STATE OF TENNESSEE
DIVISION OF TENNCARE

REQUEST FOR PROPOSALS # 31865-00637
AMENDMENT # 1
FOR Prepaid Insurance Health Plan (PIHP)

DATE: January 11, 2024

RFP # 31865-00637 IS AMENDED AS FOLLOWS:

1. This RFP Schedule of Events updates and confirms scheduled RFP dates. Any event, time, or date containing revised or new text is highlighted.

EVENT	TIME (central time zone)	DATE
1. RFP Issued		November 6, 2023
2. Disability Accommodation Request Deadline	2:00 p.m.	November 9, 2023
3. Pre-response Conference	2:00 p.m.	November 14, 2023
4. Notice of Intent to Respond Deadline	2:00 p.m.	November 15, 2023
5. Written "Questions & Comments" Deadline and Organizational Conflict of Interest Deadline	2:00 p.m.	November 27, 2023
6. State Response to Written "Questions & Comments"		January 11, 2024
7. Response Deadline	2:00 p.m.	February 13, 2024
8. State Completion of Technical Response Evaluations		April 22, 2024
9. State Notice of Intent to Award Released and RFP Files Opened for Public Inspection	2:00 p.m.	May 14, 2024
10. End of Open File Period		May 21, 2024
11. State sends contract to Contractor for signature		May 28, 2024
12. Contractor Signature Deadline	2:00 p.m.	July 1, 2024

2. State responses to questions and comments in the table below amend and clarify this RFP.

Any restatement of RFP text in the Question/Comment column shall NOT be construed as a change in the actual wording of the RFP document.

No.	RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
1.	3.1 Response Form	9	Please confirm that using a font size smaller than 12 point for graphics, charts, graphs, tables, headers/footers is allowed.	A font smaller than 12 points for graphics, charts, graphs, tables, headers/footers is allowed provided the information and text are legible.
2.	3.1 Response Form	9	Please confirm the minimum margin size allowed.	There is no minimum margin size specified, see #1 above.
3.	3.1 Response Form	9	Please confirm that Respondents can submit required RFP Attachments as formatted with the RFP as opposed to reformatting the Attachments.	RFP Attachments must be submitted as formatted in the RFP and in accordance with RFP Sections 3.1.1.1, 3.1.1.2, and 3.1.1.3
4.	3.1 Response Form	9	Please confirm that the state will allow the use of electronic signatures within the copy (not the original) of Respondent's submission.	Electronic/digital signatures are an acceptable form for both the original and copy of a Respondent's submission.
5.	3.1 Response Form	9	Please confirm section divider pages included in the response do not count toward page limits.	Divider pages included in the response do not count toward page limits for the proposal.
6.	3.1 Response Form	9	Please confirm if Respondents are required to restate the entire question as part of the response. If so, is the question excluded from the page limit?	Although preferred, it is not required that the entire question be restated as part of the response, however if the question is restated in its entirety as part of a response it will count toward the page limit.
7.	3.2 Response Delivery	10	Please confirm the electronic USB flash drive for the Technical Response should be submitted in an unencrypted state.	Yes, flash drives should be submitted unencrypted for the Solicitation Coordinator to access the contents of the proposal.
8.	3.2 Response Delivery	10	Digital Media Submission: Our interpretation of the submission requirements includes a total of: • One (1) original digital technical proposal AND one (1) redacted original digital technical proposal on one USB drive. • One (1) original digital technical proposal on one USB drive. Email Submission: How can we submit a response larger than 32 MB by email? Is there a way to upload the file into the cloud?	As an option to email submission, a respondent may contact the Solicitation Coordinator to provide a temporary cloud link to upload the proposal. An email requesting a drop box type link will need to be sent by the Respondents identified contact to the Solicitation Coordinator no later than twenty-four (24) hours prior to the Response Deadline to ensure delivery is on time and in alignment with RFP Schedule of Events and RFP Section 1.9. Respondents must have all relevant documents uploaded by the response deadline as noted in the Schedule of Events.
9.	3.2 Response Delivery	10	For the redacted version, could Tenncare elaborate or provide more detail about what should not be redacted?	Respondents must only redact information that is considered confidential and exempt from the Tennessee Public Records Act (Tenn. Code Ann. § 10-7-503 and 504). Any redacted information by a Respondent will be evaluated by the State to ensure conformity in the event of a public records request relating to this procurement.

No.	RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
10.	3.2.2 Response Delivery	10	3.2.2 A Respondent must submit original Technical Response documents and copies as specified below. 3.2.2.1 Digital Media Submission 3.2.2.2 E-mail Submission Does the State expect both Digital Media (i.e., USB) Submission & Email Submission, or is one form of submission acceptable?	Only one form of submission is required. Please see response to #8 above if utilizing Email Submission.
11.	3.2.2.2.1 Response Delivery	10	3.2.2.2.1 - The Technical Response document shall be in the form of one (1) digital document and one (1) redacted digital document in "PDF" format or other easily accessible digital format attached to an email to the Solicitation Coordinator. Both the subject and file name shall both be clearly identified as follows: "RFP # 31865-00637 TECHNICAL RESPONSE" Please confirm the email subject and file name should be the same for both the digital Technical Response document submission and the redacted digital Technical Response document submission, as opposed to the redacted digital Technical Response document submission including "REDACTED" at the end of the email subject and at the end of the file name.	Both the unredacted and redacted copies of the Technical Response may be submitted in a single email with the file name for the redacted copy labeled "REDACTED." If multiple emails are required to meet the 25mb size limitation, then multiple emails may be submitted within the 25mb size limits or the Respondent may utilize the option provided in response to question #8 above.
12.	3.2.3 Response Delivery	10	For email submissions, the Technical Response document must be dispatched to the Solicitation Coordinator in separate e-mail messages. What is the State's acceptable email file size limit? Also, it is the State's expectation the digital Technical Response submission be broken out into the acceptable email file size limit in one email chain and the redacted digital Technical Response submission be broken out into the acceptable email file size limit in a separate email chain?	The Respondent may submit multiple emails broken out into the acceptable email file size limits or utilize the option provided in response to question #8 above.
13.	3.2.2.2.1 Response Delivery	10	The customer references shall be delivered by each reference in accordance with RFP Attachment 6.3, Reference Questionnaire.	The Respondent may be copied on the submission of the reference to the Solicitation Coordinator, but this is not an RFP requirement.

No.	RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
			If customer references submit the completed Reference Questionnaire via email, is it acceptable for the customer references to cc: the Respondent on the email submission to the Solicitation Coordinator, or can the Solicitation Coordinator confirm receipt of the Reference Questionnaire to the customer reference and cc: the Respondent?	A Respondent can reach out to the Solicitation Coordinator and request an update of customer reference submission(s).
14.	3.2.3.3 Response Delivery	10	Any Respondent wishing to submit a Response in a format other than digital may do so by contacting the Solicitation Coordinator. By what date does the respondent need to inform the state if the respondent intends to submit the bid response via email instead of digital or paper?	It is recommended that the respondent contact the Solicitation Coordinator as early as possible to coordinate a submission method alternate to that which is defined in RFP Section 3.2.3.3. See response to #8 above.
15.	A.3 Mandatory Requirement Items	20	Can this letter be submitted through email or does this letter need to be mailed?	The Bank Reference Letter should be included as part of the Respondents Technical Proposal as submitted by the Respondent in accordance with RFP Section 3.2 or optional method as detailed in question #8 above.
16.	B.6, B.8, B.15, B.16, B.17, B.18, B.19, B.20, B.21 General Qualifications & Experience Items	22, 24, 25, 26	For questions requiring responses for a period of time (i.e., within the last 2, 3, 5, 10 years…), is the look-back period based on the RFP response date, RFP release date, calendar year, or some other period?	Yes, the look-back period would be from the RFP response deadline in the RFP Schedule of Events.
17.	B.16.a General Qualifications & Experience Items	24	Would the liquidated damages provided in this response be pertaining to just [REDACTED] or would this include the parent company as well? We believe this would only include liquidated damages for [REDACTED] only.	Liquidated Damages pertaining only to the Respondent are required to be disclosed. See amended language in below Item #3.
18.	B.16.b. General Qualifications & Experience Items	24	We understand this question to not include providers, for example, hospitals, individuals, and health departments. Is our understanding correct?	This question only applies to government health plan contracts similar in scope to the Pro Forma Contract. See amended language in below Item #3.
19.	Section C Technical Qualifications	30	Question C.2.a.i - Due to the number of materials that will be provided to address the response to this question, can the materials be considered "attachments" to allow proper formatting and not count in the page limit?	C.2.a.i language has been updated in the Section C question table included in below Item #4. This language should clarify that no attachments are being requested or allowed.
20.	C.1.f.ii Managing	30	Does this question refer to systems of care or information systems?	The response should focus on any information system(s) supporting the care transition and support processes

No.	RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
	Care of Children in DCS Custody and Children Transitioning Out of DCS Custody			for children in different settings. See amended language for C.1.f.ii in Section C table included in below Item #4.
21.	Section C Technical Qualifications	28	The instructions for Section C indicate that Respondents "…must address all items (below) and provide, in sequence, the information and documentation as required…" If Respondents provide requested documentation directly after the response to the item, it may leave significant amounts of white space and take away part of the page limit. Please confirm that Respondents can place requested attachments at the end of the Section C items responses.	Yes. The Respondent must also detail the response page number for each item in the appropriate space identified within each Technical Response section and found in the far-left column labeled as: Response Page # (Respondent completes).
22.	C.1.f.iii Managing Care of Children in DCS Custody and Children Transitioning Out of DCS Custody	30	Does this question refer to systems of care or information systems?	Respondents should focus on the aspects of continuity of services and systems of care for this question. See amended language for C.1.f.iii for RFP Attachment 6.2 (Section C – Comprehensive Technical Qualifications Table) included in below Item #4.
23.	C.2.f Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	40	Sub-questions of C.7.f appear to be misnumbered: C.2.f.i (should be C.7.f.i) C.2.f.ii (should be C.7.f.ii) C.2.f.iii (should be C.7.f.iii) C.2.f.iv (should be C.7.f.iv) Will these questions be renumbered or should we submit them as numbered in the original RFP?	See amended numbering in Section C table included in below Item #4.
24.	C.2 Managing Care of Children under 21 who are SSI Eligible	30	Can we attach materials requested in C.2.a.i that won't count against the page count limit.	C.2.a.i language is updated for RFP Attachment 6.2 (Section C – Comprehensive Technical Qualifications Table) included in below Item #4. This should clarify that no attachments are being requested or allowed. All materials will count towards the page limit.
25.	C.3.a and C.4c SELECTCOMMUNITY-Katie Beckett and SELECTcOMMUNITY-	31,32	The RFP references "SelectCommunity contract requirements" and "SelectCommunity Populations." Can the State please clarify the reference to SelectCommunity and its populations and provide a definition of each: 1. SelectCommunity; 2. Children in Katie Beckett Part A; 3. Individuals with I/DD grandfathered into TennCare Select	Please see response and below Item #5 and Item #10. Item #5 amends ProForma definitions. Item #10 replaces Attachment 6.9 definitions to cover all terms across the RFP and Proforma. 1. ***SelectCommunity*** is an Integrated Health Services Delivery Model for persons with intellectual and/or

No.	RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
	Non Katie Beckett		through SelectCommunity; and 4. Dual-eligible beneficiaries?	developmental disabilities and children enrolled in Katie Beckett Part A. Please see below Item #5 and Item #10. This model is outlined in section A.4. 2. ***Children in Katie Beckett Part A*** are those children enrolled in the Katie Beckett Program by TennCare based on their medical and financial eligibility for the program. This group is currently limited to 300 enrollees. Please see A.1 Definitions and Abbreviations provided on page 71 of the RFP for a complete definition. 3. ***Individuals with I/DD grandfathered into TennCare Select through SelectCommunity*** refers to those individuals no longer eligible for new enrollment into SelectCommunity, but who remained in SelectCommunity due to their prior enrollment. Please see A.1 Definitions and Abbreviations provided on page 170 of the ProForma for a complete definition. 4. ***Dual eligible beneficiaries*** are not part of SelectCommunity unless they are eligible as Katie Beckett Part A members or grandfathered I/DD members. Please see below Item #5 and Item #10.
26.	C.4.c SelectCommunity – Katie Beckett	32	We would like to seek clarification on the SelectCommunity Model of Care requirement and ask if a single Model of Care with dedicated sections for: 1. SelectCommunity; 2. Children in Katie Beckett Part A; 3. Individuals with I/DD grandfathered into TennCare Select through SelectCommunity; and 4. Dual-eligible beneficiaries, would be acceptable.	SelectCommunity is limited to children in Katie Beckett Part A and individuals with I/DD grandfathered into TennCare Select through SelectCommunity. Some of these individuals may also be dually-eligible beneficiaries. The Model of Care for TennCare Select is defined in Section A.4. A Model of Care with dedicated sections for the separate populations would be acceptable if it complies with Chapter 5 of the Medicare Managed Care Manual as well as the requirements outlined in the Pro Forma contract.
27.	C.4.d SelectCommunity – Katie Beckett	32	Can the state please clarify the intent of Electronic Visit Verification implementation question. Is it the state's intent to implement EVV for services in SelectCommunity outside of HH/PDN i.e. for HCBS services?	Yes, this is a federal requirement pursuant to the 21st Century Cures Act for home health care services and personal care services.
28.	c.6.b.ii Provider Support and Network Adequacy	35	To assist respondents in answering this question, could the state provide the applicable pro forma references? Could the state please confirm if this question is related to how the respondent	The Respondent will identify the ways in which they will improve the wait time for determinations, enrollment, and/or eligibility process for providers. This should include systems to identify network adequacy present and future,

No.	RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
			supports TennCare and members in the enrollment and disenrollment of contracted and credentialed BPN providers, other PCPs, behavioral health care providers, and medical specialists? The respondent would like to understand the intent and focus of this question. Any guidance is appreciated.	how they will monitor and report initiatives to identify enrollment times and how they will improve these processes and decrease wait times.
29.	C.8.e.vii Serve as a Back-up Managed Care Organization (MCO)	44	Please clarify if EWR is a typo. Should this be EQR (External Quality Review)?	Yes, this should be EQR. See amended language for RFP Attachment 6.2 (Section C – Comprehensive Technical Qualifications Table) included in below Item #4 below.
30.	RFP Attachment 6.7, Item 15	799	Generation of the reports stipulated in the Pro Forma (see A.30) Should the reference A.30 instead be A.2.30?	Please see amended Section for Attachment 6.7 Item 15 included in below Item #9.
31.	Program Integrity - Managed Care Program Integrity Manual (version 9)	Procurement Library	Under the current Statewide contract, Managed Care Program Integrity Manual (version 9) is effective. Should the Procurement Library be updated to include version 9?	Yes. The Procurement Library is updated to replace Version 8 with Version 10 of the Managed Care Program Integrity Manual. Procurement Library links on the Central Procurement Posting website are also updated accordingly. Please see item #11 below. https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/supplier-information/request-for-proposals--rfp--opportunities1.html
32.	2.15.7 Reportable Event and Critical Incident Reporting and Management	399-408	The One Reportable Event Management System Operational Protocol was updated with an effective date of 10/1/2023. The Request for Proposals for Prepaid Inpatient Health Plan contains verbiage from the previous One Reportable Event Management System Operational Protocol dated 9/1/2021. Please clarify if the 10/1/23 version of the One Reportable Event Management System Operational Protocol should be utilized in the RFP Response.	The 10/1/2023 version of the One Reportable Event Management System Operational Protocol should be utilized in the RFP Response. See Item #5, Item #6, Item #7, and Item #8 for amended language that aligns the Pro Forma to the 10/1/2023 Effective One Reportable Event Management System Operational Protocol updates.
33.	5.3.4, Attachment 6.1, Attachment 6.3,	18, 19, 48, 794	Are digital signatures allowed for any RFP documents requiring a signature?	Please see response to Question #4 above.

