

CONTRACT #15
RFS # 317.01-50015
FA # Pending

Finance & Administration
Benefits Administration

VENDOR:
BlueCross BlueShield of
Tennessee, Inc.



RECEIVED

JUL 29 2010

FISCAL REVIEW

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF BENEFITS ADMINISTRATION
William R. Snodgrass Tennessee Tower
312 Rosa L Parks Avenue, Suite 2600
Nashville, Tennessee 37243

Dave Goetz
COMMISSIONER

Phone: 615.741.4517
Fax: 615.253.8556

Laurie Lee
EXECUTIVE DIRECTOR

MEMORANDUM

TO: James White, Executive Director, Fiscal Review Committee

FROM: Laurie Lee *B. Hail for L. Lee*

DATE: July 29, 2010

RE: Alternative Delivery System Contract for CoverKids

This is to request a start date of September 1, 2010 for the alternative delivery system contract for the CoverKids program. This contract will implement the "Alternative Delivery System" as directed by Section 403 of Children's Health Insurance Program Reauthorization Act (CHIPRA). This legislation ensures that States that operate a title XXI program are now required to apply Medicaid Managed Care Requirements to their separate Children's Health Insurance Plans(CHIPs).

Specific Subsections of Section 1932 of the Act (Medicaid managed care rules) applicable to CHIP managed care delivery system allows a CoverKids member to disenroll from the program and offer an "Alternative Delivery System" to the member.

While legislation requiring the inclusion of an alternative delivery system became effective in 2009, the guidelines for implementation were not provided to states until August, 2009. Negotiations with the vendor did require additional time to determine implementation. Originally, the contract maximum liability included the payment of claims reflected in the approved non-competitive contract request. The vendor and the State finally determined that this contract would be an administrative services organization (ASO) arrangement.

The amendment allows CoverKids to be in compliance with the above federal legislation and ensures the continuation of the federal participation of funding for the CoverKids program at the current match level rate.

Thank you for your consideration of this request.

Supplemental Documentation Required for
Fiscal Review Committee

*Contact Name:	Marlene Alvarez	*Contact Phone:	615.253.8358		
*Original Contract Number:		*Original RFS Number:			
Edison Contract Number: <i>(if applicable)</i>		Edison RFS Number: <i>(if applicable)</i>	31701 - 50015		
*Original Contract Begin Date:	September 1, 2010	*Current End Date:	December 31, 2011		
Current Request Amendment Number: <i>(if applicable)</i>	N/A				
Proposed Amendment Effective Date: <i>(if applicable)</i>	N/A				
*Department Submitting:	Finance & Administration				
*Division:	Benefits Administration				
*Date Submitted:	July 29, 2010				
*Submitted Within Sixty (60) days:	No				
<i>If not, explain:</i>	While legislation requiring the inclusion of an alternative delivery system became effective in 2009, the guidelines for implementation were not provided to states until August, 2009. Negotiations with the vendor did require additional time to determine implementation. Originally, the contract maximum liability included the payment of claims reflected in the approved non-competitive contract request. The vendor and the State finally determined that this contract would be an administrative services organization (ASO) arrangement				
*Contract Vendor Name:	BlueCross BlueShield of Tennessee, Inc.				
*Current Maximum Liability:	\$2,500,000.00				
*Current Contract Allocation by Fiscal Year: <i>(as Shown on Most Current Fully Executed Contract Summary Sheet)</i>					
FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY: 2011	FY: 2012
\$	\$	\$	\$	\$937,500.00	\$1,562,500.00
*Current Total Expenditures by Fiscal Year of Contract: <i>(attach backup documentation from STARS or FDAS report)</i>					
FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY: 2011	FY: 2012
\$	\$	\$	\$		\$
IF Contract Allocation has been				N/A	

Supplemental Documentation Required for
Fiscal Review Committee

greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:				
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:		N/A		
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:		N/A		
*Contract Funding Source/Amount:	State:	\$625,000.00	Federal:	\$1,875,000.00
Interdepartmental:			Other:	
If "other" please define:				
Dates of All Previous Amendments or Revisions: <i>(if applicable)</i>		Brief Description of Actions in Previous Amendments or Revisions: <i>(if applicable)</i>		
Method of Original Award: <i>(if applicable)</i>		Non-Competitive Negotiation		
*What were the projected costs of the service for the entire term of the contract prior to contract award?		It is extremely hard to anticipate enrollment in this alternative delivery system so BA staff recommend the \$2,500,000.00 at this time.		

Supplemental Documentation Required for
Fiscal Review Committee

For all new non-competitive contracts and any contract amendment that changes Sections A or C.3. of the original or previously amended contract document, provide estimates based on information provided the Department by the vendor for determination of contract maximum liability. Add rows as necessary to provide all information requested.

If it is determined that the question is not applicable to your contract document attach detailed explanation as to why that determination was made.

Planned expenditures by fiscal year by deliverable. Add rows as necessary to indicate all estimated contract expenditures.

Deliverable description:	FY: 2011	FY: 2012	FY:	FY:	FY:
For the development and implementation of this Contract and its requirements	\$81,230				
for the continued provision of services related to reporting of FQHC and RHC incurred claims	\$840 per month	\$840 per month			
PMPM administrative fee	\$21.50	\$21.50			
Once there is at least one participant in the Plan, for the provision of services related to eligibility checks	\$1,000 per month	\$1,000 per month.			

Proposed savings to be realized per fiscal year by entering into this contract. If amendment to an existing contract, please indicate the proposed savings to be realized by the amendment. Add rows as necessary to define all potential savings per deliverable.

Deliverable description:	FY:	FY:	FY:	FY:	FY:

Supplemental Documentation Required for
Fiscal Review Committee

N/A					
Comparison of cost per fiscal year of obtaining this service through the proposed contract or amendment vs. other options. List other options available (including other vendors), cost of other options, and source of information for comparison of other options (e.g. catalog, Web site). Add rows as necessary to indicate price differentials between contract deliverables.					
Proposed Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:
Other Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:
Other Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:

NON-COMPETITIVE CONTRACT REQUESTThis request is NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant. *Cy10-564*

APPROVED upon favorable FRC recommendation

PER AUTHORIZED
SIGNATURE BELOW

COMMISSIONER OF FINANCE & ADMINISTRATION

AGENCY REQUEST TRACKING # 31701 - 50015	
1 PROCURING AGENCY	Finance and Administration, Benefits Administration
2 SERVICE	Provide statewide administrative services for the CoverKids program.
3 APPROVAL CRITERIA (select one)	<input checked="" type="checkbox"/> non-competitive negotiation is in the best interest of the state <input type="checkbox"/> only one uniquely qualified service provider able to provide the service
4 PROPOSED CONTRACTOR	BlueCross BlueShield of Tennessee, Inc.
5 CONTRACT BEGIN DATE (attach explanation if < 60 days after F&A receipt)	August 1, 2010
6 CONTRACT END DATE (with ALL options to extend exercised)	December 31, 2011
7 MAXIMUM CONTRACT COST (with ALL options to extend exercised)	\$7,500,000.00
8 SERVICE DESCRIPTION	<p>This contract will implement the "Alternative Delivery System" as directed by Section 403 of Children's Health Insurance Program Reauthorization Act (CHIPRA). This legislation ensures that States that operate a title XXI program are now required to apply Medicaid Managed Care Requirements to their separate Children's Health Insurance Plans(CHIPs).</p> <p>Specific Subsections of Section 1932 of the Act (Medicaid managed care rules) applicable to CHIP managed care delivery system allows a CoverKids member to disenroll from the program and offer an "Alternative Delivery System" to the member.</p>
9 EXPLANATION OF NEED FOR OR REQUIREMENT PLACED ON THE STATE TO ACQUIRE THE SERVICE	This contract is necessary in order to be in compliance with the above federal legislation that became effective in 2009 and ensures the continued federal participation of funds for the CoverKids program.
10 HAS THE PROCURING AGENCY EVER BOUGHT THE SERVICE BEFORE? <input type="checkbox"/> YES or <input checked="" type="checkbox"/> NO IF SO, WHAT PROCUREMENT METHOD WAS USED? REQUIRED INFORMATION	
11 NAME & ADDRESS OF THE CONTRACTOR'S PRINCIPAL OWNER(S) (NOT required for a TN state education institution)	BlueCross BlueShield of Tennessee, Inc. One Cameron Hill Circle

OCR

JUL 09 2010

RECEIVED

AGENCY REQUEST TRACKING # 31701 - 50015

Chattanooga, Tennessee 37402

12 EVIDENCE OF THE CONTRACTOR'S EXPERIENCE & LENGTH OF EXPERIENCE PROVIDING THE SERVICE

BlueCross BlueShield currently provides fee-for-service (FFS) plans as an option to current line of business. BCBST currently provides a fully-insured benefit for participants enrolled in CoverKids.

13 OFFICE FOR INFORMATION RESOURCES SUPPORT (required for information technology service)

ATTACHED or NOT APPLICABLE (N/A only to non-information technology service & THDA)

14 eHEALTH INITIATIVE SUPPORT (required for health-related professional, pharmaceutical, laboratory, or imaging service)

ATTACHED or NOT APPLICABLE

15 HUMAN RESOURCES SUPPORT (required for state employee training service)

ATTACHED or NOT APPLICABLE

16 DESCRIPTION OF EFFORTS TO IDENTIFY REASONABLE, COMPETITIVE, PROCUREMENT ALTERNATIVES

Currently, BCBST provides a fully-insured benefit for participants in CoverKids, and this contract will mirror the current benefits under the fully-insured plan that the Contractor provides to enrollees in the program.

17 JUSTIFICATION FOR NON-COMPETITIVE NEGOTIATION RATHER THAN A COMPETITIVE PROCESS

BCBST already provides a fully-insured benefit for participants in CoverKids, and the time frame to implement this mandate was beneficial to stay with the current contractor.

AGENCY HEAD SIGNATURE & DATE

(MUST be signed & dated by the ACTUAL procuring agency head as detailed on the current Signature Certification on file with OCR— signature by an authorized signatory is acceptable only in documented exigent circumstances)





CONTRACT

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

Agency Tracking # 31701-50015	Edison ID
Contractor BlueCross BlueShield of Tennessee, Inc.	Contractor Federal Employer Identification or Social Security # <input type="checkbox"/> C- or <input checked="" type="checkbox"/> V- 62 - 0427913

Service
Provide statewide administrative services for the CoverKids program alternative delivery system.

Contract Begin Date September 1, 2010	Contract End Date December 31, 2011	Subrecipient or Vendor <input type="checkbox"/> Subrecipient <input checked="" type="checkbox"/> Vendor	CFDA #(s)
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FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2011	\$234,375.00	\$703,125.00			\$937,500.00
2012	\$390,625.00	\$1,171,875.00			\$1,562,500.00
TOTAL:	\$625,000.00	\$1,875,000.00			\$2,500,000.00

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

OCR USE FA	Agency Contact & Telephone # Marlene D. Alvarez, Manager of Procurement and Contracting Tennessee Department of Finance and Administration Benefits Administration Division 312 Rosa L Parks Avenue, SUlte 2600 Nashville, Tennessee 37243	
	Agency Budget Officer Approval (there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred)	
	<table border="1"> <tr> <td>Speed Code FA00001747</td> <td>Account Code 7084000</td> </tr> </table>	Speed Code FA00001747
Speed Code FA00001747	Account Code 7084000	

Contractor Ownership/Control

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

Contractor Selection Method

RFP
 Competitive Negotiation *
 Alternative Competitive Method *
 Non-Competitive Negotiation *
 Other *

***Procurement Process Summary**

BCBST already provides a fully-insured benefit for participants in CoverKids, and the time frame to implement this mandate was beneficial to stay with the current contractor.

**CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
AND
BLUECROSS BLUESHIELD OF TENNESSEE, INC.**

This Contract, by and between the State of Tennessee, Department of Finance and Administration, hereinafter referred to as the "State" and BlueCross BlueShield of Tennessee, Inc., its successors and permitted assigns, hereinafter referred to as the "Contractor," is for the delivery of the Tennessee CoverKids Self-Funded Health Plan (the "Plan") services, including customer service, administrative services, claims adjudication, utilization management, case management, care management, maintain an appeal process, disease management services, and development and maintenance of a statewide provider network for the Plan; and as further defined in the "SCOPE OF SERVICES."

The Contractor is a not for profit corporation.

The Contractor's address is:

BlueCross BlueShield of Tennessee, Inc.
1 Cameron Hill Circle
Chattanooga, TN 37402

The Contractor's place of incorporation or organization is Tennessee.

The Contractor's Federal Employee Tax Identification Number is 62-0427913.

RECITALS:

WHEREAS, the U.S. Congress recently enacted the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA" or "Act"); and

WHEREAS, the Center for Medicaid and Medicare Services (CMS) has issued guidance interpreting the Act to require that the State Children Health Insurance Program (hereinafter "SCHIP") implement an alternate delivery system within Tennessee's SCHIP program by July 1, 2010; and

WHEREAS the parties hereto have conferred and determined that the most appropriate method of fulfilling CMS requirements within the time frame permitted is to offer an alternative provider network choice for Plan participants; and

WHEREAS, the time period for achieving CMS requirements is limited and imminent; accordingly, the State desires to contract with the existing Contractor in order to rapidly deploy an alternative delivery system with the least amount of expense to the State while simultaneously attempting to maintain the highest degree of current participant and provider satisfaction and incurring the lowest degree of additional expense to the State; and

NOW, THEREFORE, in conjunction with the appropriate and sufficient consideration received, the parties hereby agree to the following:

A SCOPE OF SERVICES

- A.1. The Contractor shall provide all service and deliverables as required, described, and detailed by this Scope of Services and shall meet all service and delivery timelines specified in the Scope of Services section or elsewhere in this Contract.

- a. The Contractor agrees to provide administrative services for the Plan, based upon the benefits provided for in the CoverKids Member Handbook, and the Contractor's medical necessity, utilization management and case management criteria to Participants. Contractor shall adhere to its standard administrative policies and procedures, including without limitation medical policies, claims administration procedures, provider reimbursement practices and grievance procedures, in providing administrative claims payment services in accordance with the terms of the Plan, its duties and services as described in the Member Handbook, and other duties specifically assumed by it pursuant to this Contract. The Contractor does not have a financial obligation to members with respect to Plan claims. The persons covered through the CoverKids program shall be Participants, who receive descriptions of the coverage in a Member Handbook. When used in this Contract, the term "Member" shall have the same meaning as the term "Participant."
- b. Participants are defined as:
- (1) Group One Children: Enrollees who are members of families with incomes between 150 percent and 250 percent of the Federal Poverty Level (FPL) as reported by the Eligibility Contractor to the Contractor for the coverage period.
 - (2) Group Two Children: Enrollees who are members of families below 150 percent of FPL as reported by the Eligibility Contractor to the Contractor for the coverage period.
 - (3) Pregnant women for unborn children: Enrollees reported by the Eligibility Contractor as being qualified for CoverKids pursuant to eligibility criteria defined by the State and having responsibility for an unborn child.
 - (4) AI/AN¹ Children: Enrollees who are (a) certified AI/AN and (b) members of families with incomes less than or equal to 250 percent of the FPL, as reported by the Eligibility Contractor to the Contractor for the coverage period.
 - (5) Pregnant AI/AN women for unborn children: Enrollees reported by the Eligibility Contractor as being qualified due to (a) having met the CoverKids eligibility criteria, (b) having responsibility for an unborn child, and (c) certification as AI/AN.
- c. Contractor and the State expressly acknowledge and agree that, for purposes of the services provided pursuant to this Contract, a Participant's eligibility for the Plan shall be limited to those participants: (1) who are in the CoverKids SCHIP Plan (the "SCHIP Plan") separately administered by BlueCross BlueShield of Tennessee, Inc. pursuant to that certain contract (Contract Number Edison # 2894 or FA-07-20600-00), who have disenrolled from the SCHIP Plan at the Participant's election; and (2) who have been identified by the Eligibility Contractor as an eligible Participant.
- d. ¹ Pursuant to the CoverKids State Plan and as required by Federal law, American Indian and Alaska Native individuals (individually or collectively, "AI/AN"), as defined by the Indian Health Care Improvement Act of 1976 and certified by the Eligibility Contractor, will be exempt from all cost sharing to the extent that such children are covered by SCHIP.
- e. For purposes of this Contract, the Eligibility Contractor shall be appointed by the State.

A.2. PROVIDER NETWORK

- a. The Contractor shall attempt to maintain and administer a Plan provider network covering the entire State of Tennessee service area, for Participants, in accordance with this Contract. The Contractor will seek to maintain under contract: participation by health care providers including but not limited to primary care physicians, specialist physicians, nurse practitioners/physician assistants, hospitals (all levels primary, secondary and tertiary), Centers of Excellence for high risk cost procedures, nursing homes, laboratories, pharmacies and all other health care facilities, services and providers necessary to provide high quality, cost effective services, adequate distribution, and reasonable access from a geographic and service standpoint throughout the service area(s).
- b. When requested by the State, the Contractor shall report to the State in writing any action it intends to take to correct any deficiencies in network access, as further described in Section A.10. The Contractor shall provide such report within ten (10) business days of the State's request.
- c. The Contractor shall attempt to maintain a network of specialized providers (Centers of Excellence) for the provision of service of high cost/high risk and specialization. Centers of Excellence criteria for provider inclusion within the network shall be based on price, quantity, quality, and patient outcome, as described in the Contractor's Proposal. The Contractor shall also develop specific criteria for Centers of Excellence referrals and follow-up.
- d. The Contractor shall report to the State within five working days of the end of each Contract quarter (the "Quarterly Network Changes Update Report") any changes in the designation of network hospitals, physicians, and other health care providers, but no less than thirty (30) calendar days prior to the removal of a hospital, clinic or ambulatory surgery center from the network.
- e. The Contractor cannot take action to disenroll network primary care providers or hospital providers for one (1) year beginning each January 1, except for good reason, which may include: inability to negotiate continuance of its provider agreement; provider failure in the credentialing/re-credentialing process; non-compliance with Contract requirements; provider request for disenrollment; Participant complaints against the provider; suspicion of provider impairment; loss of license or exclusion from participation in Medicare or Medicaid pursuant to Sections 1128 or 1156 of the Social Security Act.
- f. The Contractor, following review and approval by the State, shall, upon enrollment, distribute to Participants' homes provider directories, as detailed in Section A.8.j. The Contractor's provider directories must be state specific and describe and outline the Contractor's network of providers and its Drug Formulary. At the discretion of the State, the provider directory may include provider name, specialty, address and phone number and can be organized in geographic areas as small as counties.
- g. The Contractor shall maintain the capability to respond to inquiries from Participants concerning participation by providers in the network, by specialty and by county. Such capabilities shall be by toll-free telephone and an up-to-date Internet based directory of providers that includes provider search capability.
- h. The Contractor shall contract only with providers who are duly licensed to provide such medical services. In addition, the Contractor shall require that all providers maintain all licenses and accreditations in existence at the time of selection as a network provider in order to continue their status as a network provider. The

Contractor shall perform appropriate provider credentialing assures the quality of network providers. Re-credentialing of network providers must be performed at least every three years.

- i. The Contractor shall notify all network providers of and enforce compliance with all provisions relating to utilization management, care management, and case management procedures, and other services as required for participation in the provider network.
- j. The Contractor shall require all network providers to file claims associated with their services directly with the Contractor on behalf of Participants.
- k. The Contractor shall identify and sanction network providers who establish a pattern of referral to non-network providers.
- l. The Contractor shall maintain communication with providers to ensure a high degree of continuity in the provider base and ensure that the providers are familiar with the program requirements. There must be provisions for face-to-face contact in addition to telephone and written contact. Additionally, the Contractor must review and assess the practice patterns of network providers, share its findings with network providers and take measures to maintain a quality, efficient and effective network of providers.
- m. The Contractor will provide Participants access to providers outside Tennessee, in certain situations, through the BlueCard PPO Program. This program is described in Contract Attachment E, BlueCard PPO Program.

A.3. MEDICAL AND CARE MANAGEMENT SERVICES

- a. The Contractor shall provide a medical and care management system designed to help individual Participants secure the most appropriate level of care consistent with their health status. In carrying out this function, the Contractor must provide a system for reviewing the appropriateness of hospital inpatient care, skilled nursing, inpatient rehabilitative care and other levels of care as necessary. The Contractor must have in place an effective process that identifies and manages those Participants in need of inpatient care. The following services must be provided:
 - (1) Identification of patients in need of inpatient care for the purpose of reviewing the level of care requested and determining extent of care required, and the identification of appropriate additional or alternative services as needed. Process must include admission review, or the pre-certification/ authorization of inpatient stay.
 - (2) Concurrent review during the course of a patient's hospital inpatient stay, where qualified medical management personnel coordinate care with the hospital staff and patients' physicians. The concurrent review process will review the continued hospitalization of patients and identify medical necessity for stays, as well as available alternatives.
 - (3) Discharge planning, providing a process by which medical management staff work with the hospital, patients' physicians, family, and appropriate community resources to coordinate discharge and post-discharge needs of the patient. Prevention of readmission is also a goal of the discharge planning process.
 - (4) Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for the service.

- i. The Contractor shall provide a written report to the State on a semiannual basis regarding the utilization of services and the demonstrated effectiveness of the programs.
- b. The aforementioned services should be included as required and appropriate for hospital admissions. Pre-admission certification should not be employed for admissions for the normal delivery of children. Prospective review procedures may also include criteria for pre-admission testing and for same-day surgery procedures. If inpatient hospital pre-admission certification is utilized, authorization or denial must occur within one business day for urgent requests upon receipt by the Contractor of all necessary information regarding the admission. Any appeals or requests for continued hospitalization denials must be promptly processed and involve physician-to-physician consultation.
- c. The Contractor shall maintain a case management/care management program for Participants, utilizing procedures and criteria to prospectively and retrospectively identify Participants that would benefit from case management/care management services. The process of care management shall be capable of identifying the level of a patient's health status through stratification of risk in order for patients to receive the proper level of management appropriate to their condition. Care coordination/care management should consist of a full continuum of services designed to meet the level of need of the Participant (wellness information through catastrophic case management). Annually, the Contractor shall provide a written report that demonstrates the effectiveness of these programs as determined through valid and reliable measures of cost, quality and outcomes. The Contractor shall utilize a system of Evidence Based Medicine in the development and use of clinical practice guidelines, protocols or pathways incorporating national criteria and local physician input as appropriate. The Contractor shall also develop specialty care and outpatient case management/care management protocols when appropriate.
 - (1) The Contractor shall, upon cancellation or termination of the Contract for any reason, submit to the State a roster of Participants who are, at the date termination is effective, receiving Care or Case Management services, together with all the identifying information and conditions that make the Participants' care appropriate for case management.
- d. The Contractor shall maintain an internal quality assurance program. The Contractor shall submit to the State, at Contract implementation, a summary of the plan indicating areas addressed and methodology employed.
 - (1) The Contractor's CoverKids medical and case management services must be accredited by either the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or Utilization Review Accreditation Commission (URAC). If such accreditation is through NCQA, the Contractor shall annually submit to the State its HEDIS (Health Plan Employer Data and Information Set) report card.
 - (2) The State may retain an independent External Quality Review Organizational (EQRO) contractor (EQRO Contractor) to review compliance with the Children's Health Insurance Program Reauthorization Act (CHIPRA). If the Contractor is accredited by the National Committee for Quality Assurance (NCQA), satisfaction of those standards shall be deemed satisfaction of the EQRO Contractor's standards to the extent that those measures are reflective of quality assurance measures set forth in CHIPRA.
 - (3) The EQRO Contractor may schedule appointments and visits with the Contractor during regular business hours, provided that the Contractor is

given at least thirty (30) days notice in advance of any such appointment or visit. The State shall be promptly notified by the Contractor of any changes to an agreed upon appointment schedule. The EQRO Contractor shall draft a report of its review findings, including recommendations for improvement, and shall provide a draft to the State and the Contractor within thirty (30) days of completion of the EQRO Contractor's review. The Contractor shall be given an opportunity to provide additional information or comments to this draft report for a period of ten (10) business days following receipt of the draft report. A final report shall be submitted to the State within sixty (60) days following the completion of the review by the EQRO Contractor.

