to agree to cooperate with TennCare and the Contractor during discrimination complaint investigations, and
 3. Require the provider to assist TennCare enrollees in obtaining discrimination complaint forms and contact information for the Contractor's Nondiscrimination Office.
- pp. 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,
- qq. 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
- rr. 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.56. 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.
- A.57. 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.58. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.
- A.59. The Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient:
- a. for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
 - b. for any information the enrollee needs in order to decide among all relevant treatment options;
 - c. for the risks, benefits, and consequences of treatment or non-treatment; and
 - d. for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- A.60. The Contractor shall ensure that the dental provider shall use the best available information to identify enrollees with primary insurance other than TennCare. TennCare is always the payor of last resort. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the Contractor receives notification from TennCare of the enrollee's eligibility.



- A.61. 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.62. The Contractor shall give TennCare and TDCI, immediate notification in writing by Certified Mail of any administrative or legal action or complaint filed regarding any claim made against the Contractor by a provider or enrollee which is related to the Contractor's responsibilities under this Contract, including but not limited to notice of any arbitration proceedings instituted between a provider and the Contractor. The Contractor shall ensure that all tasks related to the provider agreement are performed in accordance with the terms of this Contract.
- A.63. The Contractor is not 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. The Bureau of TennCare requires that dental practices providing services to TennCare enrollees be controlled by licensed dentists. No practice in which majority ownership or majority partnership interests are controlled by a non-licensed dentist(s) shall be allowed to contract with the program. Change in ownership of any practice requires a re-credentialing of the practice. A change in ownership which results in licensed dentist(s) having less than majority ownership will preclude the entity from being re-credentialled with the TennCare program.

SUBCONTRACTORS

- A.64. Legal Responsibility. The Contractor shall be responsible for the administration and management of all aspects of this Contract and the health plan covered thereunder. If the Contractor elects to utilize a subcontractor, the Contractor shall assure that the subcontractors shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractors for purposes of this Contract, without approval of the Contractor. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the Contractor to TennCare to assure that all activities under this Contract are carried out. Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the Contractor provided the services directly (i.e. no balance billing by providers). The Contractor must ensure that it evaluates each prospective subcontractor's ability to perform the activities to be delegated and must specify in a written agreement with the subcontractors the activities and report responsibilities delegated to the subcontractors. Contractor must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. The Contractor's written agreement with the subcontractors must address the methodology for identifying deficiencies and providing corrective action plans.
- A.65. Prior approval. All subcontracts and revisions thereto shall be approved in advance by TennCare. All subcontracts shall be maintained in accordance with the applicable terms of this Contract. Once a subcontract has been executed by all of the participating parties, a copy of the signature page of the pre- approved contract fully executed subcontract shall be sent to the State within thirty (30) days of execution.
- A.66. Nondiscrimination Provisions. If the Contractor delegates its responsibilities under this Agreement to subcontractors, the Contractor shall require the direct service subcontractors to comply with the following nondiscrimination requirements:
- a. Specify that the subcontractor agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of the delegated responsibilities pertaining to this Contract or in the employment practices of the subcontractor on the grounds of handicap,



and/or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal and State laws and regulations;

- b. Specify that the subcontractor have written procedures and policies for the provision of free language interpretation and translation services including auxiliary aids and services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;
 - c. Require the subcontractor to agree to cooperate with TennCare and the Contractor during discrimination complaint investigations, and
 - d. Require the subcontractor to assist TennCare enrollees in obtaining discrimination complaint forms and contact information for the Contractor's Nondiscrimination Office.
- A.67. Assignability. Claims processing subcontracts must include language that requires that the subcontract agreement shall be assignable from the Contractor to the State, or its designee: i) at the State's discretion upon written notice to the Contractor and the affected subcontractors; or ii) upon Contractor's request and written approval by the State. Further, the subcontract agreement must include language by which the subcontractors agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the Contractor.
- A.68. Claims Processing. All claims for services furnished to a TennCare enrollee filed with the Contractor must be processed by either the Contractor or by one (1) subcontractors retained by the organization for the purpose of processing claims.
- A.69. HIPAA Requirements. The Contractor shall require all its subcontractors adhere to the HIPAA regulation requirements.
- A.70. Notice of Subcontractor Termination. When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated between the Contractor and a subcontractors, the Contractor shall give at least thirty (30) days prior written notice of the termination to TennCare and the TennCare Division, TDCI. Such notice shall include, at a minimum, a Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide TennCare with a transition plan, when requested, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees, etc. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated damages or intermediate sanctions as described in Attachment B and Section E.4. of this Contract. TennCare reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.
- A.71. Notice of Approval. Approval of subcontracts shall not be considered granted unless TennCare issues its approval in writing.
- A.72. Subcontract Relationship and Delegation: If the Contractor delegates responsibilities to a subcontractors, the Contractor shall assure that the subcontracting relationship and subcontracting document(s) comply with the requirements of the Balanced Budget Act of 1997, including but not limited to, compliance with the applicable provisions of 42 CFR § 438.230(b) and 42 CFR§ 434.6 as described below.
- a. The Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.



- b. The Contractor shall require that the agreement be in writing and specifies the activities and report responsibilities delegated to the subcontractors, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- c. The Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review consistent with industry standards or State MCO laws and regulations.
- d. The Contractor shall identify deficiencies or areas for improvement and the Contractor and the subcontractors shall take corrective action as necessary.

CLAIMS PROCESSING REQUIREMENTS

A.73. 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.74. Electronic Billing System. The Contractor shall maintain an electronic data processing system for Claims payment and processing and shall implement an electronic billing system for interested Participating Dental Providers. All Participating Dental Providers should be strongly encouraged and provided the training necessary to submit their claims electronically. The Contractor or any entities acting on behalf of the Contractor shall not charge providers for filing claims electronically. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The Contractor shall comply at all times with standardized paper billing forms/format as follows:

<u>Claim Type</u>	<u>Claim Form</u>
<i>Dental</i>	<i>ADA</i>

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

A.76. Timeliness and Accuracy of Payment. The Contractor agrees to comply with prompt pay claims processing requirements in accordance with T.C.A. §56-32-126 and shall ensure that ninety percent (90%) of claims for payment of services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of receipt of such claims. The Contractor shall process, and if appropriate pay, within sixty (60) days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program. "Pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to Contractor. "Process" means the Contractor must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If



a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. If requested by the provider, the Contractor shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment. The status report shall contain appropriate explanatory remarks related to payment or denial of the claims. The Contractor shall contract with independent reviewers for the purposes of said reviewers to review disputed claims as provided by T.C.A. § 56-32-126. 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 and/or immediate sanctions as described in Section E.4 and Attachment B of this Contract.

- A.77. Except where required by this Contract or by applicable federal or state law, rule or regulation, the Contractor shall not make payment for the cost of any dental care provided prior to the effective date of eligibility in the Contractor's plan. The Contractor shall make payment for the cost of any covered services obtained on or after 12.01 a.m. on the effective date of eligibility in the Contractor plan.
- A.78. 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 plan, the Contractor shall reimburse the provider in accordance with Section A.141 of this Contract. If the service was provided by an out of network provider, whom the Contractor has agreed to pay only for a specific service, the Contractor shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure. The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor or appropriate denial made by the Contractor.

MANAGEMENT INFORMATION SYSTEMS REQUIREMENTS

- A.79. Data Mapping. The Contractor shall complete all data mapping necessary to submit information to TennCare and respond to information provided by TennCare. This will consist of a cross-reference map of required TCMIS data and Contractor system data elements and data structures. TennCare will make any necessary data formats available to the Contractor.
- A.80. Daily Enrollment Updates. The Contractor must have a procedure to maintain and update enrollee profiles that is capable of processing daily updates.
- A.81. Contractor MIS Interface Requirements. Successful operation of the program requires ongoing interfaces with TCMIS and the Contractor MIS. The TennCare interface standard for data transfers will be via 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.82. Requirements Prior To Operations
- a. Licensure
1. Before the start date of operations and prior to accepting TennCare enrollees, the Contractor must hold all necessary, applicable business and professional licenses, including appropriate licensure from the Tennessee Department of Commerce and Insurance (TDCI). The Contractor must hold a license to act as an Administrator pursuant to Tennessee Code Annotated § 56-6-410, unless



otherwise licensed pursuant to Tennessee Code Annotated § 56-6-401(3). The contract must include evidence that the Contractor either holds a current license to act as an Administrator in Tennessee or has submitted an application to TDCI to obtain such licensure.

2. If the contract is amended to require the Contractor to bear financial risk of TennCare covered dental services, the Contractor must obtain an appropriate license from TDCI to operate as a risk-bearing entity prior to the start date of such operations.
3. Prior to the start date of operations, the Contractor shall ensure that its staff, all subcontractors and providers, and their staff are appropriately licensed.
4. The Contractor shall ensure that the Contractor and its staff, all subcontractors and staff, and all providers and staff retain at all times during the period of this Contract a valid license, as appropriate, and comply with all applicable licensure requirements.

b. Readiness Review

1. Prior to the start date of operations, as determined by TennCare, the Contractor shall demonstrate to TennCare's satisfaction that it is able to meet the requirements of this Contract.
2. The Contractor shall cooperate in a readiness review conducted by TennCare to review the Contractor's readiness to begin operations. This review may include, but is not limited to, desk and on-site review of documents provided by the Contractor, a walk-through of the Contractor's operations, system demonstrations (including systems connectivity testing), and interviews with Contractor's staff. The scope of the review may include any and all requirements of this Contract as determined by TennCare.
3. The Contractor shall work in cooperation with TennCare to ensure that their information system, claims processing system, encounter files, eligibility files and all other systems, files and/or processes satisfy all functional and informational requirements of TennCare's dental program. The Contractor will assist TennCare in the analysis and testing of these systems prior to the delivery of services. The Contractor shall provide system access to allow TennCare to test the Contractor's system through the TennCare network. Any software or additional communications network required for access shall be provided by the Contractor.
4. Based on the results of the review activities, TennCare will issue a letter of findings and, if needed, will request a corrective action plan from the Contractor. TennCare enrollees may not be enrolled with the Contractor until TennCare has determined that the Contractor is able to meet the requirements of this Contract.
5. If the Contractor is unable to demonstrate its ability to meet the requirements of this Contract, as determined by TennCare, within the time frames specified by TennCare, TennCare may terminate this Contract in accordance with Section D.4 of this Contract and shall have no liability for payment to the Contractor.

A.83. Provider Assistance. The Contractor shall be available Monday thru Friday, 7:00 am – 5:00 pm Central Time and corresponding hours during periods of Daylight Savings Time to respond to provider inquiries related to prior approval and claims status.

A.84. Help Desk for Prior Approval Operations. The Contractor shall maintain a toll-free telephone access to support the prior approval process, available between the hours of 7:00 a.m. and 5:00 pm, Central Time, Monday through Friday to respond to questions about Prior Approval Requests.

A.85. Data Validation Edits and Audits. The Contractor's claims processing system must perform the following validation edits and audits:



- a. **Prior Approval** - The system shall determine whether a covered service requires prior approval, and if so, whether approval was granted by the Contractor;
 - b. **Valid Dates of Service** - The system shall assure that dates of services are valid dates, are no older than one hundred eighty (180) days from the date of prior approval, if such prior approval was required, and are not in the future. For orthodontics, the system must assure that dates of service are valid dates meeting TennCare Rules 1200-13-13.04 and 1200-13-14.04;
 - c. **Duplicate Claims** - The system shall automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate;
 - d. **Covered Service** - The system shall verify that a service is a valid covered service and is eligible for payment under the TennCare dental benefit for that eligibility group;
 - e. **Provider Validation** - The system shall approve for payment only those claims received from providers eligible to provide dental services and have a National Provider Identifier (NPI) per HIPAA Legislation requirements;
 - f. **Enrollee Validation** - The system shall approve for payment only those claims for enrollees eligible to receive dental services at the time the service was rendered;
 - g. **Eligibility Validation** - The system shall confirm the enrollee for whom a service was provided was eligible on the date the service was incurred;
 - h. **Quantity of Service** - The system shall validate claims to assure that the quantity of services is consistent with TennCare rules and policy;
 - i. **Rejected Claims** - The system shall determine whether a claim is HIPAA compliant and therefore acceptable for adjudication and reject claims that are not, prior to reaching the adjudication system, and,
 - j. **Managed Care Organizations** - The system shall reject or deny claims that should rightly be processed and paid by an enrollee's MCO for any and all physical health treatments.
- A.86. **Prior Approval Request Tracking.** Each prior approval 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.87. **System Security.** The Contractor shall apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and to communicate the results in a Information Security Plan provided prior to the delivery of services. The risk analysis shall also be made available to appropriate Federal agencies. The following specific security measures should be included in the system design documentation and operating procedures:
- a. Computer hardware controls that ensure acceptance of data from authorized networks and providers only;
 - b. At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes;
 - c. Manual procedures that provide secure access to the system with minimal risk;



- d. Multilevel passwords, identification codes or other security procedures that shall be used by State agency or Contractor personnel;
 - e. All Contractor MIS software changes are subject to TennCare approval prior to implementation, and
 - f. System operation functions shall be segregated from systems development duties.
- A.88. Disaster Preparedness and Recovery at the Automated Claims Processing Site. The Contractor shall submit evidence that they have a Business Continuity/Disaster Recovery plan for their Central Processing Site. If requested, test results of the plan shall be made available to TennCare. The plan shall be able to meet the requirements of any applicable state and federal regulations, the TennCare Bureau and Tennessee's OIR. The Contractor's Business Continuity/Disaster Recovery Plan shall include sufficient information to show that they meet the following requirements:
- a. Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation shall be in the form of a formal Disaster Recovery Plan. The Contractor shall apply recognized industry standards governing Disaster Preparedness and Recovery including the ability to continue processing in the event that the central site is rendered inoperable;
 - b. Employees at the site shall be familiar with the emergency procedures;
 - c. Smoking shall be prohibited at the site;
 - d. Heat and smoke detectors shall be installed at the site both in the ceiling and under raised floors (if applicable). These devices shall alert the local fire department as well as internal personnel;
 - e. Portable fire extinguishers shall be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested;
 - f. The site shall be protected by an automatic fire suppression system, and
 - g. The site shall be backed up by an uninterruptible power source system.
- A.89. Transition Upon Termination Requirements. At the expiration of this Contract, or if at any time the state should terminate this Contract, the Contractor shall cooperate with any subsequent Contractor who might assume administration of the dental benefits program. TennCare shall withhold final payment to the Contractor until transition to the new Contractor is complete. The state will give the Contractor thirty (30) days notice that a transfer will occur.

COVERED BENEFITS

- A.90. Covered Benefits - The Contractor shall provide or arrange for the provision of Covered Benefits to enrollees in accordance with the terms of this Contract, including but not limited to, Section A.4 of this Contract.
- A.91. Medical Necessity Determination - All Medical Necessity Determinations shall abide by the specific definitions and guidelines set forth in the statutes and TennCare Rules, including T.C.A. § 71-5-144 and TennCare Rules 1200-13-16-.01 through 1200-13-16-.08, and any and all amendments and/or revisions thereof. The Contractor shall not impose service limitations that are more restrictive than the limits described in this Contract. However, this provision shall not limit the Contractor's ability to establish procedures for the determination of medical necessity.



The determination of medical necessity shall be made on a case by case basis. The Contractor shall not employ or permit others acting on its behalf, to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare 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 an enrollee's individual characteristics. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The Contractor may deny services that are non-covered, except as otherwise required by EPSDT or unless otherwise directed to provide by TennCare and/or an administrative law judge. Any procedures used to determine medical necessity shall be consistent with the definition of medical necessity defined by this Contract and applicable TennCare rules. All medically necessary services shall be covered for enrollees under twenty-one (21) years of age, in accordance with EPSDT requirements, including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. Braces may be covered for enrollees age twenty-one (21) and over as per the individual enrollee's Dental Benefit, TennCare Rules 1200-13-13.04 and 1200-13-14.04. Effective upon receipt of written notification from TennCare, the Contractor is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of twenty-one (21).

- A.92. Prior Authorization for Covered Services - The Contractor and/or its subcontractors shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services; have effective mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate. If prior authorization of a service is granted by the Contractor, subcontractor or an agent, payment for the pre-approved service shall not be denied based on the lack of medical necessity, assuming that the enrollee is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances that were described at the time that prior authorization was granted. Prior Authorization shall not be required for emergency services. Prior authorization requests shall be reviewed subject to the guidelines described in TennCare Rules 1200-13-13 and 1200-13-14 that include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request. The Contractor shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of utilization management (UM) decision making. The Contractor shall have written procedures documenting access to Dental Specialty Consultants to assist in making medical necessity determinations. A decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional, who has appropriate clinical expertise in treating the enrollee's condition or disease.
- a. Notice of Adverse Action Regarding Prior Authorization Requests - 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 and to decide about appealing the decision. Notices of adverse actions to providers and enrollees concerning prior authorization requests shall be provided within the following guidelines:
1. Provider Notice - The Contractor shall notify the requesting provider of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. After notice to the provider is issued, the Contractor shall make a reviewer available to discuss any denial decisions. The information given to the provider shall include the contact information for the reviewer.