No.	RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
	Attachment 6.6			
34.	Attachment 6.7, Attachment 8	798, 803	Question B.24 references Word versions of attachments 6.7 and 6.8 in the Procurement Library. However, attachments 6.7 and 6.8 in the Procurement Library are PDFs. Should we convert the PDF attachments to Word or will you send Word files for attachments 6.7 and 6.8?	The Procurement Library is updated to include Word versions of Attachment 6.7 and Attachment 6.8. Procurement Library links on the Central Procurement Posting website are also updated accordingly. Please see item #12 below. https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/supplier-information/request-for-proposals--rfp--opportunities1.html

3. RFP Attachment 6.2 Technical Response & Evaluation Guide, question B.16, Section B General Qualifications & Experience is deleted in its entirety and replaced Table of with the following (any sentence or paragraph containing revised or new text is highlighted):

B.16.	For any and all contracts including, in whole or in part, the TennCare Select Contract as detailed in *Pro Forma* Contract, Attachment 6.5, provide a full listing of: (a) Any and all liquidated damages paid, deducted, or set off from any payment due to Respondent and a narrative specifying the triggering event within the last two (2) years. **For B.16(a), Respondent shall include only the entity that has submitted a proposal**; and (b) Whether the Respondent has had a government health plan contract terminated or not renewed within the past five (5) years. If so, please describe the reason(s) for the termination/non-renewal, the parties involved, and provide the address and telephone number of the client. If the contract was terminated/non-renewed based on the Respondent's performance, please describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. For B.16(b), **Respondent shall include the Respondent's parent organization, affiliates, and subsidiaries.**

4. Delete RFP Attachment 6.2 (Section C – Comprehensive Technical Qualifications Table) in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
	C.1.	**Managing Care of Children in DCS Custody and Children Transitioning Out of DCS Custody** C.1.a The Respondent shall describe its proposed approach and innovative strategies to coordinate with the leadership and regional staff at the State's Department of Children's Services (DCS) and to provide immediate and ongoing health care services		**130**	

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		to the children, determined by DCS, that are in State Custody or transitioning out of State Custody. C.1.b The Respondent shall describe its proposed approach and innovative strategies to contract and incentivize Primary Care Providers (PCPs) to participate in a Best Practice Network (BPN) to serve children immediately upon entering State Custody as well as case managing and coordinating necessary care immediately and thereafter while eligible for TennCare Select. The Respondent shall describe how it plans to negotiate with current BPN providers in order to retain providers familiar with the needs of children in and/or transitioning out of State Custody as well as attract new PCPs to participate in the BPN. C.1.c The Respondent shall describe how they will develop relationships with Health Departments. C.1.d The Respondent shall describe its proposed approach to contract with and monitor the state-recognized Centers of Excellence (COE) for Children in or at Risk of State Custody. C.1.e The Respondent shall describe the approach for providing medical, BH, and social services to children in custody. The description shall include examples that speak to experience in providing these services to the Member population. The response shall include: C.1.e.i How academic needs will be met through school-based services C.1.e.ii Expected social service needs and approach to meet each C.1.e.iii Expected BH needs unique to the population. Treatment plans/procedures to diagnose BH issues of children in custody shall also be defined C.1.e.iv Resources that will be leveraged to assist with and address mental health needs associated with living in foster care C.1.f The Respondent shall additionally describe the approach for providing medical, BH, and social services to children transitioning out of custody into supported housing, other adult psychiatric rehabilitation services, or the community. The description shall include examples that speak to experience in providing these services to the Member population. The response shall include:			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		C.1.f.i What transition processes and supports might look like when transitioning children to different types of settings, especially for children with significant BH conditions and/or, I/DD, C.1.f.ii Information systems that that are used as tools will ensure continuity of care, C.1.f.iii Services and systems of care that will ensure continuity of care, C.1.f.iv What data will be leveraged and how, C.1.f.v How loss of healthcare coverage will be prevented during and after transitioning children out of custody, C.1.f.vi How children also transitioning to dual-eligibility will be covered through age 26, and C.1.f.vii Expected challenges for this transitioning population and how proposed challenges will be addressed. C.1.f.viii The Respondent shall describe its proposed approach to ensure that foster parents are an involved party in during custody and through the child's transition out of custody, including outreach and education activities.			
	C.2.	**Managing Care of Children under 21 who are SSI Eligible** C.2.a The Respondent shall describe the approach for managing care of children under 21 who are Supplemental Security Income (SSI) eligible. The description shall include examples that speak to experience in providing these services to the Member population. The response shall include C.2.a.i Strategies and references to the types of materials used to effectively communicate policy rule and eligibility changes to Members		**80**	

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		for increased awareness and prevention of foregone benefits. C.2.a.ii. Strategies to support the State in increasing awareness of the services available to SSI eligible children (under 21) and eligibility for other programs that aid in coverage for often expensive medical treatments, services, and medications. C.2.a.iii. Methods to support and simplify the process for Members to maintain their benefits;C.2.a.iv approach, including tools and practices to promote continuity of care and simplify the process as Members transition to new programs or age-out of their current program.			
	C.3.	**<u>SelectCommunity – Non-Katie Beckett</u>** C.3.a The Respondent shall describe the approach for managing care of Members receiving services in an institution or receiving Home- and Community-Based Services (HCBS) under a Section 1915I waiver program for persons with intellectual disabilities, including those that are a part of the previous Arlington Class enrolled February 9, 2018. The description shall include examples that speak to experience in providing these services to the Member population. The response shall include C.3.a.i Strategies to increase the efficacy of home and community-based BH benefits for children and adolescents with significant mental health conditions. C.3.a.ii Policies and practices that promote trauma informed systems of care. C.3.a.iii Strategies that address barriers for Members with multiple diagnoses including significant mental health conditions and I/DD or SUD. C.3.a.iv Early intervention services for at-risk Members without formal mental health diagnoses.		**60**	
	C.4.	**<u>SelectCommunity – Katie Beckett</u>** C.4.a The Respondent shall describe its proposed approach and innovative strategies to meet or exceed the minimum SelectCommunity Contract		**80**	

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		requirements serving each of the following populations: C.4.a.i Children in Katie Beckett Part A C.4.a.ii Individuals with I/DD grandfathered in to TennCare Select through SelectCommunity C.4.a.iii Dual-eligible beneficiaries The Respondent shall describe its relevant recent experience implementing these strategies in Medicaid programs. The Respondent shall, specifically and distinctly, describe any challenges/lessons learned from recent experience, as well as innovative strategies the Respondent has successfully implemented, the impact of those strategies, and how these would inform the Respondent's proposed approach. C.4.b The Respondent shall describe its proposed Tennessee organizational structure, systems and processes to support SelectCommunity individuals, and D-SNP operations, including how such structure relates to the broader health plan structure and how its structure, systems and processes will ensure the effective and efficient operation of these programs in accordance with Contract requirements. C.4.c The Respondent shall submit (as an attachment) an evidence-based Model of Care that comports with requirements set forth in Chapter 5 of the Medicare Managed Care Manual and with requirements set forth in the Pro Forma Contract for each of the SelectCommunity populations the Respondent is required to serve under this Contract. C.4.d The Respondent shall describe how it would implement the Electronic Visit Verification (EVV) requirements described in the Pro Forma Contract and manage such processes to improve the Member, worker, and provider experience, and ensure compliance with requirements set forth in the Pro Forma Contract and the 21st Century Cures Act. The Respondent shall describe its relevant recent experience in designing and/or implementing an EVV system in Medicaid programs, including challenges, improvements, and lessons learned, and how that informs its proposed approach. C.4.e The Respondent shall describe how it would leverage Telehealth to improve access and drive quality outcomes for SelectCommunity Members in			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		rural areas and for specialty services in Tennessee. The Respondent shall describe its recent relevant experience and outcomes achieved in using Telehealth models it commits to implement in Tennessee to improve access and drive quality outcomes for the SelectCommunity Population , including dual eligible populations in Medicaid programs, and how that informs its proposed approach. C.4.f The Respondent shall describe the approach for managing care of children receiving services through the Katie Beckett program. The description shall include examples that speak to experience in providing these services to the Member population. The response shall include: C.4.f.i Strategies to identify and maximize opportunities for cost savings that increase availability and prioritization of HCBS over institutionalized care. C.4.f.ii Strategies to incentivize direct care workers in HCBS settings. C.4.f.iii How preventive care and mental health treatments will be prioritized. C.4.f.iv Identified challenges/barriers to enrollment. C.4.f.v Strategies to achieve timely eligibility determinations and enrollments for these Members, including indicators leveraged for monitoring successful care and enrollment. C.4.f.vi Processes for appropriately managing transition of and continuity of care for children aging out of the program.			
	C.5.	**<u>Mental Health (MH) and Substance Use Disorder (SUD)</u>** <u>Mental Health</u> C.5.a The Respondent shall describe its proposed approach and innovative strategies for implementing a BH program that meets or exceeds the minimum mental health and substance use disorder TennCare Contract requirements and focuses on maintaining a high standard of care: recovery, resiliency, increased community tenure/integration, improved outcomes, screening and prevention. The Respondent shall, specifically and distinctly,		**50**	

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		describe any challenges/lessons learned from current experience, as well as innovative strategies the Respondent has successfully implemented and commits to implement in Tennessee, and the impact of those strategies. C.5.a.i The Respondent shall describe its approach to and experience with successfully serving individuals with Serious and Persistent Mental Illness (SPMI)/Serious Emotional Disorder (SED). Specifically, the Respondent shall describe the steps it commits to take as part of this TennCare Select Contract to work to increase alternative community-based services, minimize the number of emergency department presentations, psychiatric hospital (including involuntary) and residential (psychiatric and substance use disorder) treatment center admissions, and ensure follow-up care is provided as medically necessary. C.5.a.ii The Respondent shall describe its approach to and experience with successfully serving children and youth with complex BH and/or medical needs (including children in and/or transitioning out of State Custody), including innovative approaches to implementing a statewide initiative to increase specialized assessment and treatment services for these children, including design, implementation, provider and child advocate involvement and outcome measurement as part of this TennCare Select Contract. C.5.b The Respondent shall describe how its current integration of personnel and systems or its planned integration prior to the Operational Start Date of the next TennCare Select Contract will support integrated behavioral and physical case services and care coordination for Members. The Respondent shall describe how it will deliver care coordination of physical and BH care in order to improve the efficacy and quality of care for Members with BH needs. The Respondent shall further describe how its provider contracts and contracting practices, provider relations, claims payment, clinical support and other attributes will support integration of physical and BH care. These efforts shall be in addition to Tennessee Health Link (THL) program. The Respondent shall describe its relevant recent experience supporting the delivery of integrated behavioral and physical health care services and			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		care coordination for Members in Medicaid programs. <u>Substance Use Disorder (SUD)</u> C.5.c The Respondent shall describe its proposed approach and innovative strategies for providing the required SUD services and how the Respondent commits to work with TennCare Select Members with substance use disorder needs. The Respondent shall describe how it will provide treatment across the continuum of care for Members with SUD. The Respondent shall describe how it will address SUD including but not limited to providing Medication Assisted Treatment (MAT) and supporting care coordination for Members with SUD. The Respondent shall describe hIw it will measure quality of care for Members receiving treatment and use those outcomes to continually improve its approach to providing SUD services. <u>Individuals with I/DD and Co-Occurring BH Conditions or Behavior Support Needs</u> C.5.d Describe the Respondent's approach to and experience with building the statewide capacity and continuum and supporting the delivery of high value Behavioral Health Services to children and adults with I/DD and co-occurring BH conditions and/or behavior support needs. The Respondent shall describe its relevant recent experience managing BH benefits for individuals with I/DD in Medicaid programs, including outcomes achieved, challenges, improvements, and lessons learned, and how that informs its proposed approach. Specifically, please address how the Respondent will address requirements related to critical opportunities for family-centered care, collaboration with Department of Intellectual and Developmental Disabilities (DIDD), and for integration and coordination of BH and LTSS in order to improve the quality and cost-effectiveness of care for this TennCare population.			
	C.6.	**<u>Provider Support and Network Adequacy</u>** <u>Provider Support</u> C.6.a The Respondent shall describe its proposed approach to Medicaid network development, network management, and provider services for each TennCare Select program and population (including BPN providers, other PCPs, behavioral health care providers, and medical specialists). The		**40**	

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		Respondent shall specifically identify strategies and programs the Respondent has implemented to support, strengthen and develop its provider network(s) in other Medicaid programs and how it would implement those strategies under this Contract to meet the needs of each population. C.6.a.i How the Respondent will increase collaboration between the child welfare and Medicaid systems to ensure health-care coverage for youth who age out of foster care. C.6.a.ii The Respondent's approach to provider engagement, including examples of successful provider engagement strategies and how they will be implemented. C.6.a.iii The Respondent's approach to health Providers Relations & Support/Technology to better integrate BH and physical healthcare. C.6.b The Respondent shall describe how it will support its network providers to meet the requirements throughout this contract. Specifically, the Respondent shall describe: C.6.b.i How the Respondent will use data analysis and partnering with providers to improve quality and efficiency of the services received by Members. C.6.b.ii How the Respondent will improve timeliness for determinations and enrollment or eligibility processes, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals. C.6.b.iii How the Respondent will ensure that providers receive timely payment and appropriate support over the course of the Contract, including how the Respondent will support providers with high claims denial rates. C.6.b.iv The processes the Respondent will implement to effectively manage provider relations and communications including activities and approaches that it will implement to support providers to reduce the number of provider complaints, contracting issues, prior authorization, the assignment of Members, and claims concerns.			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		C.6.b.v The Respondent's approach to provider engagement, including examples of successful provider engagement strategies, how PCPs will identify specialty network providers for referrals, and how they will be implemented in Tennessee. C.6.b.vi The Respondent's method of communicating who is the provider's assigned provider relations representative and if Respondent has website lookup capability for a provider to find the name and contact information of their assigned provider relations representative. <u>Network Adequacy</u> C.6.c The Respondent shall describe how it will ensure timely access to primary care services, specialty care services, Behavioral Health Services and long-term care services necessary to promote TennCare's goals and contract requirements for all of its eligible populations. Specifically, the Respondent's proposal shall separately and distinctly include the Respondent's approach to the following: C.6.c.i Identification of network gaps (time/distance standards, after-hours clinic availability, wait time for appointments, closed panels, specialty populations, etc.) and how those gaps will be addressed; C.6.c.ii Utilization and reporting of encounter data and provider enrollment data to support Network Adequacy analyses; C.6.c.iii Strategies that will be deployed in Tennessee to increase provider capacity and meet the needs of Members where network gaps are identified; C.6.c.iv Strategies that will be deployed in Tennessee (including a description of data sources utilized) for monitoring compliance with the provider network standards in Pro Forma Contract, including timeliness to appointments; C.6.c.v Standardized processes and provider agreement language that will be included in agreements for the following provider types to			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		support Members and providers in the timely scheduling of appointments for identified provider types (determined by TennCare), such as: Allergists, Cardiologists; Chiropractors; Dermatologists; Endocrinologists; Gastroenterologists; General Surgeons; Licensed mental health specialists; Neurologists; Obstetricians/gynecologists; Oncologists/hematologists; Nephrologists; Neurosurgeons; Ophthalmologists; Orthopedists; Otolaryngologists; Opioid Use Disorder (OUD) treatment providers; PCPs (to include Nurse Practitioners/Physician Assistants); Psychiatrists (adult/child and adolescent); Urologists; or for special populations; C.6.c.vi Strategies that will be implemented in Tennessee for recruitment and retention efforts planned for each provider type, including performance metrics that will be used to determine provider's success in making progress towards TennCare's goals for access and quality; C.6.d. The Respondent shall describe its approach to meet or exceed the minimum contract requirements to ensure timely access to HH, Private Duty Nursing (PDN), and the specific actions it will take under this Contract to identify, address, and minimize gaps in care, and to ensure a network of high-quality providers that can achieve individual and program outcomes. C.6.e The Respondent shall describe how it monitors network access requirement and if it uses Quest Analytics Software.			
	C.7.	**Quality Improvement, Population Health, and EPSDT Services and Turning 21 Years of Age (T21)** <u>Quality Improvement</u> C.7.a The Respondent shall describe its approach to overall Quality Improvement and specific strategies that will be used to advance TennCare's Quality Strategy across all programs and populations, including physical health and BH of TennCare Select Members. The Respondent shall describe how it would leverage its experience to improve quality of care and quality outcomes in		**40**	

