STATE OF TENNESSEE
Division of TennCare

REQUEST FOR PROPOSALS # 31865-00603
AMENDMENT # 5
FOR MANAGED CARE ORGANIZATIONS

DATE: August 2, 2021

RFP # 31865-00603 IS AMENDED AS FOLLOWS:

Change #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		June 11, 2021
2. Disability Accommodation Request Deadline	2:00 p.m.	June 16, 2021
3. Pre-response Conference	9:30 a.m.	June 17, 2021
4. Notice of Intent to Respond Deadline	2:00 p.m.	June 22, 2021
5. Written "Questions & Comments" Deadline	2:00 p.m.	June 25, 2021
6. State Response to Written "Questions & Comments"		August 2 2021
7. Response Deadline	2:00 p.m.	September 1, 2021
8. State Schedules Mandatory Respondent Oral Presentation		September 14, 2021
9. Mandatory Respondent Oral Presentation	TBD	September 17 – September 29, 2021
10. State Completion of Technical Response Evaluations		October 5, 2021
11. State Notice of Intent to Award Released and RFP Files Opened for Public Inspection	2:00 p.m.	October 8, 2021
12. End of Open File Period		October 15, 2021
13. Negotiations of Contract Accountability Template		October 19 - 29, 2021
14. State sends Contract to Contractor for signature		November 1, 2021
15. Contractor Signature Deadline	2:00 p.m.	November 12, 2021

Change #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.

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Attachment 6.2, Technical Qualifications, Experience & Approach, Item C.5.c.iii, Quality of Care Outcomes	38	1 Please confirm that Respondents currently under contract in the state of Tennessee should submit their TN Annual Quality Survey reports performed by the EQRO. It is our understanding that the requirement to provide EQRO reports for the Medicaid contract with the largest number of members at the start of 2020 applies to non-incumbents, as this would be "affiliate" experience and not "Respondent" experience.	1 All Respondents should submit their EQR reports and corrective action plan(s) associated with the report.
Attachment 6.2 Mandatory Requirement Items, Item A.6	20	2 RFP Section A.6 requests a completed Disclosure of Ownership and Control Interest Statement. The form at the link in the RFP is subtitled “Clinical Laboratory Improvement Amendments.” Should Respondents complete this form or is there a specific form for MCOs?	2 Per Change #10, the correct file has been uploaded to the link here: https://www.tn.gov/content/dam/tn/tenncare/documents/Disclosure_of_Ownership_Form.docx
Attachment 6.2 Mandatory Requirement Items, Item A.6	20	3 Considering the Disclosure of Ownership and Control Interest Statement contains extensive personal information (name, date of birth, social security number), would TennCare allow Respondents to provide a written statement confirming that, if awarded a contract pursuant to this RFP, Respondents will complete the Disclosure Form in its entirety prior to contract signature?	3 No. TennCare recognizes the sensitivity of the information. Please see response to Question #2.
Attachment 6.2, Technical Qualifications, Experience & Approach, Item C.5.c.iii, Quality of Care Outcomes	38	4 The most current results for NCQA Health Insurance Plan ratings are for 2019-2020. See: https://www.ncqa.org/hedis/reports-and-research/ratings-2019/ Please confirm whether the State would prefer to receive those or 2018-2019 as specified in the RFP.	4 Per Change #14, the Respondent shall attach its NCQA Health Insurance Plan Ratings (2019-2020) (Accreditation Summary Report and HEDIS® Score Sheet) for all of the Respondent’s Medicaid managed care contracts with full NCQA accreditation.
Attachment 6.2, Technical Qualifications, Experience & Approach, Item C.5.c.iii, Quality of Care Outcomes	38	5 Is the requirement to submit NCQA results (C.5.c.iii) intended to apply to both Respondent and Respondent’s Medicaid affiliates?	5 RFP question C.5.c.iii applies to the Respondent, including the Respondent’s Medicaid affiliates. Please see response to Question #4.
Attachment 6.2, Technical Qualifications, Experience & Approach, Item C.5.c.iii, Quality of Care Outcomes	38	6 Please clarify if the State is requiring both “NCQA Health Insurance Plan Ratings” and “Accreditation Summary Report and HEDIS Score Sheet” as they contain the same information.	6 The Respondent does not need to submit two versions of the same information. The Respondent may submit the NCQA Health Insurance Plan Ratings which include the HEDIS score sheet. Please see response to Question #4.

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Attachment 6.9, MCO Risk Contract, A.2.15.12.2, Community Investment	242	7 Will the state please clarify in MCO Risk Contract Section A.2.15.12.2 whether the Community Investment Plan is limited to improving the health outcomes specific to Members, as written, or if it is to be expanded more broadly to those health outcomes of the greater community or specific to applicant's Members?	7 The Community Investment Plan referenced in the RFP, including in MCO Risk Contract Section A.2.15.12.2, should prioritize the health outcomes of Medicaid members but may benefit the health outcomes of the greater community.
Attachment 6.2, Technical Qualifications, Experience & Approach, Items C.7.a.i and C.7.a.ii, Population Health and Non-Medical Risk Factors	41	8 RFP Items C.7.a.i and C.7.a.ii are very similar in nature and request the same information. Did the state intend to include a different Item or may the respondent address both components in one response?	8 Please see Change #15. The original C.7.a.i question has been deleted and the following question (formerly C.7.a.ii) has been re-numbered as C.7.a.i.
Attachment 6.2, Technical Qualifications, Experience & Approach, Item C.7.b, Population Health and Non-Medical Risk Factors	41-42	9 RFP Item C.7.b requests Respondents "provide a plan that outlines their community investment approach." Sub-question C.7.b.ii states, "MCOs will be scored based on the proposed MCO Community Investment Plan." Given the expected length of the Community Investment Plan, please confirm that the State is requiring Respondents to describe their approach to developing (rather than providing) its Community Investment Plan. If you are requesting the full Community Investment Plan, please confirm it can be included as an attachment and will not count toward the page limit.	9 Please see Change #16. Question C.7.b has been modified to clarify that Respondents shall describe their Community Investment Plan. Responses to question C.7.b will be included within the page limit. Please note instructions regarding Attachment 6.11. Respondents may include more detail regarding their Community Investment Plan as part of Attachment 6.11.
A.2.28, Personnel Requirements	335	10 Can the state confirm that key staff positions in Section A.2.28.1.3.5 "Pharmacist" and Section A.2.28.1.3.46 "PBM Coordination" can be held by the same person?	10 Yes, the key staff positions in Section A.2.28.1.3.5 "Pharmacist" and Section A.2.28.1.3.46 "PBM Coordination" may be held by the same person.
Attachment 6.2, General Qualifications & Experience Items, Items B.12 and B.15	22-23	11 RFP Section B has a 25-page limit and for some items, respondents can identify supporting documentation that is excluded from the page count. Since B.15 asks for ratings information and net worth requirement compliance for affiliates, to not disadvantage Respondents with many affiliates, would TennCare consider allowing supporting documentation for this item? Similarly, Item B.12, commitment to diversity, asks for information on current business relationships and estimated participation. To not disadvantage Respondents with many diverse suppliers (current or proposed), would TennCare consider allowing supporting documentation for this item as well?	11 Please refer to Amendment #3 for B.15. In response to B.12, attachments clearly identified as supporting documentation for the state and clearly specified will be excluded from the 25-page limit as noted in Change #11. All attachments must include the RFP section title, item reference number, and the attachment title.
A.2.6.7.4.1 Cost Sharing Schedule	142	12 RFP Section 2.6.7.4.1 refers to Attachment II related to Cost Sharing Schedule. Attachment II	12 Please see Change #20 and Change #21 which removes reference to Attachment II.

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		in the Pro Forma is Capitation Rates. Should this section refer to the MCO manual Section M.1.3.2?	The current cost share schedules are included in the MCO Manual, Section M.1.3.2.
A.2.9.9.1.3-A.2.9.9.1.4, Coordination and Collaboration Among Behavioral Health Providers	188	13 RFP Items 2.9.9.1.3 and 2.9.9.1.4 are very similar in nature and request the same information. Did the state intend to include a different Item or may the respondent address both components in one response?	13 RFP items 2.9.9.1.3 and 2.9.9.1.4 are duplicate lines. Please see Change #26 for removal of duplicate language.
A.2.15.6.3, NCQA HEDIS and CAHPS	239	14 In this section, it states “Annually, beginning in 2019, the CONTRACTOR shall report the NCQA HEDIS 2019 Technical Specifications for LTSS Measures”…" Does this need to be updated to align with the contract start date?	14 Please see Change #32 for clarification on most current HEDIS reporting for annual reports.
A.2.21.5.1, Third Party Liability Resources	276	15 In the last sentence of this section, it refers to "TennCare Plan." We would like clarification on what that means as it's not a defined term or found in other sections of the Pro Forma or MCO Manual.	15 Please see Change #34. The reference to TennCare Plan has been replaced with Medicaid State Plan.
A.2.22.5.3 and A.2.22.5.5, Claims Dispute Management	283	16 The two provisions are related to provider complaint resolution and payment when claims are overturned. The two provisions have two different timeframes. Is this intentional?	16 Yes, these timeframes are purposefully different as the sections refer to two different complaint processes. A.2.22.5.3 refers to provider complaints that are adjudicated through TDCI and is regulated in Tennessee State law. A.2.22.5.5 refers to a Contractor's own review of a provider complaint.
Attachment 6.2 Mandatory Requirement Items, Item A.5	20	17 RFP Section A.5 asks for an official document or letter from an accredited credit bureau, verified and dated within the last three (3) months and including a positive credit rating for the Respondent. The ratings agencies normally update and affirm ratings once per year. If a Respondent's rating was completed outside the three-month window, may we submit a rating completed within the last 12 months?	17 The State’s Risk Manager has relayed that Most credit reporting agencies update account information to credit bureaus on at least a monthly basis. Among the types of information that is updated is account balances, payment status, credit limits, and inquires seeking credit applications. Creditors send account updates like payment status and current balance to credit bureaus at various times throughout the month, but generally every 30 days but it could be 45 days. Credit rating bureaus are required under the Fair Credit Reporting Act to provide accurate and timely credit information and they accomplish this by updating credit information on a monthly basis.
Attachment 6.2, General Qualifications & Experience Items, Item B.15.	23	18 Please confirm that ratings and net worth information is requested only for the Respondent’s affiliates contracted for publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income	18 The Ratings and net worth information only apply to publicly funded managed care contracts for Medicaid/CHIP and/or other low-income individuals.