2. Enrollee Notice - Refer to notice provisions in TennCare Rule 1200-13-13-.11 and 1200-13-14-.11.

- b. Appeals Related to Prior Authorization/Medical Necessity Denials - The Contractor is responsible for eliciting the necessary, pertinent medical history information from the treating health care provider(s) for making medical necessity determinations. If a treating health care provider is uncooperative in supplying needed information, the Contractor shall take action (e.g. sending a provider representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem. Upon request, documentation of such action shall be made available to TennCare. Pursuant to TennCare Rule 1200-13-16-.06(4) providers who do not provide requested medical record information for purposes of making a medical necessity determination for a particular medical item or service, shall not be entitled to payment for the provision of such medical item or service.
- c. The Contractor shall provide the individualized medical record information from the treating health care provider(s) that supports a decision relevant to a medical appeal. The Contractor shall take the necessary action to fulfill this responsibility within the required appeal timelines specified by TennCare and/or applicable regulation. This includes going to the provider's office to obtain the medical record information including but not limited to the provider's treatment plan, records from the referral dentist, Medical records from the primary physician, radiographs, OrthoCAD, study model, study casts, photographs of models, the hospital readiness form and orthodontic readiness form. Should a provider fail or refuse to respond to the Contractor's efforts to obtain medical information and the appeal is decided in favor of the enrollee, then the Contractor shall use its discretion or follow a TennCare directive to impose appropriate financial penalties against the provider.
- A.93. EPSDT. The Contractor shall provide EPSDT services as medically necessary to children under the age of twenty-one (21), who are eligible for EPSDT, in accordance with federal regulations described in 42 CFR part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under twenty-one (21), whether or not such services are covered under the TennCare Program State 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.94. Standards of Care. The standards of care shall be taken from published recommendations of nationally recognized authorities, such as; the American Dental Association; the American Academy of Pediatric Dentistry; and the American Association of Oral and Maxillofacial Surgeons. The standard of care for the community shall be recognized. Participating Dental Providers shall not differentiate or discriminate in the treatment of any enrollee on the basis of race, color, sex, religion, national origin, age, handicap, health, economic status, or payment source. In the event of a conflict between a Providers opinion as to the appropriate standard of care and the TennCare medical necessity rules in 1200-13-16 the TennCare medical necessity rules shall provider the controlling standard.
- A.95. Transportation. Transportation to covered services is a covered service for TennCare enrollees and is the responsibility of the enrollee's MCO. Should transportation to a dental service be necessary for an enrollee, the Contractor shall coordinate with the appropriate MCO to ensure that the transportation is provided.
- A.96. Coordination with and Management of Public Health's School Based Dental Encounter Data Files. The Contractor shall manage the encounter data files for TennCare enrollees seen in the Tennessee Department of Health's School Based Screening Referral, Follow-up, Sealant and TennCare Oral Evaluation and Outreach Program (SBDPP) in accordance with the specifications, format and timeframes outlined in the Bureau of 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.18. of this Contract. Close coordination between the Oral Health Services Section of the Tennessee Department of Health and the Contractor will be necessary to facilitate referral arrangements and to ensure that encounter data files from the SBDPP are incorporated into encounter data files provided to TennCare.

EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

- A.97. EPSDT Dental Services. Contractor shall require Dental Providers to follow practice guidelines for preventive health services identified by TennCare including EPSDT. EPSDT includes timely provision of exams, cleaning, fluoride treatment, sealants and referral for treatment of Child Enrollees. Performance objectives have been established for providing EPSDT services. Contractor will be evaluated on those performance objectives using the annual CMS 416 report which measures the following: any dental service provided using ADA CDT codes D0100- D9999; preventive dental services provided using ADA CDT codes D1000-D1999 and dental treatment services provided using ADA CDT codes D2000-D9999.
- A.98. Contractor's Outreach Activities. The Contractor shall conduct regularly scheduled outreach activities designed to educate enrollees about the availability of EPSDT services and to increase the number of children receiving services.
- a. Within forty-five (45) days of execution of this Contract, the Contractor shall submit a proposed outreach plan.
 1. The Contractor's plan shall identify the target population, service areas, specific outreach activities, schedule for completion and include copies of any material to be released to enrollees.
 2. The proposed plan and any related material shall require approval by TennCare. TennCare shall have thirty (30) days to review material and provide notice of approval or notice to make changes.
 3. A minimum of seventy-five (75) outreach events per year shall be conducted with no less than fifteen (15) per quarter, equally distributed across all three regions. At least twenty-five (25) of the member related activities and/or events must be conducted in rural areas each year. Results of the Contractor's dental screening rates as well as county demographics must be utilized in determining counties for targeted activities and in developing strategies for specific populations.
 4. The Contractor shall contact a minimum of twenty-five (25) state agencies or community-based organizations per quarter, to either educate them on services available through the Contractor or to develop outreach and educational activities. Collaborative activities should include those designed to reach enrollees with limited English proficiency, special health care needs, or those who are pregnant.
 5. The Outreach Plan shall be updated annually and submitted by November 30 in a format specified by TennCare. An annual evaluation of the Plan shall be due no later than ninety (90) days following the end of a calendar year in a format approved by TennCare. The annual evaluation shall include, but is not limited to, an assessment of the events that were conducted in the previous year.
 6. The Contractor shall be responsible for distributing annual notices to enrollees of their dental benefit encouraging them to schedule a dental appointment.



- b. The Contractor is required to participate in the Managed Care Contractor (MCC) Collaborative, and is required to submit quarterly a dental article for publication in the MCO teen newsletter according to a timeframe prescribed by TennCare.
- c. The Contractor shall submit quarterly reports of outreach activities in a format approved by TennCare.
- d. If the Contractor's TENNderCare dental screening rate is below eighty percent (80%), the Contractor shall conduct a new initiative, approved by TennCare, to increase participation of all children who have not received screenings.

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

COMPLAINTS AND APPEALS

- A.99. Enrollees shall have the right to file appeals regarding adverse actions taken by the Contractor. For purposes of this requirement, an appeal shall mean an enrollee's right to contest verbally or in writing, any adverse action taken by the Contractor to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the Contractor that impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the enrollee or by a person authorized by the enrollee to do so, including but not limited to, a provider with the enrollee's consent. Complaint shall mean an enrollee's right to contest an action taken by the Contractor or service provider that does not meet the definition of an adverse action. The Contractor shall inform enrollees of their complaint and appeal rights in the member handbook in compliance with Contract Section A.9 requirements.
- A.100. The Contractor shall have internal complaint and appeal procedures for enrollees in accordance with TennCare rules and regulations, the TennCare waivers, consent decrees, or court orders governing the appeals process. The Contractor shall devote a portion of its regularly scheduled QMP committee meetings, as described in Section A.116, to the review of received enrollee complaints and appeals.
- A.101. The Contractor shall ensure that punitive action is not taken against a provider that files an appeal on behalf of an enrollee with the enrollee's consent, supports an enrollee's appeal, or certifies that an enrollee's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.
- A.102. The Contractor's appeal process shall provide for a contact person who is knowledgeable of appeal procedures and directs all appeals, whether the appeal is verbal or the enrollee chooses to file in writing to TennCare. Should an enrollee choose to appeal in writing, the enrollee will be instructed to file by mail or by facsimile to the designated TennCare P.O. Box or fax number for medical appeals.
- A.103. The Contractor shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare enrollee. The Contractor shall notify TennCare of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.
- A.104. The Contractor shall educate its staff concerning the importance of the appeals procedure, the rights of the enrollee, and the time frames that action must be taken by the Contractor for the



handling and disposition of an appeal. As part of the appeal procedure, the Contractor shall identify the appropriate individual or body within the plan having the decision-making authority.

- A.105. The Contractor shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the Contractor. However, enrollees shall not be required to use a TennCare approved appeal form in order to file an appeal. Upon request, the Contractor shall provide enrollees TennCare approved appeal form(s);
- A.106. The Contractor shall provide reasonable assistance to all appellants during the appeal process. Neither the Contractor nor TennCare shall prohibit or discourage any individual from testifying on behalf of an enrollee.
- A.107. The Contractor shall require providers to display notices of enrollee's right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations and shall ensure that providers have correct and adequate supply of public notices.
- A.108. The Contractor shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective. TennCare may develop additional appeal process guidelines or rules, including requirements for the content and timing of notices to enrollees, that shall be followed by the Contractor.
- A.109. The Contractor shall provide general and targeted education to providers regarding expedited appeals (described in TennCare rules and regulations), including when an expedited appeal is appropriate and procedures for providing written certification and shall require providers to give written certification concerning whether an enrollee's appeal is an emergency when requested by an enrollee prior to filing such appeal, or upon reconsideration of such appeal by the Contractor when requested by TennCare.
- A.110. The Contractor shall provide notice to contracted providers regarding provider responsibility in the appeal process, including, but not limited to, the provision of medical records and/or documentation described by Section A.92.
- A.111. The Contractor shall urge providers, who feel they cannot order a drug on the TennCare Preferred Drug List (PDL), to seek prior authorization in advance, and to take the initiative to seek prior authorization, change, or cancellation of the prescription when contacted by an enrollee or pharmacy concerning denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.).
- A.112. Enrollee eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium and co-payment responsibilities shall be directed to the Department of Human Services.
- A.113. If determined by TennCare that the Contractor violated the appeal guidelines, TennCare shall require that the Contractor submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by TennCare, including an acceptable corrective action plan, may result in the Contractor being subject to possible liquidated damages as specified in Attachment B.

QUALITY OF CARE

- A.114. Quality and Appropriateness of Care. The Contractor shall prepare for TennCare approval a written description of a Quality Monitoring Program (QMP) as described in Section A.122, 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.115. Committee Meeting Requirements. The Contractor shall provide the TennCare Dental Director with ten (10) days advance notice of all regularly scheduled meetings of the Quality Monitoring Program Committee and Peer Review Committee. To the extent allowed by law, the Dental Director of TennCare, or his/her designee, may attend the committee meetings at his/her option. A copy of the written minutes for each meeting shall be forwarded to TennCare per Sections A.116.f and A.117.f of this contract.

A.116. Quality Monitoring Program (QMP) Committee

- a. The Contractor shall have a QMP Committee with established parameters for the role, structure, and the function of the committee defined. The Committee shall include a designated senior executive who is responsible for program implementation, the Contractor's Dental Director, and dental plan providers.
- b. This Committee shall analyze and evaluate the results of QMP activities, recommend policy decisions, ensure that providers are involved in the QMP, institute needed action, and ensure that appropriate follow-up occurs.
- c. The QMP Committee shall review and approve the written QMP and associated work plan (as described in Section A.122 of this contract) prior to submission to TennCare.
- d. The QMP Committee shall be accountable to the Contractor's Governing Body. The Governing Body of the organization is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the Contractor. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:
 1. Oversight of QMP - There is documentation that the Governing Body has approved the overall QMP and the annual QMP work plan.
 2. QMP Progress Reports - The Governing Body receives written reports at least quarterly from the QMP Committee describing actions taken, progress in meeting QMP objectives, and improvements made.
 3. Program Modification - Upon receipt of regular written reports from the QMP delineating actions taken and improvements made, the Governing Body takes action when appropriate and directs that the operational QMP be modified on an ongoing basis to accommodate review findings and issues of concern within the organization. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Monitoring/ Improvement.
- e. The QMP Committee shall meet on a regular basis (no less than quarterly) with specified frequency to oversee QMP activities. This frequency is sufficient to demonstrate that the structure/committee is following-up with specified frequency to oversee QMP activities.
- f. The Committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review.



g. The Contractor shall provide the Dental Director of TennCare with ten (10) calendar days advance notice of all regularly scheduled meetings of the QMP Committee. To the extent allowed by law, the Dental Director of TennCare, or his/her designee, may attend the QMP Committee meetings at his/her option.

A.117. Provider Peer Review Committee. The Contractor shall establish a Provider Peer Review Committee composed of dentists currently licensed in Tennessee and in good standing with the Tennessee Board of Dentistry. This Committee shall meet regularly (no less than quarterly) as necessary to review the processes, outcomes and appropriateness of dental care provided to enrollees by participating providers. The Contractor will submit the names of proposed committee members to TennCare within thirty (30) days of the execution date of this Contract. The Contractor's Dental Director shall be the Provider Peer Review Committee chairperson. The Committee shall include at least five (5) Participating Dentists who file at least thirty-five (35) TennCare claims per year and not otherwise employed by the current Contractor. This requirement will be waived for the first three (3) months of the contract period if the Contractor can prove an equivalent mechanism for provider peer review during that period.

- a. The Committee shall review and provide detailed written findings, recommendations and appropriate corrective action for any participating dental provider who has provided inappropriate care.
- b. The Contractor shall coordinate with TennCare's Office of Program Integrity regarding imposition of sanctions and any other corrective actions including termination of a Participating Dental Provider who has provided inappropriate care. The Contractor should also notify the Tennessee Board of Dentistry when indicated.
- c. The Contractor shall coordinate with TennCare in regard to issues involving fraud or abuse by any participating dental provider.
- d. The Contractor shall coordinate with TennCare regarding recoupment related to Fraud and abuse.
- e. The Committee shall review and recommend appropriate action on appeals or inquiries provided by Enrollees, Participating Dental Providers, TennCare or other persons regarding quality of care, access or other issues related to TennCare's Dental Program.
- f. The Committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review.

A.118. Advisory Committee. The Contractor shall participate in an Advisory Committee empowered to review and make recommendations to the Contractor and TennCare concerning the dental program. Recommendations approved by the Advisory Committee are not binding to TennCare. The Committee shall meet on a schedule established by TennCare. The Committee shall consist of not more than twenty (20) members, two (2) of whom shall be appointed by the Contractor. The Contractor will submit the names of proposed members to TennCare within thirty (30) days after the execution of this Contract. TennCare shall appoint all other committee members. Members may be selected from participating dentists serving TennCare enrollees and other parties interested in improving oral health care in Tennessee. TennCare shall also appoint the committee chairperson. The Committee shall review and make recommendations regarding other policies of the Contractor relative to services provided under this Contract.

A.119. Credentialing and Recredentialing. 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.



The Contractor is responsible for primary credentialing of providers in accordance with specifications outlined below:

- a. It is the Contractor's responsibility to completely process a credentialing/recredentialing application within thirty (30) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement/contract.
- b. Written Policies and Procedures - The Contractor has written policies and procedures for the credentialing process, which includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, re-certifying and/or reappointment of practitioners.
- c. Oversight by Governing Body - The Governing Body, or the group or individual, to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.
- d. Credentialing Entity - The plan designates a Credentialing Committee or other peer review body which makes recommendations regarding credentialing decisions.
- e. Process - The initial credentialing process obtains and reviews verification of the following information, at a minimum:
 1. Primary Verification:
 - (a) the practitioner holds a current valid license to practice within the State;
 - (b) valid DEA certificate, as applicable;
 - (c) confirmation of highest level of education and training received;
 - (d) professional liability claims history (past five (5) years) from the National Practitioner Data Bank and the State Board of Dentistry; and
 - (e) any sanctions imposed by Medicare, Medicaid, TennCare and/or the Tennessee Board of Dentistry.
 - (f) good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.)
 - (g) any revocation or suspension of a state license or DEA number.
 2. Secondary Verification (self reported)
 - (a) work history – past five (5) years. Verbal explanation for gaps greater than six (6) months, written explanation for gaps greater than one (1) year;
 - (b) the practitioner holds current, adequate malpractice insurance according to the plan's policy;
 - (c) any curtailment or suspension of medical staff privileges (other than for incomplete medical records);



- (d) the application process includes a statement by the applicant and an investigation of said statement regarding:
 - i. any physical or mental health problems that may affect current ability to provide dental care;
 - ii. any history of chemical dependency/substance abuse;
 - iii. history of loss of license and/or felony convictions;
 - iv. history of loss or limitation of privileges or disciplinary activity; and
 - v. current malpractice coverage and limits; and
 - vi. an attestation to correctness/completeness of the application.
3. The Contractor must verify licensure and valid DEA certificate, as applicable, within 180 calendar days prior to the credentialing date.
4. Any information obtained will be evaluated to determine whether any or all of said information would impact a practitioner's ability to conform to the standards established by the Contractor in accordance with the requirements placed on the Contractor by this Contract. The Contractor may decide, based on information obtained in the credentialing process, not to contract with a provider. If credentialing is denied the provider must be notified in writing and the reasons for the denial must be specified.
5. A site review will be required for a dentist's office for which the Contractor receives a complaint from an enrollee.
- f. Recredentialing - A process for the periodic reverification of clinical credentials (recredentialing, reappointment, or recertification) is described in the organization's policies and procedures.
 1. There is evidence that the procedure is implemented at least every three years.
 2. There is verification of State licensure at least every three years.
 3. The Contractor conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all dentists to decide whether to renew the participating dentist agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing on items listed in subsections "f-1" through "f-2" above.
 4. The recredentialing, recertification or reappointment process also includes review of data from:
 - (a) enrollee complaints;
 - (b) results of quality reviews;
 - (c) utilization management;
 - (d) member satisfaction surveys; and



(e) reverification of hospital privileges and current licensure.