- (4) The EQRO Contractor must communicate to the Contractor any criteria by which it will assess the Contractor's compliance with current industry, Federal, and State requirements for CHIPRA. Criteria may include review of enrollee rights and protections, quality assessment and performance improvement, structure and operation standards, measurement and improvement standards and compliance with the appeal process. The EQRO Contractor's review process may include document review, interviews with key Contractor personnel, and an assessment of the adequacy of information management systems. The EQRO may not impose greater requirements on the Contractor than are set forth in this Contract, except as required by law.
- (5) If the Contractor holds another contract with the State of Tennessee that is subject to CHIPRA, the EQRO Contractor's review shall consider the Contractor in the aggregate, including all CHIPRA contracts, for compliance with CHIPRA.

e. The Contractor, in consultation with the State, shall have in place on the Contract effective date disease management programs, acceptable to the State, for the following chronic conditions: diabetes and asthma. In addition, the Contractor shall provide a program for high-risk pregnancies. The Contractor shall provide these disease management programs to optimize the health status of Participants therefore reducing the need for high cost medical intervention. The State reserves the right to review and comment on these programs. At a minimum, each disease management program shall contain the following program components:

- (1) A Population identification process;
- (2) Evidence-based practice guidelines;
- (3) Collaborative practice models to include physician and support service providers;
- (4) Patient self-management education (may include primary prevention, behavior modification programs, compliance/surveillance);
- (5) Process and outcomes measurement, evaluation, and management; and
- (6) Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).

- i. The Contractor shall provide for each disease management program an evaluation methodology that is statistically valid and designed to measure program impact on health status, utilization of medical and pharmacy services and impact on the cost of care for the Participants identified with the chronic condition. The evaluation methodology must be reviewed and approved by the State and its' benefits consultant.
- ii. The Contractor shall provide a written report to the State, no less than semiannually, detailing Participant participation in each disease management program, and in addition, a written report

- to the State, no less than annually, with the results of the program evaluation referenced in A.3.e.(6)i.
- iii. The State reserves the right during the term of the Contract to add, based on mutually agreeable terms and conditions, additional disease management or other care management programs that have demonstrated the ability to improve the health status of Participants and effectiveness and quality of care delivered. The State shall not exercise the foregoing right unless such additional programs are simultaneously added to other existing CoverKids Plans. The State acknowledges that there may be additional costs associated with adding disease or other care management programs and the State agrees to pay such additional cost, if any.
 - iv. To assure continuity of care, the Contractor shall, upon cancellation or termination of the Contract for any reason, submit to the State a roster of Participants who are, at the date termination is effective, receiving disease management services, together with all the identifying information and conditions that make the Participants' enrollment in the specified disease management program appropriate.

A.4. PHARMACY

- a. The Contractor shall provide a retail and mail order pharmacy program that is consistent with and comparable to the policy and plan design of other existing CoverKids Plans which meets all criteria necessary to provide the benefits in the Member Handbook.
- b. Administrative and Account Management Support – the Contractor shall also:
 - (1) Provide qualified licensed pharmacy personnel and actuarial input to assist the State in the analysis of the pharmacy program, its benefits, and policy and plan design changes.
 - (2) Collaborate with the State in proactively identifying opportunities to improve the quality of service, cost effectiveness and operational efficiency of the pharmacy benefits.
 - (3) Provide quarterly written reviews of pharmacy network adequacy, Plan performance, service levels and other factors that focus on managing pharmacy benefit cost.
- c. Retail Network – the Contractor shall seek to:
 - (1) Provide a network with Participant access to retail pharmacies, which contractually agree through point-of-sale electronic transmission to verify eligibility, submit Participant claims electronically, agree not to waive co-payments or deductibles, and agree to accept the Contractor's reimbursement as payment in full for covered prescription drugs allowing no balance billing.
 - (2) Maintain a pharmacy audit program in order to ensure pharmacy compliance with the program.
 - (3) Have the ability to refill mail order prescriptions online through the website, by telephone, or by mail, subject to compliance with all applicable federal and state laws and regulations
 - (4) Require its network retail pharmacies, who have agreed with the Contractor's terms and conditions for mail order pharmacy, to provide three month drug supplies via US Postal Service, upon request by the member, as required by mail order pharmacy policy.

- d. Mail Order Customer Service – the Contractor shall seek to:
- (1) Provide a toll-free telephone number dedicated to the pharmacy mail-order program.
 - (2) Provide special telephone services for Participant consultations with a registered pharmacist.
 - (3) Provide a pharmacy claims appeal process.
 - (4) Provide a web site for Participants providing access to pharmacy plan benefits, retail pharmacy network, Preferred Drug List (PDL), drugs requiring Prior Authorization, drugs dispensed with limitations, link to mail-order, and, if available, a secure site for Participants to access their pharmacy claims.
- e. Formulary/Preferred Drug List (PDL) and Utilization Review – the Contractor shall:
- (1) Implement and maintain a Formulary/ PDL for the retail and mail order program that is consistent with and comparable to other existing CoverKids Plans, and designed to maximize the prescribing and dispensing of safe and clinically and cost effective drugs within each therapeutic class. Changes in the PDL shall be approved and communicated to the State and affected Participants no less than 30 days prior to change implementation date, unless, a shorter notification time is mutually agreed to by the Contractor and State. The State shall not unreasonably withhold its consent.
 - (2) Provide a Prospective Utilization Review program for the retail and mail order programs allowing pharmacists access to patient prescription drug profile and history in order to identify potentially adverse events, including but not limited to the following:
 - i. Drug to drug interaction
 - ii. Duplicate therapy
 - iii. Known drug sensitivity
 - iv. Over utilization
 - v. Maximum daily dosage
 - vi. Early refill indicators
 - vii. Suspected fraud
 - (3) Provide for clinical pharmacist follow-up to dispensers and prescribers in order to share relevant information from the drug utilization review analysis.
 - (4) Provide a Retrospective Utilization Review program to track provider prescribing habits and identify those who practice outside of their peer norms as well as identify patients who may be abusing prescription drugs or visiting multiple providers.
 - (5) Provide a specialty pharmacy program to address the introduction of new biological drugs and drugs to treat Participants with conditions such as hepatitis C, multiple sclerosis, arthritis and hemophilia. Such a program should provide for significant discounts off the Average Wholesale Price (AWP), delivery to the Participant, and pharmacist and nursing support.
 - (6) Have the ability to lock a Participant suspected of abusing the system into just one network pharmacy.
- f. Therapeutic Substitution and Generic Dispensing Program – the Contractor shall:
- (1) Provide a Therapeutic Substitution program with provisions for appropriate contact to prescribing physician in order to advise them of the

- potential savings resulting from substituting a costlier drug with a lower cost medically appropriate alternative drug.
- (2) Provide a Generic Dispensing program designed to maximize the acceptance and use of medically appropriate generic drugs under the retail and mail service program. The program shall target physicians, pharmacists and Participants. Results of the program should be reported to the State on an annual basis.
 - (3) Maintain a communication plan by which notification will be made to affected Participants when the most frequently utilized brand name medications lose their patent classification and become available as a generic equivalent.
- g. Remit to the State no less than quarterly a check for all pharmacy rebates on behalf of the State due to the use of pharmaceuticals by members of the CoverKids plan for the rebates accrued during the claim period ending six months prior to the rebate payment date.
- h. Pharmacy Program Audit – the Contractor shall, with provision by the State of 30 days notice and with execution of any applicable third party confidentiality agreements, submit to examination and audit of applicable pharmacy benefit data by the State, by the State's authorized independent auditor (experienced in conducting pharmacy rebate audits) during the term of this Contract and for three years after final Contract payment (longer if required by law). For the purpose of this requirement, Contractor shall include its parents, affiliates, subsidiaries and subcontractors. Such audits shall include third party confidentiality agreements between the auditor and the party being audited.

A.5. **BEHAVIORAL HEALTH**

- a. The Contractor shall maintain the ability to provide for the specialized review of treatment proposals for the provision of services for the treatment of behavioral health, mental health and substance abuse patients. This capability shall include the ability to:
- (1) Review proposed treatment plans
 - (2) Refer to a specialty provider network
 - (3) Provide case and care management services to Participants and treatment providers
 - (4) Work actively with Community Mental Health Centers to enlist that resource as a set of network providers.
 - (5) Assist in the co-management of medical and behavioral health and substance abuse cases.
- b. Services provided by primary care pediatricians for the treatment and diagnosis of behavioral health issues for Participants as recommended by the American Academy of Pediatrics shall be reimbursed at the applicable rates.

A.6. CLAIMS PROCESSING

- a. The Contractor shall process all medical claims in strict accordance with the CoverKids Member Handbook, and its clarifications and revisions. The Contractor may not modify these benefits during the term of this Contract without the approval of the State, which approval shall not unreasonably be withheld.
 - (1) Upon agreement of the parties, the Contractor shall modify its benefits administration system to reflect approved Plan benefit amendments (new, changed, or cancelled) within 30 days of the parties mutual agreement of the amendments. Should said benefit amendment(s) not be effective within 30 days, the Contractor shall have until the effective date of the amendment to modify its benefits administration system.
- b. The Contractor shall ensure that the majority of all claims will be paperless for the members. Providers will have the responsibility through their contract with the Contractor to submit claims directly to the Contractor.
- c. The Contractor shall ensure that the electronic data processing (EDP) environment (hardware and software), data security, and internal controls meet all present standards, and will meet all future standards, required by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191. Said standards shall include the requirements specified under each of the following HIPAA subsections:
 - (1) Electronic Transactions and Code Sets
 - (2) Privacy
 - (3) Security
 - (4) National Provider Identifier
 - (5) National Employer Identifier
 - (6) National Individual Identifier
 - (7) Claims attachments
 - (8) National Health Plan Identifier
 - (9) Enforcement
 - i. The Contractor shall maintain an EDP and electronic data interface (EDI) environment that meets the requirements of this Contract and meets the privacy and security requirements of HIPAA. The Contractor must maintain its disaster recovery plan for restoring the application software and current master files and for hardware backup if the production systems are destroyed.
 - ii. To maintain the privacy of personal health information, the Contractor shall provide to the State a method of secure email for daily communications between the State and the Contractor.
- d. The Contractor shall confirm eligibility of each Participant as claims are submitted, on the basis of the enrollment information provided by the State's Eligibility Contractor, which applies to the period during which the charges were incurred. The Contractor shall process said claims, in an accurate manner, either filed directly by Participants and/or the provider(s).
- e. The State shall establish all Plan benefits, and have the right to approve the Member Handbooks. Said approval shall not unreasonably be withheld. Should the Contractor have a question on benefit design, the Contractor shall request a determination in writing. The State will then respond in writing making a

determination within thirty (30) days. The Contractor shall then act in accordance with such determinations.