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		individuals. Many Respondents have affiliates operating lines of business completely unrelated to Medicaid/CHIP. If it is the State's intent to request this information for affiliates operating in other lines of business, please confirm the additional documentation can be included as supporting documentation and not count toward the Section B page limit.	
Attachment 6.2, Technical Qualifications, Experience & Approach, Item C.2.d, LTSS-CHOICES, Employment and Community First CHOICES, other Integrated MLTSS Programs for Individuals with I/DD,D-SNPs	29	19 RFP Section C.2.d. requests that the respondent submit a Model of Care (MOC) 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 LTSS populations. Please confirm the Respondent is to submit the D-SNP MOC, with evidence of CMS approval and score, and a separately attached policy demonstrating applicable Medicaid requirements where appropriate.	19 As described in RFP Section C.2.d., the Respondent should develop a MOC document that is specific to this contract, encompassing each of the LTSS populations. The MOC should comport with requirements set forth in Chapter 5 of the Medicare Managed Care Manual--i.e., the Elements of an effective MOC. However, the respondent should not simply submit the MOC for its D-SNP. Instead, it should adapt CMS MOC requirements for D-SNPs to the scope of work and populations covered under this Contract, reflective of Medicaid-specific policies or requirements.
3.2.1.1.1, Technical Response (Response Delivery)	9	20 Please confirm the electronic USB flash drive for the Technical Response and Community Investment Template should be submitted in an unencrypted state.	20 Yes, the electronic USB flash drive for the Technical Response and Community Investment Template should be submitted in an unencrypted state. Note: The State prefers to receive the responses electronically. Please review response to Question 35 regarding contacting Solicitation Coordinator regarding large file sizes and use of Respondent cloud links for submissions, if appropriate.
3.2.2.2, Technical Response, Respondent Community Investment Template (Response Delivery)	9	21 Can the State confirm that only one original and one copy is required for the Respondent Community Investment Template?	21 Yes, only one original and one copy are required to be submitted of the Community Investment Template. For more details on submission requirements, please see the requirements in 3.2.1 and 3.2.2.
3.2.2.3 Technical Response (Response Delivery)	9	22 Please clarify the outside box for the Technical Response and Respondent Community Investment Template should be labeled with RFP # 31865-00616 rather than RFP # 31865-00603.RFP # 31865-00616.	22 Please see Change #8 for clarification on the label for the outside box for the Technical Response and Respondent Community Investment Template.
3.1.1, Response Form	8	23 Will the State allow font size smaller than 12 point for graphics, charts, graphs, tables, headers/footers, etc.	23 The state will accept a smaller font than 12 pt. font for charts, graphics, graphs, tables, headers, and footers as long as all items are legible. The Respondent is responsible for ensuring that any font used is legible.
Attachment 6.11 Community Investment Template	752	24 Regarding RFP Attachment 6.11, please confirm the following instructions for Respondent Community Investment Template:	24 Please see Change #6 for an updated Attachment 6.11 with corrected references.

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		1. Step One: The first type of community investment should be listed in Cell A5, as opposed to A6. 2. Step Two: The instructions referencing total annual commitments in Cells B12, C12, and D12 should be Cells B11, C11, and D11, respectively. 3. That the state would like the current text in Cells A5 through A9 deleted and replaced with each investment description or nulled, as applicable.	
3.1, Attachments	8	25 Please confirm that Respondents can submit required RFP Attachments as formatted with the RFP as opposed to reformatting the Attachments.	25 Yes, Respondents can submit required RFP Attachments as formatted with the RFP as opposed to reformatting the Attachments.
3.2.1, Response Delivery	8	26 Will the State allow the use of electronic signatures within the copy (not the original) of Respondent's submission?	26 Yes, the State will allow the use of electronic signatures within the copy (not the original) of Respondent's submission.
Attachment 6.2, Section B, General Qualifications & Experience Items, Instructions	21	27 Some items in Section B allow supporting documentation that are excluded from the 25 page limit. The instructions for Section B indicate that Respondents "…must address all items detailed below and provide, in sequence, the information and documentation as required…" If Respondents provide supporting documentation directly after the response to the item, it may leave significant amounts of white space and take away part of the 25 page limit. Please confirm that Respondents can place supporting documentation at the end of the 25 page Section B response.	27 Please see response to Question #11.
Attachment 6.2, Section C, Technical Qualifications, Experience & Approach Instructions	26	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 200 page limit (e.g., inserting the Model of Care in C.2.d). Please confirm that Respondents can place requested attachments at the end of the Section C items responses.	28 Supporting documentation to questions in Section C may be included at the end of that Section in sequential order. Supporting documentation as requested by the state shall not count towards the modified 300-page limit. Please see Change #7 and Change #13 for modifications to Section C page limits.
Section B, MCO Risk Contract	344	29 The contract period displayed during the pre-response conference on June 17th appeared differently from Section B – Contract Period in the attachment, MCO Risk Contract – January 1, 2022. Please clarify the contract period, including the contract term and renewal options.	29 The Contract Term in Section B of the Pro Forma is correct. The first calendar year will be implementation preparation and the successful bidders that have successfully passed implementation milestones will begin serving TennCare members on January 1, 2023. SECTION B - CONTRACT PERIOD B.1 This Contract shall be effective for the period beginning January 1, 2022 and extend for a period of number (36) months after the Effective Date ("Term"). The State shall have no obligation for goods or

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			services provided by the Contractor prior to the Effective Date. B.2 Renewal Options. This Contract may be renewed upon satisfactory completion of the Term. The State reserves the right to execute up to seven (7) renewal options under the same terms and conditions for a period not to exceed twelve (12) months each by the State, at the State's sole option. In no event, however, shall the maximum Term, including all renewals or extensions, exceed a total of one hundred twenty (120) months.
Attachment 6.13, General Attestations	754	30 The revised CRA requirements Attestations in Attachment 6.13 identify the prohibition of Behavioral Health subcontracting. The language in Attachment 6.13 specifically refers to "core contracting" for these services. Will TennCare please provide a definition for the scope of "core contracting"? For example, are Contractors permitted to utilize vendors or other subcontractors for support or administrative functions for these services that may be most effectively delivered through a company with specialized expertise and staff (e.g. a 24-hour crisis hotline)?	30 In this context, 'core contracting' refers to the day-to-day administrative and clinical provision of behavioral health benefits management by the MCO. It is possible for ancillary functions such as a 24-hour crisis hotline to be subcontracted out as long as the day-to-day behavioral health benefits management is administered by the MCO.
1.10 Enrollee Assignment	6	31 In Section 1.10 Enrollee Assignment, the language indicates how enrollees will be assigned to new MCO(s) if any incumbent MCOs are not awarded a contract. Can the State please provide additional clarification on the enrollee process, including information that will be shared with members and providers, as described in this section?	31 Members will receive a letter from TennCare explaining the transition and who their new MCO will be. In accordance with CMS requirements, members will be given 90 days from the effective date of their MCO change to select a different MCO. We will work with all new MCOs to coordinate an MCO Welcome letter to **follow** TennCare's letter so the new plan can begin introducing themselves to their members.
3.1.1.2 Technical Response	8	32 Please confirm a font size smaller than 12 pt. is permissible for header/footer notations, graphics, charts, and tables.	32 Please see response to Question #23.
3.1.1.2 Technical Response	8	33 Please confirm section divider pages included in the response do not count toward page limits.	33 Section divider pages included in the response do not count toward page limits.
3.1.1.2 Technical Response	8	34 Are Respondents required to restate the question as part of the response? If so, is the question excluded from the page limit?	34 The Respondent does not need to restate the entire RFP question. The Respondent will need to clearly follow all RFP response instructions and should make sure that evaluators are able to understand which question is being responded to.
3.2.1.2 Email Submission	9	35 Technical Response documents will be too large for an E-Mail Submission. Can the State please confirm that they would like both Digital Media (3.2.2.1) and E-mail Submission	35 Respondents can submit either an email or digital media submission of Technical Response documents. If submitted via email, TennCare can accept up to 32 MB. See RFP Section 3.2 for more details on

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		(3.2.1.2), and if so, how they would like the response broken down in order to be e-mailed?	submissions. The Solicitation Coordinator can accept documents from Respondent cloud links if the file size is larger than 25 MB. It is the Respondents' responsibility to ensure that its submission is made to the State in a timely manner and failure to be able to upload or email a document in a timely manner due to size or other constraints will result in a Respondent's bid not being accepted as timely.
3.2.2 Response Delivery	9	36 Our interpretation of the submission requirements includes a total of 28 individual flash drives or CDs. Is that accurate? One (1) original digital technical proposal Twenty-five (25) digital copies of technical proposal One (1) original digital Community Investment Template One (1) digital copy of Community Investment Template	36 That is correct. Please reference requirements 3.2.1 & 3.2.2 for more detail on submissions.
3.2.2 Response Delivery	9	37 Will the State please confirm that the email submission of the Respondent Community Investment Template should have the subject and file name "RFP # 31865-00603 COMMUNITY RESPONSE TEMPLATE"	37 That is correct. The submission of the Respondent Community Investment Template should have the email subject and the attachment should have the file name "RFP # 31865-00603 COMMUNITY RESPONSE TEMPLATE“
3.1.1.1 Technical Response	8	38 Section 3.1.1.1 requires Respondents to “duplicate” Attachment 6.2 when drafting responses. Please confirm that the State does not expect Respondents to enter narrative responses within the attachment itself. If this is the State’s expectation, please clarify how the existing text in the Attachment applies to page limits.	38 The Respondents proposal should clearly indicate which Technical Response Item reference the Narrative is attempting to address. The Respondent should organize, reference, and draft the Technical Response adding appropriate page numbers as required, and using the guide as a table of contents covering the Technical Response, so proposal narrative is clear to evaluators.
Attachment 6.11 Respondent Community Investment Template	752	39 For the Community Investment Plan, in-kind assistance is allowed. Can you please define “in-kind assistance” and provide an example?	39 In-kind donations that can be considered eligible for the community reinvestment plan include non-cash gifts such as goods and services that are donated. Providing vans to a community organization is an example of an eligible in-kind donation. MCO representation on a non-profit board would not be considered an eligible in-kind donation.
C.3.8 Medical Loss Ratio and Risk Corridor for CY2020 and CY2021 Rating Periods	353	40 The risk corridor is indicated as being in place for CY2020 and CY2021. Does the state intend to continue risk corridor for the CY2023 rate period? And if so will it be the two-way risk corridor used for CY2021? If there is no risk corridor for CY2023, will there be another form of risk sharing, for example a minimum MLR with payback? If so, please provide details.	40 At the present time, the State does not intend to have a risk corridor or other form of risk sharing in place for the CY23 rating period.