- g. Reporting Requirement - There is a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.
 - h. Appeals Process - There is a provider appellate process for instances where the Contractor chooses to reduce, suspend or terminate a practitioner's privileges with the organization.
 - j. If credentialing is denied, the provider must be notified in writing and the reason for the denial must be specified.
- A.120. Standards for Facilities. The Contractor shall maintain standards for facilities in which enrollees receive care. A requirement for adherence to these standards shall be contained in all of the Contractor's provider contracts. These standards address:
- a. Compliance with existing State and local laws regarding safety and accessibility;
 - b. Availability of emergency equipment;
 - c. Storage of drugs, and
 - d. Inventory control for expired medications.
- A.121. Performance Reviews. The Contractor shall cooperate with any performance review conducted by TennCare, including providing copies of all records and documentation arising out of Contractor's performance of obligations under this Contract. Upon reasonable notice, TennCare may conduct a performance review and audit of the Contractor to determine compliance with the Contract. At any time, if TennCare identifies a deficiency in performance, the Contractor shall be required to develop a Corrective Action Plan to correct the deficiency including an explanation of how TennCare enrollees will continue to be served until the deficiency is corrected.
- A.122. Quality Monitoring Program. The CONTRACTOR shall have a written Quality Monitoring Program (QMP) that clearly defines its quality improvement structures, processes, and related activities to pursue opportunities for improvement on an ongoing basis.
- a. At a minimum the QMP shall:
 - 1. Have a QMP Committee that oversees the QMP functions as described in Section A. 116 of this contract.
 - 2. Have an annual work plan that identifies QMP activities, yearly objectives, time frames for completion, and persons responsible for oversight of QMP activities and objectives.
 - 3. Have resources – staffing, data sources and analytical resources – devoted to it. The QMP must have sufficient material resources, and staff with the necessary education, experience, or training, to effectively carry out its specified activities.
 - 4. Be evaluated annually and updated as appropriate.
 - b. The QMP shall also include written processes for taking appropriate Remedial/Corrective Action whenever, as determined under the QMP, inappropriate or substandard services are furnished, or services that should have been furnished were not. These written remedial/corrective action procedures include:
 - 1. Specification of the types of problems requiring remedial/corrective action;
 - 2. Specification of the person(s) or body responsible for making the final determinations regarding quality problems;
 - 3. Specific actions to be taken;
 - 4. Provision of feedback to appropriate dental professionals and staff;
 - 5. The schedule and accountability for implementing corrective actions;



6. The approach to modifying the corrective action if improvements do not occur and,
 7. Procedures for terminating the affiliation with the dental professional.
- c. The Contractor shall use the results of QMP activities to improve the quality of dental health with appropriate input from providers and members.
 - d. The Contractor shall take appropriate action to address service delivery, including continuity and coordination of care, access to care, utilization of services, health education, and emergency services; patient safety; provider; and other QMP issues as they are identified.
 - e. The written QMP, associated work plan, and evaluation of the QMP shall be submitted to TennCare annually. The evaluation of the QMP shall address QM studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP.
 - f. The Contractor shall make all information about its QMP available to providers and members. The Contractor shall include in all its provider contracts and employment agreements, for dentists and non-dentist providers, a requirement securing cooperation with the QMP.

A.123 Performance Improvement Projects (PIPs)

- a. The Contractor shall perform at least one (1) clinical and one (1) non-clinical PIP in a format specified by TennCare.
- b. The Contractor shall ensure that CMS protocols for PIPs are adhered to and that the following are documented for each activity:
 1. Rationale for selection as a quality improvement activity;
 2. Specific population targeted, include sampling methodology if relevant;
 3. Metrics to determine meaningful improvement and baseline measurement;
 4. Specific interventions (enrollee and/or provider);
 5. Relevant clinical practice guidelines, and
 6. Date of re-measurement.
- c. The Contractor shall ensure that the topics selected as PIPs reflect the population served by the Contractor in terms of age groups, disease categories, and special risk status.
- d. The Contractor shall identify benchmarks and set achievable performance goals for each of its PIPs. The Contractor shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.
- e. After three (3) years, the Contractor shall, using evaluation criteria established by TennCare, determine if one or all PIPs should be continued. Prior to discontinuing a PIP, the Contractor shall identify a new PIP and must receive TennCare's approval to discontinue the previous PIP and perform the new PIP.



A.124. Enrollee Rights and Responsibilities. The Contractor shall demonstrate a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities.

- a. **Written Policy and Procedure on Enrollee Rights** - The Contractor shall have a written policy and procedure that recognizes the following rights of enrollees including but not limited to the following:
 - 1. to be treated with respect, and recognition of their dignity and need for privacy;
 - 2. to be provided with information about the organization, its services, the practitioners providing care, and enrollees' rights and responsibilities;
 - 3. to be able to choose dentists within the limits of the plan network, including the right to refuse care from specific practitioners;
 - 4. to participate in decision-making regarding their dental care;
 - 5. to voice complaints or appeals about the organization or care provided;
 - 6. to be guaranteed the right to request and receive a copy of his or her dental records, and to request that they be amended or corrected as specified in 45 CFR part 164;
 - 7. to be guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - 8. to be free to exercise his or her rights, and that that exercise of those rights does not adversely affect the way the DBM and it's providers or the State agency treat the enrollee, and
 - 9. to be guaranteed the right to receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand.

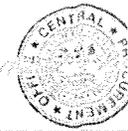
- b. **Written Policy and Procedure on Enrollee Responsibilities** - The Contractor shall have a written policy and procedure that addresses enrollees' responsibility for cooperating with those providing dental care services. This written policy addresses enrollee's responsibility for:
 - 1. providing, to the extent possible, information needed by professional staff in caring for the enrollee; and
 - 2. following instructions and guidelines given by those providing dental care services.

- c. **Communication of Policies to Providers** - A copy of the Contractor's policies and procedures on enrollee's rights and responsibilities is provided to all participating providers.

- d. **Communication of Policies and Procedures to Enrollees** - Upon enrollment, enrollees are provided a written statement that includes information on the following:
 - 1. rights and responsibilities of enrollees;
 - 2. benefits and services included and excluded as a condition of membership, and how to obtain them, including a description of:
 - (a) any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to services obtained outside the system; and
 - (b) the procedures for obtaining out-of-area coverage;
 - 3. provisions for emergency coverage;
 - 4. the organization's policy on referrals for specialty care;
 - 5. charges to enrollees, if applicable, including:
 - (a) policy on payment of charges; and
 - (b) co-payment and fees for which the enrollee is responsible;
 - 6. procedures for notifying those enrollees affected by the termination or change in any benefits, services, or service delivery office/site;



7. procedures for appealing decisions adversely affecting the enrollee's coverage, benefits, or relationship to the organization;
 8. procedures for changing practitioners;
 9. procedures for voicing complaints and/or appeals and for recommending changes in policies and services.
- e. Enrollee Complaint and Appeal Procedures - The organization has a system(s), linked to the QMP, for resolving enrollee's complaints and appeals. This system includes:
1. procedures for registering and responding to complaints and appeals in a timely fashion (organizations should establish and monitor standards for timeliness);
 2. documentation of the substance of complaints or appeals, and actions taken;
 3. procedures to ensure a resolution of the complaint or appeal;
 4. aggregation and analysis of complaint and appeal data and use of the data for quality improvement, and
 5. an appeal process for adverse actions.
- f. Steps to Assure Accessibility of Services - The Contractor shall take steps to promote accessibility of services offered to enrollees. These steps include:
1. the points of access to dental services, specialty care, and hospital or ambulatory surgical center services are identified for enrollees; and
 2. at a minimum, enrollees are given information about:
 - (a) how to obtain services during regular hours of operations;
 - (b) how to obtain emergency care, and
 - (c) how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care.
- g. Written Information for Enrollees shall comply with the requirements of this Contract, which includes, but is not limited to, Sections A.7 through A.10 set forth above -
1. Enrollee information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood.
 2. Written information is available, as needed, in the languages of the major population groups served. A "major" population group is one which represents at least 10 percent of a plan's population or 3,000 enrollees, whichever is less. All vital documents and the member handbook must be available in Spanish. All vital documents are also available to Limited English Proficiency groups identified by TennCare that constitutes five percent (5%) of the TennCare population or 1,000 enrollees, whichever is less.
- h. Confidentiality of Enrollee Information - The organization acts to ensure that the confidentiality of specified patient information and records is protected.
1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records.
 2. The organization requires that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the dental care organization.
 3. The organization shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless:
 - (a) it is required by law;
 - (b) it is necessary to coordinate the enrollee's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment, or
 - (c) it is necessary in compelling circumstances to protect the health or safety of an individual.
 4. Any release of information in response to a court order is reported to the enrollee in a timely manner.



5. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.
- i. Treatment of Minors - - The Contractor has written policies regarding the appropriate treatment of minors.
 - j. Assessment of Enrollee Satisfaction - The Contractor conducts periodic surveys of enrollee satisfaction with its services.
 1. The surveys include content on perceived problems in the quality, availability, and accessibility of care.
 2. As a result of the surveys, the Contractor:
 - (a) identifies and investigates sources of dissatisfaction;
 - (b) outlines action steps to follow-up on the findings, and
 - (c) informs providers of assessment results.
 3. The Contractor reevaluates the effects of the above activities.

A.125. Dental Record Standards.

- a. Accessibility and Availability of Dental Records
 1. The Contractor shall include provisions in provider contracts for appropriate access to the dental records of its enrollees for purposes of quality reviews conducted by the Secretary, TennCare agencies, or agents thereof
 2. Records are available to dental care practitioners at each encounter.
- b. Recordkeeping - Dental records may be on paper or electronic media. The Contractor shall take steps to promote maintenance of dental records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review as follows:
 1. Dental Record Standards - The Contractor sets standards for dental records. These standards shall, at a minimum, include requirements for:
 - (a) Enrollee Identification Information - Each page in the record contains the enrollee's name or enrollee ID number;
 - (b) Personal/biographical Data - Personal/biographical data includes: age; sex; address; employer; home and work telephone numbers; and marital status;
 - (c) Entry Date - All entries are dated;
 - (d) Entry Submission - Written submission of treatment for every date of service;
 - (e) Provider Identification - All entries are identified as to author;
 - (f) Legibility - The record is legible to someone other than the writer. Any record judged illegible by one reviewer should be evaluated by a second reviewer. If still illegible, it shall be considered deficient;
 - (g) Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (No Known Allergies - NKA) is noted in an easily recognizable location;
 - (h) Past Medical History - (for enrollees seen three or more times) Past medical history is easily identified including serious accidents, operations, illnesses. . For orthodontics requested secondary to speech



pathology, obtain speech/language records, or orthodontics requested for a nutritional problem, pediatric records of diagnosis, growth records, and treatment for nutritional deficiency. For children, past medical history relates to prenatal care and birth;

- (i) Immunizations - (for pediatric records ages 12 and under) There is a completed immunization record or a notation that immunizations are up-to-date;
- (j) Diagnostic information;
- (k) Medication information;
- (l) Identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record;
- (m) Smoking/ETOH/Substance Abuse - (For enrollees 12 years and over and seen three or more times) Notation concerning cigarettes and alcohol use and substance abuse is present. Abbreviations and symbols may be appropriate;
- (n) Referrals and Results Thereof, and
- (o) Emergency Care.

2. Enrollee Visit Data – All patient encounters must be recorded in writing and dated. Documentation of individual encounters must provide adequate evidence of, at a minimum:

- (a) History and Physical Examination - Appropriate subjective and objective information is obtained for the presenting complaints;
- (b) Plan of Treatment;
- (c) Diagnostic Tests;
- (d) Treatment rendered, medications by dosage, dispensed or prescribed;
- (e) Proper Monitoring of patients when in-office sedation is administered;
- (f) Appropriate Charting of conditions and treatment;
- (g) Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits;
- (h) Consultations, Referrals and Specialist Reports - Notes from any consultations are in the record. Consultation, lab and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans. Consultations for speech/language pathology include supporting documentation that the condition must be non-responsive to speech therapy without orthodontic treatment, and
- (i) All Other Aspects of Patient Care, Including Ancillary Services. Signature of rendering provider.

c. Record Review Process –

- 1. The Contractor has a record review process to assess the content of dental records for legibility, organization, completion and conformance to its standards.
- 2. The record assessment system addresses documentation of the items listed in Section b. above.

REPORTING REQUIREMENTS



A.126. Data Base. In order to meet information system requirements and to support the timely provision of ad hoc report requests that may be made by TennCare, the Contractor shall maintain a current data base, in a format acceptable to TennCare, capable of retrieving data on short notice. Data stored in the database shall be current through the prior week. At a minimum, the database shall include the following data:

- a. Enrollee Name;
- b. Enrollee Identification Number (SSN);
- c. Enrollee MCO;
- d. Dates of Service;
- e. Specific service provided by procedure ADA Code;
- f. Servicing Provider Number (Medicaid #);
- g. Participating Dental Provider Name;
- h. Payment status;
- i. Billed Charge Amount;
- j. Allowed Amount;
- k. Payment Amount;
- l. Received Date;
- m. Payment Date, and
- n. Any other data element required by common dental practice, ADA Guidelines, federal or state law.

A.127. Reporting Requirements. At a minimum, the Contractor shall provide to TennCare the deliverables related to reports, plans, studies or files including timeframes as outlined in Attachment C.

- a. All deliverables must be presented in a format/record layout approved by TennCare. The Contractor shall also provide such additional reports, or make revisions in the data elements or format of the reports upon request of TennCare without additional charge to TennCare. TennCare shall provide written notice of such requested revisions of format changes in a Notice of Required Report Revisions.
- b. The Contractor shall furnish the TennCare Bureau an electronic Decision Support System (DSS) described as a data gathering and storage system sufficient to meet the requirements of this Contract.
- c. The Contractor shall also furnish TennCare staff with access to the Contractor's DSS allowing TennCare to retrieve paid claims data, along with a user interface that shall allow user defined queries to address managerial concerns that would normally be requested in an ORR. The capability shall not diminish the Contractor's responsibility for responding to requests for ORRs. Contractor shall be responsible to offer assistance to TennCare associates using the Contractor's DSS as needed, including both dental staff and other departmental staff's users.

TennCare may impose liquidated damages or monetary sanctions under Section E.4 and Attachment B of the Contract based upon Contractor's failure to timely submit Standard Reports in the required format and medium.

A.128. 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.129. The Contractor shall report enrollee cost-sharing liabilities on a quarterly basis in the manner and form described by TennCare.



ENROLLMENT AND DISENROLLMENT

- A.130. The Bureau of TennCare is responsible for the enrollment of enrollees in the Contractor's plan. The Contractor shall accept daily eligibility data from the State (DCS or TennCare Select for Immediate eligibility for children in state custody).
- a. The Contractor shall accept the enrollee in the health condition the enrollee is in at the time of enrollment.
 - b. Enrollment shall begin at 12:01 a.m. on the effective date that the enrollee is enrolled in the Contractor's plan and shall end at 12:00 midnight on the date that the enrollee is disenrolled pursuant to the criteria in TennCare policy and/or TennCare rules and regulations. The Contractor shall be responsible for arranging for the provision of services and payment of all covered services during presumptive period of enrollment. In order to give children entering into DCS custody adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility, the Contractor shall accept notice from DCS and/or TennCare Select of TennCare "immediate" eligibility. If the child is not currently enrolled, the Contractor shall immediately build a forty-five (45) day eligibility record effective on the date the child was placed in state custody and identify the child as a child in state custody. The Contractor shall be responsible for arranging for the provision of services and payment of all covered services during immediate eligibility period of enrollment.
 - c. In regards to EPSDT reporting, the Contractor shall continue to only report on those children whose TennCare eligibility status is permanent, who are assigned to the DBM.
- A.131. Disenrollment. The Bureau of TennCare is responsible for the disenrollment of enrollees from the Contractor's plan. The Contractor shall not disenroll enrollees. The Contractor, may, however, provide TennCare with any information it deems appropriate for TennCare's use in making a decision regarding loss of eligibility or disenrollment of a particular Enrollee.
- a. No enrollee shall be disenrolled from a health plan for any of the following reasons: Adverse changes in the enrollee's health; Pre-existing medical conditions; High cost medical bills, a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); or Failure or refusal to pay applicable cost-sharing fees, except when TennCare has approved such disenrollment.
 - b. The Contractor's responsibility for disenrollment shall be to inform TennCare promptly when the Contractor knows or has reason to believe that an enrollee may satisfy any of the conditions for disenrollment described in TennCare policy and/or TennCare rules and regulations. Actions taken by TennCare cannot be grieved by the Contractor.

THIRD PARTY LIABILITY

- A.132. The Contractor may not withhold payment for services provided to a enrollee if third party liability or the amount of liability cannot be determined, or payment will not be available within a reasonable time. All funds recovered from third parties will be treated as offsets to claims payments. The Contractor shall provide any information necessary to assist and shall cooperate in any manner necessary as requested by TennCare, with a Cost Recovery Vendor at such time that TennCare acquires said services.