- (1) The State shall have responsibility for and authority to clarify and/or revise the benefits available through CoverKids. It is understood between the parties that the program cannot and does not cover all medical situations. In a case where the benefits are not referenced in the Member Handbook or are not clear, the Contractor shall utilize its internal administrative policies and procedures in adjudicating claims.
 - (2) The Contractor shall, when processing/adjudicating claims, employ its medical necessity guidelines to the extent that those guidelines do not conflict with or limit the provisions as outlined in the CoverKids Member Handbook.
 - (3) Pursuant to Contract Sections A.6.e. and A.6.e.(1), the State hereby approves the addition of vision benefits to the Plan, as more fully set forth in the Member Handbook.
- f. To ensure the efficient and timely processing of claims and the adequate capture of data, the Contractor shall provide Participants with identification cards. Identification cards shall contain unique identifiers for each Participant; such identifier shall NOT be the member's Federal Social Security Number. The cost of these items shall be borne by the Contractor. The State reserves the authority to review any claim forms and identification cards prior to issuance for use. Contractor shall update enrollment and shall mail Participant I.D. cards no later than 14 calendar days from receipt of the new enrollment or change in enrollment data.
- g. The Contractor shall institute its standard subrogation recovery program to protect the State's rights as stated in the Member Handbook. Additional information regarding the retention of subrogation recovery fees by the Contractor is included in Section C.10., of this Contract.
- h. To ensure coordination between the State and Contractor regarding Medicare Secondary Payer (MSP) claims issues, the Contractor shall resolve within 31 calendar days issues communicated by the State to the Contractor.
- i. The Contractor shall determine eligible expenses which are medically necessary. The Contractor must have on staff qualified and licensed medical personnel whose primary duties are to follow Contractor's standard procedures for determining both prospectively and retroactively the medical necessity of treatments and their associated claims.
- j. The Contractor shall have a process in place for determining experimental and investigational procedures and services.
- k. Upon conclusion of this Contract, or in the event of its termination or cancellation for any reason, the Contractor shall be responsible for the processing of all claims incurred for medical services rendered or medical supplies purchased during the period of this Contract.
- l. The State shall assist Contractor in identifying fraud and performing fraud investigations of Participants and providers for the purpose of recovery of overpayments due to fraud. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall simultaneously inform the Division of Insurance Administration and the Office of the Inspector General. Additionally, the Contractor will assist

the State in identifying fraud and performing fraud investigations with Participants and providers.

A.7. CLAIMS PAYMENT AND RECONCILIATION PROCESS

- a. Contractor shall follow its standard administrative procedure in adjudicating and funding claims reimbursements to providers. Nothing in this Contract shall obligate or shall be deemed to obligate Contractor to use its funds to satisfy any of the State's obligations pursuant to this Agreement. For the purposes of this Contract, claims funding is not a part of Contractor's compensation.
- b. The State shall fund the Contractor for the total issue amount of the payments, net of cancellations, voids or other payment credit adjustments, weekly or at the time of each issuance of checks or ACH, provided the Contractor's payment process includes timely delivery of checks and settlement of ACH transactions. Unless otherwise mutually agreed to in writing by the parties, the Contractor shall notify the State of the week's funding requirement amount as established by the Parties. The funding option for the State shall be by ACH debit from the Contractor to a designated State bank account. The Contractor shall notify the State of the funding amount at least forty eight (48) hours before the amount is debited. The Contractor acknowledges and agrees that since the State intends to fund payments at the time of issuance, the State shall not maintain a separate bank account or an escrow account with the Contractor or to otherwise pre-fund an account.
- c. The Contractor further acknowledges the State will monitor and age the outstanding check balance and the Contractor agrees, upon request of the State, to conduct a review and/or cancel-reissue of stale dated outstanding items. In a format mutually agreed to, the Contractor on a daily basis, shall provide a detailed listing of the payment activity, including check serial numbers and ACH payment identifiers, payee names and payment amounts balancing to the required funding amount for that day. Said listing shall enable the State to reconcile the payment detail to the required funding amount, while providing related payment information needed to record the necessary accounting entries by expense classifications. The Contractor shall further provide monthly check Reconciliation Reports that provide detail (check number, issue date, payee name, claim numbers, check amount, paid or cancel date) of all checks issued or cancelled during the month, and detailed listing of outstanding checks at each month-end. At the specific request of the State, the Contractor shall provide in an electronic file, information which provides both payment information and claim numbers.
- d. The Contractor shall issue all related Internal Revenue Service (IRS) Form 1099 reports, submit required 1099 information directly to the IRS utilizing Contractor's tax ID number, and shall maintain responsibility in matters relating to such information provided to payees and to the IRS, including the payment of any penalties or fees related to such 1099 reporting.
- e. The State will not hold the Contractor responsible for payments caused by the State's errors, errors committed by the Administrative Contractor or errors caused by any other agency or department of the State of Tennessee; however, the Contractor shall assist the State in recovery of such overpayments. The requirement that the Contractor assist the State in identifying or recovering overpayments as provided in this Section does not require the Contractor to become a party to any legal proceeding as a result thereof.
- f. Overpayments resulting from the negligent, reckless, or willful acts or omissions of the Contractor, its officers, agents or employees shall be the responsibility of

the Contractor, regardless of whether or not such overpayments can be recovered by the Contractor. Overpayments due to provider fraud or fraud of any other type, other than fraud by employees or agents of the Contractor, will not be considered overpayments for purposes of this Section.

- g. The Contractor shall maintain a year-to-date calculation of all copayments (including medical and vision services, dental services and prescription drugs) required by Participants, accumulate the amounts by family units and advise the family by letter when the covered members of the family have assumed copayments equal to 5 percent of the allowable family income. The letter will be in a form and substance approved by the State. When the family has reached this threshold, none of the Participants will be responsible for copays for the balance of the calendar year and provider payments shall be adjusted accordingly. The out of pocket limit does not apply to individuals from families with incomes in excess of 250% of the FPL.
- h. Once the State or the Administrative Contractor has notified the Contractor in writing that a Participant should be terminated as no longer eligible for coverage, Contractor shall update its systems to reflect that change in the Participant's coverage. Contractor shall use its standard commercial process to retroactively terminate Participants' coverage.
- i. The Contractor shall be entitled to retain any and all administrative fees paid by the State for such retroactively terminated Participants.
- j. A retroactive termination shall go back to the end of the last full month that the Participant was eligible for coverage, but not more than a total of ninety (90) days from the date of notice from the Administrative Contractor.
- k. The Contractor shall use its standard commercial process to attempt to recover claim payments made to providers and/or Participants during the 3 month (or shorter) period for which a Participant was covered but ineligible; however, it is expressly agreed and acknowledged by the parties that any claims paid by Contractor for an ineligible Participant are the sole responsibility of the State.
- l. Contractor shall review the enrollment files provided by the Administrative Contractor, perform eligibility checks against such files and work with the Administrative Contractor to resolve any conflicts or inconsistencies identified. The Contractor shall provide the results of such eligibility checks to the State upon request.
- m. The Contractor shall establish a financial accounting system and/or methods employed by the Contractor that leave a clear audit trail of all financial transactions and records executed and maintained by the Contractor on behalf of the Plan. The Contractor shall maintain all financial records consistent with sound business practices and based upon generally accepted United States accounting principles, and shall clearly identify all revenue and disbursements by type of transaction.
- n. The Contractor will maintain a general ledger and supporting accounting records and systems for the Plan that are adequate to meet the needs of an administrator of comparable size. This will include, but is not limited to:
 - (1) the preparation and reconciliation of monthly financial statements on a cash basis in a format prescribed by the State; and
 - (2) the preparation of accrual based quarterly financial statements prepared in accordance with statutory and/or generally accepted accounting principles prescribed.

- o. The Contractor shall:
 - (1) establish and maintain a management information reporting system that provides enrollment utilization, claims reporting, and administrative services data to the State; and
 - (2) retain and maintain all records and documents in any way relating to the Plan for **three years** after final payment by the State or any applicable statute of limitations, whichever is longer, and shall make them available for inspection and audit by authorized representatives of the State, including the State or the State's designee, at all reasonable times. All records related in any way to the Plan are to be retained for the entire time provided under this section.

A.8. CUSTOMER AND ADMINISTRATIVE SERVICES

- a. The Contractor shall maintain a full service staff to respond to inquiries, correspondence, complaints, and problems, and to assist with meetings with Participants. The Contractor shall answer, in writing, within ten (10) business days ninety percent (90%) of all written inquiries from Participants concerning requested information, including the status of claims submitted and benefits available through the CoverKids plan, its clarifications and revisions.
- b. The State shall consult with Contractor on proposed revisions to the CoverKids benefits. When so requested, the Contractor shall provide information regarding:
 - (1) Industry practices; and
 - (2) The overall cost impact to the program; and
 - (3) Any cost impact to the Contractor's fee; and
 - (4) Impact upon utilization management performance standards; and
 - (5) Necessary changes in the Contractor's reporting requirements; and
 - (6) System changes.
- c. The Contractor shall maintain a formal grievance procedure by which Participants and providers may appeal: decisions regarding benefits administration; medical necessity determinations; and disputes arising from the utilization management program. At Contract implementation, the Contractor shall provide to the State two (2) written copies describing in detail the Contractor's grievance procedures. The State reserves the right to review the procedure and make recommendation, where appropriate. The State sponsors an appeal process available to member participants of self-insured plan options. The Contractor's appeal process shall meet the standards set out in Section 56-32-110, Tennessee Code Annotated.
- d. The State appeals process is available to Participants after the Contractor's appeal process has been exhausted. The Contractor shall have the appropriate qualified professionals available to participate in the State appeal process and to be available to personally attend the State appeals meetings when requested by the State. The Contractor shall include a pediatrician in the appeals process for CoverKids. The Contractor shall have a qualified individual available to provide support to the State Appeals Coordinator in the research and development of appeals.
 - (1) Should the State override the Contractor's decision in an appeal, and mandate benefits that are not covered in the Member Handbook, the State shall directly fund the costs of those benefits and reimburse the Contractor for the costs.

- e. The Contractor shall respond to all inquiries in writing from the Division of Benefits Administration within one (1) week after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State.
- f. The Contractor shall maintain statewide, toll-free phone lines manned by qualified benefit specialists for the purpose of handling inquiries from Participants.
- g. The Contractor shall designate an individual with overall responsibility for administration of this Contract. This person shall be at the Contractor's executive level and shall designate the following positions to interface directly with the State: (1) Program Director (external and marketing operations); and (2) Program Director (internal and administrative functions). Said designees shall be responsible for the coordination and operation for all aspects of the Contract.
- h. The parties shall meet periodically, but no less than quarterly, to discuss any problems and/or progress on matters outlined by either party.
 - (1) The Contractor shall have in attendance, when requested by the State, a Program Director and representatives from its organizational units required to respond to topics indicated by the State's agenda. The Contractor shall provide advice, assistance and information to the State regarding applicable existing and proposed Federal and State laws and regulations affecting managed care entities.
 - (2) The State shall have in attendance, when requested by the Contractor, a Program Director and representatives from its organizational units required to respond to topics indicated by the State's agenda.
- i. The Contractor may assist the State, if requested, in the education and dissemination of information regarding the CoverKids Plan operations. This assistance may include but not be limited to:
 - (1) written information;
 - (2) audio/video presentations;
 - (3) attendance at meetings, workshops, and conferences; and
 - (4) training of State Insurance Benefit Analysts and Insurance Preparers on Contractor's administrative and benefits procedures.
 - i. Any on-site visits shall require the prior approval of the State.
- j. The Contractor shall, in consultation with and following approval by the State, print and distribute all Member Handbooks, identification cards, provider directories, letters, administrative forms and manuals pertaining to or sent to Participants. Said Member Handbooks, provider directories and drug formularies shall be updated and distributed to Participants' homes following Contractor's standard procedures. A distribution to all Participants may be directed by the State and executed by the Contractor, but no more frequently than annually. The cost of printing and distributing Member Handbooks, provider directories, identification cards, and administrative forms and manuals shall be the responsibility of the State. This provision excludes enrollment forms, which are also the State's responsibility.
 - (1) The Contractor must develop and print Member Handbooks, detailing the benefits, exclusions, procedures for accessing services, and other information helpful to Participants. The Member Handbook shall be mailed to the Participant's home address.