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Attachment 6.8 CY22 Preliminary Capitation Rates 2.B.ii. Data Description	68	41 Please comment on how/whether a base data time period will be used to set the CY2023 rates. If CY2020 will be used please describe how COVID and member mix will be adjusted for.	41 The State will work with its contracted actuaries to determine the most appropriate approach for the base data to be used in setting the CY2023 rates.
C.3.10.2 Withhold of the Capitation Payment for Quality Improvement/ Performance Incentives	356	42 Please provide more detail around the "Withhold of the Capitation Payment for Quality Improvement", including targeted metrics and weighting of the metrics.	42 TennCare will set the withhold percentages, measures, benchmarks, and weighting of measures at least ninety (90) days prior to the applicable calendar year measurement period.
C.3.10.2 Withhold of the Capitation Payment for Quality Improvement/ Performance Incentives	356	43 The "Withhold of the Capitation Payment for Quality Improvement" is discussed in this section but the TennCare Actuarial Documentation CY22 Preliminary Capitation rates document states that there are no withhold arrangements in place. Please confirm if there will be a quality withhold arrangement beginning CY2023.	43 There will be a quality withhold arrangement beginning in CY2023. Please see Change #36 to Section C.3.10.2 to the MCO Risk Contract.
Attachment 6.8 CY22 Preliminary Capitation Rates 1. B. Appropriate Documentation ii. Rate Ranges	68	44 Please can you confirm that, although draft rates were presented in the form of a rate range, the final rate will be specified? Also provide some commentary on how the specific rate is chosen within the range.	44 At the present time the State intends that final rates will be specific rates and not a rate range. The State will work with its contracted actuaries to establish the specific rates.
Attachment 6.8 Databook and Rates	68	45 Would it be possible to get CY22 RFP Supplemental Reports in Microsoft Excel format?	45 Yes, information will be made available for potential respondents. Please see Change #3 and Change #4
C.3.3.1 Capitation Payment Rates	346	46 Please provide Attachment X referred to in this section. If this Attachment is not available, can you please indicate when it will be?	46 Please see Change #35. The reference to Attachment X was changed to Attachment II. Today, the Cap Rate Attachment in the Pro Forma CRA is blank. The rate ranges are included in the Data Book (Attachment 6.8 of the RFP). The State will work with its contracted actuaries to establish the specific rates. Before Contract Signature, the Cap Rates will be inserted into the Attachment.
Attachment 6.8 CY22 RFP Supplemental Reports	68	47 Unless otherwise stated, is the data included in these reports from CY2019?	47 Yes, unless otherwise stated, the data included in the Supplemental Reports is from CY2019.
C.3.1.3 Payment Methodology - General	346	48 Please clarify how the risk corridor in section C3.8 interacts with the statement in this section: "TennCare shall not share with the CONTRACTOR any financial losses realized under this Contract."	48 Please see response to Question #40.

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A.2.21.6 Patient Liability	205	49 Section A.2.21.6.2 states that the CONTRACTOR will delegate collection of patient liability to the Nursing Facility (NF) or community-based residential alternative (CBRA). Can the NF or CBRA collect the patient liability after the CONTRACTOR adjudicates the NF/CBRA claim and issues payment and Remittance Advice to the NF/CBRA so that the NF knows the exact amount of Patient Liability to collect as adjudicated by the CONTRACTOR?	49 The contract does not specify requirements regarding when patient liability is collected by the NF or CBRA provider. Rather than waiting until the claim is adjudicated, the provider may determine the applicable patient liability amount via the TennCare Online Eligibility Verification system. The member is also informed of the amount of his/her patient liability obligation.
Attachment 6.2 Section B – General Qualifications & Experience Items	21	50 Item Ref. B.22 in the Technical Response and Evaluation Guide states that "The attachment will not count towards the Section B page limit." We assume that this applies to both Attachments 6.5 and 6.6, rather than just one or the other. Are we correct in our assumption? If not, please clarify.	50 Item Ref. B.22 in the Technical Response and Evaluation Guide states: "The attachments will not count towards the Section B page limit." This statement applies to both Attachments 6.5 and 6.6.
A.2.4.5 Effective Date of Enrollment	115	51 We interpret this requirement to mean that payment of claims with a date of service prior to the Start Date of Operations but on or after the TennCare enrollee's effective date of eligibility is the responsibility of the CONTRACTOR. Are we correct in this interpretation? If not, please clarify.	51 MCOs are required to pay claims for Dates of Service listed on the 834. Enrollment prior to Start Date of Operations (meaning the date an MCO has been licensed to accept TennCare members) shall be reimbursed by TennCare in accordance with Section C.3.7.1.2.1. Capitation Payment Adjustments are described in Section C.3.7.
A.2.22.9 EOBs and Related Functions	287	52 Section A.2.22.9.2 states that "the CONTRACTOR shall omit any claims in the EOB file that are associated with sensitive services." We assume that "EOB file" in this instance is synonymous with the paper and/or electronic Explanation of Benefit statement mailed and/or made electronically available to TennCare enrollees. Are we correct in our assumption? If not, please clarify.	52 Yes, EOB is Explanation of Benefits provided to a member to describe services that have been paid or denied. MCOs are responsible for monitoring sensitive services so that EOBs are not sent to members
A.2.23.4.3 Quality of Submission	293	53 Section 2.23.4.3.1 states that "Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the CONTRACTOR for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted shall be completed within one (1) business day." However, Section 2.23.4.3.2 states that "the CONTRACTOR shall, unless otherwise directed by TennCare, address entire file rejects within two (2) business days of TENNCARE's rejection…" Please clarify this apparent discrepancy.	53 This is referring to fatal (one occurrence) or threshold (2% of the file setting the threshold edit) MMIS edits setting on Encounter files causing the entire file to be rejected. The errors are to be corrected and the encounter file resubmitted within two business days of TennCare rejection of the encounter file in the MMIS. Please reference reconciliation requirements found throughout section M.16, specifically M.16.15, on reconciliation reporting and Section 2.23.4.4 Provision of Encounter Data and 2.23.4.5 Eligibility and enrollment Data Exchange for more information around submission requirements.
A.2.23.14 Other Requirements	303	54 Section 2.23.14.1.1 states that "The CONTRACTOR shall participate in a statewide	54 The referenced category includes information related to determinations of,

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		effort to tie all hospitals, physicians, and other providers' information into a data warehouse that shall include, but not be limited to, claims information, formulary information, Medically Necessary service information, cost sharing information and a listing of providers by specialty for each MCO." Can TENNCARE define "Medically Necessary service information" in this context?	coordination for and provision of Medically Necessary benefits such as home health or private duty nursing, related transportation, and mental health or substance use disorder services. Medical necessity is defined in TennCare rules.
A.2.23.14 Other Requirements	303	55 Section 2.23.14.2.3 states that "The CONTRACTOR shall provide a Web-based access vehicle for contract providers to the System described in this Contract and shall work with said providers to encourage adoption of this System." We assume "System" in this context should be synonymous with the Community Health Record for TennCare Enrollees (Electronic Medical Record). Are we correct in our assumption? If not, please clarify.	55 Yes. Please note that Section 2.23.14.2.1 states: "At such time that TennCare requires, the CONTRACTOR shall participate and cooperate with TennCare to implement, within a reasonable time frame, a secure, Web-accessible community health record for TennCare enrollees". TennCare has not required cooperation for implementation on this project.
E.22.1.2.2.7 Liquidated Damages Chart	398	56 B.35 and B.38 state that 97% of claims are paid accurately upon initial submission. We assume that both of these references should include the word "clean" in front of the word "claim." Are we correct in our assumption? If not, please clarify.	56 The definition for "Clean Claim" and Items B.34, B.36 and B.37 of Section E.22.1.2.2.7 are modified in Change #17 and Change #37 to clarify "Clean Claim" includes a claim for which no further written information or substantiation is required in order to make payment.
E.22.1.2.2.7 Liquidated Damages Chart	398	57 B.37 states that "90% of all other claims (for which no further written information or substantiation is required in order to make payment) are paid within 30 calendar days of the receipt of the claim." We assume that "for which no further written information or substantiation is required in order to make payment is synonymous with "clean claim." Are we correct in our assumption? If not, please clarify.	57 Yes, claims for which no further written information or substantiation is required in order to make payment is the definition for clean claim.
M.14.2 Prompt Payment	691	58 Section M.14.2.2 states that "The MCO will process, and if appropriate pay, within sixty (60) calendars days ninety-nine point five percent (99.5%) of all claims for covered services delivered to a TennCare/CoverKids enrollee." We assume that the word "clean" should precede the word 'claims' in this instance. Are we correct in our assumption? If not, please clarify.	58 The assumption that the word "clean" should precede the word 'claims' is incorrect. In this instance, "all claims" refers to both clean and unclean claims.
Attachment 6.10, Section M.1.1.1	450	59 If a TennCare enrollee is a patient in a Short-Term Nursing Facility, we assume that it is the MCO who must collect any required patient liability (and not the Nursing Facility in this instance). Are we correct in our assumption? If not, please clarify.	59 Section 2.6.7.2.3.2 of the Pro Forma contract states: The CONTRACTOR shall collect patient liability from CHOICES Group 2 and Group 3 and ECF CHOICES members (as applicable) who receive CHOICES HCBS or ECF CHOICES in his/her own home, **including members who are receiving short-term nursing facility care**, or who receive adult day care services and from Group 2 members who receive Companion Care.

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A.2.9.6.14.3 For all CHOICES and ECF CHOICES Members	498	60 Section A.2.9.6.14.3.3.1 makes reference to a Section 2.9.6.13.11, which does not appear in the Attachment or RFP. Please clarify what section bidders should reference in this context.	60 Please see Change #24 for section reference update.
A.23.2.2 Adherence to Data and Document Management Standards	290	61 Will TENNCARE make the TENNCARE Companion Guides (TCCGs) available to bidders to allow bidders to describe in greater detail their ability to meet relevant RFP requirements such as meeting TENNCARE Encounter Processing requirements and addressing TENNCARE enrollment and eligibility mandates?	61 No, TennCare specific companion guides cannot be provided until partners are officially onboarded.
A.2.23.4.4 Provision of Encounter Data	294	62 Section A.2.23.4.4.11 states that “In a manner prescribed by TennCare, the CONTRACTOR shall support bi-directional integrated accumulator batch feeds including, but not limited to outpatient patient pharmacy claims, physician administered drug claims, diagnosis codes, out-of-pocket expenses and cost-sharing, up to four (4) times daily.” Please clarify the meaning of “accumulator batch feed”, e.g. is this a paid claims file?	62 “Accumulator Batch Feed” in this clause describes the means to provide or receive, batches of data, where applicable including, but not limited to adjudicated segments of data pertaining to outpatient patient pharmacy claims, physician administered drug claims, diagnosis codes, out-of-pocket expenses and cost-sharing.
M.2.2.7 Tennessee Health Link	468	63 Please verify whether ECF CHOICES members are eligible for Tennessee Health Link?	63 Some but not all Employment and Community First (ECF) CHOICES members are eligible for Tennessee Health Link (THL). THL is a program with the objective of improving behavioral health service delivery to Medicaid recipients with significant behavioral healthcare needs via coordination with teams of professionals associated with a mental health clinic or other behavioral health provider who provide whole-person, patient centered, coordinated care. TennCare Members eligible for ECF CHOICES benefits could receive services from THL providers based on behavioral healthcare provider and support coordinator/team guidance if THL is determined appropriate for the member. Please see Health Link Provider Operating Manual located here for more information: https://www.tn.gov/content/dam/tn/generalservices/documents/cpo/rfp-updates/31865-00603/31865-00603-attachment-6_4-procurement-library/31865-00603-behavioral-health/THL%20Provider%20Operating%20Manual%202021.pdf
Attachment 6.2 Section C – Technical Qualifications, Experience & Approach Items; C.7.a.ii	41	64 C.7.a.ii appears to be an edited version of C.7.a.i. Please clarify which version is the correct version for which Respondents should submit a response.	64 Please see response to Question #8.