- A.133. If the Contractor has determined that third party liability exists for part or all of the services administered directly by the Contractor the Contractor shall make reasonable efforts to recover from third party liable sources the value of services rendered. This may be accomplished through the Contractor's provider network and does not require the Contractor to directly recover from third party sources.
- A.134. If the Contractor has determined that third party liability exists for part or all of the services provided to an enrollee by a provider, the Contractor shall pay the provider only the amount, if any, by which the provider's allowable claim exceeds the amount of third party liability. Cost sharing responsibilities permitted pursuant to Section A.5 of this Contract shall not be considered third party resources for purposes of this requirement.
- A.135. The Contractor shall provide Third Party Resource (TPR) data to any provider having a claim denied by the Contractor based upon a TPR. TPR shall include subrogation recoveries. The amount of any subrogation recoveries collected by the Contractor outside of the claims processing system shall be the property of the State. On a monthly basis, the Contractor shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported.

PROVIDER PAYMENT

- A.136. Dental Service Payments. The Contractor shall not be considered to be at financial risk for the provision of covered benefits to enrollees. The Contractor shall prepare checks for payment on at least a weekly basis, unless an alternative payment schedule is approved by TennCare. The Contractor shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 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.137. Interest. Interest generated from the deposit of funds for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the Contractor's bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.
- A.138. Subrogation Recoveries. The amount of provider payments shall be the net of third party recoveries captured on the Contractor's claims processing system prior to notification of TennCare of the amount to be paid. The amount of any subrogation recoveries collected by the Contractor outside of the claims processing system shall be the property of the State. On a monthly basis, the Contractor shall report to the State the amount of any subrogation recoveries collected outside the claims processing system during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported.
- A.139. Service Dates. Except where required by this Contract with TennCare or by applicable federal or state law, rule or regulation, the Contractor shall not make payment for the cost of any medical care provided prior to the effective date of eligibility in the Contractor's plan. The Contractor shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the Contractor's plan.
- A.140. Covered Services. The State shall only assume responsibility for payment of providers for the provision of covered services as specified in Section A.4 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.141. Allowable Rates. TennCare has established and maintained the Provider Reimbursement Fee Schedule for this Contract by which all claims are paid. The Fee Schedule can be accessed at <http://www.tn.gov/tenncare/forms/RFP%2031865-00355%20Fee%20Schedule.pdf>. All dentists and dental specialists will be reimbursed on a fee-for-service basis where one maximum allowable dental fee schedule for all providers is used. The provider will be reimbursed at the lesser of billed charges or the maximum allowable fee listed in the approved dental fee schedule. The Contractor shall not deviate from the approved reimbursement rates, unless TennCare provides written permission to do so.

RISK SHARING REQUIREMENTS

- A.142. The Contractor shall operate as a partial risk-bearing entity for dental services with shared savings and losses as described below. The Contractor must notify the State of any person or corporation that has 5% or more ownership or controlling interest in the entity and such person or corporation must submit financial statements. The Contractor, unless a Federally Qualified HMO, must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the debts if the entity becomes insolvent.
- a. Risk sharing calculations are influenced by three variables: annual service expenditures, annual dental participation ratio (Refer to Attachment E for a description and calculation of the annual dental participation ratio), and percentage risk level chosen by the DBM. To calculate the actual saving or loss amount, the difference between the target service expenditure baseline amount and the actual service expenditure for the period is calculated and savings or loss amounts are multiplied by the appropriate risk level percentage chosen by the DBM. In cases, where the DBM posts a savings, this initial gross bonus payment amount is then adjusted by the participation ratio achieved for the period. This adjustment is designed to ensure that any cost savings come from better management of the program and not from a reduction in the number of enrollees receiving services. If the participation ratio achieved is three (3) or more percentage points below the established target for the period, this would disqualify the DBM from any profit sharing for that period.
 - b. There can only be profit sharing if: a) there is a savings based on the established annual target service expenditure and, b) the Contractor achieves a participation ratio above a specified minimum. The specified minimum in year one (1) is 50.6% at or below which there is no profit sharing awarded despite any savings. Profit sharing will be based upon the following formula: Actual savings achieved, multiplied by the appropriate risk sharing percentage giving the gross bonus payment amount. The gross bonus payment amount will then be reduced at a proportional rate, within a tenth of a decimal point, for each reduction in the participation ratio below the target established. This proportional rate adjustment is called the adjustment factor. The adjustment factor is then applied to the gross savings bonus amount to yield the actual bonus payment amount. Refer to Tables 1 below for sample calculation under this process. There is an upper and lower limit of \$8 million per year in the amount of savings bonuses earned or loss payments made by the contractor.
 - c. An initial target service expenditure baseline will be established by TennCare based on historical trends. Appropriate adjustments to year one (1) target service expenditure



baseline will be made if there are changes to the fee schedule, significant changes to enrollment, or TennCare directed changes to the medical necessity guidelines during the year. In year two (2) and in year three (3) the annual target service expenditure will be adjusted based on the target participation ratio, the prevailing fee schedule, overall utilization patterns, enrollment changes and other budgetary factors. Both the target service expenditure rate and the target participation ratio will be released to the Contractor no later than thirty (30) days after commencement of the fiscal year.

The Contractor will not be penalized for budget overruns, where the increase above target service expenditure amount is also accompanied by a participation ratio which also exceeds the target ratio and the service expenditure is attributable to the participation ratio achieved. Nevertheless, because this scenario does not meet the goal of budget predictability and there is no savings, there will be no bonus sharing either.

- d. The Contractor must meet one of the following licensure requirements to operate as a risk bearing entity.
1. Dental Service Plan – licensed pursuant to TCA Title 56, Chapter 30;
 2. Prepaid Limited Health Service Organization – licensed pursuant to TCA Title 56, Chapter 51;
 3. Insurance Company – licensed pursuant to TCA Title 56, Chapter 2;
 4. Hospital and Medical Service Corporation – licensed pursuant to TCA Title 56, Chapter 29, or
 5. Health Maintenance Organization – licensed pursuant to TCA Title 56, Chapter 32.

Table 1 – Risk Level Scenario Calculations

DBM % Risk Level	Target Participation Ratio			Service Expenditure			Profit	Loss
	Year 1 53.6%	Year 2	Year 3	Year 1 \$174M	Year 2	Year 3		
50%	53.6%			\$164 M			\$5 M	
50%	52.1%			\$164 M			\$2.5M	
50%	50.6%			\$164M			\$0	
50%	53.6%			\$184 M				\$5 M
50%	53.6%			\$194M				\$8 M



PERFORMANCE OBJECTIVES

A.143. Administration and Management. The following performance indicators related to administration and management have been identified for on-going monitoring. The Contractor's failure to meet these benchmarks shall result in the Contractor being required to implement a corrective action plan or application of intermediate sanctions or liquidated damages as specified in Section E.4 and Attachment B of this Contract.

Prompt Pay	Processed Claims	# of claims paid timely in accordance with T.C.A. §56-32-126(b)(1)	100%	90% of provider claims for payment are paid within 30 days and 99.5% are paid within 60 days.
Claims Payment Accuracy	Monthly Claims Activity Report	# of claims paid accurately upon initial submission	100 %	97% accuracy upon initial submission
Approximate Waiting Time for Provider Response	Monthly Response Time Report	Average response time on provider services line	Average response time of 30 seconds	Average response time of 60 seconds
Abandonment rate for Member Services lines	Monthly Response Time Report	Percent of calls not answered; callers hang up while in queue	0 %	Less than 5 %of calls not answered
Approximate Waiting Time for Member Response	Monthly Response Time Report	Average Response Time on Member Services Line	Average response time of 30 seconds	Average response time of 60 seconds

A.144. The following performance indicators related to EPSDT have been identified for on-going monitoring. The Contractor's failure to meet these benchmarks shall result in the Contractor being required to implement a corrective action plan as described in Contract Sections E.4 and Attachment B. Utilization benchmarks may be established by TennCare after discussion with Contractor for specific EPSDT services or procedures.

Annual EPSDT Dental	Claims encounter data; TennCare enrollment data	Dental Screening Percentage (DSP) calculated per John B. Consent Decree (Refer to Attachment G)	80%	Liquidated Damages of \$100,000.00 will be assessed for every 1.0% decrease in DSP below 80%
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A.145. Performance Guarantees. The Contractor agrees TennCare may assess penalties for failure to meet the Performance Guarantees specified below in addition to the intermediate sanctions and liquidated damages specified in Section E.4 and Attachment B. Penalties for failure to meet a performance guarantee shall not be passed on to a provider and/or subcontractors unless the penalty was caused due to an action or inaction of the provider and/or subcontractors. All penalties shall be considered an administrative cost to the Contractor.

Network Adequacy	<p>1. Monthly Provider listing</p> <p>2. Most recent monthly provider listing and random phone surveys conducted by TennCare on a quarterly basis</p>	<p>1. Time and travel distance as measured by GeoAccess</p> <p>2. Network validation</p>	<p>1. Provider network includes sufficient numbers and geographical disbursement of providers in order to satisfy the requirements outlined in the Access and Availability to Care section of this contract, Sections A.18 – A.25.</p> <p>2. At least 90% of records for participating providers on the most recent monthly provider listing can be used to contact the provider and confirm the provider is participating in the DBM's network.</p>	<p>1. \$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis. The penalty may be lowered to \$5,000 in the event that the Contractor provides a corrective action plan that is accepted by TennCare</p> <p>2. \$25,000 if less than 90% of records can be used to contact the provider and confirm participation on a quarterly basis. The penalty may be lowered to \$5,000 in the event that the Contractor provides a corrective action plan that is accepted by TennCare, or waived if the Contractor submits sufficient documentation to demonstrate 90% of providers are participating</p>
Annual Quality Survey	1. Comprehensive audit conducted by EQRO on an annual basis	1. Every state with a managed care Medicaid program is required by federal legislation to have an EQRO assess the quality, timeliness, and accessibility of the	1. 100% overall compliance with Quality Process Standards, Performance Activity File Review, and Credentialing/ Recredentialing	1. An overall compliance score on the annual AQS survey of less than 75% will result in a \$100,000 sanction.



		care and services delivered to enrollees, including assessing provider credentialing/ recertifying activities	Activities as reported in the AQS.	

PROGRAM INTEGRITY

A.146. The Contractor shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program. All provider agreements executed by the Contractor shall:

- a. Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the provider agreement or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions);
- b. Include a statement that as a condition of participation in TennCare, the provider shall give TennCare, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, the Tennessee Bureau of Investigation Medicaid Fraud and Abuse Unit (TBI MFCU), Department of Health and Human Services Office of the Inspector General (DHHS OIG), Department of Justice (DOJ), and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the Contractor, TennCare or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ;
- c. Provide that TennCare, as a condition of payment, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Contract including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Record requests shall be filled as required by as required by 63-2-101(i). In addition, the TBI MFCU/OIG/TennCare Office of Program Integrity shall be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG/TennCare Office of Program



Integrity. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TennCare, the Office of the Inspector General (OIG), TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions;

- d. Require the provider to comply with fraud and abuse requirements of this Contract; and
 - e. Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The provider shall be required to immediately report to the Contractor any exclusion information discovered. The provider shall be informed that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare enrollees;
- A.147. 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.148. The following statement shall be clearly posted in all facilities performing services to TennCare enrollees: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to www.state.tn.us/tenncare and click on 'Report Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."
- A.149. Explanation of Benefits (EOBs) and Related Functions: The Contractor shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TennCare. EOBs shall be designed to address requirements found in 42 CFR 455.20 and 433.116 as well as requirements associated with a change in TennCare policy and may include claims for services with benefits limits. On a monthly basis, the Contractor shall sample a minimum of one hundred (100) claims and associated EOBs. The sample shall be based on a minimum of twenty-five (25) claims per check run. The EOBs shall be examined for correctness based on how the associated claim was processed and for adherence to the EOB requirements. The Contractor shall ensure that the examined EOBs constitute a representative sample of EOBs from all types of services and provider types. To the extent that the Contractor and/or TennCare considers a particular type of service or provider to warrant closer scrutiny, the Contractor shall over sample as needed. Based on the EOBs sent to TennCare enrollees, the Contractor shall track any complaints received from enrollees and resolve the complaints according to its established policies and procedures. The resolution may be enrollee education, provider education, or referral to TennCare, TBI and/or OIG. The Contractor shall use the feedback received to modify or enhance the EOB sampling methodology.
- A.150. The Contractor shall be required to have the following statements contained in its Provider Agreement:
- a. Provider understands that payment TennCare is conditioned upon the invoice or bill and the underlying transaction complying with Medicaid laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute, and the Stark law and federal requirements on disclosure, debarment and exclusion screening), and is conditioned on Subcontractor's compliance with all applicable conditions of participation in Medicaid. Subcontractor understands and agrees that each invoice or bill submitted by



Subcontractor to TennCare constitutes a certification that Subcontractor has complied with all applicable Medicaid laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), in connection with payment and the services provided under this Agreement.

- b. 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.151. Return of Overpayments: In accordance with the Affordable Care Act and TennCare policy and procedures, the CONTRACTOR and its subcontractors and providers shall report overpayments and, when it is applicable, return overpayments within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may result in a penalty pursuant to state or federal law.
- A.152. False Claims Act: The Contractor and its subcontractors and Providers shall comply with the provisions of 42 U.S.C. § 1396a(a)(68) *et seq.*, as applicable, regarding policies and education of employees as regards the terms of the False Claims Act and whistleblower protections.

NON-DISCRIMINATION COMPLIANCE REQUIREMENTS

- A.153. The Contractor shall comply with Section D.7 of this Contract regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.
- A.154. In order to demonstrate compliance with the applicable federal and state civil rights laws and regulations, which include, but are not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, 42 U.S.C.A. § 18116, 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. G, Sec. 508 (d), 123 Stat. 3034, 3279-80), the Contractor shall designate a staff person to be responsible for non-discrimination compliance as required in Section A.17.k(3). This person shall develop a Contractor *Non-discrimination Compliance Training Plan* within thirty (30) days of the execution of this Contract, to be submitted to and approved by the Bureau of TennCare. This person shall be responsible for the provision of instruction regarding the plan to all Contractor staff within sixty (60) days of the execution of this Contract. This person shall be responsible for the provision of instruction regarding the plan to providers and direct service subcontractors within ninety (90) days of the execution of this Contract. The Contractor shall be able to show documented proof of such instruction.
- A.155. The Contractor's *Non-discrimination Compliance Training Plan* shall include written policies and procedures that demonstrate non-discrimination in the provision of services to members. The policy shall *also* demonstrate non-discrimination in the provision of language interpretation and translation services for members with Limited English Proficiency and those requiring auxiliary aids and services (refer to Contract Section A.27.) These policies and procedures shall be prior approved in writing by TennCare.
- A.156. The Contractor shall, at a minimum, emphasize non-discrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.



A.157. The Contractor shall ask all staff to provide their race or ethnic origin and sex. The Contractor is required to request this information from all Contractor staff. Contractor staff response is voluntary. The Contractor is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts.

A.158. The Contractor and its providers and direct service subcontractors shall be required to comply with Title III of the Americans with Disabilities Act of 1990 in the provision of equal opportunities for enrollees with disabilities. In the event that a reasonable modification or effective communication assistance in alternative formats for an enrollee is not readily achievable by the Contractor's providers or direct service subcontractors the Contractor shall provide the reasonable modification or effective communication assistance in alternative formats for the enrollee unless the Contractor can demonstrate that the reasonable modification would impose an undue burden on the Contractor.

A.159. All discrimination complaints against the Contractor, Contractor's employees, Contractor's providers, Contractor's provider's employees and Contractor's subcontractors shall be resolved according to the provisions of this Section.

a. Discrimination Complaints Against the Contractor and/or Contractor's Employees. When complaints concerning alleged acts of discrimination committed by the Contractor and/or its employees related to the provision of and/or access to TennCare covered services are reported to the Contractor, the Contractor's nondiscrimination compliance officer shall send such complaints within two (2) business days of receipt to TennCare. TennCare shall investigate and resolve all alleged acts of discrimination committed by the Contractor and/or its employees. The Contractor shall assist TennCare during the investigation and resolution of such complaints. TennCare reserves the right to request that the Contractor's nondiscrimination compliance officer assist with conducting the initial investigations and to suggest resolutions of alleged discrimination complaints. If a request for assistance with an initial investigation is made by TennCare, the Contractor's nondiscrimination compliance officer shall provide TennCare with all requested information, including but not limited to, the identity of the party filing the complaint; the complainant's relationship to the Contractor; the circumstances of the complaint; date complaint filed; and the Contractor's suggested resolution. TennCare shall review the Contractor's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section A.156.c. below.

b. Discrimination Complaints Against the Contractor's Providers, Provider's Employees and/or Provider's Subcontractors. Should complaints concerning alleged acts of discrimination committed by the Contractor's providers, provider's employees and/or subcontractors related to the provision of and/or access to TennCare covered services be reported to the Contractor, the Contractor's nondiscrimination compliance officer shall inform TennCare of such complaints within two (2) business days from the date Contractor learns of such complaints. The Contractor's nondiscrimination compliance officer shall, within five (5) business days of receipt of such complaints, begin to document and conduct the initial investigations of the complaints. Once an initial investigation has been completed, the Contractor's nondiscrimination compliance officer shall report his/her determinations to TennCare. At a minimum, the Contractor's nondiscrimination compliance officer's report shall include the identity of the party filing the complaint; the complainant's relationship to the Contractor; the circumstances of the complaint; date complaint filed; and the Contractor's suggested resolution. TennCare shall review the Contractor's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section A.156.c. below. TennCare reserves the right to investigate and resolve all complaints concerning alleged acts of discrimination committed by the Contractor's providers, and subcontractors.