- (2) Upon mutual agreement of the State and the Contractor, electronic means may be utilized to inform Participants of the Member Handbook and/or network of providers.
- k. If the Contractor maintains State-dedicated Internet pages, it shall provide up to date information concerning plan benefits, the drug formulary and the provider networks. The Contractor shall provide advice and assistance with regard to questions regarding effective dates, benefit levels and cessation of coverage as requested by the State, Participants, and providers.
- l. The Contractor shall perform, following review and approval by the State, customer satisfaction surveys. The survey shall be conducted no more frequently than once during each calendar year at a time mutually agreed upon by the State and the Contractor and shall involve a statistically valid random sample of Participants. The State reserves the right to review and mandate changes in the survey it feels are necessary to obtain valid, reliable, unbiased results. Those changes may include, but are not limited to, changes in the research design, units of analysis or observation, study dimension, sample size, sample frame, sample method, coding, or evaluation method. Based upon the results of the survey, the Contractor and the State shall jointly develop an action plan to correct problems or deficiencies identified through this activity.
- m. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Prospective Payments
- (1) At the end of thirty (30) days following the end of each calendar quarter during the term of this Contract, commencing with the fourth quarter of calendar year 2009, the Contractor shall provide a report to the State to assist the State in identifying and confirming claims incurred at an FQHC or RHC and adjudicated within the calendar quarter, for services covered under the CoverKids program for members covered by SCHIP. The State shall be responsible for identifying each FQHC and RHC and providing the Contractor with a current and up-to-date list of FQHCs and RHCs for which to pull the report.
- (2) The State shall be responsible for determining the amount of any payment due to each FQHC or RHC pursuant to the prospective payment system ("PPS") as directed by Section 503 of CHIPRA (each, a "Prospective Payment"). The State shall be responsible for any and all remittances of Prospective Payments to a FQHC or RHC. The State and Contractor expressly acknowledge and agree that the State has sole responsibility for determining and issuing the Prospective Payment owed to the FQHC and RHC under the PPS.
- (3) The State shall be responsible for resolving any FQHC or RHC inquiries regarding Prospective Payments, including but not limited to the resolution of any adjustment inquiries and payments or payments returned to the State after remittance to the FQHC or RHC. The State shall have sole responsibility for resolving any overpayment or underpayment of the Prospective Payment to any FQHC or RHC as well as the recovery of any potential third party liability that may or may not be available to offset against the amount of the Prospective Payment. In addition, the State shall be responsible for providing FQHCs and RHCs any notice, report or other form or filing required by federal or state law for tax, regulatory or other purposes, including without limitation the provision of Form 1099s, related to the Prospective Payment.
- (4) The State may request, and upon request the Contractor shall provide, assistance with claims incurred at a FQHC or RHC to resolve any Prospective Payment inquiries, at the time the inquiry is presented to the

State. The State shall not wait until the end of the quarter to reconcile or the end of the year to resolve FQHC and RHC inquiries.

- i. In the event that the Contractor is requested by the State to provide assistance with inquiries from FQHCs or RHCs, the State shall pay the Contractor a hourly fee for researching the inquiry with a with a minimum one hour charge for each inquiry.
- (5) The Contractor shall develop and implement the quarterly report referenced in A.8.m.(1), and the State will pay for the initial development, programming, implementation and quarterly production of the report detailing information to assist the State in identifying and confirming claims incurred at an FQHC or RHC and adjudicated within the calendar quarter, for services covered under the CoverKids program for members covered by SCHIP.
- (6) For purposes of Contract Section A.8.m., the parties expressly acknowledge and agree that the Contractor is acting at the State's direction to provide a quarterly report to the State for the sole purposes of facilitating Prospective Payments to FQHCs and RHCs. Contractor is not acting as an insurer under the laws of the State of Tennessee. The State is solely responsible for determining the accuracy and appropriateness of any Prospective Payment made to a FQHC or RHC.
- (7) Any obligations imposed on the Contractor for purposes of Contract Section A.8.m., shall not survive beyond the termination of this Agreement and all such obligations hereunder shall be deemed complete and fulfilled upon the termination of this Agreement.

A.9. DATA AND SPECIFIC REPORTING REQUIREMENTS

a. The Contractor shall:

- (1) Maintain an electronic data interface with the CoverKids Eligibility Contractor for the purpose of accessing enrollment information. The Contractor is responsible for equipping itself with the hardware and software necessary for achieving and maintaining access.
- (2) Notwithstanding the requirement to maintain enrollment data, the Contractor is not authorized to initiate data changes to the system without the State's approval. This prohibition shall include, but not necessarily be limited to: initiation, termination, and/or changes of coverage.
- (3) Maintain, in its computer system, in-force enrollment records of all Participants.
- (4) Maintain a duplicate set of all records relating to the benefit payments in electronic medium, usable by the State and Contractor for the purpose of disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft- protected facility located away from the storage location of the originals. The duplicate data processing records shall be updated, at a minimum, on a daily basis and retained for a period of 60 days from the date of creation. Upon notice of termination or cancellation of this Contract, the original and the duplicate data processing records medium, and the information they contain shall be conveyed to the State on or before the effective date of termination or cancellation.
- (5) Reconcile, within ten (10) working days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.
- (6) The Contractor is required to transmit plan enrollment data monthly and medical and prescription drug claims quarterly to the State's healthcare decision support system (DSS) vendor until all claims incurred during the

term of this Contract have been paid. Data shall be submitted in the format detailed in Attachment D. The Contractor shall ensure that all claims processed for payment have valid provider identifications and complete ICD-9 and CPT4 codes (and when applicable, updated versions).

- i. For each quarter of the Contract term, and any extensions thereof, claims data must meet the quality standards detailed in Contract Attachment B, Performance Guarantee # 7, as determined by the State's healthcare claims DSS/EIS data management vendor. Claims data from this Contract shall be aggregated with claims data from the contract with BlueCross BlueShield of Tennessee, Inc. for the CoverKids program (Contract number Edison # 2894 or FA-07-20600-00) for the purposes of determining whether a Performance Guarantee under both contracts has been met.
- ii. The Contractor will work with the State's DSS vendor to identify a mutually-agreeable data format similar to the format detailed in Attachment D for these transmissions. If the State's DSS vendor has a charge per new contractor, the State will pay any applicable cost. Furthermore, during the full term of this Contract, the Contractor will pay all applicable fees as assessed by the State's DSS vendor related to any data format changes which are Contractor-initiated; data format changes that are due to meeting compliance with new or changing regulations shall be the responsibility of the State. The Contractor will also pay all applicable fees related to any DSS vendor efforts to correct Contractor data quality errors that occur during the term of this Contract.
- iii. Claims data are to be submitted to the State's data management vendor no later than the last day of the month following the end of each calendar quarter.
- iv. Until a Member is covered under this Contract, Contractor shall not generate these reports.

A.10. **SUBMIT MANAGEMENT REPORTS**

- a. The Contractor shall submit Management Reports in a mutually agreeable electronic format (MSWord, MSEXcel, etc.), of the type, at the frequency, and containing the detail described in Contract Attachment C. Reporting shall continue for the twelve (12) month period following termination of the Contract. Until a Member is covered under this Contract, Contractor shall not generate these reports.
- b. The Contractor shall also generate and submit to the State, within five working days of the end of each Contract quarter, a Quarterly Network Changes Report (see Section A.2.c.), also in electronic format.

A.11. SERVICES PROVIDED BY THE STATE

- a. The State shall through an Eligibility Contractor provide enrollment records. These records shall include changes in the status of Participants. The Contractor's computer system shall be compatible or have the capability to utilize the enrollment information provided by the Eligibility Contractor, in the State's proprietary transaction formats.
- b. The State shall provide on-line access, or other access deemed mutually acceptable, to all enrollment information maintained by the State and instructions required to interpret such information. The Contractor, at its expense, will provide and maintain the necessary software, phone lines, modems, CRTs and other equipment required for this purpose.

A.12. AUDIT

- a. The Contractor shall allow for periodic audits to be performed by the State of Tennessee's Division of State Audit, Office of the Comptroller of the Treasury, or other qualified entity(ies) designated by the State. For the purpose of this requirement, the Contractor shall include its parent organization, affiliates, subsidiaries, and subcontractors. The selected auditor shall be qualified to conduct such audits and shall not present any conflict of interest with the Contractor that would compromise any Contractor proprietary information. The Contractor shall provide the auditor access to all information necessary to perform the examination, and the State will work with the Contractor in defining the scope of the audit, requirements and time frame for conducting the audit. The State shall provide reasonable notice to Contractor of not less than 30 days. Contractor agrees to be fully prepared for any on-site audit on the mutually agreed upon date. To the extent allowed by applicable law, the State agrees that persons or organizations conducting audits of the Contractor shall be prohibited from disclosing confidential patient records or proprietary or confidential information reasonably designated as such by the Contractor.
- b. For the purpose of conducting these audits, the Contractor agrees to the following:
 - (1) Audits may be conducted by the State to ensure that all rebates, discounts, special pricing considerations and financial incentives have accrued to the State and PPO plan participants and that all costs incurred are in accordance with the Contract terms and PPO benefits. In addition, risk sharing arrangements, Performance Guarantees and administrative processes as specified in this Contract may be audited by the State or its qualified representative(s). Data from this Contract will be aggregated with data from contract number FA-07-20600-00 for the purposes of determining whether Performance Guarantees under this contract have been met.
 - (2) Audits may commence at any time within the three (3) year period following the period being audited.
 - (3) State shall not be required to pay for any Contractor data, reporting, time, expenses or other related costs incurred by Contractor for the preparation of, or participation in, such audits.
 - (4) The Contractor shall not restrict the State audit sample size or sample selection methodology. The State retains the authority to select a random sampling process, whereby a statistically valid sample of transactions completed during the audit period are analyzed, or an electronic audit process, whereby one hundred percent of transactions completed during

the audit period are analyzed. In the event that the random sampling process is selected, audit results/error rates may be extrapolated for purposes of financial penalties and/or recoveries in accordance with generally accepted auditing principles. For any audit performed for purposes other than Performance Guarantee validation, State retains the right to choose the sampling method.