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Attachment 6.2 Section C – Technical Qualifications, Experience & Approach Items; C.7.b.i and C.7.b.ii.	42	65 Please confirm that C.7.b.i and C.7.b.ii of the Technical Qualifications, Experience and Approach Items are instructions to be followed and not questions that require a response. If the two sections are questions that require a response, please clarify the State's intent for a desired response, such as affirmation of the instructions.	65 C.7.b.i and C.7.b.ii are instructions to be followed. As noted in C.7.b.i and C.7.b.ii any funding proposals related to its community investment plan should be included in Attachment 6.11. There should be no reference to financial information included in response to C.7.b.
M.4.5.4 Specific Transition Language	532	66 Is the language in M.4.5.4.d intended to apply to all special populations a-d, not just the dually diagnosed (d)? If not, please provide the transition language for the populations indicated in a-c.	66 Please see Change #5 for MCO manual updates.
3.6 Additional Services	11	67 Please confirm that the Contract Accountability Template should only reflect commitments made in the Respondent's narrative proposal response to items in Attachment 6.2, to include the Community Investment Template, not areas of the Pro Forma Contract that the Respondent is not explicitly asked to cover in response to Attachment 6.2.	67 Yes, the Contract Accountability Template should only reflect commitments made in the Respondent's narrative proposal response to items in Attachment 6.2, in particular C.7.b. The Respondent Community Investment Template must be packaged separately as required by RFP Section 3.2.3. See Technical Response and Evaluation Guide, Section C: Technical Qualifications, Experience & Approach, Paragraph 6 for further information regarding Contract Accountability Template
Attachment 6.2, Technical Qualifications, Experience & Approach, Item C.1.h	28	68 Please confirm that question C.1.h. is requesting the Respondent's approach to authorization denial appeals.	68 C.1.h. is referring to the contractor's approach to appeals of all adverse benefit determinations. This includes authorization denials as well as any other form of adverse benefit determination. This question is included to ensure the respondent understands the contractual requirements for all forms of adverse benefit determinations and is prepared to implement processes to meet or exceed these requirements.
1.1	3	69 More than 125,000 Tennesseans are DSNP enrollees. Assuming arguendo that the three current incumbents were to be awarded contracts, the DSNP members who are assigned to plans not awarded would be forced to enroll in a different plan under the current RFP language. Appreciating that CMS star ratings, provider participation, and chronic care expertise are highly valued by DSNP enrollees, and that many DSNP enrollees are extremely satisfied with their current Medicare plans, would TennCare consider allowing Tennesseans to continue to freely choose from existing DSNP plans?	69 As specified in the RFP, "effective January 1, 2023, only successful Respondents who are awarded a contract under this RFP will be contracted by TennCare to operate a statewide D-SNP to serve members with dual eligibility for Medicare and full Medicaid benefits. The State may continue to contract with other entities already contracted to operate a statewide D-SNP to serve dual eligible members with partial Medicaid benefits (i.e., Medicaid coverage of Medicare premiums and/or cost-sharing), subject to integration requirements set forth in federal regulation." The current D-SNP agreements are available at:

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			Cariten Health Plan, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPCariten59448.pdf HealthSpring of Tennessee, LLC.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPHealthSpring59449.pdf Volunteer State Health Plan Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPVSHP59450.pdf UnitedHealthCare Plan of the River Valley, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPUnited59452.pdf Amerigroup Texas, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPAmeriGroup59453.pdf Harmony Health Plan Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPHarmony59460.pdf Amerigroup Tennessee, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPAmerigroupTenn67080.pdf
1.1	3	70 If a non-incumbent MCO submits a bid, how will TennCare take into account the quality of their D-SNP offerings for scoring purposes?	70 The contracting status of a respondent (incumbent/non-incumbent) has no bearing on the evaluation or how a proposal is scored. Medicare Part C Star Ratings and any warning letters, corrective action plans, or deficiency notices related to the Respondent's Medicare Parts C and D plans are specified in B.19. The maximum possible score for all Section B components (Qualifications & Experience) is 150 points.
1.1	3	71 If a lower star rated D-SNP plan is awarded a Medicaid contract, how will TennCare transition members from their current higher-rated plan?	71 TennCare plans to coordinate with CMS to facilitate passive enrollment effective 1/1/23 into the D-SNP aligned with the person's Medicaid enrollment. As provided in regulation, this will include the opportunity for opt-out.
1.1	3	72 Would TennCare consider implementing its proposed plan regarding full benefit dual eligible enrollment later than 2023 in order to facilitate coordination of care for current D-SNP enrollees?	72 No. The award will be made in 2021, leaving more than a full year for coordination and transition.

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1.1	3	73 Would a current DSNP plan that is not awarded a Medicaid contract be permitted to subcontract its DSNP Plan to one of the three Medicaid MCO awardees?	73 No. A current D-SNP plan that is not awarded a contract, may not subcontract to another Medicaid plan to continue to serve as a D-SNP.
TECHNICAL RESPONSE & EVALUATION GUIDE, A.6 Disclosure of Ownership and Control Interest Statement	20	74 Will the state confirm that the form titled "Disclosure of Ownership and Control Interest Statement-TN Clinical Laboratory Improvement Amendments" at the link provided in A.6 is the correct form for this Item? (https://www.tn.gov/content/dam/tn/health/documents/Disclosure_of_Ownership_Form.pdf)	74 Please see response to Question #2.
TECHNICAL RESPONSE & EVALUATION GUIDE Section C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH	26	75 Would the state confirm that Attachment 6.12 Contract Accountability Template should be included with TECHNICAL RESPONSE & EVALUATION GUIDE Section C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH in the submitted proposal?	75 Yes, Attachment 6.12 Contract Accountability Template should be included with TECHNICAL RESPONSE & EVALUATION GUIDE Section C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH in the submitted proposal. This Attachment provides additional contractual requirements, that the Respondent will commit to fulfilling beyond those required in the pro forma contract and should be included in the Technical Response.
Pro Forma Contract and MCO Manual	Pro Forma Contract p. 51, MCO Manual pages 89, 91, 99-100	76 There appear to be sections throughout the Pro Forma Contract and/or MCO Manual that do not reference CHOICES and/or ECF CHOICES, such as: 2.6.1.2.7 Was ECF CHOICES intended to be included in this section? In the MCO Manual, section M.4.6, should this section be titled Care Coordination and Support Coordination as it is reflective of both CHOICES and ECF CHOICES? In the MCO Manual, section M.4.6.2 title refers to both CHOICES first and then ECF CHOICES; however, the section goes into ECF CHOICES and interweaves CHOICES and ECF CHOICES within this section. In the MCO Manual, section M.4.6.3, it appears that both CHOICES and ECF CHOICES are interwoven in this section and in some sections it is unclear if the references are to CHOICES or ECF CHOICES, such as: Section 4.6.3.3 – this is referring to ECF CHOICES, but it does not say ECF CHOICES.	76 Section M.4.6 entitled "Care Coordination" includes requirements pertaining to Care Coordination in CHOICES and Support Coordination in ECF CHOICES Please see Change #5 for modifications to the MCO Manual.
C.3.4.2 Capitation Rate Adjustment	347	77 Pro-forma contract section C.3.4.2 provides: “Should Contractor refuse to continue Contract under new rates, Contractor may activate the Termination Notice provisions prescribed by TennCare,” however, the pro-forma contract does not provide provisions which outline Contractor Termination. Is it TennCare’s intent to incorporate provision “E.14.7 Termination by	77 Section C.3.4.2 provides for the termination opportunity for the MCO in the event the MCO does not accept new rates. 3.4.2 The CONTRACTOR and TennCare further agree that adjustments to capitation rates shall occur only by written notice from TennCare to the CONTRACTOR and

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		Contractor" as it reads in the currently active MCO contracts?	followed up with Contract amendment. The notice will be given at least thirty (30) calendar days before the new rates are paid. Should the CONTRACTOR refuse to continue this Contract under the new rates, the CONTRACTOR then may activate the Termination provisions as prescribed by TennCare. During the six (6) month Termination Notice period the CONTRACTOR will continue to be paid under the new rates. In the event the CONTRACTOR indicates that it is refusing to accept the new rates, but does not choose to institute Termination proceedings as prescribed by TennCare then the State may at its option: 3.4.2.1 Declare that a public exigency exists under Section E.11 of this Contract. If the State makes this declaration the CONTRACTOR will continue to be paid under the new rates, 3.4.2.2 Declare that the Contract is Terminated for Convenience in whole or in part (one or more Grand Regions) under the provisions of Section D.5 of this Contract. If the State makes this declaration the CONTRACTOR will continue to be paid under the new rates for the period of time until the Termination date.
Pro Forma Contract and MCO Manual	N/A	78 There does not appear to be any reference in the Pro Forma or MCO Manual (effective 1/1/2022) related to the IDD Integration process being implemented effective 9/1/2021, such as: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Community Informed Choice, etc. Will the state clarify if these requirements should be included?	78 Requirements pertaining to I/DD Integration in TennCare's existing CRA are effective with the July 1, 2021 amendment. The current CRA can be found on the TennCare Public Website here: https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf
6.10 MCO Manual	444	79 Will TennCare add Amendment 14 to the procurement library?	79 The MCO Contract with the July 1, 2021 Amendment 14 blended can be found here: https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf
Attachment 6.2 Technical Response & Evaluation Guide; (Sections C.4.b. Episodes)	33	80 The third paragraph of the question asks for a description of the "types and timing of technical assistance and data. . .such as streamlined, real-time data". With regard to the Episodes program, please confirm that "real time" is defined as data available to the provider timely, so that the provider can use the data to influence performance.	80 The "types and timing of technical assistance and data" referenced in this section C.4.b. may include, but is not limited to streamlined, real-time data. This could include data available to the provider in a timely manner, so that the provider can use that data to influence performance. The Respondent may also describe other types of real-time data it anticipates using to meet this requirement.
Attachment 6.2 Technical Response & Evaluation Guide; (Sections C.4.c. THL)	34	81 The second paragraph of the question asks for a description of the "types and timing of technical assistance and data. . .such as streamlined, real-time data". With regard to the THL program, please confirm that "real-time" is defined as data available to	81 The second paragraph of question C.4.c asks for a description of the "types and timing of technical assistance and data. . .such as streamlined, real-time data". With regard to the THL program, "real-time" is defined as a level of responsiveness that a user senses as sufficiently immediate or that enables the solution(s) to keep up with