- c. Corrective Action Plans to Resolve Discrimination Complaints. If a discrimination complaint against the Contractor, Contractor's employees, Contractor's providers, Contractor's provider's employees, or Contractor's subcontractors is determined by TennCare to be valid, TennCare shall, at its option either (i) provide the Contractor with a corrective action plan to resolve the complaint, or (ii) request that the Contractor submit a proposed corrective action plan to TennCare for review and approval that specifies what actions the Contractor proposes to take to resolve the discrimination complaint. Upon provision of the corrective action plan to Contractor by TennCare, or approval of the Contractor's proposed corrective action plan by TennCare, the Contractor shall implement the approved corrective action plan to resolve the discrimination complaint. TennCare, in its sole discretion, shall determine when a satisfactory discrimination complaint resolution has been reached and shall notify Contractor of the approved resolution. A discrimination complaint resolution corrective action plan may consist of approved nondiscrimination training on relevant discrimination topics. Prior to use, the nondiscrimination training material shall be reviewed and approved by TennCare. Time periods for the implementation of the corrective action plan nondiscrimination training shall be designated by TennCare.
- A.160. The Contractor shall develop and have available a standardized complaint form to provide to a complainant upon request. This complaint form shall be in a format specified by TennCare. The discrimination complaint form shall be provided to TennCare enrollees upon request and in the member handbook. This complaint form shall be available in English and Spanish. When requests for assistance to file a discrimination complaint are made by enrollees, the Contractor shall assist the enrollees with submitting complaints to TennCare. In addition, the Contractor shall inform its employees, providers, and subcontractors how to assist TennCare enrollees with obtaining discrimination complaint forms and assistance from the Contractor with submitting the forms to TennCare and the Contractor.
- A.161. The Contractor shall provide all required reports pursuant to non-discrimination activities as described in this contract.
- A.162. Non-Discrimination Compliance Reports - On an annual basis the Contractor shall submit a copy of the Contractor's non-discrimination policy that demonstrates non-discrimination in the provision of services to members. The policy shall *also* demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring auxiliary aids or services. This shall include a report that lists all language interpretation and translation services including auxiliary aids or services used by the Contractor in providing services to members with Limited English Proficiency and/or handicaps/disabilities. The listing shall identify the providers by full name, address, phone number, languages spoken, and hours services are available.
- A.163. Annually, TennCare shall provide the Contractor with a Nondiscrimination Compliance Plan Template. The Contractor shall answer the questions contained in the Compliance Plan Template and submit the completed Compliance Plan to TennCare within ninety (90) days of the end of the calendar year with any requested documentation, which shall include, but is not limited to, the Assurance of Nondiscrimination. The signature date of the Contractor's Nondiscrimination Compliance Plan shall be the same as the signature date of the Contractor's Assurance of Nondiscrimination. These deliverables shall be in a format specified by TennCare.
- A.164. The Contractor shall submit a quarterly *Non-discrimination Compliance Report* which shall include the following:
- a. A summary listing totaling the number of supervisory personnel by race or ethnic origin and sex. This report shall provide the number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnicity as indicated by TENNCARE and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or

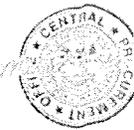


Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin females as indicated by TennCare;

- b. A listing of all complaints filed by employees, members, providers and subcontractors in which discrimination is alleged related to the provision of and/or access to TennCare covered services provided by the Contractor. Such listing shall include, at a minimum, the identity of the party filing the complaint, the complainant's relationship to the Contractor, the circumstances of the complaint, date complaint filed, the Contractor's resolution, date of resolution, and the name of the Contractor staff person responsible for adjudication of the complaint, and
- c. A listing of all member requests for language and communication assistance. The report shall list the member, the member's identification number, the date of the request, the date the service was provided and the name of the service provider.

FRAUD AND ABUSE

- A.165. The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21). The contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities. The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. The Contractor shall suspend payment to any provider upon notification from TennCare that such provider has had a Credible Allegation of Fraud found against them pursuant to Section 6402(h) of the Affordable Care Act. This payment suspension shall be effective from when written notice was received by the Contractor until the Contractor receives notice from TennCare that the payment suspension has been canceled.
- A.166. The Contractor shall cooperate with all appropriate state and federal agencies, including the TennCare Office of Program Integrity and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU), as well as the Office of the Inspector General (OIG),. Additionally, the Contractor shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Contract. The Contractor shall report all confirmed or suspected fraud and abuse to the appropriate agency as follows:
 - a. Suspected fraud and abuse in the administration of the program shall be reported to the TennCare Office of Program Integrity, TBI MFCU, and the OIG, and
 - b. All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU, and the TennCare Office of Program Integrity, and
 - c. All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG.
 - d. The Contractor shall simultaneously notify TBI MFCU and TennCare Office of Program Integrity in a timely manner regarding all internal (such as data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to TennCare providers' billing anomalies and/or to safety of TennCare enrollees
(http://www.ibi.state.tn.us/ibi_tips.shtml; ProgramIntegrity.TennCare@tn.gov).
Along with a notification, the Contractor shall take steps to triage and/or substantiate these tips and simultaneously provide timely updates to TBI MFCU and the TennCare



Office of Program Integrity when the concerns and/or allegations of any tips are authenticated.

- A.167. The Contractor shall use the Fraud Reporting Forms currently used by TennCare Program Integrity or such other form as may be deemed satisfactory by the agency to whom the report is to be made under the terms of this Contract.
- A.168. Pursuant to TCA § 71-5-2603(d) the Contractor shall be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to OIG, the TennCare Office of Program Integrity, or TBI MFCU, as appropriate.
- A.169. The Contractor shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the Contractor shall not take any of the following actions as they specifically relate to TennCare claims:
- a. Contact the subject of the investigation about any matters related to the investigation;
 - b. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
 - c. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- A.170. The Contractor shall promptly provide the results of its preliminary investigation and all administrative, data analytics, financial and medical records relating to the delivery of items or services for which TennCare monies are expended to the TennCare Office of Program Integrity or to another agency upon that agency's request, designated by the agency that received the report and shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation. The State shall not transfer its law enforcement functions to the Contractor.
- A.171. The Contractor and providers shall, upon request and as required by this Contract or state and/or federal law, make available to the TennCare Office of Program Integrity, TBI MFCU, and/or OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TennCare Office of Program Integrity, TBI MFCU, and/or OIG shall be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TennCare Office of Program Integrity, TBI MFCU, and/or OIG. The Contractor shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section.
- A.172. The Contractor shall have a written fraud and abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit within ninety (90) calendar days of Contract execution and annually thereafter. TennCare shall provide notice of approval, denial, or modification to the Contractor within thirty (30) calendar days of receipt. The Contractor shall make any requested updates or modifications available for review to TennCare as requested by TennCare and/or the TennCare Program Integrity Unit within thirty (30) calendar days of a request. The Contractor shall annually provide to the TennCare Office of Program Integrity a complete copy of the Policies and Procedures in use by the Contractor. This copy of



the Policies and Procedures shall also include all updates, including additions and/or deletions, made in the course of the preceding year.

- A.173. The Contractor's fraud and abuse compliance plan shall:
- a. Require that the reporting of suspected and/or confirmed fraud and abuse be done as required by this Contract;
 - b. Ensure that all of its officers, directors, managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;
 - c. Contain procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this Contract; and
 - d. Include a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:
 1. Claims edits;
 2. Post-processing review of claims;
 3. Provider profiling and credentialing;
 4. Prior authorization;
 5. Utilization management;
 6. Relevant subcontractor and provider agreement provisions; and
 7. Written provider and member material regarding fraud and abuse referrals.
 - e. Contain provisions for the confidential reporting of plan violations to the designated person;
 - f. Contain provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports;
 - g. Ensure that the identities of individuals reporting violations are protected and that there is no retaliation against such persons;
 - h. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
 - i. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to the TennCare Office of Program Integrity and TBI MFCU, and that enrollee fraud and abuse be reported to the OIG; and
- A.174. The Contractor shall submit to TennCare Office of Program Integrity an annual *Fraud and Abuse Activities Report*. This report shall summarize the results of its fraud and abuse compliance and other fraud and abuse prevention, detection, reporting, and investigation measures, and should cover results for the fiscal year ending June 30. The report shall be submitted by September 30 of each year in the format reviewed and approved by TennCare as part of the Contractor's compliance plan.
- A.175. The Contractor shall submit to TennCare Office of Program Integrity an annual fraud and abuse compliance plan. On an annual basis, the Contractor shall submit its policies for employees, contractors, and agents that comply with Section 1902(a)(68) of the Social Security Act. These policies shall be submitted by July 1 of each year.
- A.176. The Contactor shall submit to TennCare Office of Program Integrity a Quarterly Utilization Outlier Report listing peer benchmarks and outliers by specialty types and by category of services.



A.177. Effective January 1, 2014, the Contractor shall submit to TennCare Office of Program Integrity a quarterly Disclosure Submission Rate report which shall provide the percentage of providers for which the Contractor has obtained a complete and current disclosure form in accordance with 42 CFR 455, TennCare policies and procedures, and this Contract. The rate shall be provided for all tax-reporting entities with billing activities during the prior quarter. The quarterly report shall include a companion listing which shall include all tax-reporting entities with reimbursement amounts received in the prior reporting quarter along with the disclosure status. For all subcontractors and providers with a signed contract and/or with billing activities, the Contractor shall maintain a minimum of ninety-five percent (95%) compliance on all entities excluding providers who bill under emergency provisions. Should the Contractor attain a disclosure rate below ninety-five percent (95%), the Contractor shall be subject to liquidated damages as specified in Attachment B and shall submit a corrective action plan that shall address the root causes of the non-compliance.

A.178. The Contractor shall submit to TennCare Office of Program Integrity a monthly Program Integrity Exception List report that identifies employees or contractors that have been reported on the HHS-OIG LEIE (List of Excluded Individuals/Entities) (http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp), the Excluded Parties List System (EPLS), and/or the listing of Monthly Disciplinary Actions issued by the Professional Health Board.

A.179. The Contractor shall submit to the TennCare Office of Program Integrity a Quarterly Report, due the last day of the month in the months of January, April, July and October of each year. This report shall include reporting on Program Integrity activities conducted by the plan in the preceding quarter. This plan shall be submitted using an Excel Workbook in the format prescribed by the TennCare Office of Program Integrity and contain the following informational tabs:

- Education/Corrective Action Plans/Referrals
- Recoupments
- Peer Review Files
- Complaint and Review Log
- Tips
- Medical Loss Ratio
- Utilization Review
- Outliers
- Fraud and Abuse Report
- Benchmark Report
- Involuntary Terminations

A.180. The Contractor shall consistently use file name conventions when transmitting any provider files to, TBI MFCU and OIG. The file name convention to be used shall be: <provider last name>_<provider first name>_<file type>_<date>. An example of this would be: Provider_Good_TIP_10312012

File types shall be designated in the following manner:

- CAP = Corrective Action Plan
- COMP = Complaint
- COB = Coordination of Benefits
- EDU = Education
- REF = Fraud Referral
- TIP = Tip

Peer Review Reports shall be named as PRC_<date>. Date shall be given as numeric: 2-digit month, 2-digit day, 4-digit year, with no spaces. Example: PRC_10312012.



A.181. On the 1st and 15th of each month, the contractor shall be required to report any investigation activities that have been designated as either in need of investigation or upon which an investigation has begun, to the TennCare Office of Program Integrity in a format prescribed by TennCare. These activities are known as "TIPS" and should be reported as such. TIPS may or may not lead to a Referral. If an investigated TIP shows evidence of Fraud, Waste or Abuse, it will become a Referral, and should be submitted to the TennCare Office of Program Integrity in a format prescribed by TennCare. All activities surrounding Fraud, Waste and Abuse performed by the contractor shall be reported, in a format prescribed by the TennCare Office of Program Integrity, quarterly.

WEBSITE

A.182. The Contractor shall have available an up-to-date web-site dedicated to TennCare that shall aid providers and enrollees in all aspects of the dental program. The web-site shall be available for TennCare approval at least one (1) month prior to the commencement of claims processing and be available on the internet two (2) weeks prior to the commencement of claims processing. The web-site shall contain a home page with general dental information with links to dedicated areas for providers and enrollees. Each of these sections shall contain information that shall answer, in an interactive format, the majority of questions that each group would ask. This shall include, but is not limited to:

a. Home Page, which includes:

- (1) General information related to dental benefit, and recent changes occurring within the TennCare Dental Program, including pertinent fact sheets, and
- (2) Navigation tool bar that links to enrollee information, provider information, finding a dentist, policy and guidelines.

b. Provider Page, which includes:

- (1) Applying to become a participating provider;
- (2) Provider credentialing and recredentialing;
- (3) Provider Office Reference Manual;
- (4) Current Dental Fee Schedule;
- (5) Program policies and procedures;
- (6) Procedures for obtaining Prior Authorizations (PA's);
- (7) Printable provider education material;
- (8) Provider newsletters;
- (9) Procedures for electronic billing;
- (10) Fluoride varnish program;
- (11) Information about Peer Review Committee, and
- (12) Call Center hours of operation and contact numbers.

c. Enrollee Page, which includes:

- (1) A description of services provided including limitations, exclusions and out-of-network use;
- (2) Member Handbook including provider directory;
- (3) Call Center hours of operation and contact numbers;
- (4) Copay information;
- (5) Transportation assistance;
- (6) Translation assistance;
- (7) Printable education material specific to enrollees, and



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

A.183. The Contractor's system shall be a secure, HIPAA-compliant and data-encrypted electronic system. The system shall have the ability to be easily customized and have interactive communication capabilities to meet the needs of TennCare and its providers. The Contractor shall provide support and maintenance of the website and guarantee any data exchange between the Contractor and TennCare or its providers and enrollees shall be secure and compliant with current HIPAA guidelines concerning data encryption and/or password protection. TennCare shall transmit eligibility/enrollment information to the Contractor by the standard HIPAA 834 transaction defined by the TennCare Companion Guide.

OBLIGATIONS OF THE STATE

A.184. 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 Dental Program.

A.185. 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.186. TennCare shall provide a means for dental providers to verify Enrollee eligibility on line. The Contractor may provide additional means of eligibility verification to its contracted dentists.

A.187. TennCare shall pay the Contractor pursuant to Section C.1 of this Contract for the Contractor's performance of all duties and obligations hereunder. No additional payment shall be made to Contractor by TennCare for the services required under this Contract.

B. CONTRACT TERM:

B.1. This Contract shall be effective for the period beginning May 15, 2013 and ending on September 30, 2016. Actual delivery of services shall begin on October 1, 2013 after completion of transition, should one be necessary, and completion of readiness review. The Contractor hereby acknowledges and affirms that the State shall have no obligation for services rendered by the Contractor which were not performed within this specified contract period.

B.2. Term Extension. The State reserves the right to extend this Contract for an additional period or periods of time representing increments of no more than one year and a total contract term of no more than five (5) years, five (5) months, provided that such an extension of the contract term is effected prior to the current, contract expiration date by means of a contract amendment. If a term extension necessitates additional funding beyond that which was included in the original Contract, an increase of the State's maximum liability will also be effected through contract amendment, and shall be based upon payment rates provided in the original Contract.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Thirty Eight Million One Hundred Thousand Dollars (\$38,100,000.00). The payment rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.



The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the payment rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

C.2. Compensation Firm. The payment rates and the maximum liability of the State under this Contract are firm for the duration of the Contract and are not subject to escalation for any reason unless amended.

C.3. Payment Methodology. The Contractor shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in section C.1.

- a. The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in section A.
- b. The Contractor shall be compensated for said units, milestones, or increments of service based upon the following payment rates:

- (1) For service performed from October 1, 2013, through September 30, 2016, the following rates shall apply:

Service Description	Amount (per compensable increment)
Administrative Fee Per Child (Under Age 21) Eligible for Full Dental Benefit Package	\$ 0.30 per member per month

- (2) Should term extension option be utilized, for service performed from October 1, 2016, through September 30, 2017, the following rates shall apply:

Service Description	Amount (per compensable increment)
Administrative Fee Per Child (Under Age 21) Eligible for Full Dental Benefit Package	\$ 0.30 per member per month

- c. The Contractor shall assume risk levels of at least 20% based on levels submitted in Cost Proposal (Contract Section A.142).