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		Tennessee, including how it will monitor and assure compliance with contract requirements, and how it will drive Quality Improvement across all programs and populations. The Respondent shall describe its plan to implement the minimum contract requirements. C.7.a.i The Respondent shall describe how it will share performance data with TennCare Select providers in a timely, actionable manner, describe any challenges/lessons learned from current experience, as well as innovative strategies the Respondent has successfully implemented and commits to implementing in Tennessee, and the impact of those strategies. Identify specific supports/tools the Respondent will make available to TennCare providers to assist their efforts to improve care quality. Identify firm dates these tools will be available to providers in Tennessee. C.7.a.ii. The Respondent shall provide (as an attachment) documentation from NCQA for all of the Respondent's Medicaid managed care contracts that shows full accreditation status. The 1-2 page document shall include at a minimum: product line, accreditation status, effective date, and expiration date. C.7.a.iii. The Respondent shall provide (as an attachment) a copy of the Respondent's two most recent External Quality Review (EQR) report (pursuant to Section 1932(c)(2) of the Social Security Act) that provide a review of compliance with Medicaid regulations. The reports shall be provided for the Medicaid contracts that had the largest number of Members as of August 4, 2023. The most recent report shall include the entire EQR report with copies of any request for corrective action plan(s) associated with the report and response provided. The second most recent report does not require the entire EQR report, nor will it require the specific CAPs and associated follow-ups. Instead it shall include an Executive Summary that includes an overview of the report, methodology, results (including number of any non-compliant findings and corrective action			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		plans), and brief reference to the standards and measures reviewed. C.7.b The Respondent shall describe its experience leading and participating in collaborative Quality Improvement projects with other Medicaid programs and propose two ideas for collaborative Quality Improvements to improve TennCare Select Members' outcomes and reduce the cost of their care such as community initiatives to improve care for specific populations and/or collecting, analyzing, and sharing provider performance data in a more collaborative manner and standardized format for primary care and/or other participating providers. C.7.c The Respondent shall describe its experience and plan to implement Quality Improvement that aims to reduce disparities by targeting key health outcome measures and by applying a population health lens. <u>Population Health</u> C.7.d The Respondent shall describe how it will address Non-Medical Risk Factors (NMRF) to improve the health status of the Members. NMRF are defined as the factors in a Member's life outside of traditional medical care that contribute to the risks and resiliency of their health. NMRF can include the Member's community, employment, education, housing, access to nutritious food, stress, etc. C.7.d.i The Respondent shall describe its approach to and experience with collecting data on NMRF for targeted Medicaid populations, the types of domains and metrics collected, standardized screening tools that are utilized, and methods used to analyze and act on the data. C.7.d.ii In the case that the state does not supply an aligned Closed-Loop Referral System (CLRS), the Respondent shall include detail on the community-based referral platform it plans to use to monitor or close the loop on referrals and/or monitor community-based partnership development activities. In the case that the state supplies an aligned CLRS, the respondent shall describe how it will work to address NMRF. C.7.d.iii. The Respondent shall describe how data on TennCare Members' NMRF will be used to inform care management, and how it			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		will use this data and analysis to inform its partnerships with health care providers. <u>Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services</u> C.7.e The Respondent shall describe its approach to providing EPSDT for Medicaid enrolled children under age 21. The Respondent shall include detailed examples of experience providing EPSDT services in Tennessee and/or other states. C.7.e.i What expectations and management of service delivery across various settings for well-childcare at acute visits looks like. C.7.e.ii What care coordination and case management looks like, including connections with families, communities, and other key partners; and how will it support special populations including children in State Custody and children with I/DD? What specific interventions and supports will it provide to those populations? C.7.e.iii What tools and materials are in place to provide clear guidance to families and providers on the range of services covered. C.7.e.iv How it will measure and enforce compliance of required components of well-childcare visits being held, including lab tests. C.7.e.v How it will improve quality and structure of service, including provider allocation to maximize availability of health professionals. C.7.e.vi The Respondent shall describe its proposed approach and innovative strategies to prepare Members who are approaching the transition from children's EPSDT benefit packages to adult benefits in Medicaid programs. <u>Transitioning to 21</u> C.7.f The Respondent shall describe the approach for identifying all Members receiving services, as defined in TennCare Rule 1200-13-13-.01, in excess of adult benefit limits prior to the Member turning twenty-one (21) years of age in accordance with Section 2.9.5 of the Pro Forma Contract. The response shall also include: C.7.f.i A description of the internal mechanism that will be used to track and review all cases, including outreach and education, assessment and transition planning discussions for Member at or older than eighteen (18) years of age			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		receiving Home Health (HH) and PDN services in excess of adult benefit limits. C.7.f.ii A description of the strategies that will be employed to meet the milestones and reporting requirements outlined in Section 2.9.5 of the Pro Forma Contract. C.7.f.iii A description of how the Respondent will collaborate with LTSS to discuss transition of Members receiving Home Health (HH) or PDN services in excess of adult benefit limits, considering CHOICES of ECF, including but not limited to developing a person centered support plan to provide to Member/Member's family for consideration. C.7.f.iv Describe the approach that will be taken by Respondent to ensure Members' smooth transition from TennCare Select to their newly assigned MCO if applicable.			
	C.8	**Serve as a Back-up Managed Care Organization (MCO)** The Contract outlines the Respondent's responsibility and requirement to additionally provide managed care services for TennCare MCO enrollees in the case that a current MCO cannot uphold its contractual obligations. In this circumstance, the PIHP would be contractually obligated to uphold the MCO Risk Contract for all MCO enrollees assigned. C.8.a Controlling Cost Trends and Utilization The Respondent shall describe its relevant recent experience administering Medicaid managed care programs to address the following involving children and adults, including children and adults with physical disabilities and/or I/DD: C.8.a.i Super-utilizers of emergency departments and High Utilization of crisis Behavioral Health Services (i.e. crisis response, emergency department (ED), and inpatient psychiatric) C.8.a.ii Control the utilization of low value, avoidable, or not indicated health care services C.8.a.iii Support providers with high prior authorization denial rates		**20**	

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		C.8.a.iv Appropriate and medically necessary utilization of HH and/or PDN services C.8.a.v Meeting or exceeding the minimum Contract Risk Agreement (CRA) requirements for handling appeals of adverse benefit determinations <u>C.8.b LTSS-CHOICES, ECF CHOICES, other Integrated MLTSS Programs for Individuals with I/DD, D-SNPs</u> The Respondent shall describe its relevant recent experience administering Medicaid managed care programs to deliver person-centered planning and practices in the CHOICES and ECF CHOICES, other integrated MLTSS programs for individuals with I/DD, and D-SNP programs to demonstrate the following: C.8.b.i An evidenced-based Model of Care that complies with Chapter 5 of the Medicare Managed Care Manual C.8.b.ii Any certifications, accreditations, etc. C.8.b.iii Consumer direction in LTSS C.8.b.iv EVV and the 21st Century Cures Act requirements C.8.b.v Telehealth to improve access to LTSS, particularly in rural areas <u>C.8.c Mental Health and Substance Use Disorder</u> The Respondent shall describe its relevant recent experience administering Medicaid managed care programs to deliver mental health and substance use disorder services to children and adults, including children and adults with physical disabilities and/or I/DD to address the following:			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		C.8.c.i An integrated model of delivering case management and care coordination services across behavioral health, physical health, and long-term services and supports C.8.c.ii Serving persons with complex BH and/or medical needs, including specialized assessment, treatment services, and provider and child advocate involvement C.8.c.iii Serious and Persistent Mental Illness (SPMI)/Serious Emotional Disorder (SED) including ensuring that follow-up care is medically necessary, maximizing alternative community-based services, and minimizing emergency department presentations, psychiatric hospital (including involuntary), and residential (psychiatric and substance abuse) treatment center admissions <u>C.8.d Delivery System Transformation (including Patient-Centered Medical Home (PCMH); EoC; THL; and QuILTSS</u> The Respondent shall describe its relevant recent experience administering Medicaid managed care programs to deliver delivery system transformation strategies to children and adults, including children and adults with physical disabilities and/or I/DD to address the following: C.8.d.i PCMH model that involves the Respondent's experts and senior leadership, offers technical assistance and data to providers, and facilitates PCMH payment arrangements C.8.d.ii EoC model that involves the Respondent's experts and senior leadership, offers technical assistance and data to providers, and facilitates EoC payment arrangements			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		C.8.d.iii THL model that involves the Respondent's experts and senior leadership, offers technical assistance and data to providers, and facilitates THL payment arrangements C.8.d.iv QuILTSS model that involves Respondent's experts and senior leadership, offers technical assistance and data to providers, and facilitates quality incentive payments and/or arrangements <u>C.8.e Access to Care and Quality</u> The Respondent shall describe its relevant recent experience administering Medicaid managed care programs to promote access to care and to deliver high quality services to children and adults, including children and adults with physical disabilities and/or I/DD to address the following: C.8.e.i Network gaps (e.g. time/distance standards, after-hours clinic availability, wait time for appointments, closed panels, specialty populations, etc.) and how these gaps will be addressed C.8.e.ii Utilization and reporting of encounter data and provider enrollment data to support Network Adequacy analyses C.8.e.iii Strategies to meet the needs of Members where network gaps are identified C.8.e.iv Standardized processes and provider agreement language for provider types identified by TennCare (e.g. Cardiologists, Endocrinologists, Licensed Mental Health Specialists, Neurologists, Obstetricians/Gynecologists, Orthopedists, Primary Care Providers, Psychiatrists, and Pulmonologists) C.8.e.v Strategies for recruitment and retention efforts for each provider type, including			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		performance metrics that will be used to determine provider's success in making progress towards TennCare's goals for access and quality C.8.e.vi Most recent available NCQA Health Insurance Plan Ratings Accreditation summary report and Healthcare Effectiveness Data and Information Set (HEDIS) score sheet for all of the respondent's Medicaid managed care contracts with full NCQA accreditation C.8.e.vii Most recent EQR report (pursuant to Section 1932(c)(2) of the Social Security Act that provide a review of compliance with Medicaid and CHIP managed care regulations. C.8.f Provider Relations and Support The Respondent shall describe its relevant recent experience administering Medicaid managed care programs to promote provider relations across providers of physical health, BH, LTSS, and I/DD services to address the following: C.8.f.i Data integrity and information exchange C.8.f.ii timely claims payment and accurate claims approval and/or denials C.8.f.iii Provider complaints, contracting issues, prior authorization, Member assignment, and claims concerns C.8.f.iv Provider engagement strategies including but not limited to professional development, Continuing Education Units (CEUs), and assigned provider representatives C.8.f.v If Respondent has website lookup capabilities for a provider to easily identify name and contact information of their assigned provider relations representative.			

Section C – Comprehensive Technical Qualifications					
RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		C.8.g Population Health and Non-Medical Risks Factors The Respondent shall describe its relevant recent experience administering Medicaid managed care programs to promote population health management and strategies targeting NMRF to address the following: C.8.g.i Data collection on NMRF for targeted Medicaid populations C.8.g.ii Standardized methodologies and screening tools to identify health disparities affecting specific subsets of TennCare's Member population C.8.g.iii Care management model including but not limited to a CLRS (or community-based referral platform) and any existing and/or proposed strategies for community investment being sure to specify which NMRF are being addressed and specific interventions to reduce health disparities			
				Section C Total Raw Weighted Score: Numbers shall be whole numbers and not include decimal places	

The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point. *Raw weighted score = Item Score * Evaluation Factor*	**Total Raw Weighted Score:** *(sum of all Raw Weighted Scores above)* **Total Raw Weighted Score X 80 (Maximum Possible) = SCORE** **Weighted Score**

State Use – Evaluator Identification:

5. **Attachment 6.5 Pro Forma Contract Section A.1. definitions have been modified to add language for the definitions of "Additional Reportable Events and Interventions" and "SelectCommunity"; and modified to add the term "Dual-eligible Beneficiaries" after the term "Divisions of TennCare" as seen below (any sentence or paragraph containing revised or new text is highlighted).**

Additional Reportable Events and Interventions – An Additional Reportable Event is an event which is not related to abuse, neglect, or exploitation, that the provider, MCO, or FEA staff shall be responsible for reporting to the ~~MCO and/or~~ DIDD as specified in TennCare protocol. A Reportable Intervention is a measure taken to promote the health and safety of the person, which is not related to abuse, neglect, or exploitation, that the provider, MCO, or FEA staff shall be responsible for reporting to the MCO and/or DIDD as specified in TennCare protocol.

SelectCommunity - SelectCommunity is a special component of the TennCare Select program as an Integrated Health Services Delivery Model, developed specifically for individuals with I/DD and children enrolled in Katie Beckett Part A. Person- and family-centered planning will be conducted for children enrolled in SelectCommunity in a manner consistent with CFR 441.301(c)(1), using SelectCommunity Nurse Care Managers who have specialized training in developmental disabilities, and in a family-centered approach.

Dual-eligible Beneficiaries - Individuals eligible for both Medicaid and Medicare.

6. **Attachment 6.5 Pro Forma Contract Section A.2.9.7.12.17 is deleted in its entirety and replaced with the below (any sentence or paragraph containing revised or new text is highlighted):**

2.9.7.12.17 If at any time a Tier 1 Reportable Event is suspected, the member's care coordinator or the FEA shall report the allegations to ~~the to~~ the DIDD Abuse Hotline as soon as possible, but no later than four (4) hours after the occurrence of the event or the discovery thereof. Subsequently, ~~and a typed report is submitted by~~ the Event Management Coordinator (EMC) or designee shall submit a Reportable Event Form to ~~the~~ DIDD ~~Event Management Unit at Central Office and the MCO~~ within one (1) business day in accordance with the Contractor's abuse and neglect plan protocols. The notification shall be completed using a Reportable Event Form as prescribed by TennCare. If the allegation is in reference to a worker or representative and concerns physical or sexual abuse, the FEA shall contact the member/representative to determine if the member/representative wants to place the worker or representative on administrative leave until DIDD has completed its investigation. If the representative is the subject of the allegation, the representative shall not be allowed to decide whether to take leave, and such a decision shall solely be up to the member. The member/representative may additionally decide to remove staff at their discretion for allegations concerning other Tier 1 or Tier 2 events, as applicable. The FEA shall notify the Contractor regarding this communication with the member/representative and the member or representative's decision. The care coordinator shall work with the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, and results in the placement on any registry included in Section A.2.11.10.4.1.2.4, then the representative or worker shall no longer be allowed to participate in the CHOICES program as a representative or worker. If the investigation is inconclusive, the member may elect to retain the worker or representative. The member's care coordinator, with assistance from the FEA as appropriate, shall make any updates to the member's plan of care and/or risk assessment/risk agreement deemed necessary to help ensure the member's health and safety, and shall provide, at least annually, education of the member and their

representative of the risk of, and signs and symptoms of, abuse and neglect. The Contractor may initiate action to involuntary disenroll the member from consumer direction at any time the Contractor feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction.

7. Attachment 6.5 Pro Forma Contract Section A.2.15.7.1.3 is deleted in its entirety and replaced with the below (any sentence or paragraph containing revised or new text is highlighted):

2.15.7.1.3 Reportable Events, for the purposes of CHOICES Groups 2 and 3, I/DD MLTSS Programs, and the Katie Beckett program, shall be stratified into three groups: Tier 1, Tier 2, and Additional Reportable Events. Reportable Events shall include the following Reportable Events when they occur in a home and community-based and/or long-term services and supports delivery setting (as defined in Section 2.15.7.1.1. above).

8. Attachment 6.5 Pro Forma Contract Section A.2.15.7.1.3.1.1 is deleted in its entirety and replaced with the below (any sentence or paragraph containing revised or new text is highlighted):

2.15.7.1.3.1.1 Any event involving alleged wrongful conduct affecting the person by acts or omissions of abuse, neglect, exploitation, or misappropriation of money or property, and resulted in one or more of the following consequences to the person : death, serious injury, or physical harm; physical or sexual abuse; significant pain, intimidation or mental anguish that required medical intervention or loss of funds or property greater than one thousand dollars ($1,000) in value, or missing prescription controlled medication with a replacement value greater than $1,000. Notice is given to the DIDD Abuse Hotline as soon as possible but within four (4) hours, and a typed report is submitted by the Event Management Coordinator (EMC) to the DIDD Event Management Unit at Central Office and the MCO within one (1) business day. For purposes of this section, abuse, neglect, and exploitation shall be defined as in T.C.A. 33-2-402 and implemented as specified in TennCare protocol. Sexual abuse includes sexual battery by an authority figure as defined in T.C.A. 39-13-527;

9. RFP Attachment 6.7, item #15, included in the Information Systems Profile Table is deleted in its entirety and replaced with the following(any sentence or paragraph containing revised or new text is highlighted):

15	Generation of the reports stipulated in the Contract (see A.2.30)							

10. Attachment 6.9 Definitions, Acronyms, and Abbreviations is deleted in its entirety and replaced with the below Attachment 6.9 Definitions, Acronyms, and Abbreviations, which includes all terms not previously included from Attachment 6.5 Proforma Section A.1 Definitions; modifies the term "Additional Reportable Events and Interventions"; and adds the terms "SelectCommunity" and "Dual-eligible Beneficiaries" as seen below (any sentence or paragraph containing revised or new text is highlighted).

11. Version 8 of the Managed Care Program Integrity Manual is deleted in its entirety and replaced with Version 10 of the Managed Care Program Integrity Manual. This can be found on the CPO website utilizing the link found in #31 above.

DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

The Attachment 6.9 – Definitions section is intended to provide definitions for terms and/or their respective acronyms as found within this RFP document and Pro Forma language as found within Section A.1 of RFP Attachment 6.5.

12. The Procurement Library is updated to include Word versions of Attachment 6.7 Information System Profile and Attachment 6.8. Information Systems Organization Profile. This can be found on the CPO website utilizing the link found in #34 above.

1915(c) Waiver Home and Community-Based Services (HCBS) – Services provided pursuant to an HCBS waiver approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act which are available only to eligible persons enrolled in such waiver. Only certain 1915(c) waiver HCBS are eligible for Consumer Direction. 1915(c) waiver HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although home health and private duty nursing services are subject to estate recovery and shall, for members enrolled in the Statewide HCBS Waiver, be counted for purposes of determining whether the member's needs can be safely met in the community within their Individual Institutional Cost Limit.

1915(c) Waiver – One of the three waivers (Statewide, Comprehensive Aggregate Cap, and Self-Determination) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act to which provide HCBS not otherwise available under the State Plan to eligible persons with I/DD enrolled in such waivers.

1915(c) Waiver Member – A member who has been enrolled by TennCare into one of the three 1915(c) waivers.

21st Century Cures Act – The 21st Century Cures Act (Public Law No. 114-255) is a federal law enacted in 2016 that established federal requirements for the use of electronic visit verification (EVV) systems for Medicaid-covered personal care services and home health services.

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (see 42 CFR 455.2).

Additional Reportable Events and Interventions – An Additional Reportable Event is an event which is not related to abuse, neglect, or exploitation, that the provider, MCO, or FEA staff shall be responsible for reporting to the DIDD as specified in TennCare protocol. A Reportable Intervention is a measure taken to promote the health and safety of the person, which is not related to abuse, neglect, or exploitation, that the provider, MCO, or FEA staff shall be responsible for reporting to the MCO and/or DIDD as specified in TennCare protocol.

Administrative Cost – All costs to the Contractor related to the administration of this Contract that are non-medical in nature including, but not limited to:

1. Meeting requirements in Sections A.2.1 and A.2.2;

2. Enrollment and disenrollment in accordance with Sections A.2.4 and A.2.5;

3. Additional services and use of incentives in Section 2.6.5;

4. Health education and outreach in Section 2.7.5;

5. Meeting requirements for coordination of services specified in Section A.2.9, including care coordination for CHOICES members and the Contractor's EVV system except as otherwise provided in Section C.3.7 but excluding Medical Case Management;

6. Establishing and maintaining a provider network in accordance with the requirements specified in Sections A.2.11 and A.3, Attachments III, IV and V;

7. Utilization Management as specified in Section A.2.14;

8. Quality Management/ Quality Improvement activities as specified in Section A.2.15;

9. Production and distribution of Member Materials as specified in Section A.2.17;

10. Customer service requirements in Section A.2.18;

11. Grievance and appeals processing and resolution in accordance with Section A.2.19;

12. Claims Processing in accordance with Section A.2.22;

13. Maintenance and operation of Information Systems in accordance with Section A.2.23;

14. Personnel requirements in Section A.2.29;

15. Production and submission of required reports as specified in Section A.2.30;

16. Administration of this Contract in accordance with policies and procedures;

17. All other Administration and Management responsibilities as specified in Attachments II through IX and Sections A.2.20, A.2.21, A.2.24, A.2.25, A.2.26, A.2.27, and A.2.28;

18. Premium tax; and

19. All costs related to third-party recovery or subrogation activities whether performed by the Contractor or a subcontractor.

    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 (e.g., claims processing) are considered to be an "administrative cost".

Adult Protective Services (APS) – An office within the Tennessee Department of Human Services that investigates reports of abuse, neglect (including self-neglect) or financial exploitation of vulnerable adults. APS staff assess the need for protective services and provide services to reduce the identified risk to the adult.

Advance Determination – A decision made by TennCare in accordance with the process and requirements described in Rule 1200-13-01-.05(6) that an Applicant would not qualify to enroll in CHOICES Group 3 (including Interim CHOICES Group 3) when enrollment into CHOICES Group 3 has not actually been denied or terminated, and which may impact the person's NF LOC eligibility.

Adverse Benefit Determination – As defined at 42 C.F.R. §438.400(b).

Affiliate – Any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership, and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the Contractor.

Allergist – A medical practitioner specializing in the diagnosis and treatment of allergies.

Area Agency on Aging and Disability (AAAD) – Agencies designated by the Commission on Aging and Disability or its successor organization to plan for and provide services to the elderly and disabled within a defined geographic area as provided by T.C.A. Title 71, Chapter 2.

Arlington Class – The Comprehensive Aggregate Cap (CAC) Waiver (#0357.R04), formerly known as the Arlington Waiver, offers supports to individuals with intellectual disabilities who are former Members of the certified class in the United States vs. the State of Tennessee, et al. (Arlington Developmental Center), former Members of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), persons discharged from the Harold Jordan Center following a stay of at least 90 days, and individuals transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2020, because they were identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver.

At-Risk – As it relates to the CHOICES program, SSI eligible adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined in TennCare rules and regulations, such that, in the absence of the provision of a moderate level of home and community-based services, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As it relates to Interim CHOICES Group 3, open for enrollment only between July 1, 2012, and June 30, 2015, "at risk" is defined as adults aged sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meet Nursing Financial eligibility criteria, and also meet the Nursing Facility level of care in effect on June 30, 2012.

Back-up Plan – A written plan that is a required component of the plan of care for all CHOICES members receiving companion care or non-residential CHOICES or 1915(c) waiver HCBS, all Katie Beckett Part A members receiving Katie Beckett Part A HCBS, and all members (including, but not limited to CHOICES, 1915(c) waiver, and Katie Beckett Part A members) receiving home health (HH) or private duty nursing (PDN) services in their own home and which specifies family members, other unpaid persons as well as paid consumer-directed workers and/or contract providers (as applicable) who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled CHOICES, 1915(c) waiver, or Katie Beckett Part A HCBS providers or workers, or home health or private duty nurses or aides are unavailable or do not arrive as scheduled. A CHOICES, 1915(c) waiver, or Katie Beckett Part A member or their representative may not elect, as part of the back-up plan, to go without services nor may a person receiving HH and/or PDN go without needed services. Inpatient admission shall not be considered an adequate back-up plan. The back-up plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The member and their representative (as applicable) or for children in Katie Beckett Part A, the child's parent(s) or other legal guardian shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services. The FEA will assist as needed with the development and verification of the initial back-up plan for consumer direction. The CHOICES care coordinator, 1915(c) waiver independent support coordinator, DIDD case manager, or Katie Beckett Part A nurse care manager shall be responsible for assistance as needed with implementing the back-up plan and for updating and verifying the back-up plan on an ongoing basis.

Behavioral Health Assessment – Procedures used to diagnose mental health or substance use disorder conditions and determine treatment plans.

Behavioral Health Services – Mental health and/or substance use disorder services.

Beneficiary Support System – The Beneficiary Support System is an entity independent of TennCare MCOs that provides support to applicants and enrollees before and after enrollment pursuant to 42 C.F.R § 438.71. Specific to CHOICES, Katie Beckett, and I/DD MLTSS Programs, the State's Beneficiary Support System contractor will assist applicants and enrollees with navigation of the Contractor's appeals and grievance processes upon request by applicants and enrollees.

Benefit Appeal – As distinguished from an Eligibility Appeal, a "Benefit Appeal" concerns an enrollee's request to contest an MCC's adverse benefit determination by receiving a State Fair Hearing (SFH). CMS has determined that the provisions contained in 42 C.F.R. 438 subpart F, which require MCOs to maintain an internal appeal system, and which require enrollees to exhaust the MCO internal appeal process before being permitted to request an SFH, are satisfied by TennCare's requirement that the Contractor comply with the "Reconsideration" phase of the state fair hearing process (also called the "appeal process"). In accordance with CMS approval, the Contractor shall not have an internal appeal process that enrollees are required to exhaust before they may request a SFH through the TennCare appeal process. The Contractor's "Reconsideration" of its initial adverse benefit determination during the TennCare appeal process is deemed by CMS to satisfy the requirement for a MCO-level appeal.

Benefit Appeal System – Synonymous with State Fair Hearing (SFH) System, SFH Process, Appeal System, and Appeal Process. References to Appeal System or Appeal Process refers to both (1) the processes the Contractor implements to comply with its TennCare Appeal Process-related obligations (such as timely issuance of a compliant Notice of Adverse Benefit Determination (NABD), timely compliance with the Reconsideration phase of the Appeal Process, timely compliance with TennCare-issued directives instructing Contractor to approve and arrange provision of a benefit in accordance with an Order resulting from the Appeal Process, etc.), and (2) the processes the Contractor implements to collect, track and maintain the information gathered in accordance with the Appeal Process.

Benefits – The package of health care services, including physical health, behavioral health (BH), and long-term care services, that define the covered services available to TennCare enrollees assigned to the Contractor's MCO pursuant to this Contract.

Best Practice Guidelines – Guidelines for provision of health and Behavioral Health Services to children in State custody.

Best Practice Network (BPN) – A network of organizations formed to serve children immediately upon entering State Custody.

Best Practice Provider (BPP) – A provider (primary care, behavioral health, or dental) who has been determined by the state to have the interest, commitment, and competence to provide appropriate care for children in State custody, in accordance with the Remedial Plan and statewide Best Practice Guidelines, and who has agreed to be in the MCO network.

Breach (with respect to Protected Health Information (PHI)) – The acquisition, access, use, or disclosure of protected health information in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the protected health information.

Business Associate Agreement (BAA) – Business associate agreements form the backbone of an organization's compliance program(s) (e.g., HIPAA and HITECH). These agreements made between the agency and the Contractor are reasonably necessary to keep TennCare and the Contractor in compliance with HIPAA and HITECH and include clauses outlining the permissible and impermissible uses of Protected Health Information (PHI), each party's liabilities, consequences of failing to comply with stated requirements, and more.

Business Day – Monday through Friday, except for State of Tennessee holidays.

CAHPS (Consumer Assessment of Healthcare Providers and Systems) – A comprehensive and evolving family of surveys that ask consumers and patients to evaluate various aspects of health care.

Cardiologist – A doctor who specializes in the study or treatment of heart diseases and heart abnormalities.

Care Coordination Team – If an MCO elects to use a care coordination team, the care coordination team shall consist of a care coordinator and specific other persons with relevant expertise and experience who are assigned to support the care coordinator in the performance of care coordination activities for a CHOICES member as specified in this Contract and in accordance with Section 2.9.7, but shall not perform activities that must be performed by the Care Coordinator, including needs assessment, caregiver assessment, development of the plan of care, and minimum Care Coordination contacts.

Care Coordination Unit – A specific group of staff within the MCO's organization dedicated to CHOICES that is comprised of care coordinators and care coordinator supervisors and which may also include care coordination teams.

Care Coordinator – The individual who has primary responsibility for performance of care coordination activities for a CHOICES member as specified in the Contract and meets the qualifications specified in Section 2.9.7 of the Contract.

Caregiver – For purposes of CHOICES or 1915(c) waivers, a person who is (a) a family member or is unrelated to the member but has a close, personal relationship with the member and (b) routinely involved in providing unpaid support and assistance to the member. A caregiver may be also designated by the member as a representative for CHOICES or 1915(c) waivers or for consumer direction of eligible CHOICES or 1915(c) wavier HCBS. For purposes of Part A of the Katie Beckett Program, the "caregiver" is generally the child's parent(s) or other legal guardian except when someone other than the child's parent(s) or other legal guardian are routinely involved in providing unpaid support and assistance to the child.

Carve-out for Children in State Custody – An arrangement that TennCare establishes so that all children in State custody are assigned to one MCO.

Case Manager – An organization or a provider responsible for supervising or coordinating the provision of initial and primary care to patients; for initiating and/or authorizing referrals for specialty care; and for monitoring the continuity of patient care services.

CEA – Cost Effective Alternative (see Section 2.6.5 of this Contract).

Centers of Excellence (COE) for AIDS – Integrated networks designated by the State as able to provide a standardized and coordinated delivery system encompassing a range of services needed by TennCare enrollees with HIV or AIDS.

Centers of Excellence (COE) for Behavioral Health – COEs that provide a limited range of direct services to children in and at risk for State custody (i.e., not just DCS children/youth). These services are to augment the existing service system. Therefore, COEs for Behavioral Health typically only provide services where there is sufficient complexity in the case to warrant the COE for Behavioral Health resources and/or all other means to provide the service in the TennCare network have been exhausted.

Center of Excellence (COE) for Children in or at Risk of State Custody – Tertiary care academic medicine center designated by the state as possessing, or being in a position to quickly develop, expertise in pediatrics, child behavioral health issues (including aggression, depression, attachment disorders and sexualized behaviors), and the unique health care needs of children in or at risk of State custody.

Certificate of Authority – The contractor needs to maintain a standard Certificate of Authority (COA) from TDCI to operate as a Health Maintenance Organization (HMO) in Tennessee in the service area covered by the contract.

CFR – Code of Federal Regulations.

Child Protective Services (CPS) – A program division of the Tennessee Department of Children's Services whose purpose is to investigate allegations of child abuse and neglect and provide and arrange preventive, supportive, and supplementary services.

Children At Risk of State Custody – Children who are determined to belong in one of the following two groups:

1. Children at imminent risk of entering custody - Children who are at risk of entering State custody as identified pursuant to T.C.A. 37-5-103(10).
2. Children at serious risk of entering custody - Children whom DCS has identified as a result of a CPS referral; or children whose parents or guardians are considering voluntary surrender (who come to the attention of DCS); and who are highly likely to come into custody as a result of being unable to access Behavioral Health Services.

Children in Katie Beckett Part A – Part A of the Katie Beckett Program serves children with the most significant disabilities or complex medical needs.

Children with Special Health Needs Steering Panel (CSHN Steering Panel) – An entity comprised of representatives of providers, advocates, the State, the plaintiffs of the court order related to the provision of services to children in State custody, managed care entities, and referral sites whose responsibility will be to guide and assess the development of a health service system for children in State custody, and where appropriate, make recommendations.

Children's Health Insurance Program (CHIP) – The Children's Health Insurance Program (CHIP) is a state-federal partnership program that provides low-cost coverage with comprehensive benefits for uninsured children in families that earn too much money for children to qualify for Medicaid.

CHOICES At-Risk Demonstration Group – Individuals who are age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who (1) meet nursing home financial eligibility for TennCare-reimbursed long-term services and supports, (2) meet the nursing facility level of care in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare CHOICES HCBS available through CHOICES Group 3, are At Risk for Institutionalization as defined in TennCare Rules. The CHOICES At-Risk Demonstration Group is open only between July 1, 2012, through June 30, 2015. Individuals enrolled in the CHOICES At-Risk Demonstration Group as of June 30, 2015, may continue to qualify in this group after June 30, 2015 so long as they (1) continue to meet Nursing Facility financial eligibility and the LOC criteria in place when they enrolled; and (2) remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES 3.

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

Group 1
Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility.

Group 2
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving CHOICES HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TennCare has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

Group 3

Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are "at-risk" for nursing facility care, as defined by the State. TennCare has the discretion to apply an enrollment target to this group as described in TennCare rules and regulations.

Interim Group 3 (open for new enrollment only between July 1, 2012, through June 30, 2015) Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of CHOICES At-Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. There is no enrollment target on Interim Group 3.

All requirements set forth is this Contract regarding Group 3 members are applicable to Interim Group 3 members, except as explicitly stated otherwise. Interim Group 3 members are not subject to an enrollment target.

CHOICES Home and Community-Based Services (HCBS) – Services that are available only to eligible persons enrolled in CHOICES Group 2 or Group 3 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within their individual cost neutrality cap.

CHOICES Implementation Date – The date, as determined by TennCare, when the Contractor shall begin providing long-term care services to CHOICES members.

CHOICES Member – A member who has been enrolled by TennCare into CHOICES.

Chronic Condition – As defined by Population Health (and AHRQ) is a condition that lasts 12 months or longer and meets one of both of the following tests: (a) it places limitation on self-care, independent living, and social interactions; (b) it results in the need for ongoing intervention with medical products, services, and special equipment (see Perrin et al., 1993).

Clean Claim – A claim received by the Contractor for adjudication that requires no further information, adjustment, or alteration (including written information or substantiation) by the provider of the services in order to be processed and paid by the Contractor.

Clinical Practice Guidelines – Systematically developed tools or standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances. Such guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus, including consultation with network providers.

Cloning of Medical Notes – Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Closed-Loop Referral System (CLRS) – CLRS will support TennCare's Health Starts Initiative by increasing Member assessments, identifying Non-Medical Risk Factors, and referring Members to CBOs, while also expanding care coordination.