- (5) Such audits are permissible and required pursuant to the Sarbanes-Oxley Act of 2002; the American Institute of Certified Public Accounts standards; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and the fiduciary obligations of the State. Accordingly, the Contractor shall not restrict State access to Protected Health Information (PHI) as that term is defined in HIPAA, provided the appropriate Business Associate Agreement and confidentiality agreements are in place and all applicable federal and State laws are followed.
- (6) If requested, the Contractor agrees to provide all of the following in anticipation of any audit:
 - i. Requested claim and/or eligibility data must be provided in Microsoft Access format and include a complete data dictionary/manual defining the codes or other nomenclature used therein. Prescription drug claims data must be provided in NCPDP format version 2.0 or higher.
 - ii. An Operations Questionnaire completed and returned at least two weeks before commencement of any on-site audit. The Contractor shall not unduly restrict the size or scope of such questionnaire. A current SAS-70 report may be provided to supplement the questionnaire.
 - iii. Provide complete on-line computer system access to eligibility information which will allow the auditors to verify eligibility, and effective and termination dates.
 - iv. Complete on-line computer access to auditing/inquiry mode of the automated system and fulltime use of a computer terminal for each auditor that will allow for complete re-adjudication of any claim.
 - v. Access to network provider fee schedules, pricing modules, rebundling software, reasonable and customary schedules, case management, utilization review notes, contracts and any internal policies or procedures as they relate to the payment structure and managed care administration provisions of the State's benefit plans.
 - vi. Assistance/instruction in utilizing the on-line computer system and with questions regarding system coding/functions, and claim handling procedures. This includes at least one claims administrator representative to remain with the Auditors for the first full day of the on-site audit. This individual should be knowledgeable regarding system use and the audited benefit plan, and responsible for providing written responses to claims questions/potential errors. Thereafter, a representative of the claim administration staff must provide accurate and complete written responses to questions and/or potential errors identified for the audited claims within one working day.
 - vii. Access to detailed plan descriptions and internal administrative guidelines, manuals, etc., relating to both State and general administrative claim procedures. If applicable, for Prescription Drugs / Rebates: Access to a minimum of five manufacturer

contracts designated by the State. These will be based on cost and utilization.

B CONTRACT TERM

Contract Term. This Contract shall be effective for the period commencing on September 1, 2010 and ending on December 31, 2011. The State shall have no obligation for services rendered by the Contractor, which are not performed within the specified term.

C PAYMENT TERMS AND CONDITIONS

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Two Million Five Hundred Thousand Dollars (\$2,500,000.00). The payment rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

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

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

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

- a. Payment rates do not include claims funding or other State costs specifically stated in this Contract, such as in Section A.8.j.
- b. The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones or increments of service defined in Section A.
- c. The Contractor shall be compensated for said units, milestones, or increments of service based upon the following payment rates:

Per Member Per Month (PMPM) Administrative Fee	2010	2011
CoverKids PPO Plan	\$21.50	\$21.50

d. The State shall pay the Contractor the one time sum of Eighty one Thousand Two Hundred Thirty and 00/100 Dollars (\$81,230.00) for the development and implementation of this Contract and its requirements. The Contractor shall include this one-time amount in the first monthly invoice pursuant to this Contract.

- e. The Contractor shall submit monthly invoices for services other than claims funding, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated. The State shall compensate the Contractor monthly for all non-claims funding services outlined in this Contract, at the PMPM and other service based rates indicated, based upon the number of members certified by the Contractor to the State. The Contractor shall bill the State for those children who have been certified by the Eligibility Contractor as eligible on or before the 15th day of each month. The State shall not be billed for those children who are certified by the Eligibility Contractor as disenrolled from the program on or before the 15th day of the month in which the child is disenrolled.
- f. The State shall pay the Contractor a sum of Eight Hundred Forty and 00/100 Dollars (\$840.00) per quarter for the continued provision of services related to reporting of FQHC and RHC incurred claims. The Contractor shall invoice the State quarterly, in arrears, for such amounts due, beginning after the first calendar year quarter following the execution date of this Amendment. In the event that the Contractor is requested by the State to provide assistance with inquiries from FQHCs or RHCs, the State shall pay the Contractor a fee of Twenty-eight and 50/100 Dollars (\$28.50) per hour, with a minimum one hour charge for each inquiry in the performance of duties detailed in A.8.m.(4)i. In the event the State requests changes to the reports, and such changes require additional programming by Contractor in excess of twelve hours per quarter, then Contractor shall be reimbursed for such additional work at a rate of Seventy and 00/100 Dollars (\$70.00) per hour, and the total cost for all such requested services shall not exceed Twenty Thousand and 00/100 Dollars (\$20,000.00). The State shall approve estimates for any such work in writing in advance of any work performed. The Contractor shall include any amount due for the inquiry(ies) in the monthly invoice to the State next following the date of such request.
- g. Once there is at least one participant in the Plan, the State shall pay Contractor \$1,000.00 per month for the provision of services related to eligibility checks by Contractor pursuant to Section A.7.i over the term of this Contract. The Contractor shall include the monthly amount in its standard monthly invoice to the State beginning with the first invoice issued to the State in which payment is due for this service after the effective date of this Contract.
- h. Pursuant to Section A.8.j., the cost of printing and distributing Member Handbooks, provider directories, identification cards, enrollment forms, and administrative forms and manuals shall be the responsibility of the State. Should the State want Contractor to print and/or distribute any of these items, Contractor shall present a price to the State for this service, and the parties shall agree in writing on Contractor's compensation. The Contractor shall include any amount due for this service in the monthly invoice to the State next following the date such services are performed.
- i. Performance Guarantees. The Contractor agrees to be bound by the provisions contained in Contract Attachment B, Performance Guarantees, and to pay amounts due upon notification of Contractor non-compliance by the State. In determining compliance with any Performance Guarantees, the State shall construe the Performance Guarantees in this Contract as cumulative and determine compliance as a whole between this Contract and other existing contracts the Contractor may have simultaneously in effect for the CoverKids program.

- (1) The appropriate data from this Contract shall be aggregated with contract number FA-07-20600-00 for the purposes of determining whether a Performance Guarantee under this contract has been met.
- (2) For a penalty to apply, the underlying data utilized must be statistically valid. To determine this, an initial assessment will be completed on contract number FA-07-20600-00, Contractor will then re-run the Performance Guarantee data to include both participants in contract number FA-07-20600-00 and those in this Contract. If the results reflect cumulative negative performance for the same Performance Guarantee in this Contract and other existing contracts the Contractor has in effect for the CoverKids program, Contractor will pay the penalty assessed pursuant to Attachment B.

j. Performance Guarantees under Contract Extension. If this Contract is extended, the Performance Guarantees shall remain unchanged for the years extended.

C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

C.5. Invoice Requirements.

The Contractor shall invoice the State only for completed increments of service and for the amount stipulated in Section C.3, above, and as required below prior to any payment.

a. The Contractor shall submit non-claims funding invoices no more often than monthly, with all necessary supporting documentation, to:

Marlene Alvarez, Procurement & Contracting Manager
 Tennessee Department of Finance & Administration
 Benefits Administration
 William R. Snodgrass Tennessee Tower
 312 Rosa L Parks Avenue, Suite 2600
 Nashville, Tennessee 37243-1102

b. The Contractor agrees that each invoice submitted shall clearly and accurately (all calculations must be extended and totaled correctly) detail the following required information.

- (1) Invoice/Reference Number (assigned by the Contractor);
- (2) Invoice Date;
- (3) Invoice Period (period to which all invoiced charges are applicable);
- (4) Contract Number (assigned by the State to this Contract);
- (5) Account Name: Department of Finance and Administration, Benefits Administration
- (6) Account/Customer Number (uniquely assigned by the Contractor to the above-referenced Account Name);
- (7) Contractor Name;
- (8) Contractor Federal Employer Identification Number or Social Security Number (as referenced in this Contract);
- (9) Contractor Contact (name, phone, and/or fax for the individual to contact with billing questions);
- (10) Contractor Remittance Address;
- (11) Complete Itemization of Charges, which shall detail the following:

i. Service or Milestone Description (including name /title as applicable) of each service invoiced;

- ii. Number of Completed Units, Increments, Hours, or Days as applicable, of each service invoiced;
 - iii. Applicable Payment Rate (as stipulated in Section C.3.) of each service invoiced;
 - iv. Amount Due by Service; and
 - v. Total Amount Due for the invoice period.
 - c. The Contractor understands and agrees that an invoice to the State under this Contract shall:
 - (1) include only charges for service described in Contract Section A and in accordance with payment terms and conditions set forth in Contract Section C;
 - (2) not include any future work but will only be submitted for completed service; and
 - (3) not include sales tax or shipping charges.
 - d. The Contractor agrees that timeframe for payment (and any discounts) begins when the State is in receipt of each invoice meeting the minimum requirements above.
 - e. The Contractor shall complete and sign a "Substitute W-9 Form" provided to the Contractor by the State. The taxpayer identification number contained in the Substitute W-9 submitted to the State shall agree to the Federal Employer Identification Number or Social Security Number referenced in this Contract for the Contractor. The Contractor shall not invoice the State for services until the State has received this completed form.
 - f. The parties may modify these requirements by written mutual agreement.
- C.6. Payment of Invoice. The payment of the invoice by the State shall not prejudice the State's right to object to or question any invoice or matter in relation thereto. Such payment by the State shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein. The timeframe for payment is Thirty (30) days from the State's receipt of the invoice.
- C.7. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute proper remuneration for compensable services.
- C.8. Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the Contractor.
- C.9. Automatic Deposits. The Contractor shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits) Form." This form shall be provided to the Contractor by the State. Once this form has been completed and submitted to the State by the Contractor all payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee shall be made by Automated Clearing House (ACH). The Contractor shall not invoice the State for services until the Contractor has completed this form and submitted it to the State.
- C.10. Maximum Administrative Fee for Subrogation Recoveries. The State authorizes the Contractor to retain subrogation recovery fees of no more than 5% of the gross recoveries received by Contractor in administering its subrogation recovery program. The Contractor

may retain an additional 20% of the gross recoveries, when such recoveries are made by subrogation subcontractor(s). Recovery of subrogation claims includes claims paid as a result of work related illnesses or injuries relative to worker's compensation claims.

- C.11. Access Fees. The State agrees that access fees required by the Contractor, and its licensees, for use of the BlueCard program by members covered under the Plan shall be deducted from the aggregate discount savings realized from the Blue Card Program with the savings balance accruing to the State. The maximum fees under the Blue Card program are as follows:

Type of Claim	State's cost per Claim (2010)	State's cost per Claim (2011)
Professional Claim	\$5.00	\$5.00
Institutional Claim	\$11.00	\$11.00
Claim Based Access Fee Only if Charged by Host Plan	6.6% of the discount received from the Host Plan if required. Maximum of \$2,000 per claim.	6.12% of the discount received from the Host Plan if required. Maximum of \$2,000 per claim.

- a. All other fees related to the Blue Card Program, as described in Contract Attachment E Blue Card PPO Program shall be borne by the Contractor, and should not be charged separately to the State regardless of any contrary statement in Attachment E. The State is under no obligation for any fees or compensation under the Blue Card Program other than those contained in this section.
- b. Contractor shall provide the State with quarterly reports on the utilization of the Blue Card Program including claims paid, realized savings and Blue Card Program fees paid out of savings for the program during the quarter. Reports should be provided by the last day of the month following the quarter. Until a Member is covered under this Contract, Contractor shall not generate these reports.

D STANDARD TERMS AND CONDITIONS

- D.1. Required Approvals. Neither the State, nor the Contractor, are bound by this Contract until it is approved by the appropriate State officials in accordance with applicable Tennessee State laws and regulations.
- D.2. Modification and Amendment: This Contract may be modified only by a written amendment executed by all parties hereto and approved by the appropriate Tennessee State officials in accordance with applicable Tennessee State laws and regulations.
- D.3. Termination for Convenience. The Contract may be terminated by either party by giving written notice to the other, at least One Hundred-Eighty (180) days before the effective date of termination. Should the State exercise this provision, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Should the Contractor exercise this provision, the State shall have no liability to the Contractor except for those units of service which can be effectively used by the State. The final decision as to what these units of service are, shall be determined by the State. In the event of disagreement, the Contractor may file a claim with the Tennessee Claims Commission in order to seek redress.
- D.4. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to immediately terminate the Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the

above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.

- D.5. Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, they shall contain, at a minimum, sections of this Contract below pertaining to "Conflicts of Interest," "Nondiscrimination," and "Records" (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime contractor and shall be responsible for all work performed.
- D.6. Conflicts of Interest. The Contractor warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed relative to this Contract.
- D.7. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Contractor shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.
- D.8. Prohibition of Illegal Immigrants. The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.
- a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document as Attachment A, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the contractor and made available to state officials upon request.
 - b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the contractor and made available to state officials upon request.
 - c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.
 - d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner

of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Contract.