Risk Levels	
DBM assumes 50% of loss	DBM share 50% of any savings

- C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.
- C.5. Invoice Requirements. The Contractor shall invoice the State only after completion of all work, described in section A of this Contract, and present said invoices no more often than required, with all necessary supporting documentation, to:

Division of Health Care Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

- a. Each invoice shall clearly and accurately detail all of the following required information (calculations must be extended and totaled correctly).
- (1) Invoice Number (assigned by the Contractor);
 - (2) Invoice Date;
 - (3) Contract Number (assigned by the State);
 - (4) Customer Account Name: Department of Finance and Administration, Division of Health Care Finance and Administration, Bureau of TennCare
 - (5) Customer Account Number (assigned by the Contractor to the above-referenced State Agency);
 - (6) Contractor Name;
 - (7) Contractor Federal Employer Identification, Social Security, or Tennessee Edison Registration ID Number Referenced in Preamble of this Contract;
 - (8) Contractor Contact for Invoice Questions (name, phone, and/or fax);
 - (9) Contractor Remittance Address;
 - (10) Description of Delivered Service;
- b. The Contractor understands and agrees that an invoice under this Contract shall:
- (1) Include only charges for service described in Contract Section A and in accordance with payment terms and conditions set forth in Contract Section C;
 - (2) Only be submitted for completed service and shall not include any charge for future work;
 - (3) Not include sales tax or shipping charges; and
 - (4) Initiate the timeframe for payment (and any discounts) only when the State is in receipt of the invoice, and the invoice meets the minimum requirements of this section C.5.
- C.6. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice or matter in relation thereto. A payment by the State shall not be construed as acceptance of any part of the work or service provided or as approval of any amount invoiced.
- C.7. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any payment, invoice or payment theretofore made which are determined by the State, on the



basis of audits conducted in accordance with the terms of this Contract, not to constitute proper remuneration for compensable services.

- C.8. Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any Contract between the Contractor and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the Contractor.
- C.9. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following documentation properly completed.
 - a. The Contractor shall complete, sign, and present to the State an "Authorization Agreement for Automatic Deposit (ACH Credits) Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once said form is received by the State, all payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee shall be made by Automated Clearing House (ACH).
 - b. The Contractor shall complete, sign, and present to the State a "Substitute W-9 Form" provided by the State. The taxpayer identification number detailed by said form must agree with the Contractor's Federal Employer Identification Number or Tennessee Edison Registration ID referenced in this Contract.

D. STANDARD TERMS AND CONDITIONS:

- D.1. Required Approvals. The State is not bound by this Contract until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).
- D.2. Modification and Amendment. This Contract may be modified only by a written amendment signed by all parties hereto and approved by both the officials who approved the base contract and, depending upon the specifics of the contract as amended, any additional officials required by Tennessee laws and regulations (said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).
- D.3. Termination for Convenience. The State may terminate this Contract without cause for any reason. Said termination shall not be deemed a Breach of Contract by the State. The State shall give the Contractor at least sixty (60) days written notice before the effective termination date. The Contractor shall be entitled to receive compensation for satisfactory, authorized service completed as of the termination date, but in no event shall the State be liable to the Contractor for compensation for any service which has not been rendered. Upon such termination, the Contractor shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.
- D.4. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to immediately terminate the Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.
- D.5. Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, each shall contain, at a minimum, sections



of this Contract below pertaining to "Conflicts of Interest," "Nondiscrimination," and "Records" (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime contractor and shall be responsible for all work performed.

- D.6. Conflicts of Interest. The Contractor warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed relative to this Contract.

The Contractor acknowledges, understands, and agrees that this Contract shall be null and void if the Contractor is, or within the past six months has been, an employee of the State of Tennessee or if the Contractor is an entity in which a controlling interest is held by an individual who is, or within the past six months has been, an employee of the State of Tennessee.

- D.7. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Contractor shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

- D.8. Prohibition of Illegal Immigrants. The requirements of TCA 12-4-124, *et seq.*, addressing the use of illegal immigrants in the performance of any Contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

- a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment D, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the Contractor and made available to state officials upon request.
- b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the Contractor and made available to state officials upon request.
- c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.
- d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of *Tennessee Code Annotated*, Section 12-4-124, *et seq.* for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services



for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Contract.

- e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.
- D.9. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.
- D.10. 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.11. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.
- D.12. Strict Performance. Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.
- D.13. Independent Contractor. The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.
- The Contractor, being an independent contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Contractor's employees, and to pay all applicable taxes incident to this Contract.
- D.14. State Liability. The State shall have no liability except as specifically provided in this Contract.
- D.15. Force Majeure. The obligations of the parties to this Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, natural disasters, riots, wars, epidemics, or any other similar cause.
- D.16. State and Federal Compliance. The Contractor shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.
- D.17. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract.



The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising there from, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.

- D.18. Completeness. This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.
- D.19. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.
- D.20. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

E. SPECIAL TERMS AND CONDITIONS:

- E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.
- E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by 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. Any such communications, regardless of method of transmission, shall be addressed to the respective party at the appropriate mailing address, facsimile number, or EMAIL address as set forth below or to that of such other party or address, as may be hereafter specified by written notice.

The State:

Deputy Commissioner
Department of Finance and Administration
Division of Health Care Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville TN 37243
(615) 507-6443 (Phone)
(615) 253-5607 (FAX)

The Contractor:

Brett Bostrack, Regional Vice President
DentaQuest USA Insurance Co., Inc.
12121 N. Corporate Parkway
Mequon, Wisconsin 53092
Telephone # 1-800-417-7140 x 43578
Brett.bostrack@dentaquest.com



All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

E.3. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate the Contract upon written notice to the Contractor. Said termination shall not be deemed a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. Should such an event occur, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Upon such termination, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.4. Breach. A party shall be deemed to have breached the Contract if any of the following occurs:

- failure to perform in accordance with any term or provision of the Contract;
- partial performance of any term or provision of the Contract;
- any act prohibited or restricted by the Contract, or
- violation of any warranty.

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

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

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

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

- (3) Partial Default— In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of:



(1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor.

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

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

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

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

E.5. Tennessee Consolidated Retirement System. The Contractor acknowledges and understands that, subject to statutory exceptions contained in *Tennessee Code Annotated*, Section 8-36-801, *et. seq.*, the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to *Tennessee Code Annotated*, Title 8, Chapter 35,



Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor, if a retired member of TCRS, may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the period of this Contract.

- E.6. 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 shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

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

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

- E.7. HIPAA and HITECH Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA) and their accompanying regulations, and as amended.

Contractor warrants to the State that it is familiar with the requirements of HIPAA and HITECH and their accompanying regulations, and shall comply with all applicable HIPAA and HITECH requirements in the course of this Contract including but not limited to the following:

1. Compliance with the Privacy Rule, Security Rule, Notification Rule;
2. The creation of and adherence to sufficient Privacy and Security Safeguards and Policies;
3. Timely Reporting of Violations in the Access, Use and Disclosure of PHI; and
4. Timely Reporting of Privacy and/or Security Incidents.

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



The State and the Contractor shall sign documents, including but not limited to business associate agreements, as required by HIPAA and HITECH and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA and HITECH.

- E.8. As a party to this Contract, the Contractor hereby acknowledges its designation as a covered entity and/or business associate under the HIPAA regulations and agrees to comply with all applicable HIPAA and HITECH (hereinafter "HIPAA/HITECH") regulations. In accordance with HIPAA/HITECH regulations, the Contractor shall, at a minimum:
- a. Comply with requirements of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), including, but not limited to, the transactions and code sets, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data sharing agreements required under the regulations;
 - b. Transmit/receive from/to its providers, subcontractors, clearinghouses and TennCare all transactions and code sets required by the HIPAA/HITECH regulations in the appropriate standard formats, utilizing appropriate and adequate safeguards, as specified under the law and as directed by TennCare so long as TennCare direction does not conflict with the law;
 - c. Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA/HITECH standards, that it will be in breach of this Contract and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between TennCare and the Contractor and between the Contractor and its providers and/or subcontractors to a halt, if for any reason the Contractor cannot meet the requirements of this Section, TennCare may terminate this Contract in accordance with the Business Associate Agreement ancillary to this Contract;
 - d. Ensure that Protected Health Information (PHI) exchanged between the Contractor and TennCare is used only for the purposes of treatment, payment, or health care operations and health oversight and its related functions. All PHI not transmitted for these purposes or for purposes allowed under the federal HIPAA/HITECH regulations shall be de-identified to secure and protect the individual enrollee's PHI;
 - e. Report to TennCare's Privacy Office immediately upon becoming aware of any use or disclosure of PHI in violation of this Contract by the Contractor, its officers, directors, employees, subcontractors or agents or by a third party to which the Contractor disclosed PHI;
 - f. Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the Contractor pursuant to this Section;
 - g. Make available to TennCare enrollees the right to amend their PHI in accordance with the federal HIPAA regulations. The Contractor shall also send information to enrollees educating them of their rights and necessary steps in this regard;
 - h. Make an enrollee's PHI accessible to TennCare immediately upon request by TennCare;
 - i. Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services



for the purposes of determining compliance with the HIPAA/HITECH regulations upon request;

- j. Create and adopt policies and procedures to periodically audit adherence to all HIPAA/HITECH regulations, and for which Contractor acknowledges and promises to perform, including but not limited to, the following obligations and actions:
- k. Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of TennCare agrees to use reasonable and appropriate safeguards to protect the PHI.
- l. If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with this Section of this Contract. The Contractor shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement. The Contractor shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, the Contractor shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which cannot feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;
- m. Implement all appropriate administrative, physical and technical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Contract and, including, but not limited to, privacy, security and confidentiality requirements in 45 CFR Parts 160 and 164;
- n. Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;
- o. Create and implement policies and procedures to address present and future HIPAA/HITECH regulatory requirements as needed, including, but not limited to: use and disclosure of data; de-identification of data; minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint;
- p. Provide an appropriate level of training to its staff and employees regarding HIPAA/HITECH-related policies, procedures, enrollee rights and penalties prior to the HIPAA/HITECH implementation deadlines and at appropriate intervals thereafter;
- q. Track training of Contractor staff and employees and maintain signed acknowledgements by staff and employees of the Contractor's HIPAA/HITECH policies;
- r. Be allowed to use and receive information from TennCare where necessary for the management and administration of this Contract and to carry out business operations where permitted under the regulations;
- s. Be permitted to use and disclose PHI for the Contractor's own legal responsibilities;
- t. Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by Contractor employees and other persons performing work for the Contractor to have only minimum necessary access to PHI and personally identifiable data within their organization;



- u. Continue to protect and secure PHI AND personally identifiable information relating to enrollees who are deceased;
- v. Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations;
- w. Make available PHI in accordance with 45 CFR 164.524;
- x. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR 164.526; and
- y. Obtain a third (3rd) party certification of their HIPAA transaction compliance ninety (90) calendar days before the start date of operations.

The Contractor shall track all security incidents as defined by HIPAA/HITECH, and, as required by the HIPAA/HITECH Reports. The Contractor shall periodically report in summary fashion such security incidents.

- E.9. TennCare and the Contractor are "information holders" as defined in TCA 47-18-2107. In the event of a breach of the security of Contractor's information system, as defined by TCA 47-18-2107, the Contractor shall indemnify and hold TennCare harmless for expenses and/or damages related to the breach. Such obligations shall include, but not be limited to, mailing notifications to affected enrollees. Substitute notice to written notice, as defined by TCA 47-18-2107(e)(2)and(3), shall only be permitted with TennCare's express written approval. The Contractor shall notify TennCare's Privacy Office immediately upon becoming aware of any security incident that would constitute a "breach of the security of the system" as defined in TCA 47-18-2107.
- E.10. Notification of Breach and Notification of Provisional Breach - The Contractor shall notify TennCare's Privacy Office immediately upon becoming aware of any incident, either confirmed or provisional, that represents or may represent unauthorized access, use or disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained or held by the Contractor, including any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the Contractor 's system. This includes, but is not limited to, loss or suspected loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and/or disks.
- E.11. Applicable Laws, Rules and Policies. Contractor agrees to comply with all applicable federal and State laws, rules, regulations and executive orders, including, but not limited to, Constitutional provisions regarding due process and equal protection of the laws.
- E.12. State Ownership of Work Products. The State shall have ownership, right, title, and interest, including ownership of copyright, in all work products, including computer source code, created, designed, developed, derived, documented, installed, or delivered under this Contract subject to the next subsection and full and final payment for each "Work Product." The State shall have royalty-free and unlimited rights and license to use, disclose, reproduce, publish, distribute, modify, maintain, or create derivative works from, for any purpose whatsoever, all said Work Products.
 - a. To the extent that the Contractor uses any of its pre-existing, proprietary or independently developed tools, materials or information ("Contractor Materials"), the Contractor shall retain all right, title and interest in and to such Contractor Materials, and the State shall acquire no right, title or interest in or to such Contractor Materials EXCEPT the



Contractor grants to the State an unlimited, non-transferable license to use, copy and distribute internally, solely for the State's internal purposes, any Contractor Materials reasonably associated with any Work Product provided under the Contract.

- b. The Contractor shall furnish such information and data as the State may request, including but not limited to computer code, that is applicable, essential, fundamental, or intrinsic to any Work Product and Contractor Materials reasonably associated with any Work Product, in accordance with this Contract and applicable state law.
- c. Nothing in this Contract shall prohibit the Contractor's use for its own purposes of the general knowledge, skills, experience, ideas, concepts, know-how, and techniques obtained and used during the course of providing the services requested under this Contract.
- d. Nothing in the Contract shall prohibit the Contractor from developing for itself, or for others, materials which are similar to and/or competitive with those that are produced under this Contract.

E.13. 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. this Contract document with any attachments or exhibits (excluding the items listed at subsections b. through e., below);
- b. any clarifications of or addenda to the Contractor's proposal seeking this Contract;
- c. the State solicitation, as may be amended, requesting proposals in competition for this Contract;
- d. any technical specifications provided to proposers during the procurement process to award this Contract;
- e. the Contractor's proposal seeking this Contract.

E.14. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's proposal responding to RFP 31865-00355 (Attachment 6.2) and resulting in this Contract.

The Contractor shall assist the State in monitoring the Contractor's performance of this commitment by providing, as requested, a quarterly report of participation in the performance of this Contract by small business enterprises and businesses owned by minorities, women, and persons with a disability. Such reports shall be provided to the state of Tennessee Governor's Office of Diversity Business Enterprise in form and substance as required by said office.

E.15. Prohibited Advertising. The Contractor shall not refer to this Contract or the Contractor's relationship with the State hereunder in commercial advertising in such a manner as to state or imply that the Contractor or the Contractor's services are endorsed. It is expressly understood and agreed that the obligations set forth in this section shall survive the termination of this Contract in perpetuity.

E.16. 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 undersigned, to any person for influencing or attempting to influence an officer or



employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

- 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 this contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- 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 sub recipients 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 section 31 United States Code Annotated (USC) § 1352.

E.17. 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 offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and
- d. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

The Contractor shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded or disqualified.

E.18. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Contractor to the State.



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

- E.19. Partial Takeover. The State may, at its convenience and without cause, exercise a partial takeover of any service which the Contractor is obligated to perform under this Contract, including but not limited to any service which is the subject of a subcontract between Contractor and a third party, although the Contractor is not in Breach (hereinafter referred to as "Partial Takeover"). Said Partial Takeover shall not be deemed a Breach of Contract by the State. Contractor shall be given at least 30 days prior written notice of said Partial Takeover with said notice to specify the area(s) of service the State will assume and the date of said assumption. Any Partial Takeover by the State shall not alter in any way Contractor's other obligations under this Contract. The State may withhold from amounts due the Contractor the amount the Contractor would have been paid to deliver the service as determined by the State. The amounts shall be withheld effective as of the date the State assumes the service. Upon Partial Takeover, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.
- E.20. Federal Funding Accountability and Transparency Act (FFATA). This Contract requires the Contractor to provide supplies and/or services that are funded in whole or in part by federal funds that are subject to FFATA. The Contractor is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the Contractor provides information to the State as required.

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 C.F.R. § 170.320 (and sub awards); 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 sub awards); and
 - iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/excomp.htm>.)

Executive means officers, managing partners, or any other employees in management positions.



(2) Total compensation means the cash and noncash dollar value earned by the executive during the Contractor's preceding fiscal year and includes the following (for more information see 17 C.F.R. § 229.402(c)(2)):

- i. Salary and bonus.
 - ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
 - iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.
 - iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
 - v. Above-market earnings on deferred compensation which is not tax qualified.
 - vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds \$10,000.
- b. The Contractor must report executive total compensation described above to the State by the end of the month during which this Contract is awarded.
- c. If this Contract is amended to extend its term, the Contractor must submit an executive total compensation report to the State by the end of the month in which the amendment to this Contract becomes effective.
- d. The Contractor will obtain a Data Universal Numbering System (DUNS) number and maintain its DUNS number for the term of this Contract. More information about obtaining a DUNS Number can be found at: <http://ifedgov.dnb.com/webform/>

The Contractor's failure to comply with the above requirements is a material breach of this Contract for which the State may terminate this Contract for cause. The State will not be obligated to pay any outstanding invoice received from the Contractor unless and until the Contractor is in full compliance with the above requirements.

E.21. Social Security Administration (SSA) Required Provisions for Data Security. The Contractor shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology guidelines. In addition, the Contractor shall have in place administrative, physical, and technical safeguards for data.

- a. The Contractor shall 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.