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		the provider timely, so that the provider can use the data to influence performance.	some external process (for example, presentation of visualizations based on timely healthcare data and information that can be used to improve provider decision making and member outcomes).
Attachment 6.2 Technical Response & Evaluation C.5.a.v Access to Care	37	82 Please define the meaning of "or for special populations" at the end of the paragraph.	82 As referred to in question C.5a.v, special populations refer to populations such as those with intellectual/developmental disabilities (IDD) that may have a more difficult time accessing care.
A.2.2.6, MCO Risk Contract	108	83 A.2.2.6 of the MCO Risk Contract states, "The CONTRACTOR shall work with TennCare to align, whenever possible, enrollment of dual eligible Members in the same plan for both Medicare and Medicaid services." Please clarify the term "whenever possible." Will TennCare continue to maintain contracts with standalone D-SNP contractors who do not have a Medicaid MCO contract?	83 The term "whenever possible" takes into account that a Medicare beneficiary can choose how s/he wishes to receive his Medicare benefits, including original Medicare or Medicare Advantage. Dual eligible beneficiaries may enroll in a D-SNP and may choose from eligible plans contracted with TennCare. As specified in the RFP, "effective January 1, 2023, only successful Respondents who are awarded a contract under this RFP will be contracted by TennCare to operate a statewide D-SNP to serve members with dual eligibility for Medicare and full Medicaid benefits. The State may continue to contract with other entities already contracted to operate a statewide D-SNP to serve dual eligible members with partial Medicaid benefits (i.e., Medicaid coverage of Medicare premiums and/or cost-sharing), subject to integration requirements set forth in federal regulation." The current D-SNP agreements are available at: Cariten Health Plan, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPCariten59448.pdf HealthSpring of Tennessee, LLC.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPHealthSpring59449.pdf Volunteer State Health Plan Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPVSHP59450.pdf UnitedHealthCare Plan of the River Valley, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPUnited59452.pdf Amerigroup Texas, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPAmeriGroup59453.pdf Harmony Health Plan Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPHarmony59460.pdf

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			Amerigroup Tennessee, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPAmerigroupTenn67080.pdf
Credentialing Language	214	84 Wondering if the citation for the reference to TennCare being CR Accredited is accurate? I want to respond in sync with the state's priorities	84 Change #31 clarifies the credentialling requirements.
		85 Should potential subcontractor partners submit the intent to respond form even if we would not be submitting as we would not be the prime vendor?	85 No.
	23	86 Within section B, items B.14, B.15 B.18, B.19, and B.20 ask for significant amount of information. Would the state confirm they are also excluded from the 25 page limit?	86 Please see response to Change #11. Additionally, sections B.14, B.18, B.19, and B.20 already state that "Note: Pages clearly identified as supporting documentation for this requirement are excluded from the 25 page limit.".
		87 Can the capitation rate exhibits be shared in Excel format?	87 Please see response to Question #45.
		88 Is there a TennCare policy/requirement for the managed care organizations as it relates to payments/payment levels for ER visits to Out-Of-Network providers?	88 Yes, TennCare Rule 1200-13-13-.08 on Non-Participating Providers (2) Non-Participating Providers. (a) In situations where a MCC authorizes a service to be rendered by a provider who is not a Participating Provider with the MCC, as defined in this Chapter, payment to the provider shall be no less than eighty percent (80%) of the lowest rate paid by the MCC to equivalent participating network providers for the same service. (b) Covered medically necessary outpatient emergency services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(D) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(D)), shall be reimbursed at seventy-four percent (74%) of the 2006 Medicare rates for these services. Emergency care to enrollees shall not require preauthorization. (c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(B) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(B)), shall be reimbursed at 57 percent of the 2008 Medicare Diagnostic Related Groups (DRG) rates (excluding Medical Education and Disproportionate Share components) determined in accordance with 42 C.F.R. § 412 for those

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			services. For DRG codes that are adopted after 2008, 57 percent of the rate from the year of adoption will apply. Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a contract hospital or to another contract service, whichever comes first. (d) Non-Participating Providers who furnish covered CHOICES services are reimbursed in accordance with Rule 1200-13-01-.05. (e) Non-Participating Providers who furnish covered ECF CHOICES services are reimbursed in accordance with Rule 1200-13-01-.31.
		89 Can you provide more information on how TennCare envisions managing contractor risk agreements for MCOs that serve Medicaid and DSNP members?	89 Current DSNP agreement will remain in place through the end of 2022. At which time all DSNP requirements will be effective in this contract. This will be added via an amendment by July 1, 2022. The current D-SNP agreements are available at: Cariten Health Plan, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPCariten59448.pdf HealthSpring of Tennessee, LLC.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPHealthSpring59449.pdf Volunteer State Health Plan Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPVSHP59450.pdf UnitedHealthCare Plan of the River Valley, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPUnited59452.pdf Amerigroup Texas, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPAmeriGroup59453.pdf Harmony Health Plan Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPHarmony59460.pdf Amerigroup Tennessee, Inc.: https://www.tn.gov/content/dam/tn/tenncare/documents2/SNPAmerigroupTenn67080.pdf

Change #3:

RFP Attachment 6.4 – Procurement Library has been updated under RFP Amendment #5 to include the following additional documents: Revisions of the original RFP document are emphasized within the new release. Any sentence or paragraph containing revised or new text is highlighted.

- **Excel version of the CY22 CHOICES Rate Exhibit under RFP Attachment 6.8 – Data Book and Supplemental Reports**
- **Excel version of the CY22 Non-CHOICES Rate Exhibit under RFP Attachment 6.8 – Data Book and Supplemental Reports**

- **Excel version of the CY22 CoverKids Rate Exhibit under RFP Attachment 6.8 – Data Book and Supplemental Reports**

Change #4:

Add Attachment 6.8 Databook and Rates Attachment #4 – Excel versions in as requested by Question #45. Any sentence or paragraph containing revised or new text is highlighted.

- **Attachment 6.8 in Excel Format**

Change #5:

RFP Attachment 6.10 – MCO Manual has been updated by RFP Amendment #4 to include the language changes within the following sections of the MCO Manual: Revisions of the original RFP document are emphasized within the new release. Any sentence or paragraph containing revised or new text is highlighted.

#	Section	
1	M.4.2 Modifications	M.4.2.2 For medically necessary covered services, other than long-term services and supports, being provided by a contract provider, the MCO will provide continuation of such services from that provider but may require prior authorization for continuation of such services from that provider beyond thirty (30) calendar days. The MCO may initiate a provider change only as otherwise specified in the Contract. M.4.2.4 For a member in CHOICES Group 2 or 3 or ECF CHOICES transferring from another MCO, within thirty (30) days of notice of the member's enrollment with the MCO, a Care Coordinator or Support Coordinator, as applicable, will conduct a face-to-face visit (see Section M.4.5.2.3- M.4.5.2.4.14 and M.4.6.2.10 – M.4.6.2.13.1.15), including a comprehensive assessment and a caregiver assessment, and develop a PCSP, as applicable, and the MCO will authorize and initiate CHOICES HCBS or ECF CHOICES HCBS in accordance with the new PCSP. If a member in Group 2 or 3 or ECF CHOICES Group 4, 5, or 6 is receiving short-term nursing facility care on the date of enrollment with the MCO, a Care Coordinator or Support Coordinator, as applicable, will complete a face-to-face visit prior to the expiration date of the level of nursing facility services approved by TENNCARE, but no later than thirty (30) days after enrollment to determine appropriate comprehensive assessment and care planning activities (see Section M.4.5.2.3- M.4.5.2.4.14 and M.4.6.2.10 – M.4.6.2.13.1.15 for members who will be discharged from the nursing facility and remain in Group 2 or 3 or ECF CHOICES and Section A.2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to thirty (30) days after enrollment, and the MCO is unable to conduct the face-to-face visit prior to the expiration date, the MCO will be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate prior to the member's exhaustion of the 90-day short-term NF benefit. M.4.2.5 If at any time before conducting a comprehensive assessment for a member in CHOICES Group 2 or 3 or ECF CHOICES, the MCO becomes aware of an increase in the member's needs, a Care Coordinator, Support Coordinator, or the Integrated Support Coordination Team, as applicable, will immediately conduct a comprehensive assessment and update the member's PCSP, and the MCO will initiate the change in services within ten (10) days of becoming aware of the increase in the member's needs. 4.2.8.1 Transition residents or residents of community-based residential alternatives to another facility unless

		4.2.8.2 Transition Group 1 members to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 or the member meets the at-risk level of care and is enrolled in CHOICES Group 3 (see Section A.2.9.6.12 and M.4.6.9 for requirements regarding nursing facility to community transition);
2	M.4.3 Additions	M.4.3.1 For each member who is enrolled in CHOICES or ECF CHOICES and newly enrolled with the MCO as of the date of implementation, in each Grand Region covered by the Contract, as identified by TENNCARE (herein referred to as "transitioning CHOICES members"), the MCO will assign a Care Coordinator or Support Coordinator prior to the first face-to-face visit. If the face-to-face visit will not occur within ten (10) days after the implementation of the Contract, the MCO will send the member written notification within ten (10) calendar days of implementation that explains how the member can reach the care coordination unit for assistance with concerns or questions pending the assignment of a specific Care Coordinator or Support Coordinator . M.4.3.2 For each transitioning CHOICES or ECF CHOICES member, the MCO will be responsible for the costs of continuing to provide covered long-term care services authorized by the member's previous MCO, including, as applicable, CHOICES or ECF CHOICES HCBS in the member's approved PCSP and nursing facility services without regard to whether such services are being provided by contract or non-contract providers for at least thirty (30) days, which will be extended as necessary to ensure continuity of care pending the provider's contracting with the MCO or the member's transition to a contract provider; if the member is transitioned to a contract provider, the MCO will facilitate seamless transition to the new provider. M.4.3.3 For members in CHOICES Groups 2 and 3 or ECF CHOICES the MCO will continue HCBS in the member's approved PCSP for a minimum of thirty (30) days after the member's enrollment and thereafter will not reduce HCBS unless the member's Care Coordinator or Support Coordinator has conducted a comprehensive needs assessment and developed a PCSP and the MCO has authorized and initiated HCBS in accordance with the member's new PCSP. If a member in CHOICES Groups 2 or 3 or ECF CHOICES is receiving short-term nursing facility care, the MCO will continue to provide nursing facility services to the member in accordance with the level of nursing facility services and/or reimbursement approved by TENNCARE (see Section A.2.14.1.14). 4.3.3.1 For a transitioning member in CHOICES Group 2 or 3 or ECF CHOICES , within ninety (90) days of implementation, the member's Care Coordinator or Support Coordinator will conduct a face-to-face visit, including a comprehensive assessment, and develop a PCSP, and the MCO will authorize and initiate CHOICES or ECF CHOICES HCBS in accordance with the new PCSP. If a member in Groups 2 or 3 or ECF CHOICES is receiving short-term nursing facility care on the date of enrollment with the MCO, the member's Care Coordinator or Support Coordinator will complete a face-to-face visit prior to the expiration date of the level of nursing services approved by TENNCARE, but no more than ninety (90) days after implementation, to determine appropriate comprehensive assessment and care planning activities (see Section M.4.5.2.3- M.4.5.2.4.14 and M.4.6.2.10 – M.4.6.2.13.1.15 for members who will be discharged from the nursing facility and remain in Group 2 or 3 or ECF CHOICES and Section A.2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to ninety (90) days after implementation, and the MCO is unable to conduct the face-to-face visit prior to the expiration date, the MCO will be

		responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate. 4.3.3.2 If at any time before conducting a comprehensive assessment for a transitioning member in CHOICES Groups 2 or 3 or ECF CHOICES , the MCO becomes aware of an increase in the member's needs, the member's Care Coordinator or Support Coordinator will immediately conduct a comprehensive assessment and update the member's PCSP, and the MCO will initiate the change in services within ten (10) days of becoming aware of the change in the member's needs. b. Transition Group 1 members to CHOICES or ECF CHOICES HCBS unless the member chooses to receive CHOICES or ECF CHOICES HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 or ECF CHOICES; c. Admit a member in CHOICES Group 2 or 3 or ECF CHOICES to a nursing facility unless (1) the member requires a short-term nursing facility care stay (see Section A.2.6.1.5.3.1 and M.1.1.2.3); (2) the member chooses to transition to a nursing facility and enroll in Group 1 and meets the nursing facility level of care standards in effect as of July 1, 2012; or (3) the MCO determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap, and the member agrees to transition to a nursing facility and enroll in Group 1; or d. Transition members in Group 2 or 3 or ECF CHOICES to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the MCO will provide continuation of CHOICES or ECF CHOICES HCBS from that provider for at least thirty (30) days, which will be extended as necessary to ensure continuity of care pending the provider's contracting with the MCO or the member's transition to a contract provider; if the member is transitioned to a contract provider, the MCO will facilitate a seamless transition to the new provider.
3	M.4.6.2 Modification	4.6.2.3 For persons wishing to apply for CHOICES, TENNCARE or its designee may employ a screening process, using the tools and protocols specified by TENNCARE, to assist with intake for persons new to both TENNCARE and CHOICES. For potential applicants for ECF CHOICES, TENNCARE or its designee will employ an electronic referral form, using the protocols specified by TENNCARE, to assist with referral and screening for persons new to both TENNCARE and ECF CHOICES. The ECF CHOICES self-referral and screening process is mandatory. For both programs, such screening process will assess: (1) whether the potential applicant appears to meet categorical and financial eligibility criteria for CHOICES or ECF CHOICES, as applicable; and (2) whether the potential applicant appears to meet level of care eligibility for enrollment in CHOICES or ECF CHOICES. For ECF CHOICES, the screening process will also gather information that can be used by TENNCARE to prioritize the potential applicant for intake based on established prioritization and enrollment criteria. If the initial contact is not telephonic, or if TENNCARE or its designee is not able to provide assistance at the point of contact, within two (2) business days, TENNCARE or its designee will contact the applicant to provide assistance to the potential applicant, as needed, in completing the online self-referral.
4	M.4.6.3 Addition	4.6.3.31 Upon receiving notification from TENNCARE that a member's eligibility has ended, the CONTRACTOR shall within two (2) business days notify all providers of ongoing HCBS and for members receiving services through Consumer Direction the FEA that the member's CHOICES or ECF CHOICES eligibility has ended, which may be accomplished by notification in the EVV system when applicable. Such notification shall not be provided in advance of the actual end date of member's CHOICES or ECF CHOICES eligibility, as a prospective end date could be extended

5	M.4.6.4 Addition	4.6.4.1 For members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving community-based residential alternative services that are covered in CHOICES, the CONTRACTOR shall, immediately upon notice of the member's enrollment in CHOICES, authorize such services from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not transition members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving services in a community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR; or (3) the facility where the member is residing is not a contract provider; if the facility is a non-contract provider, the CONTRACTOR shall authorize medically necessary services from the non-contract provider for at least thirty (30) days which shall be extended as necessary to ensure continuity of care pending the facility's enrollment with the CONTRACTOR or the member's transition to a contract provider.
6	M.4.6.7 Addition	*For Members in CHOICES Group 1* 4.6.7.1 The member's Care Coordinator will participate as appropriate in the nursing facility's care planning process and advocate for the member.
7	M.4.6.9 Additions	4.6.9.1 The MCO will develop and implement methods for identifying members who may have the ability and/or desire to transition from a nursing facility to the community, including; 4.6.9.2 The Care Coordinator or Support Coordinator will include other individuals such as the member's family and/or caregiver in the transition planning process if the member requests and/or approves, and such persons are willing and able to participate. 4.6.9.3 As part of transition planning, prior to the member's physical move to the community, the Care Coordinator or Support Coordinator will visit the residence where the member will live to conduct an on-site evaluation of the physical residence and meet with the member's family or other caregiver who will be residing with the member (as appropriate). The Care Coordinator or Support Coordinator will include in the transition plan activities and/or services needed to mitigate any perceived risks in the residence including but not limited to an increase in face-to-face visits beyond the minimum required contacts in Sections M.4.6.9.11 and M.4.6.9.12. 4.6.9.4 The transition plan will address all services necessary to safely transition the member to the community and include at a minimum member needs related to housing, transportation, availability of caregivers, and other transition needs and supports. The transition plan will also identify any barriers to a safe transition and strategies to overcome those barriers. 4.6.9.5 The MCO will approve the transition plan and authorize any covered or cost effective alternative services included in the plan within ten (10) business days of completion of the plan. The transition plan will be fully implemented within ninety (90) days from approval of the transition plan, except under extenuating circumstances which must be documented in writing. 4.6.9.6 The member's Care Coordinator will also complete a PCSP that meets all criteria described in this Contract for members in CHOICES Groups 2 and 3 including but not limited to completing a comprehensive assessment, completing a risk assessment, and making a final determination of cost neutrality. The

		member's Support Coordinator will also complete a PCSP for members in ECF CHOICES, including but not limited to completing a comprehensive assessment and will identify risks and strategies to mitigate risks as part of the transition plan and PCSP. The PCSP will be authorized prior to and initiated upon the member's transition to the community. a. If a transitioning member is enrolled in CHOICES Group 1, any CHOICES HCBS or ECF CHOICES HCBS that must be completed prior to a member's transition from a nursing facility to the community in order to ensure the member's health and safety upon transition (e.g., for a CHOICES member, minor home modifications, adaptive equipment, or PERS installation; or for an ECF CHOICES member, minor home modifications, assistive technology, etc.) will be completed while the member is enrolled in Group 1, but will be billed as a Group 2 or ECF CHOICES service once the member is enrolled into Group 2 or ECF CHOICES, as applicable, with the date of service the effective date of enrollment in CHOICES Group 2 or ECF CHOICES. b. If a transitioning member is enrolled in CHOICES Group 2 or 3 or ECF CHOICES Groups 4, 5, or 6, but is receiving short-term nursing facility care, any CHOICES HCBS or ECF CHOICES HCBS that must be completed prior to a member's transition from a nursing facility to the community in order to ensure the member's health and safety upon transition (e.g., for a CHOICES member, minor home modifications, adaptive equipment, or PERS installation; or for an ECF CHOICES member, minor home modifications, assistive technology, etc.) will be completed while the member resides in the facility and billed as a Group 2 or Group 3 or ECF CHOICES service, as applicable. However, a member will not be transitioned from CHOICES Group 1 into Group 2 or 3 or ECF CHOICES for receipt of short-term nursing facility services in order to provide these services. Short-term nursing facility care is available only to a CHOICES 2 or CHOICES 3 or ECF CHOICES Groups 4, 5, or 6 participant who was receiving home and community based services upon admission to the short-term nursing facility stay. 4.6.9.7 For members requesting transition from Group 1 to Group 2, the MCO will not prohibit a member from transitioning to the community once the member has been counseled regarding risk. However, the MCO may determine that the member's needs cannot be safely and effectively met in the community and at a cost that does not exceed nursing facility care. In such case, the MCO will seek written review and approval from TENNCARE prior to denial of any member's request to transition to the community. If TENNCARE approves the MCO's request, the MCO will notify the member in accordance with TennCare rules and regulations and the transition assessment protocol, and the member will have the right to appeal the determination. 4.6.9.8 Once completed, the MCO will submit to TENNCARE documentation, as specified by TENNCARE to verify that for members transitioning to Group 2, the member's needs can be safely and effectively met in the community and within the cost neutrality cap. Before transitioning a member, the MCO will verify that the member has been approved for enrollment in CHOICES Group 2 or Group 3 or ECF CHOICES, as applicable, effective as of the planned transition date. 4.6.9.9 Ongoing CHOICES HCBS or ECF CHOICES HCBS and any medically necessary covered home health or private duty nursing services needed by the member will be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2, CHOICES Group 3, or ECF HCBS) and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and ongoing CHOICES HCBS or ECF CHOICES HCBS.

		4.6.9.10 The member's Care Coordinator/care coordination team or Support Coordinator/support coordination team will monitor all aspects of the transition process and take immediate action to address any barriers that arise during transition. 4.6.9.11 For members transitioning to a setting other than a community-based residential alternative setting, the Care Coordinator/care coordination team or Support Coordinator/support coordination team will upon transition utilize the EVV system to monitor the initiation and daily provision of services in accordance with the member's new plan of care or PCSP, as applicable, and will take immediate action to resolve any service gaps. 4.6.9.12 For members who will live independently in the community or whose on-site visit during transition planning indicated an elevated risk, within the first twenty-four (24) hours, the Care Coordinator or Support Coordinator will visit the member in his/her residence. During the initial ninety (90) day post-transition period, the Care Coordinator or Support Coordinator will conduct monthly face-to-face in-home visits to ensure that the plan of care or PCSP, as applicable, is being followed, that the plan of care or PCSP, as applicable, continues to meet the member's needs, and the member has successfully transitioned to the community. 4.6.9.13 For members transitioning to a community-based residential alternative setting or who will live with a relative or other caregiver, within the first twenty-four (24) hours the Care Coordinator or Support Coordinator will contact the member and within seven (7) days after the member has transitioned to the community, the Care Coordinator or Support Coordinator will visit the member in his/her new residence. During the initial ninety (90) day post-transition period, the Care Coordinator or Support Coordinator will (1) at a minimum, contact the member by telephone each month to ensure that the plan of care or PCSP, as applicable is being followed, that the plan of care or PCSP, as applicable, continues to meet the member's needs, and the member has successfully transitioned to the community; and (2) conduct additional face-to-face visits as necessary to address issues and/or concerns and to ensure that the member's needs are met. 4.6.9.14 The MCO will monitor hospitalizations and nursing facility re-admission for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes. 4.6.9.15 The MCO will be permitted to coordinate or subcontract with local community-based organizations to assist in the identification, planning and facilitation processes related to nursing facility-to-community transitions that are not specifically assigned to the Care Coordinator or Support Coordinator. 4.6.9.16 The MCO will develop and implement any necessary assessment tools, transition plan templates, protocols, or training necessary to ensure that issues that may hinder a member's successful transition are identified and addressed. Any tool, template, or protocol must be prior approved in writing by TENNCARE.
8	M.4.7 Addition	4.7.1.7.4 Members who participate in consumer direction and choose to serve as the employer of record of their workers are responsible for:
	M.4.7.3 Additions	M.4.7.3 Coordination with Fiscal Employer Agent (FEA) *In addition to requirements in the Contract, the FEA will fulfill the following financial administration and supports brokerage functions*

		4.7.3.1 The FEA will fulfill, at a minimum, the following financial administration and supports brokerage functions, as specified in the MCO's contract with the FEA and the FEA's contract with TENNCARE, for all CHOICES members electing consumer direction of eligible CHOICES HCBS and all ECF CHOICES members electing consumer direction of eligible ECF CHOICES HCBS. *FEA Training* *The MCO is responsible for providing training to the FEA and its staff on the following topics:* 4.7.3.15.7 The role and responsibilities of the Care Coordinator or Support Coordinator, including as it relates to members electing to participate in consumer direction;
9	M.4.7.7 Addition	4.7.7.2 MCO will ensure that members and/or representatives will receive training on the following topics through the FEA broker:
10	M.5.5.1 Addition	M.5.5.1 Credentialing Providers 5.5.1.1 Except as otherwise described by TennCare for Behavioral Health and LTSS services, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.
11	M.14.2. Modification	14.2.4.2 Ninety-nine-point five percent (99.5%) of claims for NEMT will be processed and if appropriate paid within sixty (60) calendar days of the receipt.
12	M.16.14 Modification	**GENERAL** M.16.14.1 The MCO will submit a monthly Claims Payment Accuracy Report. The report will include the results of the internal audit of the random sample of all "processed or paid" claims (described in Section A.2.22.6) and will report on the number and percent of claims that are paid accurately. If the MCO subcontracts for the provision of any covered services, and the subcontractor is responsible for processing claims, then the MCO will submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report for each subcontractor will include the results of the internal audit conducted and will report on the number and percent of claims that are paid accurately.
13	General Modification	All affected references shall be amended as applicable based on the amended language to Attachment 6.9 Pro Forma Contract and Attachment 6.10 MCO Manual in this Amendment 4 to the RFP 31865-00603.