- e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.
- D.9. Records. The Contractor shall maintain documentation for all charges against the State under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.
- D.10. Monitoring. The Contractor's activities conducted and records maintained, pursuant to this Contract, shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.
- D.11. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.
- D.12. Strict Performance. Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.
- D.13. Independent Contractor. The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship, or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party, for any purpose whatsoever.

The Contractor, being an independent contractor, and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Contractor's employees, and to pay all applicable taxes incident to this Contract.

The State acknowledges its understanding that this Contract constitutes a contract solely between the State and Contractor, which is an independent corporation operating under a license from the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield Plans (the "Association") permitting Contractor to use the BlueCross and BlueShield Service Marks in the State of Tennessee, and that Contractor is not contracting as the agent of the Association. The State further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Contractor and that neither the Association nor any other Blue Cross Blue Shield licensee shall be considered to be a party to this Contract. This paragraph

shall not create any additional obligations whatsoever on the part of Contractor other than those obligations created under other provisions of this Contract.

Contractor is responsible for providing administrative claims payment services in accordance with the terms of the Plan, its duties and services as described in the Member Handbook, and other duties specifically assumed by it pursuant to this Contract. Contractor does not assume any financial risk or obligation with respect to Plan claims.

- D.14. State Liability. The State shall have no liability except as specifically provided in this Contract.
- D.15. Force Majeure. The obligations of the parties to this Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, natural disasters, riots, wars, epidemics, or any other similar cause.
- D.16. State and Federal Compliance. The Contractor shall comply with all applicable State and Federal Laws and regulations in the performance of this Contract.
- D.17. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.
- D.18. Completeness. This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.
- D.19. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.
- D.20. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.
- D.21. The State acknowledges its understanding that this Contract constitutes a contract solely between the State and Contractor, which is an independent corporation operating under a license from the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield Plans (the "Association") permitting Contractor to use the BlueCross and BlueShield Service Marks in the State of Tennessee, and that Contractor is not contracting as the agent of the Association. The State further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Contractor and that neither the Association nor any other Blue Cross Blue Shield licensee shall be considered to be a party to this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Contractor other than those obligations created under other provisions of this Contract.

E SPECIAL TERMS AND CONDITIONS

- E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.
- E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by EMAIL or facsimile transmission with recipient confirmation. Any such communications, regardless of method of transmission, shall be addressed to the respective party at the appropriate mailing address, facsimile number, or EMAIL address as set forth below or to that of such other party or address, as may be hereafter specified by written notice.

The State:

Marlene D. Alvarez, Manager of Procurements and Contracting
Tennessee Department of Finance and Administration,
Benefits Administration
312 Rosa L Parks Avenue, Suite 2600
Nashville, TN 37243
marlene.alvarez@tn.gov
Telephone: 615.253.8358
FAX: 615.253.8556

The Contractor:

Rebecca Owen, Product Manager
BlueCross BlueShield of Tennessee, Inc.
1 Cameron Hill Circle
Chattanooga, Tennessee 37402
Rebecca_Owen@bcbst.com
Telephone: 423.535.8347
FAX: 423.591.9111

with a copy to:

BlueCross BlueShield of Tennessee, Inc.
1 Cameron Hill Circle
Chattanooga, TN 37402
Attention: Deputy General Counsel
Tena_Roberson@bcbst.com
Fax: 423.535.1984

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

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

- E.4. Tennessee Consolidated Retirement System. The Contractor acknowledges and understands that, subject to statutory exceptions contained in ***Tennessee Code Annotated***, Section 8-36-801, *et. seq.*, the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to ***Tennessee Code Annotated***, Title 8, Chapter 35, Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the period of this Contract.
- E.5. Voluntary Buyout Program. The Contractor acknowledges and understands that, for a period of two years beginning August 16, 2008, restrictions are imposed on former state employees who received a State of Tennessee Voluntary Buyout Program (VBP) severance payment with regard to contracts with state agencies that participated in the VBP.
- a. The State will not contract with either a former state employee who received a VBP severance payment or an entity in which a former state employee who received a VBP severance payment or the spouse of such an individual holds a controlling financial interest.
 - b. The State may contract with an entity with which a former state employee who received a VBP severance payment is an employee or an independent contractor. Notwithstanding the foregoing, the Contractor understands and agrees that there may be unique business circumstances under which a return to work by a former state employee who received a VBP severance payment as an employee or an independent contractor of a State contractor would not be appropriate, and in such cases the State may refuse Contractor personnel. Inasmuch, it shall be the responsibility of the State to review Contractor personnel to identify any such issues.
 - c. With reference to either subsection a. or b. above, a contractor may submit a written request for a waiver of the VBP restrictions regarding a former state employee and a contract with a state agency that participated in the VBP. Any such request must be submitted to the State in the form of the *VBP Contracting Restriction Waiver Request* format available from the State and the Internet at: www.state.tn.us/finance/rds/ocr/waiver.html. The determination on such a request shall be at the sole discretion of the head of the state agency that is a Party to this Contract, the Commissioner of Finance and Administration, and the Commissioner of Human Resources.
- E.6. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

The Contractor's obligations under this section do not apply to information in the public

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

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

E.7. HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

- a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this Contract.
- b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA.
- c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by HIPAA and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA. This provision shall not apply if information received by the State under this Contract is NOT "protected health information" as defined by HIPAA, or if HIPAA permits the State to receive such information without entering into a business associate agreement or signing another such document.

E.8. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;
- b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and
- d. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

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

E.9. Breach. A party shall be deemed to have breached the Contract if any of the following occurs:

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

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

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

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

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

- (3) Partial Default— In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor.

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

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

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

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

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

CONTRACTOR SIGNATURE

DATE

PRINTED NAME AND TITLE OF AUTHORIZED CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. GOETZ, JR., COMMISSIONER

DATE

**CONTRACT ATTACHMENT A
ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE**

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	BlueCross BlueShield of Tennessee, Inc.
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	62-0427913

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

**SIGNATURE &
DATE:**

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

Contract Attachment B Performance Guarantees

The Contractor shall pay to the State the indicated total dollar assessment upon notification by the State that an amount is due, through the life of the Contract. For a penalty to apply, the underlying data utilized must be statistically valid. To determine this, an initial assessment will be completed on contract number FA-07-20600-00, Contractor will then re-run the Performance Guarantee data to include both participants in contract number FA-07-20600-00 and those in this Contract. If the results reflect negative performance, Contractor will pay the penalty assessed pursuant to the chart below. When calculating the guarantees below, the appropriate data from this Contract shall be aggregated with contract number FA-07-20600-00 for the purposes of determining whether a Performance Guarantee under both contracts has been met.

1. Claims Payment Dollar Accuracy	
Guarantee	The average quarterly financial accuracy for claims payments will be 99% or higher.
Definition	Claims Payment Dollar Accuracy is defined as the absolute value of financial errors divided by the total paid value of Contractor audited dollars paid.
Assessment	\$100 for each full percentage point below 99% for each contracted quarter.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.
2. Claims Processing Accuracy	
Guarantee	The average quarterly processing accuracy will be 99% or higher.
Definition	Claims Processing Accuracy is defined as the absolute number of claims with no in processing or procedural errors, divided by the total number of claims within the audit sample. <u>This excludes financial errors.</u>
Assessment	\$100 for each full percentage point below 99%, for each contracted quarter.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.
3. Claims Turnaround Time	
Guarantee	The average quarterly claims payment turnaround time will not be greater than: <ul style="list-style-type: none"> • 14 calendar days for 90% of non-investigated (clean) claims; and • 30 calendar days for 96% of all claims
Definition	Claims Turnaround Time is measured from the date the claim is received in the office to the date processed, including weekends and holidays. Any claims that include COB and subrogation will be excluded when calculating compliance with the "investigated claims" performance standard.
Assessment	Non-Investigated Claims (clean): \$100 for each full percentage point below the required minimum standard of 90% within 14 days. Quarterly Guarantee. All Claims: \$100 for each full percentage point below the required minimum standard of 96% within 30 days. Quarterly Guarantee.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.
4. Telephone Response Time	
Guarantee	Ninety-five percent (95%) of incoming Participant services calls will be answered by a member services representative in 30 seconds or less.
Definition	Telephone Response Time is defined as the amount of time elapsing between the time a call is received into the phone system and when a live member services representative answers the phone.
Assessment	\$500 for each full second over the 30 second benchmark. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
5. Participant Satisfaction	
Guarantee	The level of overall customer satisfaction, as measured annually by a State approved Participant Satisfaction survey(s), will be equal to or greater than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the Contract term.
Definition	Participant Satisfaction will be measured utilizing the most current National Committee on Quality Assurance (NCQA) Adult Participant Satisfaction Survey question that measures overall satisfaction.
Assessment	\$300. Annual guarantee.
Compliance report	The Compliance Report is the Contractor's results from National Committee Quality Assurance (NCQA) annual Adult Participant Satisfaction Survey. Performance will be measured, reported, and reconciled annually.

6. Member Handbooks and Provider Network Directories Distributed		
Guarantee	Member Handbooks and Provider Network Directories will be distributed to Participants within 14 calendar days of the effective date of enrollment or to individuals requesting information within 5 business days of the request. (The handbook and provider directory may be a single document).	
Definition	Member Handbook and Provider Network Directories will be measured based on date of distribution.	
Assessment	Should either of the above listed documents not be distributed as required, the total assessment shall be \$250 per year in which the standard is not met.	
Compliance report	The Compliance Report reported by Division of Insurance Administration Plan operations. Annual guarantee is measured, reported, and reconciled annually.	
7. Claims Data Quality		
Guarantee	Claims Data Quality is measured by the State's Claims Data Management vendor. The Contractor's quarterly data submission to DSS/EIS vendor must meet the following Data Quality measures.	
Definition	<i>Measure</i>	<i>Benchmark</i>
	Gender	Data missing for <=/ 3% of claims
	Date of birth	Data missing for <=/ 3% of claims
	Outpatient diagnosis coding	Data invalid or missing for <=/ 5% of outpatient claims
	Outpatient provider type missing	Data missing for <=/ 1.5% of outpatient claims
Assessment	\$2500 if <u>ANY</u> of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Compliance report	Compliance Report consists of the DSS/EIS vendor Quarterly Data Quality report provided by DSS/EIS vendor. Performance measured and reported (by DSS/EIS vendor) quarterly; reconciled annually.	
8. Submission of Quarterly Data to Data Management Vendor		
Guarantee	Quarterly claims data will be submitted by the contractor to the state's data management vendor (DSS/EIS vendor) no later than the last day of the month following the end of each calendar quarter.	
Definition	Quarterly claims data are received by DSS/EIS vendor no later than the last day of the month following the end of each calendar quarter.	
Assessment	Failure to submit quarterly claims data no later than the last day of the month following the end of each quarter will result in an assessment of \$100 per day for the first and second working days past the compliance date, and \$500 for each working day thereafter, to a maximum of \$1,000.00 per quarter.	
Compliance report	Compliance reporting submitted by DSS/EIS vendor upon receipt of quarterly claims data. Performance is measured, reported, and reconciled quarterly.	
9. Member ID Card Distribution		
Guarantee	Member ID cards must be distributed (defined as "mailed") to a minimum of 98% of Participants within 14 calendar days of the receipt of enrollment information.	
Definition	The actual distribution of a member ID card to 98% of all Participants by the specified dates.	
Assessment	Should the above standard not be met, the total amount shall be \$1500 per year in which the standard is not met.	
Compliance report	Compliance Report submitted by Contractor. Performance is measured, reported, and reconciled annually.	
10. Provider/Facility Network Accessibility		
Guarantee	As measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis for all BlueCross BlueShield of Tennessee members in Network P, the Contractor's provider and facility network will assure that 95% of all Participants will have the Access Standard indicated.	
Definition	Provider Group	Access Standard
	Acute Care Hospitals	1 facility within 10 miles
	Pediatricians, general practice, internists, family practice physicians	2 physicians within 20 miles
	Pediatric Specialists	5 physicians within 100 miles
Assessment	\$100 annually if <u>ANY</u> of the above listed standards are not met, either individually or in combination measured annually at the State's discretion.	
Compliance report	Compliance report is the annual GeoNetworks® Analysis submitted by Contractor. The Annual guarantee is Measured, reported and reconciled annually.	