- b. The Contractor agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.
- c. The Contractor shall provide a current list of the employees of such contractor with access to SSA data and provide such lists to TennCare.
- d. The Contractor shall restrict access to the data obtained from TennCare to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Contract. The Contractor shall not further duplicate, disseminate, or disclose such data without obtaining TennCare's prior written approval.
- e. The Contractor shall ensure that its employees:
 - (1) properly safeguard PHI/PII furnished by TennCare under this Contract from loss, theft or inadvertent disclosure;
 - (2) understand that they are responsible for safeguarding this information at all times, regardless of whether or not the Contractor employee is at his or her regular duty station;
 - (3) ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;
 - (4) send emails containing PHI/PII only if encrypted or if to and from addresses that are secure; and,
 - (5) limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

Contractor employees who access, use, or disclose TennCare or TennCare SSA-supplied data in a manner or purpose not authorized by this Contract may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

- f. **Loss or Suspected Loss of Data** – If an employee of the Contractor becomes aware of suspected or actual loss of PHI/PII, he or she must immediately contact TennCare immediately upon becoming aware to report the actual or suspected loss. The Contractor will use the Loss Worksheet located at http://www.tn.gov/tenncare/forms/phi_piiworksheet.pdf to quickly gather and organize information about the incident. The Contractor must provide TennCare with timely updates as any additional information about the loss of PHI/PII becomes available.

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.

- g. TennCare may immediately and unilaterally suspend the data flow under this Contract, or terminate this Contract, if TennCare, in its sole discretion, determines that the Contractor has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Contract.
- h. In order to meet certain requirements set forth in the State's Computer Matching and Privacy Protection Act Agreement (CMPPA) with the SSA, the Parties acknowledge that this Section shall be included in all agreements executed by or on behalf of the State. The Parties further agree that FISMA and NIST do not apply in the context of data use and disclosure under this Agreement as the Parties shall neither use nor operate a



federal information system on behalf of a federal executive agency. Further, NIST is applicable to federal information systems; therefore, although encouraged to do so, the State, its contractors, agents and providers are not required to abide by the NIST guidelines.

i. This Section further carries out Section 1106(a) of the Act (42 U.S.C. 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. 3541 et seq.), and related National Institute of Standards and Technology ("NIST") guidelines, which provide the requirements that the SSA stipulates that the Contractor must follow with regard to use, treatment, and safeguarding data in the event data is exchanged with a federal information system.

j. Definitions

- (1) "SSA-supplied data" – information, such as an individual's social security number, supplied by the Social Security Administration to TennCare to determine entitlement or eligibility for federally-funded programs (CMPPA between SSA and F&A; IEA between SSA and TennCare).
- (2) "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 C.F.R. 160.103; OMB Circular M-06-19) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
- (3) "Individually Identifiable Health Information" – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- (4) "Personally Identifiable Information" – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

E.22. The Contractor shall comply and submit to TennCare the disclosure of ownership and control information in accordance with the requirements specified in 42 C.F.R. Part 455, Subpart B, using the form approved by TennCare

E.23. Offer of Gratuities. By signing this contract, the Contractor signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the federal General Accounting Office, federal Department of Health and Human Services, the Center for Medicare and Medicaid Services, or any other state or federal agency has or will benefit financially or materially from this Contract. This Contract may be terminated by TennCare as provided in Section D.4, if it is determined that gratuities of any kind were offered to



or received by any of the aforementioned officials or employees from the Contractor, its agent, or employees.

- E.24. Employees Excluded from Medicare, Medicaid or CHIP. The Contractor does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly employ, in the performance of this Contract, employees who have been excluded from participation in the Medicare, Medicaid, and/or CHIP programs pursuant to Sections 1128 of the Social Security Act.
- E.25. Unencumbered Personnel. All persons assigned by the Contractor to perform services for the State under this Contract, whether they are employees, agents, subcontractors, or principals of the Contractor, shall not be subject to any employment contract or restrictive covenant provisions which would preclude those persons 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. If the Contractor provides the State with the services of any person subject to a restrictive covenant or contractual provision in violation of this provision, any such restrictive covenant or contractual provision will be void and unenforceable, and the Contractor will pay the State and any person involved all of its expenses, including attorneys fees, caused by attempts to enforce such provisions.
- E.26. Records Discovery. In addition to the records audits referenced in D.9, the Contractor shall make available all records of whatever media (correspondence, memoranda, databases, worksheets, training material, etc.), in their original form, be it electronic or paper, including emails with metadata preserved. These records shall be produced to TennCare at no cost to the State, as required to satisfy evidence discovery demands of any of litigation, including state or federal class action, affecting TennCare. The State shall endeavor to keep the evidence discovery requests as limited as reasonably possible. The Contractor shall retain the right to object in court to any evidence discovery requests it may feel is too broad or otherwise unduly burdensome.
- E.27. Ownership & Control Disclosure Information. The Contractor and their subcontractors shall disclose, to TennCare, the Comptroller General of the United States or CMS, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in the time and manner set forth in accordance with federal and state requirements, including but not limited to 42 C.F.R. § 455.101 *et seq.*; 42 C.F.R. § 1001.1001 and 42 C.F.R. § 455.436. These disclosures shall be made on the form provided by TennCare.

The Contractor shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128 B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The results of said screenings shall be provided to TennCare on a monthly basis. The word "contractors" in this section shall refer to all individuals listed on the disclosure form such as board members, owners, agents, managing employees, etc.

The Contractor and its subcontractors agree to disclose business transaction information upon request and as otherwise specified in federal and state regulations.

In the event that the federal regulations require a site visit for a particular provider as part of the screening process, Contractor shall make the required site visit if requested to do so by the Bureau of TennCare.

- E.28. Performance Bond. The Contractor shall provide to the State a performance bond guaranteeing full and faithful performance of all undertakings and obligations under this Contract and in the amount equal to One Million Dollars (\$1,000,000.00). The Contractor shall submit the bond no later than the day immediately preceding the Contract start date and in the manner and form



prescribed by the State (refer to Attachment F hereto), and the bond shall be issued through a company licensed to issue such a bond in the state of Tennessee. The performance bond shall guarantee full and faithful performance of all undertakings and obligations under this Contract for:

- a. the Contract term and all extensions thereof; or
- b. the first, calendar year of the Contract (ending December 31st following the Contract start date) in the amount of One Million Dollars (\$1,000,000.00) and, thereafter, a new performance bond in the amount of One Million Dollars (\$1,000,000.00) covering each subsequent calendar year of the contract period. In which case, the Contractor shall provide such performance bonds to the State no later than each December 10th preceding the calendar year period covered beginning on January 1st of each year.

Failure to provide to the State the performance bond(s) as required herein prior to the Contract start date and, as applicable, no later than December 10th preceding each calendar year period covered beginning on January 1st of each year, shall result in contract termination. The Contractor understands that the stated amount of the performance bond required hereunder shall not be reduced during the contract period for any reason.

IN WITNESS WHEREOF,

DENTAQUEST USA INSURANCE CO., INC.:

May 1, 2013

CONTRACTOR SIGNATURE

DATE

Steven J. Pollock, President

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

May 3, 2013

MARK A. EMKES, COMMISSIONER

DATE



ATTACHMENT A

Terms and Definitions

1. Administrative Cost – All costs to the Contractor related to the administration of this Contract. Costs of subcontractors engaged solely to perform a non-medical administrative function for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract (including, but not limited to, claims processing, marketing, postage, personnel, rent) are considered to be an "administrative cost".
2. Administrative Services Fee - The per member per month amount that the Contractor will charge for provision of the services outlined in this Contract.
3. Adverse Action - Any action taken by the Contractor to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness or availability of such benefits.
4. Appeal Procedure - The process to resolve an enrollee's right to contest verbally or in writing, any adverse action taken by the Contractor to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by TennCare Rule 1200-13-13-.11 and any and all applicable court orders. Complaint shall mean an enrollee's right to contest any other action taken by the Contractor or service provider other than those that meet the definition of an adverse action.
5. Benefits - A schedule of health care services to be delivered to enrollees covered by the Contractor
6. Auxiliary Aids and Services - include, but are not limited to:
 - a. Qualified interpreters on-site or through video remote interpreting (VRI) services; notetakers; 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 C.F.R. § 36.303.
7. Case Manager - An organization or a provider responsible for supervising or coordinating the provision of initial and primary care to enrollees; for initiating and/or authorizing referrals for specialty care; and for monitoring the continuity of patient care services.



8. CFR - Code of Federal Regulations
9. Clean Claim - A claim received by the Contractor for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the Contractor.
10. CMS - Centers for Medicare and Medicaid Services (formerly HCFA).
11. Community Service Area - Community Service Area (CSA) shall mean one (1) or more counties in a defined geographical area in which the Contractor is authorized to enroll providers and serve TennCare enrollees.

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

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



12. Corrective Action Plan (CAP) – The steps and timelines identified by the Contractor to correct, compensate for, and/or remedy each violation of the Contract.
13. Covered Service - See Benefits at A.3 of the Contract
14. Cultural Competence - The level of knowledge-based skills required to provide effective clinical care to enrollees of particular ethnic or racial groups.
15. DBM – Dental Benefits Manager.
16. Dental Home - A dental practice that maintains an ongoing relationship between the dentist and the patient inclusive of all aspects of oral health care delivered in a comprehensive, medically necessary, continuously accessible, and coordinated way.
17. 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.
18. Effective Communication – means taking the appropriate steps to ensure that communications with disabled applicants, participants, members of the public, and their companions are as effective as communications with others by providing alternative formats such as auxiliary aids as defined in USCA .
19. Eligible Person - Any person certified by TennCare as eligible to receive services and benefits under the TennCare Program.
20. Emergency Services – Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act and that are needed to evaluate or stabilize an emergency medical condition.
21. Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.
22. Enrollee - A Medicaid recipient or Medicaid Waiver recipient who is currently enrolled in an Managed Care Organization (MCO), Pre-paid Inpatient Health Plan (PIHP), Pre-aid Ambulatory Health Plan (PAHP) or Primary Case Care Management Program (PCCM) in a given managed care program.
23. Enrollee Month – A month of health care coverage for the TennCare eligible enrolled in a Dental Plan.
24. Enrollment - The process by which a person becomes a member of the Contractor's plan through the TennCare Bureau.
25. 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.
26. Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to this Contract; or (b) maintained by a subcontractor or provider to provide services on behalf of the Contractor.
27. Fee-for-Service - A method of making payment for health services based on a fee schedule that specifies payment for defined services.
28. FTE - Full time equivalent position.
29. 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:

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

30. 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.

31. Health Maintenance Organization (HMO) - An entity certified by the Department of Commerce and Insurance under applicable provisions of TCA Title 56, Chapter 32.
32. 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.
33. Managed Care Organization ("MCO") - An HMO which participates in the TennCare Program.



34. 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.
35. 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.
36. Member - A person who is eligible for the Contractor's plan under the provisions of this Contract with TennCare. (See Enrollee, also).
37. NAIC – National Association of Insurance Commissioners.
38. Non-TennCare Provider – A provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.
39. Office of the Inspector General - A Unit established to help prevent, identify and investigate fraud and abuse within the healthcare system, most notably the TennCare system.
40. Out-of-Plan Services - Services provided by a non-TennCare provider.
41. Participating Dental Provider – A TennCare provider, as defined herein and in the TennCare Rules, who has entered into a contract with the Dental Benefits Manager.
42. 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.
43. 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.
44. 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.
45. 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.
46. Prior Authorization - The act of authorizing specific services or activities before they are rendered or activities before they occur.
47. 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.



48. Program Integrity - The Program Integrity unit is responsible for assisting with the prevention, identification and investigation of fraud and abuse within the health care system.
49. 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.
50. 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.
51. 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.
52. 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.
53. 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.
54. Service Site - The locations designated by the Contractor at which enrollees shall receive oral health treatment and preventive services.
55. Services - The benefits described in this Contract, including but not limited to, Section A.3.
56. Shall - Indicates a mandatory requirement or a condition to be met.
57. Specialty Services - Includes Endodontics, Oral Surgery, Orthodontics, Pediatric Dentistry, Periodontics, Prosthodontics
58. State - State of Tennessee.
59. 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.3 of this Contract shall be considered Provider Agreements and governed by Sections A.48–A.60 of this Contract. If a subcontractor will also be a Provider the requirements for Provider Agreements must also be met.
60. 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.
61. 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.

62. 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 Program and the terms of this Contract. Such entities include, but are not limited to, the Division of HealthCare Finance and Administration Bureau 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 Division within the Tennessee Department of Commerce and Insurance (C&I) and the Tennessee Bureau of Investigation (TBI), Medicaid Fraud Control Unit (MFCU).
63. TennCare Medicaid Enrollee – an enrollee who qualifies and has been determined eligible for benefits in the TennCare program through Medicaid eligibility criteria as described in the Medicaid/TennCare Rules and Regulations .(See also "Member")
64. TennCare Provider - A provider who accepts as payment in full for furnishing benefits to a TennCare 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.
65. 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".
66. Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The State agency responsible for the investigation of provider fraud and abuse in the State Medicaid Program.
67. 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.
68. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party payor.
69. 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.
70. Utilization Rate – An adjusted proportion of enrollees, ages 2-20, with a minimum 90 days eligibility who have received any dental service during the past federal fiscal year.
71. Vital Documents – Consent and complaint forms, intake and application forms with the potential for important consequences, and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents shall be available in Spanish.



ATTACHMENT B

LIQUIDATED DAMAGES

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

The Contractor may dispute any Liquidated Damage assessment imposed by TennCare. If informal discussions between Contractor and TennCare fail to resolve the issue, Contractor shall have the right to file a claim with the Claims Commission to resolve the issue. Contractor shall have a period of one year, starting from the day that the TennCare sends the notice assessing the actual liquidated damages amount to file the claim. The Contractor agrees that this provision acts as a statute of limitations for a disputed liquidated damages assessment, and that failure by the Contractor to file a claim bars any further action to recover the disputed amount.

In addition to the specific liquidated damages listed below, TennCare shall have the right to assess a general liquidated damages claim of five hundred dollars (\$500) per calendar day for each day that the Contractor fails to comply with the provisions and requirements of this Contract. The damage that may be assessed shall be \$500 per calendar day for each separate failure to comply with the Contract, plus, if applicable, an additional \$500 per calendar day for each affected TennCare enrollee.

1. TennCare may impose any or all of the sanctions below upon TennCare's reasonable determination that the Contractor fails to comply with any corrective action plan (CAP) or is otherwise deficient in the performance of its obligations under the Contract, provided, however, that TennCare only impose those sanctions it determines to be appropriate for the deficiencies identified. TennCare may impose intermediate sanctions on the Contractor simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe or numerous. Intermediate sanctions may include application of liquidated damages as described in Section E.4.

2. **Liquidated Damages**

Reports and Deliverables

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



<u>DELIVERABLES</u>	<u>DATE AGREED UPON BY THE PARTIES</u>
Monthly Reports	Thirty (30) days after the end of each calendar month unless otherwise specified. See Attachment C.
Quarterly Reports,	Thirty (30) days after the end of each calendar quarter unless otherwise specified. See Attachment C.
Annual Reports	Ninety (90) days after the end of the calendar year, unless otherwise specified. See Attachment C.
On Request Reports	Within three (3) business days from the date of request when reasonable unless otherwise specified by TennCare.
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
Requests for Information (RFIs)	As Requested

Program Issues

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

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

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

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

<u>CLASS</u>	<u>PROGRAM ISSUES</u>	<u>DAMAGE</u>
A.1	Failure to comply with claims processing requirements described by Sections A.73–A.78 of this Contract.	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 the requirements of Sections A.73–A.78.
A.2	Failure to comply with licensure requirements in Section A.16 of this Contract.	The damage that may be assessed shall be five thousand dollars (\$5,000) per calendar day that staff/provider/agent/subcontractor is not licensed as required by applicable state law, plus, the amount paid to the staff/provider/agent/subcontractor during that period.