Change #6:

RFP Attachment 6.11 – Respondent Community Investment Template has been updated under RFP Amendment #4 to include the following language changes under Step One and Two of the Instructions: Any sentence or paragraph containing revised or new text is highlighted.

INSTRUCTIONS - ATTACHMENT 6.11 RESPONDENT COMMUNITY INVESTMENT TEMPLATE

Step One: In Column A of the following table, consistent with the Respondent's proposed Community Investment Plan described in response to question C.7.b in the Technical Proposal, list the different types of community investments the Respondent proposes to use in the first three years of the Contract. The first type of community investment should be listed in Cell A5 (labeled Line1). The Respondent may use up to 5 different rows to describe the types of community investments being proposed.

Step Two: For each Line in Column A, the Respondent shall complete Columns B, C and D by identifying the financial investment, including the value of in-kind assistance, which the Respondent is committing to allocate for each type of community investment in each of the first three years of the contract if offered an award. The Respondent's total annual commitment to community investment as noted in cells C11 and D11 must at least equal, if not exceed, the financial commitment indicated in cell B11 for Year One (Calendar Year 2023). The Respondent's financial and in-kind support related to a Respondent's proposed Community Investment Plan will not be included in the development of MCO capitation rates and will also be excluded from the federal and state medical loss ratio (MLR) requirements.

Change #7 is included in this Amendment Five to denote that Section 3.1.1.2 of RFP #31865-00603 was deleted and replaced in Amendment 3.:

Delete Section 3.1.1.2 of RFP #31865-00603 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted.)

Please refer to Amendment 3.

Change #8:

Delete RFP section 3.2.2.3. in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

3.2.2.3. The separately sealed Technical Response and Respondent Community Investment Template may be enclosed in a larger package for mailing or delivery, provided that the outermost package is clearly labeled:

"RFP # 31865-00603 SEALED TECHNICAL RESPONSE & SEALED RESPONDENT COMMUNITY INVESTMENT TEMPLATE [RESPONDENT LEGAL ENTITY NAME]"

Change #9:

Reserved

Change #10:

Delete RFP Attachment 6.2 Mandatory Requirement Items, Item A.6 in its entirety, and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

Provide completed Disclosure of Ownership and Control Interest Statement https://www.tn.gov/content/dam/tn/tenncare/documents/Disclosure_of_Ownership_Form.docx

Change #11:

Delete Question B.12 of RFP Attachment 6.2 Technical Response & Evaluation Guide in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

Provide documentation of the Respondent's commitment to diversity as represented by the following:

(a) Business Strategy. Provide a description of the Respondent's existing programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please also include a list of the Respondent's certifications as a diversity business, if applicable.
(b) Business Relationships. Provide a listing of the Respondent's current contracts with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please include the following information:

(i) contract description;
(ii) contractor name and ownership characteristics (i.e., ethnicity, gender, service-disabled veteran-owned or persons with disabilities); and
(iii) contractor contact name and telephone number.

(c) Estimated Participation. Provide an estimated level of participation by business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises if a contract is awarded to the Respondent pursuant to this RFP. Please include the following information:

(i) a percentage (%) indicating the participation estimate. (Express the estimated participation number as a percentage of the total estimated contract value that will be dedicated to business with subcontractors and supply contractors having such ownership characteristics only and **DO NOT INCLUDE DOLLAR AMOUNTS**);
(ii) anticipated goods or services contract descriptions; and
(iii) names and ownership characteristics (i.e., ethnicity, gender, service-disabled veterans, or disability) of anticipated subcontractors and supply contractors.

NOTE: In order to claim status as a Diversity Business Enterprise under this Contract, businesses must be certified by the Governor's Office of Diversity Business Enterprise (GoDBE). Please visit the Go-DBE website at https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810 for more information.

(d) Workforce. Provide the percentage of the Respondent's total current employees by ethnicity and gender.

NOTE: Respondents that demonstrate a commitment to diversity will advance State efforts to expand opportunity to do business with the State as contractors and subcontractors. Response evaluations will recognize the positive qualifications and experience of a Respondent that does business with enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises and who offer a diverse workforce.

Note: Pages clearly identified as supporting documentation for this requirement are excluded from the 25-page limit.

Change #12 is included in this Amendment Five to denote that Section B.22 of RFP #31865-00603 was deleted and replaced in Amendment 3.:

Delete Section B.22 of RFP Attachment 6.2 Technical Response & Evaluation Guide in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

Please refer to Amendment 3.

Change #13 is included in this Amendment Five to denote that the first paragraph of SECTION C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH within Attachment 6.2 Technical Response and Evaluation Guide of RFP #31865-00603 was deleted and replaced in Amendment 3.:

Delete the first paragraph of SECTION C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH within Attachment 6.2 Technical Response and Evaluation Guide in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted.)

Please refer to Amendment 3.

Change #14:

Delete RFP section C.5.c.iii. Technical Qualifications, Experience & Approach Items in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

C.5.c.iii. The Respondent shall attach its NCQA Health Insurance Plan Ratings (2019-2020) (Accreditation Summary Report and HEDIS® Score Sheet) for all of the Respondent's Medicaid managed care contracts with full NCQA accreditation.

Change #15:

RFP section C.7 is updated under RFP Amendment #4 to include the following additional subsections: (any sentence or paragraph containing revised or new text is highlighted)**:**

C.7.a.i The Respondent shall describe its approach to and experience with collecting data on non-medical risk factors 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. In the case that the state does not supply an aligned closed loop referral system, 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 closed loop referral system, the respondent shall describe how it will work to address nonmedical risk factors.

C.7.a.ii. The Respondent shall describe how data on TennCare members' non-medical risk factors will be used to inform care management, and how it will use this data and analysis to inform its partnerships with health care providers.

Change #16:

Delete C.7.b of RFP Attachment 6.2 Technical Response & Evaluation Guide in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

C.7.b The Respondent shall describe their community investment plan and proposed approach. The community investment plan shall aim to address health outcomes through targeting members' unmet non-medical risk factors and reflect adequate, data-driven approaches. The plan shall contain, including but not limited to, the non-medical risk factors to be addressed, population(s) of focus, and an evaluation plan.

C.7.b.i MCOs must submit their funding investment proposal, which may also include in-kind contributions, separately as Attachment 6.11 of the RFP in alignment with the requirements outlined in RFP Section 3 Response Requirements. It is important that this financial information is only included in Attachment 6.11 and not in the community investment plan itself. The financial information associated with the response shall not deduct from other expenses such as administrative and medical costs.

C.7.b.ii MCOs will be scored based on their description of their proposed MCO Community Investment Plan in response to C.7.b. While Attachment 6.11 will not be scored, it will be reviewed by the Solicitation Coordinator who will, if necessary, request subject matter expert assistance to ensure that the MCO Community Investment Plan is achievable based on the optional funding investment that has been allocated.

Change #17:

Delete Pro Forma Section A.1, the Definition for Clean Claim in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

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.

Change #18:

Delete Pro Forma Section A.2.4.4.8.1.1 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

2.4.4.8.1 Family Unit

If an individual is determined eligible for TennCare and has another family member already enrolled in an MCO, that individual shall be enrolled in the same MCO. This does not apply when the individual or family member is assigned to TennCare Select. If the newly enrolled family member opts to change MCOs during the 90-day change period (see Section A.2.4.7.2.1), all family members in the case will be transferred to the new MCO, unless a family member is enrolled in MLTSS program.

Change #19:

Delete Pro Forma Section A.2.6.1.2.7 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

2.6.1.2.7 The CONTRACTOR's administrator/project director/CEO/President (see Section A.2.28.1.3.1) shall be the primary contact for TennCare regarding all issues, regardless of the type of service, and shall not direct TennCare to other entities. The CONTRACTOR's administrator/project director/CEO/President. Shall coordinate with the CONTRACTOR's Behavioral Health Director who oversees behavioral health activities (see Section A.2.28.1.3.6) for all behavioral health issues and the senior executive responsible for CHOICES activities (see Section A.2.28.1.3.9) for all issues pertaining to MLTSS programs and services.

Change #20:

Delete Pro Forma Section A.2.6.6.7.1 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted):

2.6.6.7.1 The current TennCare cost sharing schedules are determined and provided by TennCare. The CONTRACTOR shall not waive or use any alternative cost sharing schedules, unless required by TennCare.

Change #21:

Delete Pro Forma Section A.2.6.7.4.1 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

2.6.7.4.1. The current TennCare cost sharing schedule is included in Attachment 6.10 MCO Manual, Section M.1.3.2. The CONTRACTOR shall not waive or use any alternative cost sharing schedules, unless required by TennCare

Change #22:

Delete Pro Forma Section A.9.6.2.4 of RFP in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

2.9.6.2.4 Functions of the CONTRACTOR for Members in CHOICES Group 1

The following requirements detail the minimum operational requirements that the MCO must adhere to when reviewing, fulfilling, and monitoring requests for comprehensive assessments:

Change #23:

Add the following as Pro Forma Section A.2.9.6.12.3 and renumber any subsequent sections as necessary:

2.9.6.12.3 Notwithstanding the nursing facility-to-community transition requirements set forth in Section A.2.9.6.16 and M.4.5.9, the MCO will be responsible for monitoring all Group 1 members' level of care eligibility and for completing the process to re-establish nursing facility level of care or transition to Group 3, 4, or 5 HCBS, as appropriate, prior to expiration of nursing facility level of care.

Change #24:

Delete Pro Forma Section A.2.9.6.14.3.3.1 of RFP Attachment 6.9 Pro Forma Contract in its entirety and insert the following in its place with any sentence or paragraph containing revised or new text is highlighted.