CMS – Centers for Medicare & Medicaid Services.

Community-Based Residential Alternatives to Institutional Care (Community-Based Residential Alternatives) – Residential services that offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, community living supports, community living supports-family model, assisted care living facility services, critical adult care homes, and companion care. As provided in Section A.2.6 of this Contract, community-based residential alternatives shall be available to members in CHOICES Group 2.

Community Informed Choice – The process in which an applicant to an ICF/IID must participate prior to approval for placement in an ICF/IID to ensure opportunity to receive services in the most integrated setting appropriate, in accordance with federal law. This process is conducted by an entity other than the ICF/IID provider to ensure that the applicant fully understands the full array of community-based options available to meet their needs, and having been fully informed, affirmatively chooses the institutional placement. A comparable process is also applicable to individuals under the age of 21 seeking placement in a NF.

Community Living Supports (CLS) – A CBRA licensed by the DIDD in accordance with T.C.A. Title 33 and TDMHSAS Rules 0940-05-24, 0940-05-28 or 0940-05-32, as applicable, that encompasses a continuum of residential support options for up to four individuals living in a home that supports each resident's independence and full integration into the community; ensures each resident's choice and rights; and comports fully with standards applicable to HCBS settings detailed in 42 C.F.R. 441.301(c)(4) and (5), including those requirements applicable to provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need and set forth in the person-centered support plan. For purposes of CHOICES and ECF CHOICES, this service is available only to CHOICES Group 2 and 3 members and ECF CHOICES Group 5 and 6 members as appropriate.

Community Living Supports Family Model (CLS-FM) – A CBRA licensed by the DIDD in accordance with T.C.A. Title 33 and TDMHSAS Rules 0940-05-26 that encompasses a continuum of residential support options for up to three individuals living in the home of trained family caregivers (other than the individual's own family) in an "adult foster care" arraignment. In this type of shared living arrangement, the provider allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and a family and provide the individualized services that supports each resident's independence and full integration into the community; ensures each resident's choice and rights; and support each resident in a manner that comports fully with standards applicable to HCBS settings detailed in 42 C.F.R. 441.301(c)(4) and (5), including those requirements applicable to provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need and set forth in the person-centered support plan. For purposes of CHOICES and ECF CHOICES, this service is available only to CHOICES Group 2 and 3 members and ECF CHOICES Group 5 and 6 members as appropriate.

Comprehensive Aggregate Cap (CAC) Home and Community-Based Services (HCBS) Waiver – A HCBS Waiver (Control Number TN 0357) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act which serves individuals with intellectual disabilities who are former members of the certified class in the United States vs. the State of Tennessee, et al. (Arlington Developmental Center), former members of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), persons discharged from the Harold Jordan Center following a stay of at least 90 days, and individuals transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, because they were identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver. These are individuals who have been institutionalized in a public institution, were part of a certified class because they were determined to be at risk of placement in a public institution, or have significant services/support needs consistent with that of the population served in a public ICF/IID and who qualify for and, absent the provision of services provided under the CAC waiver, would require placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The CAC Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participant's Person-Centered

Support Plan, based on the person's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Confidential Information – Any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is created under this Contract. Any such information relating to individuals enrolled in the TennCare program ("TennCare members") or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained under this Contract, shall also be treated as "Confidential Information" to the extent that confidential status is afforded such information under state and federal laws or regulations. All Confidential Information shall not be subject to disclosure under the Tennessee Public Records Act.

Consumer – Except when used regarding consumer direction of eligible CHOICES HCBS, an individual who uses a mental health or substance use disorder service.

Consumer-Directed Worker (Worker) – An individual who has been hired by a CHOICES or 1915(c) waiver member participating in consumer direction of eligible CHOICES or 1915(c) waiver HCBS or their representative or by a parent or other legal guardian of a Katie Beckett Part A member participating in consumer direction of eligible Katie Beckett HCBS to provide one or more eligible CHOICES HCBS or eligible Katie Beckett HCBS to the member. Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the member.

Consumer Direction of Eligible CHOICES, or 1915(c) waiver HCBS – The opportunity for a CHOICES or 1915(c) waiver member assessed to need specified types of CHOICES or 1915(c) waiver HCBS including for purposes of CHOICES, attendant care, personal care, in-home respite, companion care; and for purposes of 1915(c) waiver HCBS, personal assistance, respite, and individual transportation services, or any other service specified in TennCare rules as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s) and for 1915(c) waivers, the delivery of each eligible 1915(c) waiver HCBS within the authorized budget for that service, as applicable. Consumer direction of services in the Self-Determination Waiver is called self-direction. Any reference to consumer direction regarding the Self-Determination Waiver refers to self-direction.

Consumer Direction of Eligible Katie Beckett HCBS – The opportunity for the parent or other legal guardian of a child enrolled in Katie Beckett Part A assessed to need specified types of Katie Beckett HCBS as set forth in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or in limited circumstances to have a representative direct and manage) certain aspects of the provision of such services – primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s) and the delivery of each eligible Katie Beckett HCBS within the authorized budget for that service. Eligible Katie Beckett HCBS do not include home health or private duty nursing services.

Continuing Education Units (CEUs) – One Continuing Education Unit (CEU) is defined as 10 contact hours (1 hour = 60 minutes) of participation in an organized continuing education experience under responsible sponsorship, capable direction, and qualified instruction.

Contract Provider – A provider that is employed by or has signed a provider agreement with the Contractor to provide covered services.

Contractor Risk Agreement (CRA) – Contractor Risk Agreement (CRA) means the document delineating the terms of the agreement entered into by the Bureau of TennCare and the Managed Care Contractors.

Corrective Action Plan – A Corrective Action Plan (CAP) is a document that the Contractor will need to prepare outlining a set of steps to address issues or gaps in operations or processes that could negatively impact the business.

Cost Neutrality Cap – The requirement that the cost of providing care to a member in CHOICES Group 2, including CHOICES HCBS and Medicaid reimbursed home health and private duty nursing, shall not exceed

the cost of providing nursing facility services to the member, as determined in accordance with TennCare policy.

Covered Services – See Benefits.

Cultural Competency – Is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

Days – Calendar days unless otherwise specified.

DCS Custody Children – Children who have been identified by DCS as belonging in one of the following groups:

1. Children in the custody of DCS—Children in the legal and physical custody of DCS whose living arrangement is provided by DCS.

Children in the legal, but not physical, custody of DCS—Children who are in DCS's legal custody but who reside with parents.

Dental Benefits Manager (DBM) – An entity responsible for the provision and administration of dental services, as defined by TennCare.

Dermatologist – A medical practitioner specializing in the diagnosis and treatment of skin disorders.

DHHS – United States Department of Health and Human Services.

DIDD Case Manager – A qualified individual employed by DIDD who provides support coordination services to members in the Self-Determination Waiver and is responsible for the assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals with intellectual and developmental disabilities enrolled in the program to identify and achieve individualized goals related to work (in competitive, integrated employment), personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and control over their own lives, and personal health and wellness as specified in the Person-Centered Support Plan (PCSP), and the tracking and measurement of progress and outcomes related to such individualized goals, as well as the provider's performance in supporting the person's achievement of these goals.

Disenrollment – The removal of an enrollee from participation in the Contractor's MCO and deletion from the outbound 834 enrollment file furnished by TennCare to the Contractor.

Division of TennCare – The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers the TennCare program. For the purposes of this Contract, Division of TennCare shall mean the State of Tennessee and its representatives.

Dual-eligible Beneficiaries – Individuals eligible for both Medicaid and Medicare.

Dual-eligible Special Needs Plans (D-SNP) – Dual eligible special needs plans (D-SNPs) are a type of Medicare Advantage plan designed to meet the specific needs of dually eligible beneficiaries.

Electronic Visit Verification (EVV) System – An electronic system that meets the minimum functionality requirements prescribed by TennCare which provider staff must use to check-in at the beginning and check-out at the end of each period of service delivery to monitor Member receipt of specified services including any home health and private duty nursing service, CHOICES, ECF CHOICES, and 1915(c) waiver HCBS and which may also be utilized for submission of claims. Any such system shall comply with the 21st Century Cures Act.

Eligible – Any person certified by TennCare as eligible to receive services and benefits under the TennCare program. As it relates to CHOICES and I/DD MLTSS Programs a person is eligible to receive CHOICES or an I/DD MLTSS Programs benefits only if he/she has been enrolled in CHOICES or an I/DD MLTSS Program by TennCare. As it relates to Katie Beckett, a person is eligible to receive Katie Beckett Part A benefits only if he/she has been enrolled in Part A of the Katie Beckett Program by TennCare.

Eligible 1915(c) Waiver HCBS – Personal assistance, respite, individual transportation services, and/or any other 1915(c) waiver HCBS specified in TennCare rules as eligible for consumer direction which a 1915(c) waiver member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s) and the delivery of each eligible 1915(c) waiver HCBS within the authorized budget for that service. Eligible 1915(c) waiver HCBS do not include home health or private duty nursing services.

Eligible CHOICES HCBS – Attendant care, personal care, in-home respite, companion care services and/or any other CHOICES HCBS specified in TennCare rules and regulations as eligible for consumer direction for which a CHOICES member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s). Eligible CHOICES HCBS do not include home health or private duty nursing services.

Eligible Individual – With respect to Tennessee's Money Follows the Person Rebalancing Demonstration (MFP) and pursuant to Section 6071(b)(2) of the Deficit Reduction Act of 2005 (DRA), (Pub. L. 109-171 (S. 1932)) (Feb. 8, 2006) as amended by Section 2403 of the Patient Protection and Affordable Care Act of 2010 (ACA), (Pub. L. 111-148) (May 1, 2010), the Medicaid Extenders Act of 2019 (P.L. 116-3), the Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), the Sustaining Excellence in Medicaid Act of 2019 (P.L 116-39), Sec 205: Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Sec 3811: Coronavirus Aid, Relief, and Economic Security Act, 2020 (P.L. 116-136), and Consolidated Appropriations Act, 2021 (P.L. 116-260), the State's approved MFP Operational Protocol and TennCare Rules, a member who qualifies to participate in MFP. Such person, immediately before beginning participation in the MFP demonstration project, shall:

1. Reside in a Qualified Institution, i.e., a Nursing Facility (NF), hospital, or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and have resided in any combination of such Qualified Institutions for a period of not less than sixty (60) consecutive days.

    a. Inpatient days in an institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) may be counted only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under twenty-one (21) years of age.

    b. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall be counted for purposes of meeting the sixty (60)-day minimum stay in a Qualified Institution as long as the individual is Medicaid eligible at least one day prior to transition.

    c. Short-term continuous care in a nursing facility, for episodic conditions to stabilize a condition rather than admit to hospital or to facilitate hospital discharge, and inpatient rehabilitation facility services reimbursed by the Contractor (i.e., not covered by Medicare) as a cost-effective alternative (Refer to Section 2.6.5) and provided in a Qualified Institution shall be counted for purposes of meeting the sixty (60) day minimum stay in a Qualified Institution.

2. For purposes of this Contract, an Eligible Individual must reside in a Qualified Institution and be eligible to enroll and transition seamlessly into CHOICES Group 2, or one of the 1915(c) HCBS Waivers, without delay or interruption.

3. Meet nursing facility or ICF/IID level of care, as applicable, and, but for the provision of ongoing CHOICES HCBS or 1915(c) Waiver HCBS, continue to require such level of care provided in an inpatient facility.

Eligible Katie Becket HCBS – Respite, Supportive Home Care, Community Transportation and any other Katie Beckett HCBS specified in TennCare rules and regulations as eligible for consumer direction for which a Katie Beckett member is determined to need and which the member's parent or other legal guardian elects to direct and manage (or in limited circumstances to have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s) and, as applicable, the delivery of each eligible Katie Beckett HCBS within the authorized budget for that service. Eligible Katie Beckett HCBS do not include home health or private duty nursing services.

Emergency Medical Condition – A physical or behavioral 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 immediate medical attention to result in the following (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition.

Employment and Community First (ECF CHOICES) – Employment and Community First CHOICES is for people of all ages who have an intellectual or developmental disability (I/DD).

Employment Informed Choice – For purposes of 1915(c) waivers, the process that ISCs or DIDD Case Managers, as applicable, shall complete for working age members (ages sixteen (16) to sixty-two (62) enrolled in a 1915(c) waiver when the member is not either: (1) working in Individualized Integrated Employment or Individualized Integrated Self-Employment (with or without support services, depending on need); or (2) actively pursuing Individualized Integrated Employment or Individualized Integrated Self-Employment (with Supported Employment Individual or comparable Vocational Rehabilitation/Special Education/Workforce services). The Employment Informed Choice process includes, at minimum, an orientation to Individualized Integrated Employment and Individualized Integrated Self-Employment, employment supports/services, Vocational Rehabilitation, and basic benefits/work incentives education provided by the member's Independent Support Coordinator or DIDD Case Manager. The process may also include and the authorization and completion of Exploration services, subject to the member's willingness to participate in such services, in order to explore various employment options that are aligned with the member's interests, aptitudes, experiences and/or skills, to address concerns or questions, and ensure an informed choice regarding Individualized Integrated Employment and Individualized Integrated Self-Employment. Upon completion of Exploration services, if the member elects to pursue Individualized Integrated Employment or Individualized Integrated Self-Employment, the Independent Support Coordinator or DIDD Case Manager shall proceed with authorization of the appropriate employment service(s) and/or referral to Vocational Rehabilitation, as appropriate.

Employer of Record – The member participating in consumer direction of eligible CHOICES or 1915(c) waiver HCBS or a representative designated by the member to assume the consumer direction of eligible CHOICES or 1915(c) waiver HCBS functions on the member's behalf, or the parent or other legal guardian of a Katie Beckett Part A member participating in consumer direction of eligible Katie Beckett HCBS. In limited circumstances, the parent or legal guardian of a child in Katie Beckett Part A may delegate a representative for consumer direction.

Endocrinologist – A doctor who has special training in diagnosing and treating disorders of the endocrine system (the glands and organs that make hormones).

Engaged – When a member has interactive contact with care management or other member facing/engagement programs.

Enrollee – A person who has been determined eligible for TennCare and who has been enrolled in the TennCare program (see Member, also). Synonymous with Member. For purposes of Enrollee Benefit Appeals and the Enrollee Benefit Appeal-related provisions in Section A.2.19 herein, "Enrollee" means (1) enrollee, (2) enrollee's parent, (3) enrollee's legal guardian, or (4) Enrollee-Authorized Representative. For purposes of provider agreements in Sections 2.12.23 and missed visits of home health services in Section 2.15.9, "Enrollee" means not only (1) the enrollee, (2) the enrollee's parent, or (3) the enrollee's legal guardian, but also a person who has a close, personal relationship with the enrollee and is routinely involved in providing unpaid support and assistance to them.

Enrollee-Authorized Representative – For purposes of Enrollee Benefit Appeals, and the Enrollee- Benefit Appeal-related provisions in Section A.2.19 herein, "Enrollee Authorized Representative" means a competent adult who has the Enrollee's signed, written authorization to act on the Enrollee's behalf during the appeal process in accordance with 42 CFR 435.923. The written authority to act shall specify any limits of the representation. For example, if the enrollee wants to authorize their treating provider to frame the issue under dispute and file their request for a SFH, but if their treating provider will not be receiving the Notice of Hearing and will not be representing the enrollee during the hearing, these limitations shall be indicated on the Enrollee-Authorized Representative documentation.

Enrollee Marketing – Any communication, from the Contractor to a TennCare enrollee who is not enrolled in the Contractor's MCO, that can reasonably be interpreted as intended to influence the person to enroll in the Contractor's MCO, or either to not enroll in, or to disenroll from, another MCO's TennCare product.

Enrollees with Special Health Care Needs – For purposes of requirements in Section 2.9.17 of this Contract, enrollees with special health care needs shall refer to enrollees who are in the custody of the Department of Children's Services (DCS).

Enrollment – The process by which a TennCare enrollee becomes a member of the Contractor's MCO.

EPSDT – The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OB'A '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The federal regulations for EPSDT are in 42 CFR Part 441, Subpart B.

Episodes of Care (EoC) – An episode of care is a term for the services provided by a health care facility or provider to treat a specific medical problem, condition, or procedure.

Essential Hospital Services – Tertiary care hospital services to which it is essential for the Contractor to provide access. Essential hospital services include, but are not limited to, neonatal, perinatal, pediatric, trauma and burn services.

Ethical and Religious Directives (often called the ERDs) – A document that offers moral guidance on various aspects of health care delivery and is based on a religious organization's theological and moral teachings.