A.3	Failure to respond to a request by DCS or TennCare to provide service(s) to a child at risk of entering DCS custody as described in Section A.130 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.
A.4	Failure to comply with obligations and timeframes in the delivery of TENNderCare screens and related services.	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.
A.5	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized by the TennCare Chief Medical Officer.	The 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.
A.6	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TennCare (pursuant to an appeal) to do so, or upon approval of the service or payment by the Contractor during the appeal process, or within a longer period of time that has been approved by TennCare upon a plan's demonstration of Good Cause as defined in <i>Revised Grier Consent Decree</i> , Section C.16.c.	The damage that may be assessed shall be five hundred dollars (\$500) per calendar day beginning on the next calendar day after default by the plan in addition to the cost of the services not provided.
A.7	Failure to provide proof of compliance to the TennCare Office of Contract Compliance and Performance within five (5) calendar days of a reasonable and appropriate directive from TennCare or within a longer period of time that has been approved by TennCare upon a plan's demonstration of Good Cause as defined in <i>Revised Grier Consent Decree</i> , Section C.16.c.	The damage that may be assessed shall be five hundred dollars (\$500) per calendar day beginning on the next calendar day after default by the plan.
A.8	Failure to comply with the notice requirements of the TennCare rules and regulations and all court orders governing appeal procedures, as they become effective or are modified.	The damage that may be assessed shall be five hundred dollars (\$500) per occurrence in addition to five hundred dollars (\$500) per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every



		aspect and/or each day the appeal is not handled according to the provisions set forth by this Contract or required by TennCare.
A.9	Failure to provide continuation or restoration of services where enrollee was receiving the service as required by the TennCare rules, all applicable state or federal law, and all court orders governing appeal procedures as they become effective, or are modified.	<p>The damage that may be assessed shall be an amount sufficient to at least offset any savings the Contractor achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense.</p> <p>The damage that may be assessed shall be five hundred dollars (\$500) per calendar day for each calendar day beyond the 2nd business day after an On Request Report regarding an enrollee's request for continuation of benefits is sent by TennCare.</p>
A.10	Failure to forward an expedited appeal to TennCare within twenty-four (24) hours or a standard appeal in five (5) days.	The damage that may be assessed shall be five hundred dollars (\$500) per calendar day.
A.11	Failure to provide complete documentation, including medical records, pediatric records, speech pathology records, radiographs, OrthoCAD, study model, photograph of model, hospital readiness form or orthodontic readiness form, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations, and all court orders and consent decrees governing appeals procedures as they become effective, or are modified.	The damage that may be assessed shall be five hundred dollars (\$500) per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Contract or required by TennCare.
A.12	Failure to submit a timely corrected notice of adverse action to TennCare for review and approval prior to issuance to the enrollee.	The damage that may be assessed shall be one thousand dollars (\$1,000) per occurrence if the notice is not timely corrected plus a per calendar day assessment in increasing increments of five hundred dollars (\$500) (i.e., five hundred dollars (\$500) for the first day, one thousand dollars (\$1,000) for the second day, one thousand, five hundred dollars (\$1,500) for the third day, etc.) for each day the notice is late and/or remains defective.



A.13	Per the <i>Revised Grier Consent Decree</i> , "systemic problems or violations of the law" (e.g., a failure in 20% or more of appealed cases over a 60-day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures, as they become effective, or are modified.	The damage that may be assessed shall be: For the first occurrence, five hundred dollars (\$500) per instance of such "systemic problems or violations of the law," even if damages regarding one or more particular instances have been assessed (in the case of "systemic problems or violations of the law" relating to notice content requirements, five hundred dollars (\$500) per notice even if a corrected notice was issued upon request by TennCare). Damages per instance may increase in five hundred dollar (\$500) increments for each subsequent "systemic problem or violation of the law" (five hundred dollars (\$500) per instance the first time a "systemic problem or violation of the law" relating to a particular requirement is identified; one thousand dollars (\$1,000) per instance for the 2nd time a "systemic problem or violation of the law" relating to the same requirement is identified; etc.
A.14	Systemic violations regarding any aspect of the requirements in accordance with this Contract and the TennCare rules and regulations.	The damage that may be assessed shall be: For the first occurrence, five hundred dollars (\$500) per instance of such systemic violations, even if damages regarding one or more particular instances have been assessed. Damages per instance may increase in five hundred dollar (\$500) increments for each subsequent systemic violation (five hundred dollars (\$500) per instance the first time a systemic violation relating to a particular requirement is identified; one thousand dollars (\$1,000) per instance for the 2nd time a systemic violation relating to the same requirement is identified, etc.)
A.15	Failure to 1) provide an approved service timely (i.e., in accordance with timelines specified in the Special Terms and Conditions for Access in the TennCare Waiver) or when not specified therein, with reasonable promptness, and issue appropriate notice of delay in providing services to the enrollee,	The damage that may be assessed shall be the cost of services not provided plus five hundred dollars (\$500) per calendar day for each affected TennCare enrollee, for each day that either of the following occurs: 1) approved care is not provided timely, and notice of delay is not provided to the enrollee,



	and failure to 2) provide an approved service timely (i.e., in accordance with timelines specified in the Special Terms and Conditions for Access in the TennCare Waiver) or when not specified therein, with reasonable promptness, and, upon request from TennCare, issue appropriate notice of delay with documentation of ongoing diligent efforts to provide such approved service.	and 2) approved care is not provided timely and the Contractor fails to provide, upon request from TennCare, sufficient documentation of ongoing diligent efforts to provide such approved service.
A.16.	Failure to implement Non-Traditional Fluoride Varnish and Dental Screening Program within six months of contract start as referenced in Section A.4.d.	The damage that may be assessed shall be five hundred dollars (\$500) per calendar day past expected implementation date.
B.1	Failure to provide listings of participating dentists to enrollees as required.	The damage that may be assessed shall be five hundred dollars (\$500) per calendar day for each day beyond 30 days after Contractor's receipt of notice of member's enrollment in a plan and five hundred dollars (\$500) per calendar day for each enrollee per calendar day that Contractor fails to provide the required updated provider directory on an annual basis..
B.2	Failure to complete or comply with Corrective Action Plans as required by TennCare.	The damage that may be assessed shall be five hundred dollars (\$500) per calendar day for each day the corrective action is not completed or complied with as required.
B.3	Failure to disclose Lobbying Activities as specified in Section E.16.	The damage that may be assessed shall be one thousand dollars (\$1000)) per calendar day that disclosure is late.
B.4	Failure to comply with Offer of Gratuities constraints described in Section E.23.	The damage that may be assessed shall be one hundred and ten percent (110%) of the total benefit provided by the Contractor to inappropriate individuals and possible termination of the Contract Breach described in Section E.4
B.5	Failure to obtain approval of member materials as required by Sections A.9 - A.13 of this Contract	The damage that may be assessed shall be five hundred dollars (\$500) per day for each calendar day that TennCare determines the Contractor has provided enrollee material that has not been approved by TennCare.
B.6	Failure to comply with Marketing timeframes for providing Member Handbooks, Provider Directories, and Newsletters.	The damage that may be assessed shall be five thousand dollars (\$5000) for each occurrence.



B.7	Failure to maintain a complaint and appeal system required in Section A.99 of this Contract.	The damage that may be assessed shall be five hundred dollars (\$500) per calendar day for each day that Contractor does not maintain a complaint and appeal system.
B.8	Failure to comply with fraud and abuse provisions as described in A.165. of this Contract	\$500 per calendar day for each day that the Contractor does not comply with fraud and abuse provisions
B.9	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement/contract .	<p>\$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.</p> <p>\$1,000 per application per calendar day for each day beyond thirty (30) calendar days that a completed credentialing application has not been processed.</p>
B.10	Failure to maintain provider agreements in accordance with Section A.51 of this Contract.	\$5,000 per provider agreement found to be non-compliant.
B.11	Failure to comply with HIPAA and HITECH Rules resulting in an unauthorized disclosure of PHI as described in Sections E.7 and E.8.	Up to \$50,000 per incident.
B.12.	Failure to have adequate Privacy and Security Safeguards and Policies as described in Sections E.7 and E.8.	Up to \$25,000
B.13.	Failure to timely report violations in use and Disclosure of PHI as described in Sections E.7 and E.8.	\$500.00 per calendar day until cured.
B.14.	Failure to timely report Privacy/Security incidents as described in Sections E.7 and E.8.	\$500.00 per calendar day until cured.
B.15	Failure to ensure that all State data containing protected health information (PHI), as defined in HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5 on the HHS Web site which compromises the security or privacy of TennCare enrollee protected health information (See ancillary Business Associate Agreement executed between the	The damage that may be assessed shall be Five Hundred Dollars (\$500) per recipient per occurrence, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those State recipients whose PHI was placed at risk by CONTRACTOR's failure to comply with the terms of this Agreement, the CONTRACTOR shall be liable for all costs associated with the provision of such safeguard services.



	parties)	
B.16	Failure to seek express written approval from the State, including the execution of the appropriate agreements to effectuate transfer and exchange of State recipient PHI or State 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 for any purpose other than the purpose of this Agreement. (See ancillary Business Associate Agreement executed between the parties)	The damage that may be assessed shall be Five Hundred Dollars (\$500) per recipient per occurrence.
B.17	Failure by the Contractor to prevent the use or disclosure of State recipient data or State confidential in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States (See ancillary Business Associate Agreement executed between the parties)	The damage that may be assessed shall be One Thousand Dollars (\$1,000) per recipient per occurrence.
C.1	Failure to comply in any way with staffing requirements described in Sections A.14 - A.17 of this Contract.	The damage that may be assessed shall be two hundred and fifty dollars (\$250) per calendar day for each day that staffing requirements described in Sections A.14 - A.17 of this Contract are not met.
C.2	Failure to report provider notice of termination of participation in the Contractor's Plan.	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.
C.3	Failure to submit a Provider Enrollment File that meets TennCare's specifications.	\$250 per day after the due date that the Provider Enrollment File fails to meet TennCare's specifications.

3. Payment of Liquidated Damages

It is further agreed by TennCare and the Contractor that any liquidated damages assessed by TennCare shall be due and payable to TennCare within thirty (30) calendar days after Contractor receipt of the



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

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



ATTACHMENT C

DBM Deliverables Requirement

DBM Dental Deliverables	Scheduled Due Dates	Initial Due Date
Monthly Reports: <ul style="list-style-type: none"> • Batch Claims operation • PI Exclusion Report • PI TIPs (received on 1st and 15th)¥ • Involuntary Termination Report • Claims Lag Triangle • Claims Activity • Subrogation recoveries collected outside claims processing system 	30 calendar days after the end of each <u>calendar month</u>	By November 30, 2013
<ul style="list-style-type: none"> • Encounter Data Report (837D) • Provider Enrollment File☼ 	Forty-eight (48) hours after weekly payment cycle By fifth business day <u>each month</u>	Forty-eight (48) hours after weekly payment cycle October 5, 2013
Quarterly Reports: <ul style="list-style-type: none"> • EOB Report • Enrollee Cost Sharing • Customer Service Report <ul style="list-style-type: none"> ◦ Referral time by county ◦ Phone response time ◦ Request for assistance • Non-Discrimination Compliance Reports • Quarterly Financials/ Income Statements • TENNderCare/EPSTDT Report • QMP Committee Meeting Minutes • Quality Indicator • PI Referral ¥ • Quarterly Program Integrity Report • Non-Traditional FI Varnish Program Report • “Insure Kids Now” (IKN) File☼ 	30 days after the end of each <u>calendar quarter</u> 10 days after the end of <u>each calendar quarter</u>	By January 30, 2014 By April 30, 2014 By October 10, 2013
Annual Reports/ Plans/Studies: <ul style="list-style-type: none"> • Audited Financial Statements • Member Satisfaction Surveys* • Provider Satisfaction Surveys* • Non-Discrimination Compliance Plan & Assurance of Non-Discrimination • Community Outreach Plan Evaluation • <u>Two (2) PIPs Dental Studies†</u> • QMP Report‡ (QMP, work plan, and evaluation) 	90 days after end of <u>calendar year</u> By June 30 each year By June 30 each year	By March 31, 2014



<ul style="list-style-type: none"> • Community Outreach Plan§ • Licensure Documentation • Annual Access Report# 	By November 30 each year By September 15 each year By November 30 each year	By November 30, 2013 By October 1, 2013 By November 30, 2014
<ul style="list-style-type: none"> • Fraud And Abuse Compliance Plan 	By July 1 each year	By November 30, 2013
Ad Hoc Reports:	Within ten (10) business days from the date of the request when reasonable unless otherwise specified by TennCare.	Within ten (10) business days from the date of the request when reasonable unless otherwise specified by TennCare.
Progress Reports	As Requested	As Requested
On Request Reports (ORRs)	Within three (3) business days from the date of request when reasonable unless otherwise specified by TennCare.	Within three (3) business days from the date of request when reasonable unless otherwise specified by TennCare.
Requests for Information (RFIs)	As Requested	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 must comply with specifications as outlined by TennCare.

* First submissions by DBM will consist of the satisfaction survey tools only and are due by March 31, 2014. All subsequent submissions will consist of a detailed summary of survey results and will be due 90 days at the end of each calendar year.

† First submissions by DBM will consist of the PIPs study designs only and are due by March 31, 2014. All subsequent submissions will consist of a detailed PIPs study results and will be due by June 30 each year.

‡ First submission by DBM will consist of the QMP and the work plan and is due by March 31, 2014. All subsequent submissions will consist of an updated QMP, work plan, and evaluation of the previous year's QMP due by June 30 each year.

§ First submission by DBM is due by November 30, 2013. All subsequent submissions are due by November 30 each year.

First submission by DBM is due by November 30, 2014. All subsequent submissions are due by November 30th each year.



ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	31865-00355
CONTRACTOR LEGAL ENTITY NAME:	DENTAQUEST USA INSURANCE CO., INC
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	20-2970185

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

Steven J. Pollock, President

PRINTED NAME AND TITLE OF SIGNATORY

May 2 2013

DATE OF ATTESTATION



Annual Dental Participation Ratio

Description

The weighted percentage of qualifying members 2 – 20 years of age who had one (1) or more qualifying dental services during the measurement year.

Eligible Population

Members age 2 – 20 with a minimum 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 90 days
- Anchor Date** - Mid-point of reporting period
- Benefit** - Dental

Qualifying Services

Claims with a qualifying paid service.

Codes to identify qualifying services¹ HCPSC/CDT: D0100 – D9999.

¹CDT (Current Dental Terminology) is the equivalent dental version of the CPT Physician Procedural Coding System

Metric Formulation

- Numerator** - The sum of the FTE for qualifying eligibles with 1 or more qualifying services in the measurement year
- Denominator** - Sum of FTE for all qualifying eligibles

FTE equals the number of days eligible divided by 365.25

Mathematical Formulation

- i. Participant Ratio Weight for Individual *i*

$$W_i = \frac{Fte_i}{\sum_{i=1}^I Fte_i}; \text{ Where } I \text{ equals the total qualifying eligibles}$$

$$\text{Where } \sum_{i=1}^I W_i = 1$$



ATTACHMENT E (continued)

ii. Qualifying Service Indicator

$$f(s) = \begin{cases} 1, & \text{if received qualifying service} \\ 0, & \text{if not} \end{cases}$$

iii. Participation Ratio for Individual i

$$PR_i = W_i * f(s)$$

iv. Overall Participant Ratio

$$PR = \sum_{i=1}^n PR_i$$



PERFORMANCE BOND

PERFORMANCE BOND

The Surety Company issuing bond shall be licensed to transact business in the State of Tennessee by the Tennessee Department of Commerce and Insurance. Bonds shall be certified and current Power-of-Attorney for the Surety's Attorney-in-Fact attached.

KNOW ALL BY THESE PRESENTS:

That we,

(Name of Principal)

(Address of Principal)

as Principal, hereinafter called the Principal, and

(Name of Surety)

(Address of Surety)

as Surety, hereinafter call the Surety, do hereby acknowledge ourselves indebted and securely bound and held unto the State of Tennessee as Obligee, hereinafter called the Obligee, and in the penal sum of

One Million Dollars (\$1,000,000.00).

good and lawful money of the United States of America, for the use and benefit of those entitled thereto, for the payment of which, well and truly to be made, we bind ourselves, our heirs, our administrators, executors, successors, and assigns, jointly and severally, firmly by these presents.

BUT THE CONDITION OF THE FOREGOING OBLIGATION OR BOND IS THIS:

WHEREAS, the Obligee has engaged the Principal for a sum not to exceed

(Contract Maximum Liability)

to complete Work detailed in the Scope of Services detailed in the State of Tennessee Request for Proposals bearing the RFP Number:

RFP NUMBER 31865-00355

a copy of which said Request for Proposals and the resulting Contract are by reference hereby made a part hereof, as fully and to the same extent as if copied at length herein.

NOW, THEREFORE, if the Principal shall fully and faithfully perform all undertakings and obligations under the Contract hereinbefore referred to and shall fully indemnify and hold harmless the Obligee from all costs and damage whatsoever which it may suffer by reason of any failure on the part of the Principal to do so, and shall fully reimburse and repay the Obligee any and all outlay and expense which it may incur in making good any such default, and shall fully pay for all of the labor, material, and Work used by the Principal and any immediate or remote subcontractor or furnisher of material under the Principal in the performance of said Contract, in lawful money of the United States of America, as the same shall become due, then this obligation or bond shall be null and void, otherwise to remain in full force and effect.

AND for value received, it is hereby stipulated and agreed that no change, extension of time, alteration, or addition to the terms of the Contract or the Work to be performed there under or the specifications accompanying the same shall in any wise affect the obligation under this bond, and notice is hereby waived of any such change, extension of time, alteration, or addition to the terms of the Contract or the Work or the specifications.



IN WITNESS WHEREOF the Principal has hereunto affixed its signature and Surety has hereunto caused to be affixed its corporate signature and seal, by its duly authorized officers, on this

_____ day of _____ .

WITNESS:

(Name of Principal)

(Name of Surety)

(Authorized Signature of Principal)

(Signature of Attorney-in-Fact)

(Name of Signatory)

(Name of Attorney-in-Fact)

(Title of Signatory)

(Tennessee License Number of Surety)



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)



ATTACHMENT G (con't)

DRAFT Dental Report: Oct. 2010 to Sep. 2011		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)							