2.9.6.14.3.3.1 The CONTRACTOR shall have systems in place to facilitate timely communication and information exchange between internal departments and the Care Coordinator or Support Coordinator to ensure that each Care Coordinator or Support Coordinator receives all relevant information regarding his/her Members, e.g., Member services, Population Health, utilization management, and claims processing. For dual eligible Members, the CONTRACTOR shall ensure that all available Medicare claims data, including data from the CONTRACTOR's D-SNP, and Medicare claims data made available by TennCare, is loaded into the case management system described in A.2.9.6.18.6, for purposes of care coordination or support coordination. The Care Coordinator or Support Coordinator, as applicable, shall follow-up on this information as appropriate, e.g., documentation in the Member's plan of care or PCSP, monitoring of outcomes, and, as appropriate, needs reassessment and updating the plan of care or PCSP.

Change #25:

Delete Pro Forma Section A.2.9.6.14.4 of RFP in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

2.9.6.14.4 *Minimum Care Coordinator and Support Coordinator Contacts*

The following requirements detail the minimum operational requirements that the MCO must adhere to when reviewing, fulfilling, and monitoring requests for comprehensive assessments:

Change #26:

Delete Pro Forma Section A.2.9.9.1.3 and A.2.9.9.1.4 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

2.9.9.1.3. Description of how treatment plans will be coordinated between behavioral health service providers;

Change #27:

Delete Pro Forma Section A.2.9.13.9.3 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

2.9.12.1.1 The Care Coordinator of any dual eligible Member enrolled in CHOICES and in the CONTRACTOR's D-SNP and the Support Coordinator of any dual eligible Member enrolled ECF CHOICES and in the CONTRACTOR's D-SNP shall be responsible for coordinating the full range of Medicaid, including LTSS, and Medicare benefits, have access to all of the information needed to do so, and the CONTRACTOR's systems and business process shall support an integrated approach to care coordination and service delivery. The CONTRACTOR shall ensure that all available Medicare claims data, including data from the CONTRACTOR's D-SNP, and Medicare claims data made available by TennCare, is loaded into the case management system described in 2.9.6.18.6, for purposes of care coordination or support coordination.

Change #28:

Delete Pro Forma Section A.2.9.15.1.6.1 of RFP in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

2.9.15.1.6.1. Tennessee Department of Education (DOE) and Local Education Agencies (LEAs) for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;

Change #29:

Add the following as Pro Forma Section 2.9.15.6.4 and Section 2.9.15.6.5 and renumber any subsequent sections as necessary:

2.9.15.6.4 The CONTRACTOR may choose not to require LEAs to send eligible students' IEPs to the CONTRACTOR prior to the CONTRACTOR being responsible to pay for the medically necessary covered services.

2.9.15.6.4.1 If the CONTRACTOR has chosen not to receive an IEP in advance of paying for covered services in the school based setting, the CONTRACTOR shall, at a minimum, conduct regular post payment sample audits of IEPs and all other documentation to support the medical necessity of the school based services reimbursed by the CONTRACTOR. When the CONTRACTOR requests a copy of an IEP, the provider must also include a copy of the appropriate parental consent.

2.9.15.6.5 If the CONTRACTOR requires LEAs to submit an IEP to the CONTRACTOR as a request for covered services, LEAs shall include a copy of parental consent and the CONTRACTOR shall:

2.9.15.6.5.1 Either accept the IEP as indication of a medical problem and treat the IEP as a request for service or assist in making an appointment to have the child evaluated by the child's PCP or another contract provider. If the CONTRACTOR does not accept the documentation provided with the IEP as indication of a medical problem, the CONTRACTOR shall have the child re-evaluated in order to make a decision about the appropriateness of the requested service.

2.9.15.6.5.2 Send a copy of the IEP and any related information (e.g. action taken by the MCO in response to receipt of the IEP, action the MCO expects the PCP to take) to the PCP.

2.9.15.6.5.3 Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery) within fourteen (14) days of the CONTRACTOR's receipt of the IEP.

Change #30:

Delete Pro Forma Section A.2.11.10.5.1 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

2.11.10.5.1 TennCare has the discretion to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions in future contract years. The CONTRACTOR shall operationalize any such Health Home initiatives which may include, but may not be limited to, a health home model designed for Individuals with Substance Use Disorders (SUD) and/or Intellectual and Developmental Disabilities. The CONTRACTOR shall support the model(s) with, at a minimum:

Change #31:

Delete Pro Forma Section A.2.11.11 Credentialing its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

A.2.11.11 Credentialing

2.11.11.1 Credentialing of Contract Providers

2.11.11.1.1 Except as provided in Sections A.2.11.11.3 and A.2.11.11.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

2.11.11.1.2 The CONTRACTOR shall completely process credentialing applications from all types of providers (physical health, behavioral health and long-term care providers) within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean that the CONTRACTOR shall review, approve, and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.11.1.3 To the extent the CONTRACTOR has delegated credentialing agreements in place with any approved delegated credentialing agency, the CONTRACTOR shall ensure all providers submitted to the CONTRACTOR from the delegated credentialing agent are loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.

2.11.11.1.4 The CONTRACTOR shall notify TENNCARE OPI when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

2.11.11.2 Credentialing of Non-Contract Providers

2.11.11.2.1 The CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the CONTRACTOR selects and directs its members to see a specific provider or group of providers.

2.11.11.2.2 The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable. Completely process shall mean that the CONTRACTOR shall review, approve, and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.11.2.3 The CONTRACTOR shall notify TENNCARE OPI when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

2.11.11.3 Credentialing of Behavioral Health Entities

2.11.11.3.1 The CONTRACTOR shall ensure each behavioral health provider's service delivery site meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approval per state requirements.

2.11.11.3.2 When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the CONTRACTOR to ensure, based on applicable state licensure rules and/or programs standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

2.11.11.4 Credentialing of Long-Term Services and Supports Providers

2.11.11.4.1 TennCare may establish specific requirements for credentialing or recredentialing Long-Term Services and Supports Providers, which shall be implemented by the CONTRACTOR in a manner that minimizes MCO and provider burden resulting from duplicative review processes when a provider is contracted with more than one MCO.

2.11.11.5 CHOICES and ECF CHOICES Quality Monitoring

2.11.11.5.1 The CONTRACTOR shall cooperate and actively participate with all quality monitoring processes and requirements as prescribed by TennCare, including quality assurance surveys performed by DIDD for specified CHOICES and ECF CHOICES providers.

2.11.11.6 Compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988

2.11.11.6.1 The CONTRACTOR shall require that all laboratory testing sites providing services under this Contract have either a current CLIA certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificate of registration may perform a full range of laboratory tests. The CONTRACTOR shall comply with the provisions of CLIA 1988.

2.11.11.7 Weight Watchers Centers or Other Weight Management Program

2.11.11.7.1 The CONTRACTOR is not required to credential Weight Watchers centers(s) or another weight management program used as a cost-effective alternative service.

2.11.11.8 Future Credentialing of TennCare Providers

2.11.11.8.1 At a time to be determined by TennCare, TennCare will implement centralized data collection processes for credentialing and re-credentialing of providers. Providers must enroll with TennCare and provide supporting documentation through the electronic application process. TennCare, will utilize a Centralized Credentials Verification Organization to provide standardized primary source verified data sets to the CONTRACTOR. The CONTRACTOR shall maintain its Credentialing Committee for determination of eligibility to participate in the CONTRACTOR's network. The CONTRACTOR shall not directly require providers to submit supplemental or additional information for purposes of making credentialing decisions unless approved by TennCare. Requests for additional provider information must be made to TennCare. TennCare will then request additional information from the provider and provide to the CONTRACTOR utilizing standardized data sets.

Change #32:

Delete Pro Forma Section 2.15.6.3 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted.)

2.15.6.3 Annually, , the CONTRACTOR shall report the most current NCQA HEDIS Technical Specifications for LTSS Measures as identified by TennCare.

Change #33:

Delete Pro Forma Section 2.15.9.1 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

2.15.9.1 - The contractor shall comply with Section M.9.5 regarding monitoring, investigating, and remediating missed visits for home health services with the expectation that the contractor shall be complaint with Section 12006 of the 21st Century Cures Act regarding use of EVV for Home Health Services by January 1, 2023. The contractor shall maintain compliance with requirements 2.15.9.1 to 2.15.9.10 of the Statewide MCO Contract regarding missed visits of home health services until EVV is determined operational by TennCare.

Change #34:

Delete Pro Forma Section 2.21.5.1 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

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

Change #35:

Delete Pro Forma Section C.3.3.1 in its entirety and insert the following in its place with any sentence or paragraph containing revised or new text is highlighted.

3.3.1 The CONTRACTOR will be paid a base capitation rate for each enrollee based on the enrollee's rate category in accordance with Attachment II. Rate categories are based on various factors, including the enrollee's enrollment in CHOICES or ECF CHOICES, category of aid, CoverKids category, age/sex combination and the Grand Region served by the CONTRACTOR under this Contract. TennCare shall take Third Party Liability (TPL) into account in the development of capitation rates consistent with this Contract (Section A.2.21.4, M.13.1 and the definition of Medical Expenses described herein). This recognizes that it is the CONTRACTOR that is primarily responsible for TPL recoveries and that medical claims experience used for rate setting is net of any TPL recoveries of subrogation activities. The rate categories and the specific rates associated with each rate category are specified in Attachment II of the Contract.

Change #36:

Delete Pro Forma Section C.3.10.2.1 in its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted**):**

3.10.2.1 Quality Withhold: Beginning in CY2023, each month, TennCare shall withhold a percentage of the CONTRACTOR's applicable Capitation Payment equal to the identified withhold percent for each of the withhold arrangements.

Change #37:

Delete line items B.34, B.36 and B.37 of Pro Forma Section E.22.1.2.2.7 its entirety and insert the following in its place (any sentence or paragraph containing revised or new text is highlighted)**:**

Items B.34, B.36 and B.37 of Section E.22.1.2.2.7 shall be amended as follows:

B.34	Process ninety percent (90%) of clean NEMT claims (for which no further written information or substantiation is required in order to make payment) within thirty (30) calendar days of the receipt of the claim. Process ninety-nine-point five percent (99.5%) of all claims (clean and unclean) within sixty (60) calendar of receipt (see Section M.14.2.13.3 and Section M.14.2.13.4)		$10,000 for each month determined not to be in compliance Comment: The highlighted revised text looks fine to me.
B.36	Ninety percent (90%) of clean electronic claims (for which no further written information or substantiation is required in order to make payment) for nursing facility services and CHOICES HCBS and ECF CHOICES HCBS are processed and paid within fourteen (14) calendar days of receipt. Ninety-nine point five percent (99.5%) of clean electronic claims (for which no further written information or substantiation is required in order to make payment) for nursing facility and CHOICES HCBS and ECF CHOICES HCBS shall be processed and paid within twenty-one (21) calendar days of receipt.		$10,000 for each month determined not to be in compliance Comment: The highlighted revised text looks fine to me. Comment: The highlighted revised text looks fine to me.
B.37	Ninety percent (90%) of all clean claims (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of claim. Ninety-nine-point five percent (99.5%) of all claims (clean and unclean) are processed within sixty (60) calendar days.		$10,000 for each month determined not to be in compliance Comment: This highlighted revised text looks fine to me.