Evidence-Based Practice – A clinical intervention that has demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness; specifically, the evidence-based practices recognized by the Substance Use Disorder and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS).

Expenditure Cap – The annual limit on expenditures for CHOICES or 1915(c) waiver services that a member enrolled in CHOICES Group 3 or the Self-Determination Waiver, as applicable, can receive. For purposes of the Expenditure Cap for members in CHOICES Group 3, the cost of minor home modifications is not counted in calculating annual expenditures for CHOICES HCBS. The Expenditure Cap for CHOICES members shall be implemented in accordance with the approved 1115 Waiver and TennCare Rules, including any exceptions defined therein. For purposes of the Self-Determination Waiver, "Expenditure Cap" refers to the "Cost Limit Lower than Institutional Cost" as defined in the approved Section 1915(c) waiver.

External Quality Review Report – An External Quality Review (EQR) report is the analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid beneficiaries.

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.

Family Member – For purposes of a Qualified Residence under the State's MFP Rebalancing Demonstration, a family member includes a person with any of the following relationships to the member, whether related by blood, marriage, or adoption, and including such relationships (as applicable) that may have been established through longstanding (a year or more) foster care when the member was a minor:

1. Spouse, and parents and siblings thereof;
2. Sons and daughters, and spouses thereof;
3. Parents, and spouses and siblings thereof;
4. Brothers and sisters, and spouses thereof;
5. Grandparents and grandchildren, and spouses thereof; and
6. Domestic partner and parents thereof, including domestic partners of any individual in 2 through 5 of this definition. A domestic partner means an adult in a committed relationship with another adult. Committed relationship means one in which the member, and the domestic partner of the member, are each other's sole domestic partner (and are not married to or domestic partners with anyone else); and share responsibility for a significant measure of each other's common welfare and financial obligations.

Step and in-law relationships are included in this definition, even if the marriage has been dissolved, or a marriage partner is deceased.

Family member may also include the member's legal guardian or conservator or someone who was the legal guardian or conservator of the member when the member was a minor or required a legal guardian or conservator;

Family Model Residential Support – A type of residential service having individualized services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

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

Fiscal Employer Agent (FEA) – An entity contracting with the State and/or an MCO that helps CHOICES, 1915(c) waiver, and Katie Beckett Part A members participating in consumer direction of eligible CHOICES, 1915(c) waiver, or eligible Katie Beckett HCBS. The FEA provides both financial administration and supports brokerage functions for CHOICES or 1915(c) waiver members participating in consumer direction of eligible CHOICES HCBS and parents or other legal guardians of Katie Beckett Part A members participating in

consumer direction of eligible Katie Beckett HCBS. This term is used by the IRS to designate an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6 and Notice 2003-70, as the agent to members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA and FUTA taxes. The FEA also files state income tax withholding and unemployment insurance tax forms and pays the associated taxes and processes payroll based on the eligible CHOICES, 1915(c) waiver, or eligible Katie Beckett HCBS authorized and provided.

FQHC – Federally Qualified Health Center.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (see 42 CFR 455.2).

Gastroenterologist – A medical practitioner specializing in the diagnosis and treatment of disorders of the gastrointestinal tract and related organs.

General Marketing – Any communication or activity that can reasonably be interpreted as intended to promote the Contractor, including, but not limited to, advertising, publicity, and positioning.

General Surgeon – General surgeons are doctors who specialize in surgical procedures.

Grand Region – A defined geographical region that includes specified counties in which the Contractor is authorized to enroll and serve TennCare enrollees in exchange for a monthly administrative fee payment. The Contractor shall serve an entire Grand Region. The following counties constitute the Grand Regions in Tennessee:

East Grand Region – Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union, and Washington Counties

Middle Grand Region – Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson Counties

West Grand Region – Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, and Weakley Counties

Grand Rounds – As used with respect to CHOICES members residing in a nursing facility, a planned quarterly meeting between nursing facility staff and MCO staff, including, at minimum, the care coordinator(s) assigned to residents of the facility conducted in order to: (1) address issues or concerns regarding members who have experienced a potential significant change in needs or circumstances or about whom the nursing facility or MCO has concerns (not necessarily all members who are residents of the facility); (2) identify any change in services or interventions for the members, including but not limited to changes in the members' plans of care or supplements to the members' plans of care; and (3) facilitate access to and coordination of physical health and/or Behavioral Health Services needed by the members and to ensure the proper management of the members' acute and/or chronic conditions. At least two of the quarterly Grand Rounds per year shall be conducted on-site in the facility.

Grievance – A complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right

to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. See 42 C.F.R. §438.400(b).

Grievance System – The processes the Contractor implements to handle grievances, as well as the processes to collect and track information about them. See 42 C.F.R. §438.400(b).

Gynecologist – A gynecologist specializes in diagnosing and treating conditions of the female reproductive system.

Health Coaching – A method of guiding and motivating members participating in Population Health programs to address their health by engaging in self-care and, if needed, make behavioral changes to improve their health. Health coaching operates on the premise that increasing a member's confidence in managing their health and achieving their own goals will have a more lasting effect on outcomes.

Health Maintenance Organization (HMO) – An entity certified by TDCI under applicable provisions of T.C.A. Title 56, Chapter 32.

Health Starts Initiative – Describes programming and initiatives intended to address social risk factors through the utilization of screening for social risk factors, referring to community-based organization, and closing the loop on referrals.

Healthcare Effectiveness Data and Information Set (HEDIS) – The most widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance.

Hematologist – A doctor who has special training in diagnosing and treating blood disorders.

High Utilization – High healthcare utilizers are a small group of patients who impose a disproportionately high burden on the healthcare system due to their elevated resource use, and often have unmet care needs or receive unnecessary care.

HIPAA – Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164.

HITECH – Health Information Technology for Economic and Clinical Health Act, Pub.L.111-5, Div. A, Title XIII, § 13001(a), Feb. 17, 2009, 123 Stat. 226.

Home and Community-Based Services (HCBS) – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES or 1915(c) waiver HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within their individual cost neutrality cap. The cost of home health and private duty nursing shall also be counted against the Individual Institutional Cost Limit for Statewide 1915(c) waiver members.

Home Health (HH) – Home health is medical care delivered in your home, usually by skilled professionals such as nurses, therapists, or aides.

Hospice – Services as described in TennCare rules and regulations and 42 CFR Part 418, which are provided to terminally ill individuals who elect to receive hospice services provided by a certified hospice agency.

I/DD MLTSS Programs – Long-term services and supports for individuals with intellectual or developmental disabilities delivered through the managed care program; for purposes of this contract, refers collectively to the three 1915(c) HCBS waivers and ICF/IID services. (This contract does not include administration of ECF CHOICES.)

ICF/IID member – A member who has been enrolled in TennCare and is receiving services in an ICF/IID.

Immediate Eligibility – Temporary eligibility granted to a child upon entering into State custody in order to give children in State custody adequate access to medical and Behavioral Health Services, including TennCare Kids, until a final determination can be made on their TennCare eligibility.

Implementation Team (IT) – A team consisting of a physician, mental health professional(s) and other support(s) who are charged with staffing the steering panel and implementing the plan for children in State custody which has been provided and/or approved by the court as directed by TennCare.

Independent Support Coordinator – A qualified individual employed by a Support Coordination provider agency contracted with one or more MCOs to provide support coordination services to members in the Statewide or CAC Waivers and is responsible for the assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals with intellectual and developmental disabilities enrolled in the program to identify and achieve individualized goals related to work (in competitive, integrated employment), personal relationships, community involvement, understanding and exercising personal rights and responsibilities, financial management, increased independence and control over their own lives, and personal health and wellness as specified in the Person-Centered Support Plan (PCSP), and the tracking and measurement of progress and outcomes related to such individualized goals, as well as the provider's performance in supporting the person's achievement of these goals.

Individual Institutional Cost Limit – The federal requirement described in Section 1915(c)(4)(A) of the Social Security Act and 42 CFR 441.301(a)(3) and individually applied that the cost of providing care to a member in the Statewide 1915(c) Waiver, including 1915(c) Waiver HCBS and Medicaid reimbursed home health and private duty nursing, shall not exceed the average annual cost of services in a private ICF/IID, as determined in accordance with TennCare policy.

Individual(s) with I/DD – One or more persons who have an intellectual or other developmental disability as defined under state law. Includes all individuals determined to have I/DD, whether or not they are receiving services through an I/DD MLTSS program.

Individuals with I/DD and Co-Occurring Behavioral Health Conditions or Behavior Support Needs – People with intellectual and developmental disabilities (IDD) who also have mental health conditions and behavioral support needs.

Individual Program Plan (IPP) (42 CFR 483.440(c) – The plan for individuals with intellectual disabilities in intermediate care facilities, developed by the facility's interdisciplinary team, which includes opportunities for individual choice and self-management and identifies: the discrete, measurable, criteria-based objectives the individual is to achieve; and the specific individualized program of specialized and generic strategies, supports, and techniques to be employed. The IPP must be directed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

Individualized Integrated Employment – Sustained paid employment in a competitive or customized job with an employer:

(A) for which an individual is compensated at or above the state's minimum wage and is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, not including supervisory personnel or individuals providing services to the employee with a disability, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills; or in the case of an individual who is self-employed, yields an income that is comparable to the income received by other individuals who are not individuals with disabilities, and who are self-employed in similar occupations or on similar

tasks and who have similar training, experience, and skills; and is eligible for the level of benefits provided to other employees; and is engaged, preferably, in full-time work; and

(B) is at a location typically found in the community; and

a. to be typically found in the community, an employment location should be found in the competitive labor market and not formed for the specific purpose of employing individuals with disabilities; and

(C) where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and

(D) that, as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions; and

(E) that is not paid employment or training in a business enterprise owned or operated by a provider of the individual's employment services.

Individually Identifiable Health Information – Any information, including demographic information, collected from an individual, that (a) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (b) 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 identifies the individual; with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

Individuals with Limited English Proficiency (LEP) – Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand the English language.

Information System(s) (Systems) – A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which may include digitized audio and video) and documents as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.

Intellectual or Developmental Disabilities (I/DD) – Intellectual or developmental disabilities, also called IDD or I/DD, are chronic conditions that affect cognitive function and/or adaptive behavior.

Interactive Contact – As it pertains to Population Health, it is two-way interaction between the MCO and the member, during which the member receives self-management support, health education, or care coordination through one of the following methods: telephone; in-person contact (i.e., individual or group); online contact; interactive web-based module; live chat; secure email; video conference; or interactive voice response. Interactive Contact shall not include any of the following: completion of a health appraisal; contact made for the sole purpose of making an appointment, leaving a message, or verifying receipt of materials; contact made for the sole purposes of informing members of the availability of affinity programs (e.g., subsidized gym memberships, device purchases, discounted weight loss subscriptions).

Interactive Intervention (Touch) – As it pertains to Population Health it is a two way interaction in which the member receives self-management support or health education by one of the following modes: an interactive mail-based communication (i.e. mail-based support or education requested by the member, communication in the form of a member survey, quiz or assessment of member knowledge gained from reading the communication); an interactive telephone contact; including an interactive voice response (IVR) module; an in person contact; and online contact including contact by an interactive web-based module; live chat and secure e-mail. Interactive contacts do not include completion of a health risk appraisal or contacts made only to make an appointment, leave a message, or acknowledge receipt of materials.

Intervention – An action or ministration that is intended to produce an effect or that is intended to alter the course of a pathologic process.

Katie Beckett Home and Community-Based Services (HCBS) – Specified wraparound services that are available only to eligible children enrolled in Katie Beckett Part A. Only certain Katie Beckett Part A HCBS are eligible for Consumer Direction. Katie Beckett Part A HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX State Plan or under the TennCare demonstration for all eligible children, although such services shall be counted for purposes of determining whether the cost of providing a Katie Beckett Part A member's needs at home will exceed the estimated Medicaid cost of institutional care.

Katie Beckett Part A Member – A member who has been enrolled by TennCare into Part A of the Katie Beckett Program.

Katie Beckett Part A – One of two components of Tennessee's Katie Beckett Program that serves a limited number of children with the most significant disabilities or complex medical needs who meet institutional level of care, as established by TennCare, and who qualify for Medicaid only by waiving the deeming of parents' income and/or assets to the child. Children enrolled by TennCare into Katie Beckett Part A are eligible to receive all covered, medically necessary Medicaid benefits, including benefits provided under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program as well as case management and specified wraparound home- and community-based services not otherwise covered by the Medicaid program, including respite. Part A will consist of children who are under age 18 who (1) have medical needs that are likely to last at least twelve months or result in death; and result in severe functional limitations based on medical eligibility criteria developed by TennCare specifically for children; (2) qualify for care in a medical institution; and (3) qualify for supplemental security income (SSI) due to the child's disability – except for the parent's income and/or assets. To qualify for (initial and continued) enrollment in Katie Beckett Part A, a licensed physician must agree and certify that in-home care will meet the child's needs, the cost of providing the child's care at home (including traditional Medicaid benefits and wraparound HCBS) cannot exceed the estimated Medicaid cost of institutional care, and the child cannot be Medicaid-eligible or receiving long-term services and supports in another Medicaid program.

Katie Beckett Part B – One of two components of Tennessee's Katie Beckett Program operated by the Department of Intellectual and Developmental Disabilities (DIDD) which offers only a capped package of wraparound services and supports including premium assistance on a sliding fee scale to a broader group of children with disabilities, including those "at risk" of institutionalization.

Law – Statutes, codes, rules, regulations, and/or court rulings.

Legal Guardian – For purposes of Part A of the Katie Beckett Program, the individual with physical custody of the child and the legal authority to make decisions concerning the child's protection, education, care, medical treatment, etc., including the child's PCSP for Katie Beckett Part A. Generally, the child's parent(s) is the legal guardian except when guardianship has been otherwise established through court proceedings.

Legally Appointed Representative – Any person appointed by a court of competent jurisdiction or authorized by legal process (e.g., power of attorney for health care treatment, declaration for mental health treatment) to determine the legal and/or health care interests of an individual and/or their estate.

Licensed Mental Health Specialist – A physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist licensed by the state to engage in the practice of psychology or psychiatric nursing or to provide professional therapy or counseling services.

Limited English Proficient (LEP) – Means potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. See 42 C.F.R. §438.10(a).

Long-Term Services and Supports (LTSS) – Services and supports provided under the CHOICES, ECF CHOICES, 1915(c) HCBS Waivers, PACE program, and to individuals in ICFs/IID, of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the

beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Long-Term Services and Supports Ombudsman Program – A statewide program for the benefit of individuals residing in long-term care facilities, which may include nursing homes, residential homes for the aged, assisted care living facilities, and community-based residential alternatives developed by the State. The Ombudsman is available to help these individuals and their families resolve questions or problems. The program is authorized by the federal Older Americans Act and administered by the Tennessee Commission on Aging and Disability (TCAD).

Maintenance of Effort (MOE) – Provisions in the American Recovery and Reinvestment Act (ARRA) (Pub. L. 111–5) (Feb. 17, 2009) and the Affordable Care Act (ACA) to ensure that States' coverage for adults under the Medicaid program remains in place and that "eligibility standards, methodologies, and procedures" are not more restrictive than those in place as of July 1, 2008 for purposes of the ARRA and March 23, 2010, for purposes of the ACA pending the establishment of specific provisions of ACA (i.e., a fully operational Exchange) on January 1, 2014.

Managed Care Organization (MCO) – An HMO that participates in the TennCare program.

Managed Long-Term Services and Supports (MLTSS) – The delivery of long-term services and supports through Medicaid managed care programs.

Mandatory Outpatient Treatment (MOT) – Process whereby a person who was hospitalized for psychiatric reasons and who requires outpatient treatment can be required by a court to participate in that behavioral health outpatient treatment to prevent deterioration in their mental condition.

MCO Risk Contract – An at-risk agreement with an entity certified by TDCI under applicable provisions of TCA Title 56, Chapter 32 that participates in the TennCare program under a capitated payment model providing medical, behavioral, and long-term care services in each region of the State.

Medicaid – Medicaid is a program that provides healthcare coverage to certain categories of people, primarily low-income children, low-income pregnant women, low-income parents or caretaker relatives of dependent children, and individuals who are elderly or who have a disability. Medicaid is jointly funded by states the federal government and is administered by states. TennCare is the state of Tennessee's Medicaid program.

Medical Expenses – Shall be determined as follows:

1. Medical Expenses include the amount paid to providers for the provision of covered physical health, behavioral health, and/or long-term care services to members pursuant to the following listed Sections of the Contract:

   a. Section 2.6.1, Contractor Covered Benefits;

   b. Section 2.6.4, Second Opinions;

   c. Section 2.6.5, Use of Cost Effective Alternative Services;

   d. Section A.2.7, Specialized Services except TennCare Kids member and provider outreach and education, health education and outreach and advance directives;

   e. Capitated payment to licensed providers;

   f. Medical services directed by TennCare or an Administrative Law Judge; and

   g. Net impact of reinsurance coverage purchased by the Contractor.

2. Preventive Services: In order for preventive services in Section A.2.6 (including, but not limited to, health education, medical case management and health promotion activities) to qualify as medical expenses, the service must be targeted to and limited to the Contractor's enrollees or targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs must be approved by TennCare.

3. Medical case management may qualify as medical expenses if the service is targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs is approved by TennCare.

4. Medical Expenses do not include:

   a. 2.6.2 TennCare Benefits Provided by TennCare;

   b. 2.6.7 Cost Sharing and Patient Liability;

   c. 2.10 Services Not Covered;

   d. Services eligible for reimbursement by Medicare;

   e. The activities described in or required to be conducted in Attachments II through XI, which are administrative costs; and

   f. The two percent HMO tax.

5. Medical expenses shall be net of any TPL recoveries or subrogation activities.

6. This definition does not apply to NAIC filings.

Medical Home – As defined by Population Health and per NCQA, the Medical Home is a model for care provided by physician practices aimed at strengthening the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship.

Medical Necessity – Medical Necessity and Medically Necessary as used in this Contract shall have the meaning contained in Tenn. Code Ann. 71-5-144 and TennCare Rule 1200-13-16, and other TennCare rules, as applicable.

Medical Records – All medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

Medical Residential Services – A type of residential service provided in a residence where all residents require direct skilled nursing services and habilitative services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting. Medical Residential Services must be ordered by the enrollee's physician, physician assistant, or a nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services. The enrollee who receives Medical Residential Services shall require direct skilled nursing services on a daily basis and at a level which cannot for practical purposes be provided through to or fewer daily skilled nursing visits. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

Medicare Managed Care Manual – Refers to the most recent edition of chapter guidance published by CMS for the management of its Medical Assistance plans.

Medication Assisted Treatment (MAT) – Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and other therapeutic techniques, to provide a "whole-patient" approach to the treatment of substance use disorders.

Member – A TennCare enrollee who enrolls in the Contractor's MCO under the provisions of this Contract (see Enrollee, also).

Member Month – A month of coverage for a TennCare enrollee enrolled in the Contractor's MCO.

Memorandum of Understanding (MOU) – A memorandum of understanding is a document that describes an agreement between two or more parties.

Mental Health Services – The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

Model of Care – A "Model of care" broadly defines the way health services are delivered.

MOE Demonstration Group – Individuals who are age 65 and older and adults age 21 and older with disabilities who (1) meet nursing home financial eligibility, (2) do not meet the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare CHOICES services, are "at risk" of institutionalization. The MOE Demonstration Group is open only between July 1, 2012, through June 30, 2015. Individuals enrolled in the MOE Demonstration Group as of June 30, 2015, may continue to qualify in this group after June 30, 2015, so long as they (1) continue to meet Nursing Facility financial eligibility and the LOC criteria in place when they enrolled; and (2) remain continuously enrolled in the MOE Demonstration Group and in CHOICES 3.

Money Follows the Person Rebalancing Demonstration (MFP) – A federal grant established under the Deficit Reduction Act and extended under the Affordable Care Act, the Medicaid Extenders Act of 2019 (P.L. 116-3), the Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), the Sustaining Excellence in Medicaid Act of 2019 (P.L 116-39), Sec 205: Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Sec 3811: Coronavirus Aid, Relief, and Economic Security Act, 2020 (P.L. 116-136), and Consolidated Appropriations Act, 2021 (P.L. 116-260), that will assist Tennessee in transitioning Eligible Individuals from a Qualified Institution into a Qualified Residence in the community and in rebalancing long-term care expenditures. The grant provides enhanced match for HCBS provided during the first 365 days of community living following transition.

NAIC – National Association of Insurance Commissioners.

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

NCQA Health Insurance Plan Rating Accreditation – NCQA Health Insurance Plan Accreditation is widely recognized as the stamp of approval for health plans and is built on flexible, yet rigorous, standards.

NCQA Health Insurance Plan Ratings – NCQA evaluates health plans to provide ratings based on the quality of care patients receive and how happy patients are with their care, and health plans' efforts to keep improving.

Nephrologist – A doctor who has special training in diagnosing and treating kidney disease.

Network Adequacy – Network adequacy is the ability of a health plan to provide reasonable access to enough in-network providers and services for its enrollees.

Neurologist – A medical specialist in the diagnosis and treatment of disorders of the nervous system.

Neurosurgeon – A surgeon specializing in surgery on the nervous system, especially the brain and spinal cord.

Non-Contract Provider – Any provider that is not directly or indirectly employed by or does not have a provider agreement with the Contractor or any of its subcontractors pursuant to the Contract between the Contractor and TennCare.

Non-Interactive Intervention (Touch) – As it pertains to Population Health it is a one way attempt to interact or communicate with members. There is no confirmation of receipt. This does not include completion of a health appraisal.

Non-Medical Risk Factors (NMRF) – Factors that fall outside the sphere of medical/health care, generally speaking, but that have been shown to affect health status and, in some cases, access to health services.

Notice of Readiness Review Findings – A notice issued by TennCare to Contractor via control memorandum based on the results of the Readiness Review activities.

Non-Quantitative Treatment Limitations (NQTL) – Non-quantitative Treatment Limitations (NQTL) include various strategies, standards, or processes, with no numerical value attached, that insurers leverage to limit a duration or scope of benefits provided by an insurance plan. NQTLs could include, as an example, different requirements for pre-authorizations, network tiers, and pharmaceutical formularies.

Nurse Practitioner – A nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor.

Obstetrician – A physician or surgeon qualified to practice in obstetrics. Obstetrics (the OB) involves care during pre-conception, pregnancy, childbirth, and immediately after delivery.

Office of the Comptroller of the Treasury – The Comptroller of the Treasury is a State of Tennessee constitutional officer elected by the General Assembly for a term of two years. Statutes prescribe the comptroller's duties, the most important of which relate to audit of state and local government entities and participation in the general financial and administrative management of state government.

Office of Inspector General (OIG) – The State of Tennessee agency that investigates and may prosecute civil and criminal fraud, waste, and abuse of the TennCare program or any other violations of state law related to the operation of the TennCare program administratively, civilly or criminally.

One-Time CHOICES HCBS – Specified CHOICES HCBS which occur as a distinct event or which may be episodic in nature (occurring at less frequent irregular intervals or on an as needed basis for a limited duration of time). One-time HCBS include in-home respite, in-patient respite, assistive technology, minor home modifications, and/or pest control.

Ongoing CHOICES HCBS – Specified CHOICES HCBS which are delivered on a regular and ongoing basis, generally one or more times each week, or (in the case of community-based residential alternatives and PERS) on a continuous basis. Ongoing HCBS include community-based residential alternatives, personal care, attendant care, home-delivered meals, personal emergency response systems (PERS), and/or adult day care.

Operational Start Date – The date by which a Contractor begins operations to support TennCare and its enrollees.

Ophthalmologist – A specialist in the branch of medicine concerned with the study and treatment of disorders and diseases of the eye.

Opioid Use Disorder (OUD) – According to the DSM-5, opioid use disorder is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress.

Oral Interpretation – Is the act of listening to something in one language (source language) and orally translating it into another language (target language).

Orthopedist – An orthopedist (also spelled orthopedist) is a medical specialty focusing on injuries and diseases affecting your musculoskeletal system (bones, muscles, joints and soft tissues).

Otolaryngologist – Otolaryngologists are doctors who specialize in problems of the head and neck, especially the ears, nose, and throat.

PASRR – Preadmission Screening and Resident Review.

Patient-Centered Medical Home (PCMH) – The patient-centered medical home or PCMH (sometimes referred to as medical home, or advanced primary care) is an innovation in health care delivery designed to improve patient experience, improve population health, and reduce the cost of care.

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

Per Member Per Month (PMPM) – PMPM is a fixed fee structure that is paid to the Contractor for the administration of services delivered. This fee is apart and in addition to any payments made to the Contractor for approved invoices as defined in the Contract.

Person-Centered Support Plan (PCSP) – As it pertains to 1915(c) waivers, the PCSP is a written plan developed by the independent support coordinator or DIDD case manager in accordance with person-centered planning requirements set forth in federal regulation, and in TennCare policies and protocols, 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 member's MCO and other payor sources. The person-centered planning process is directed by the member with long-term support needs and may include a representative whom the member has freely chosen to assist the member with decision-making, and others chosen by the member to contribute to the process. If the member has a guardian or conservator, the member shall lead the planning process to the maximum extent possible, and the guardian or conservator shall have a participatory role as needed and defined by the individual, except as explicitly defined under State law and the order of guardianship or conservatorship. Any decisions made on the member's behalf should be made using principles of substituted judgment and supported decision-making. This planning process, and the resulting PCSP, will assist the member in achieving a personally defined lifestyle and outcomes in the most integrated community setting appropriate, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health, welfare, and personal growth. Services in 1915(c) waivers shall be authorized, provided, and reimbursed only as specified in the PCSP. For purposes of 1915(c) waivers members, these plans were called Individual Support Plans (ISPs) prior to July 1, 2021.

Pharmacy Benefits Manager (PBM) – An entity responsible for the provision and administration of pharmacy services.

Physician Assistant – Licensed clinicians who practice medicine in every specialty and setting.

Plan of Care – As it pertains to Population Health the plan of care is a personalized plan to meet a member's specific needs and contains the following elements: prioritized goals that consider member and care giver needs which are documented; a time frame for re-evaluation; the resources to be utilized; a plan for continuity of care, including transition of care and transfers; and uses a collaborative approach including family participation. The plan of care is built upon the information collected from the health assessment to actively engage the member in developing goals and identifying a course of action to respond to the members' needs. The goals and actions in the plan of care must address medical, social, educational, and other

services needed by the member. Providing educational materials alone does not meet the intent of this factor.

As it pertains to Part A of the Katie Beckett Program, the plan of care is a written document developed by the Nurse Care Manager in accordance with this Contract and in a manner consistent with CFR §441.301(c)(1) through a person- and family-centered planning process that assesses the child's strengths, needs, goals and challenges; and outlines the services and supports (including unpaid supports voluntarily provided by family members and other caregivers, and paid services provided by private insurance, the Contractor, and other payor sources) that will be provided to the child to meet the child's physical and behavioral health and long-term services and supports needs and support the child in achieving their individualized goals. The child should be involved in helping to define their individualized goals and develop the plan of care to the maximum extent possible and appropriate. This planning process, and the resulting person- and family-centered plan of care shall: 1) ensure the delivery of services in a manner that reflects the child and family's strengths, needs, preferences and choices; 2) assist the child in achieving personally defined outcomes in the most integrated community setting, which shall include planning and preparation for the child's transition to employment and community living with as much independence as possible upon becoming an adult;, and 3) help to engage, strengthen, support, and build the capacity and confidence of the family in order to ensure the child's safety, well-being and permanency. Services in the Katie Beckett Program shall be authorized, provided, and reimbursed only as specified in the plan of care.

For purposes of CHOICES, 1915(c) waivers, and Part A of the Katie Beckett Program "plan of care" shall be used interchangeably with "person-centered support plan" or "PCSP".

Population Health Care Coordination Program – The program addresses acute health needs or risks which need immediate attention. Assistance provided to enrollees is short-term and time limited in nature. Activities may include, but are not limited to, assistance with making appointments, transportation, social services, etc. and should not be confused with activities provided through CHOICES Care Coordination, 1915(c) waiver Independent Support Coordination or Case Management.

Post-stabilization Care Services – Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e), to improve or resolve the member's condition.

Prepaid Limited Health Service Organization (PLHSO) – An entity certified by TDCI under applicable provisions of T.C.A. Title 56, Chapter 51.

Presumptive Eligibility – An established period of time during which certain pregnant women are eligible for TennCare Medicaid. During this period of time the presumptively eligible enrollee must complete a full application for Medicaid in order to stay on the program. Eligibility extends from the presumptive eligibility effective date through the end of the following month unless a full Medicaid application is completed. When a full Medicaid application is completed, presumptive eligibility is provided until an eligibility determination is made on the full Medicaid application.

Primary Care Physician – A physician responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is generally a physician who has limited their practice of medicine to general practice or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Geriatrician, or Family Practitioner. However, as provided in Section 2.11.2.4 of this Contract, in certain circumstances other physicians may be primary care physicians if they are willing and able to carry out all PCP responsibilities in accordance with this Contract.

Primary Care Provider (PCP) – A primary care physician or other licensed health practitioner practicing in accordance with state law who is responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A PCP may practice in various settings such as local health departments, FQHCs or community mental health agencies (CMHAs) provided that the PCP is willing and able to carry out all PCP responsibilities in accordance with this Contract.

Primary Treatment Center (PTC) – A center developed by DCS for the purpose of providing short-term evaluation and treatment to children who have just come into custody, children already in State custody, children who have been released from State custody and who have been recommitted, and children who are at imminent risk of entering custody.

Prior Authorization – The act of authorizing specific services or activities before they are rendered or occur.

Priority Enrollee – An enrollee that has been identified by TennCare as vulnerable due to certain mental health diagnoses.

Privacy Breach – The acquisition, access, use, or disclosure of PHI in a manner which compromises the security or privacy of the PHI as governed by the provisions of HIPAA and other federal and state laws. For purposes of this definition, "compromises the security or privacy of the protected health information" means poses a significant risk of financial, reputational, or other harm to the individual.

Privacy Rule – Standards for the Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164.

Private Duty Nursing (PDN) – Private duty nursing is a home-based health service by nurses who may be licensed as RNs or LPNs/LVNs.

Program of All-Inclusive Care for the Elderly (PACE) – PACE is a program that provides comprehensive medical and social services to frail, elderly people who are eligible for both Medicare and Medicaid and who can live safely in the community instead of a nursing home.

Protected Health Information (PHI) – Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

Provider – An institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished. Provider does not include consumer-directed workers (see Consumer-Directed Worker); nor does provider include the FEA (see Fiscal Employer Agent).

Provider Agreement – An agreement, using the provider agreement template approved by TDCI, between the Contractor and a provider or between the Contractor's subcontractor and a provider that describes the conditions under which the provider agrees to furnish covered services to the Contractor's members.

Psychiatrist – A medical practitioner specializing in the diagnosis and treatment of mental illness.

Qualified Institution – With respect to Tennessee's MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(3) of the DRA, a hospital, nursing facility, or ICF/IID.

Qualified Residence – With respect to Tennessee's MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(6) of the DRA, the residence in the community in which an Eligible Individual will reside upon transition to the community which shall be one of the following:

1. A home owned or leased by an Eligible Individual or the individual's family member;

2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the Eligible Individual or the individual's family has domain and control; or

3. A residence in a community-based residential setting in which no more than four (4) unrelated individuals reside.

Additional requirements pertaining to a Qualified Residence set forth in MFP Policy Guidance issued by the Centers for Medicare and Medicaid Services (CMS) shall apply for all persons participating in MFP.

Quality Improvement in Long Term Services and Supports or QuILTSS – Quality Improvement in Long Term Services and Supports or QuILTSS is a value-based purchasing initiative, led by the Bureau of TennCare, to promote the delivery of high-quality Long-Term Services and Supports (LTSS), focusing on the performance measures that are most important to people who receive LTSS and their families.

Quality Management/Quality Improvement (QM/QI) – The development and implementation of strategies to assess and improve the performance of a program or organization on a continuous basis. This includes the identification of key measures of performance, discovery and data collection processes, identification and remediation of issues, and systems improvement activities.

Quest Analytics Software – Quest Analytics Software, or Quest Enterprise Services TM (QESTM) is a self-service SaaS platform that gives organizations the capability to analyze, manage and report on provider network adequacy and provider data accuracy across the organization and all lines of business.

Readiness Review – Readiness Reviews may include, but are 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 the Contract, as determined by TennCare.

Reconsideration – Mandatory component of the TennCare Benefit Appeal Process by which an MCO reviews and renders a decision affirming or reversing the adverse benefit determination at issue in the enrollee's request for SFH. An MCO satisfies the plan-level requirements of 42 C.F.R. 438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a physician other than the original reviewing physician; and produces a timely written finding.

Record Request – Written request seeking access to a record.

Recovery – A consumer driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite a disability.

Regulatory Requirements – Any requirements imposed by applicable federal, state or local laws, rules, regulations, court orders and consent decrees, a program contract, or otherwise imposed by TennCare in connection with the operation of the program or the performance required by either party under an agreement.

Repayment – The process by which an MCO, the State of Tennessee or the Federal government, or any of their Bureaus, Agencies or Contractors recover Title XIX monies paid to an MCO, provider or enrollee.

Reportable Event – For the purposes of CHOICES HCBS and I/DD MLTSS Programs, a Reportable Event is an event that is classified as Tier 1, Tier 2, or Additional Reportable Events, as defined by TennCare, that the contracted provider, Contractor, or FEA staff shall be responsible for reporting to the Contractor and/or DIDD, as specified by TennCare. The contracted provider, Contractor, and/or DIDD, as applicable, shall be responsible for managing, tracking and trending in order to prevent similar occurrences in the future whenever possible as is further detailed in Section 2.15.7 of this Contract.

Representative – In general, for CHOICES or 1915(c) waiver members, a person who is at least eighteen (18) years of age and is authorized in writing by the member to participate in care planning and implementation and to speak and make decisions on the member's behalf, including but not limited to identification of needs, preference regarding services and service delivery settings, and communication and resolution of complaints and concerns. As it relates to consumer direction of eligible CHOICES or 1915(c) waiver HCBS, a person who is authorized by the member to direct and manage the member's worker(s) and signs a representative agreement. The representative for consumer direction of eligible CHOICES HCBS must also: be at least eighteen (18) years of age; have a personal relationship with the member and understand their support needs; know the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in

the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate workers.

Representative Agreement – The agreement between a CHOICES or 1915(c) waiver member electing consumer direction of eligible CHOICES or 1915(c) waiver HCBS who has a representative direct and manage the consumer's worker(s) and the member's representative that specifies the roles and responsibilities of the member and the member's representative.

Residential Habilitation – A type of residential service having individualized services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It may also include medication administration as permitted under Tennessee's Nurse Practice Act.

Resilience – A dynamic developmental process for children and adolescents that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Risk Agreement – An agreement signed by a CHOICES Group 2 or 3 member who will receive CHOICES HCBS (or their representative) that includes, at a minimum, identified risks to the member of residing in the community and receiving HCBS, the possible consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding their acceptance of risk. For members electing to participate in consumer direction, the risk agreement must include any additional risks associated with the member's decision to act as the employer of record, or to have a representative act as the employer of record on their behalf. See Section 2.9.7 of this Contract for related requirements.

Risk Assessment – As part of the person-centered planning process for members in 1915(c) waivers, the Contractor shall assess risk based on member preference for service delivery, including risks specific to consumer direction, and shall further assess risk in instances in which a member's health, safety, or wellness has changed. If, during this assessment, risk is identified, each risk shall be incorporated individually into the PCSP in the applicable section(s), and each risk must include a corresponding mitigation strategy. The Contractor shall routinely assess risks identified in the member's PCSP, as well as corresponding mitigation strategies, to determine whether such risks are ongoing, and if so, whether the existing mitigation strategies continue to be appropriate.

Routine Care – Non-urgent and non-emergency medical or behavioral health care such as screenings, immunizations, or health assessments.

Safeguarding Enrollee Information – To maintain reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of the information; to protect against any reasonably anticipated threats or hazards to the security or integrity of the information; and to protect against unauthorized uses or disclosures of the information.

Savings – Residual monies remaining after the administrative costs described in this Contract are deducted from administrative payment fees paid by TennCare.

Security Incident – The attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with the system operations in an information system.

Security Rule – The Final Rule adopting Security Standards for the Protection of Electronic Health Information at 45 CFR Parts 160 and 164.

SelectCommunity – SelectCommunity is a special component of the TennCare Select program as an Integrated Health Services Delivery Model, developed specifically for individuals with I/DD and children enrolled in Katie Beckett Part A. Person- and family-centered planning will be conducted for children enrolled

in SelectCommunity in a manner consistent with CFR 441.301(c)(1), using SelectCommunity Nurse Care Managers who have specialized training in developmental disabilities, and in a family-centered approach.

Self-Determination Waiver Program – A Home and Community-Based Services (HCBS) Waiver (Control Number TN 0427) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act which serves children and adults with intellectual disabilities and children under age six with developmental delay who qualify for and, absent the provision of services provided under the Self-Determination waiver, would require placement in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The Self-Determination Waiver Program affords persons supported the opportunity to directly manage selected services, including the recruitment and management of service providers. Participants and families (as appropriate) electing self-direction are empowered and have the responsibility for managing, in accordance with waiver service definitions and limitations, a self-determination budget affording flexibility in service design and delivery. The Self-Determination Waiver Program serves persons who have an established non-institutional place of residence where they live with their family, a non-related caregiver or in their own home and whose needs can be met effectively by the combination of waiver services through this program and natural and other supports available to them. The Self-Determination Waiver does not include residential services such as supported living. The Self-Determination Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participant's Person-Centered Support Plan, based on the person's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Self-Direction of Health Care Tasks – A decision by a CHOICES or 1915(c) waiver member participating in consumer direction or the parent or other legal guardian of a Katie Beckett Part A member to direct and supervise paid worker delivering eligible CHOICES or 1915(c) waiver HCBS or eligible Katie Beckett HCBS in the performance of health care tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather health care-related duties and functions (such administration of medications) that a CHOICES or 1915(c) waiver member participating in consumer direction or the parent or other legal guardian of a child enrolled in Part A of the Katie Beckett Program may elect to have performed by a consumer-directed worker as part of the delivery of eligible CHOICES or 1915(c) waiver HCBS or eligible Katie Beckett HCBS s/he is authorized to receive.

Serious and Persistent Mental Illness (SPMI) – Severe persistent mental illnesses are those that are prolonged and recurrent, impair activities of daily living, and require long-term treatment. Common diagnoses include schizophrenia, bipolar disorder, and major depression.

Serious Emotional Disorder (SED) – Serious emotional disorder means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) AND has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis.

Service Agreement – The agreement between a CHOICES or 1915(c) waiver member electing consumer direction of eligible HCBS (or the member's representative) and the member's consumer-directed worker that specifies the roles and responsibilities of the member (or the member's representative) and the member's worker.

Service Gap – A delay in initiating any long-term care services and/or a disruption of a scheduled, ongoing CHOICES or 1915(c) waiver HCBS that was not initiated by a member, including late and missed visits.

Shall – Indicates a mandatory requirement or a condition to be met.

Social Needs – Basic resources, such as food, safe housing, or transportation.

Social Risk Factors – Conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of individual and Population Health, functioning, and quality of life outcomes

and risks. Social risk factors include socioeconomic status, education, neighborhood, and physical environment (e.g., Housing), employment, social support networks and access to health care. These social and structural factors are key drivers of health care utilization and disparities in health status.

Social Security Act – The Social Security Act is the federal law under which Medicaid is authorized. Medicaid is governed by Title XIX of the Social Security Act.

Span of Control – Information systems and telecommunications capabilities that the Contractor itself operates or for which it is otherwise legally responsible according to this Contract. The Contractor's span of control also includes Systems and telecommunications capabilities outsourced by the Contractor.

Specialty Services – Includes Essential Hospital Services, services provided by Centers of Excellence, and specialty physician services.

SSA – Social Security Administration.

SSI – Supplemental Security Income.

Start Date of Operations – The date, as determined by TennCare, when the Contractor shall begin providing services to members.

State – The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Tennessee Department of Finance and Administration, the Office of Inspector General, the Division of TennCare, the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit, the Tennessee Department of Mental Health and Developmental Disabilities, the Tennessee Department of Children's Services, the Tennessee Department of Health, the Tennessee Department of Commerce and Insurance, and the Office of the Attorney General.

State Custody – State custody means that a child is in the custody of a state department, division, or agency, including secure care.

State Fair Hearing (SFH) – The Benefit Appeal Process set forth in subpart E of part 431 chapter IV, title 42 under which TennCare enrollees have the right to request a SFH (synonymous with "Appeal") to contest MCC-proposed Adverse Benefit Determinations. CoverKids/CHIP program enrollees do not have the right to receive a SFH, but may receive a CoverKids "Review". See 42 CFR §438.400(b).

Statewide Home and Community-Based Services (HCBS) Waiver – A HCBS Waiver (Control Number TN 0128) approved by the Centers for Medicare and Medicaid Services pursuant to Section 1915(c) of the Social Security Act which serves children and adults with intellectual disabilities and children under age six with a developmental disability who qualify for and, absent the provision of services provided under the Statewide Waiver, would require placement in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The Statewide Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participant's Person-Centered Support Plan, based on the person's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Subcontract – An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract (e.g., claims processing, disease management) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Contract. This shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract. Agreements to provide covered services as described in Section A.2.6 of this Contract shall be considered provider agreements and governed by

Section A.2.12 of this Contract. Agreements that provide both covered services and administrative services shall be treated as provider agreements.

Substance Use Disorder (SUD) – According to DSM-5, a substance use disorder involves patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects.

Substance Use Disorder Services – The assessment, diagnosis, treatment, detoxification, residential care, rehabilitation, education, training, counseling, referral or supervision of individuals who are abusing or have abused substances.

Super-utilizers – The Centers for Medicare and Medicaid Services (CMS) has defined super-utilizers as "patients who accumulate large numbers of emergency department (ED) visits and hospital admissions which might have been prevented by relatively inexpensive early interventions and primary care".

Supported Living – A type of residential service having individualized services and supports that enable an enrollee to acquire, retain or improve skills necessary to reside in a home that is under the control and responsibility of the enrollee. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

Supports Broker – An individual assigned by the FEA to each CHOICES, 1915(c) waiver, or Katie Beckett Part A member participating in consumer direction who assists the member/representative as needed in performing certain employer of record functions as follows: developing job descriptions; recruiting, interviewing, and hiring workers; member and worker enrollment in consumer direction and consumer direction training; and developing (as part of the onboarding process for new workers) a schedule for the member's workers that comports with the schedule at which services are needed by the member as reflected in the plan of care. The supports broker shall also assist the member as needed with developing and verifying the initial back-up plan for consumer direction. The supports broker collaborates with the member's care coordinator, support coordinator, independent support coordinator, nurse care manager, or DIDD case manager, as appropriate. The supports broker does not have authority or responsibility for consumer direction. The member or member's representative must retain authority and responsibility for consumer direction.

System Unavailability – As measured within the Contractor's information systems span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "Enter" or other function key.

T.C.A.– Tennessee Code Annotated.

Telehealth – The provision of healthcare remotely by means of telecommunications technology.

TennCare – TennCare shall have the same meaning as "State."

TennCare or TennCare Program – The program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare CHOICES in Long-Term Care (CHOICES) – A program in which long-term care services for elders and/or persons with physical disabilities are integrated into TennCare's managed care delivery system.

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 TennCare rules and regulations.

TennCare Pre-Admission Evaluation Tracking System (PAE Tracking System) – A component of the State's Medicaid Management Information System and the system of record for all Pre-Admission Evaluation (i.e.,

level of care) submissions and level of care determinations, as well as enrollments into and transitions between LTSS programs, including CHOICES, ECF CHOICES, 1915(c) waivers, and the State's MFP Rebalancing Demonstration (MFP), as a tracking mechanism for referral list management in ECF CHOICES, and which shall also be used to gather data required to comply with tracking and reporting requirements pertaining to MFP.

TennCare Standard Enrollee – An enrollee who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as "TennCare Standard" as described in the approved TennCare waiver and the TennCare rules and regulations.

TennCare Kids – Tennessee's EPSDT program; see EPSDT.

Tennessee Bureau of Investigation, Medicaid Fraud Control Division (TBI MFCD) – The Tennessee Bureau of Investigation's Medicaid Fraud Control Unit has the authority to investigate and prosecute (or refer for prosecution) violations of all applicable state and federal laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, the activities of providers of medical assistance in the state Medicaid program (TennCare), allegations of abuse or neglect of patients in health care facilities receiving payments under the state Medicaid program, misappropriation of patients' private funds in such facilities, and allegations of fraud, waste, and abuse in board and care facilities.

Tennessee Department of Children's Services (DCS) – The state agency responsible for child protective services, foster care, adoption, programs for delinquent youth, probation, aftercare, treatment and rehabilitation programs for identified youth, and licensing for all child-welfare agencies, except for child (day) care agencies and child support.

Tennessee Department of Commerce and Insurance (TDCI) – The state agency having the statutory authority to regulate, among other entities, insurance companies and health maintenance organizations.

Tennessee Department of Finance and Administration (F&A) – The state agency that oversees all state spending and acts as the chief corporate office of the state. It is the single state Medicaid agency. The Division of TennCare is a division of the Tennessee Department of Finance and Administration.

Tennessee Department of Health (DOH) – The state agency having the statutory authority to provide for health care needs in Tennessee.

Tennessee Department of Human Services (DHS) – The state agency having the statutory authority to provide human services to meet the needs of Tennesseans and enable them to achieve self-sufficiency.

Tennessee Department of Intellectual and Developmental Disabilities (DIDD) – The state entity contracted by TennCare to serve as the operational lead agency for Katie Beckett Part B and I/DD MLTSS Programs, including ECF CHOICES, the 1915(c) waivers, and ICF/IID services as set forth in the Interagency Agreements between TennCare and DIDD and the Program Operations between DIDD and the Contractor and DIDD. DIDD is also contracted by TennCare for the performance of certain intake, quality assurance, reportable event management and other functions as specified in the Interagency Agreements between TennCare and DIDD.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) – The state agency having the authority to provide care for persons with mental illness, and /or substance use disorder needs.

Tennessee Health Link (THL) – Tennessee Health Link is a program that incentivizes increased care coordination for TennCare Members with the highest behavioral health needs.

Tertiary Pediatric Center (Center of Excellence for Children in or at risk of Custody) – A site recognized by the services it offers to be a referral site for children needing the highest level of physical care. The five recognized tertiary care centers for pediatrics are in Johnson City, Knoxville, Chattanooga, Nashville, and Memphis.

Third Party Liability (TPL) – Any amount due for all or part of the cost of medical, behavioral health, or long-term care services from a third party.

Third Party Resource – Any entity or funding source other than the enrollee or their responsible party, which is or may be liable to pay for all or part of the cost of health care of the enrollee.

Transition Allowance – A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of the Contractor, be provided as a cost-effective alternative to continued institutional care for a CHOICES Group 1 or I/DD MLTSS Programs member in order to facilitate transition from a nursing facility or ICF/IID to the community when such member will, upon transition to CHOICES Group 2 or Group 3, receive more cost-effective non-residential home and community-based services or companion care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain and that are essential in order to establish a community residence when such residence is not already established and to facilitate the member's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

Transition Team – Teams the Contractor shall maintain beginning July 1, 2015 to fulfill its obligations pursuant to Nursing Facility to Community Transitions (see Section 2.9.7.8) and the MFP Rebalancing Demonstration (see Section 2.9.8). The Transition Team shall consist of at least one (1) dedicated staff person without a caseload in each Grand Region in which the Contractor serves TennCare members, who also meets the qualifications of a care coordinator specified in Section 2.9.7.13. The transition team may also include other persons with relevant expertise and experience who are assigned to support the care coordinator(s) in the performance of transition activities for a CHOICES Group 1 member. Any such staff shall not be reported in the care coordinator ratios specified in Section 2.9.7.13, and shall be responsible for proactively identifying TennCare members in NFs who are candidates to transition to the community and to further assist with the completion of the transition process specified in Section 2.9.7.8. All transition activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator.

Unsecured PHI – PHI information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of DHHS.

Urologist – A doctor who specializes in the study or treatment of the function and disorders of the urinary system.

USC – United States Code.

Vital Documents – Vital Documents may include, but are not limited to, consent and complaint forms, intake and application forms with the potential for important consequences, notices pertaining to the reduction, denial, delay, suspension or termination of services, certain critical outreach documents (i.e. case management and Population Health documents) and any other documents designated by the State. At a minimum, all Vital Documents shall be available in the Spanish and Arabic languages.

Warm Transfer – A telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.

Waste – Is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Wellness – An approach to health care that emphasizes not merely the absence of disease or infirmity but the pursuit of optimum health. It is an active process of helping members become aware of and make choices that will help them to achieve a healthy and more fulfilling life. Wellness includes preventing illness, prolonging life, and improving quality of life, as opposed to focusing solely on treating diseases. Wellness is

a condition of good physical and mental health, especially when accomplished and maintained by personal choice and action, including proper diet, exercise, and health habits.

Worker – See Consumer-Directed Worker.

Written Translation – Is the replacement of a written text from one language (source language) into an equivalent written text in another language (target language).

11. RFP Amendment Effective Date. The revisions set forth herein shall be effective upon release. All other terms and conditions of this RFP not expressly amended herein shall remain in full force and effect.