¹ The Telephone Response Time Performance Guarantee will be measured by combining the data from members served by this Contract and those served under contract number FA-07-20600-00. The data for the two contracts under this guarantee cannot be separated.

Contract Attachment C Management Reporting Requirements

As required by Contract Section A.8, the Contractor shall submit Management Reports by which the State can assess the CoverKids program's general activity and usage, as well as treatment and success tendencies. Reports shall be submitted electronically, and shall be of the type and at the frequency indicated below. Management Reports shall include:

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

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

2) **Paid Claims Data by Quarter**, including 30 day run-out, and demonstrating Year-to-Date totals.

- Number of Member Months for Kids and Low Income Kids and number of Pregnant Women (unborn children).
- Total earned premium
- Total Paid Medical Expenses
- Inpatient data:

<ul style="list-style-type: none"> ○ Admissions per 1,000 Participants, for: 	<ul style="list-style-type: none"> ▪ Medical/Surgical ▪ Maternity ▪ Other ▪ Total
<ul style="list-style-type: none"> ○ Days per 1,000 Participants, for: 	<ul style="list-style-type: none"> ▪ Medical/Surgical ▪ Maternity ▪ Other ▪ Total
<ul style="list-style-type: none"> ○ Average Length of Stay 	

- Outpatient data:

<ul style="list-style-type: none"> ○ Distribution of Dollars paid for Outpatient Services (expressed as percentages), for: 	<ul style="list-style-type: none"> ▪ Medical ▪ Surgery/ Diagnostic/Therapeutic ▪ Anesthesia ▪ Other ▪ Total
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- Enrollment analysis, indicating:

<ul style="list-style-type: none"> ○ Month 1, Month 2, Month 3 of the current quarter, and YTD, for: 	<ul style="list-style-type: none"> ▪ Number of Participants by coverage type ▪ Number of Patients
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- Prescription drug utilization- Retail and Mail Order:

<ul style="list-style-type: none"> ○ Number of Prescriptions (total and per Participant) ○ Total Cost ○ Average Cost per Prescription ○ Average Cost per Participant per month 	
--	--

- Top 10 Drugs by Number of Claims, demonstrating:

<ul style="list-style-type: none"> ○ Drug Name ○ Number of Prescriptions ○ Brand Name or Generic ○ Allowed Ingredient Change ○ Allowed Quantity ○ Cost per Unit 	
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- Top 10 Drugs by Cost, demonstrating:

<ul style="list-style-type: none"> ○ Drug Name ○ Number of Prescriptions ○ Brand Name or Generic ○ Allowed Ingredient Change ○ Allowed Quantity ○ Cost per Unit 	
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A. **Quarterly Network Changes Update Report**, submitted electronically.

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a monthly eligibility file for plan participants administered through <Data Supplier>.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

Data will be provided in a monthly file that reflects the status as of the end of the month, i.e. a "snapshot" as of a point in time. For example, if a project requires 36 months of historical data, Medstat will expect to receive 36 records for each member, one for each month. Ongoing file submissions would include one record for each member for the latest month only.

METHOD OF SUBMISSION

[To be determined] Medstat supports a number of file submission options including: FTP, Web Submission, as well as physical media.

FREQUENCY OF SUBMISSION

The data will be submitted to Medstat on a monthly basis.

TIMING OF SUBMISSION

Monthly files should be submitted on or before the 15th of the month following the close of each month.

SELECTION CRITERIA

Members and their dependents who are eligible for medical, prescription drug, mental health, hearing, dental, or vision coverage, as well as employees who have opted-out of coverage should be included. This includes one record for each participant and one record for each dependent for the reporting month. A record should be created if the person eligible/enrolled at any time within the month (e.g. If an employee was terminated, there should be a record in the month of termination, but not in the subsequent month. The exception to this would be an employee who terminates but continues company-paid benefits under a severance plan).

Data should include:

- Covered active members and their covered dependents including retirees, surviving spouses/beneficiaries, LOA, LTD, STD, Permanent Disability, Military Leave, and FMLA.
- Employees who have opted-out of coverage
- Employees who have terminated but retain medical coverage through a severance plan paid by the company.
- COBRA enrollee information (if this information is being provided from this data supplier for the client).

Data need not include:

- It is not necessary to include employees and dependents who are not eligible for medical, prescription drug, mental health, hearing, dental, or vision coverage.

- Medstat would not want to receive information on terminated employees who do not continue company-paid benefits beyond the month of termination.
- If COBRA enrollee information will be supplied from a 3rd party, Medstat would **NOT** want to receive two records for one person.

DATA FORMATTING

Character Fields

- Includes A - Z (lower or upper case), 0 – 9, and spaces
 - Left justified, right blank/space filled
- Unrecorded or missing values in character fields are blank/spaces

Numeric Fields

- All numeric fields should be right-justified and left zero-filled.
- **Unrecorded or missing values in numeric fields should be set to zero.**

Financial Fields

- All financial fields should be right-justified and left zero-filled.
- Medstat prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example, the data string "1234567" would represent \$12,345.67. Please do not include an actual decimal point in the data.
- Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal).

POPULATION OF DATA ONTO DEPENDENT RECORDS

For certain fields, e.g. Family ID and Employee Status, we would like to have information copied down from the employee to the dependent record. For others, e.g. Gender or Date of Birth, we would like the data to be specific to the person. For financial or quantity fields, (e.g. Employee Medical Contribution), to avoid over-counting, we would only want to see this information on the employee record.

For each field, Medstat has noted one of the three values below in the right-most column.

Member-specific = information relevant to the member (e.g. Date of Birth, Medstat would like each member's date of birth). Please populate on each record with the information specific to that member.

Employee-specific = information relevant to the employee/contract holder, but also "**copied down**" to the dependent's record (e.g. Family ID, Medstat would like the SSN of the employee also copied to each dependent's record).

Employee/Contract-Holder Only = information relevant to the employee/contract holder that Medstat would like on the **employee record or contract holder only**, i.e. not copied onto the dependent's records.

ELIGIBILITY LAYOUT – Detail Records

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier/Instructions/Notes	Population of Employee/Dependent Records
Standard Medstat Fields								
1	Record Type	1	1	1	Character	Record Type Identifier	Hard Code 'D'	Member-Specific
2	Business Unit Code	2	5	4	Character	Client-specific code for the business unit.	Business Unit values will be identified in the Data Dictionary .	Employee-Specific
3	Coverage Indicator Dental	6	6	1	Character	Indicator of Dental Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
4	Coverage Indicator Drug	7	7	1	Character	Indicator of Drug Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
5	Coverage Indicator Hearing	8	8	1	Character	Indicator of Hearing Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
6	Coverage Indicator Medical	9	9	1	Character	Indicator of Medical Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
7	Coverage Indicator MHSA	10	10	1	Character	Indicator of MHSA Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
8	Coverage Indicator Vision	11	11	1	Character	Indicator of Vision Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
9	Coverage Tier Code	12	15	4	Character	Medical Coverage Tier Code	Customer-specific values.	Member-Specific
10	Date of Birth	16	25	10	Date	Birth date of the person	MM/DD/CCYY format	Member-Specific
11	Date of Eligibility Month	26	35	10	Date	First day of eligibility month	MM/DD/CCYY Format	Member-Specific
12	Employee Status Code	36	40	5	Character	Client-specific values of employee status.	Employee Status code values will be identified in the Data Dictionary .	Employee-Specific
13	Family ID	41	49	9	Character	Employee SSN		Employee-Specific
14	Gender	50	50	1	Character	Gender of the person.	M or F	Member-Specific
15	Employee Medicare Eligible Indicator	51	51	1	Character	A code indicating whether an employee is Medicare eligible.	Y = Yes N = No	Employee-Specific

16	Part-Time/Full-time Indicator	52	52	1	Character	A code indicating whether an employee is full-time or part-time.	P = Part-time F = Full-time	Employee-Specific
17	PCP Type Code	53	53	1	Character	A code indicating the Primary Care Physician's specialty or type ex. General Practice, Family Practice, OB/GYN	PCP Type code values will be identified in the Data Dictionary .	Member-Specific
18	PCP ID	54	66	13	Character	The provider identifier of the Primary Care Physician.	The Tax ID number for the provider is preferred.	Member-Specific
19	Plan Code	67	72	6	Character	The code for the medical plan in which the member is enrolled.	Plan code values will be identified in the Data Dictionary . It's desirable to have a plan code explicitly identifying " Opt-outs ".	Member-Specific
20	Race Code	73	73	1	Character	A code specifying the race or ethnicity of the person.	Race code values will be identified in the Data Dictionary .	Member-Specific
21	Region Code	74	78	5	Character	Client-specific code for the geographic region of the person.	Region code values will be identified in the Data Dictionary .	Member-Specific
22	Relationship Code	79	83	5	Character	Client-specific values that specify the relationship of the member to the subscriber.	Relationship code values will be identified in the Data Dictionary .	Member-Specific
23	Salaried Indicator	84	84	1	Character	An indicator of whether the employee status is salaried or hourly.	Y = Salaried N = Hourly	Employee-Specific
24	Union Worker Indicator	85	85	1	Character	An indicator that the employee belongs to a union.	Y = Union N = Non-Union	Employee-Specific
25	Zip Code	86	95	10	Character	The zip code of the residence of the member at the time of the eligibility month.		Member-Specific
26	Monthly Employee Medical Contribution	96	105	10	Numeric	The monthly amount contributed by the employee for their medical benefits	Format 9(7)v99 (2 -- digit, implied decimal) Only recorded on employee record (zero-filled on dependent records). Zero-filled for opt-outs.	Employee/Contract Holder Only
27	Monthly Medical Premium	106	115	10	Numeric	The employer-paid monthly premium for medical benefits (fully-insured plans)	Format 9(7)v99 (2 -- digit, implied decimal) This field should contain total premium amounts paid by the employer for fully-insured plans and not premium equivalents. <it should not be the net amount (minus employee contrib) as this will be calculated within the Medstat product. It should be populated only on employee records for those employees enrolled in fully-	Employee/Contract Holder Only

28	Monthly Medical Admin Fees	116	125	10	Numeric	The employer-paid monthly admin/ASO fees for medical benefits (self-insured plans)	Format 9(7)v99 (2 - digit, implied decimal) This field is to be populated on employee records only for those employees enrolled in self-insured medical plans. For all other records, this field should be zero filled.	Employee/Contract Holder Only
	Field Name	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	Population of Employee / Dependent Records	
Customer-specific fields								
<Add any Customer-specific fields here and adjust the field numbering and start/end positions accordingly>								
40	Filler1	178	299	122	Character	Reserved for future use	Fill with blanks	
41	Last Character	300	300	1	Character	Identification of last character in each row of data.	Hard Code 'Z'	

ELIGIBILITY LAYOUT – Trailer Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instruction/Notes	Population of Employee/Dependent Records
1	Record Type	1	1	1	Character	Record Type Identifier	Hard Code 'T'	N/A – only 1 trailer record will be provided.
2	Eligibility Start Date	2	11	10	Date	Eligibility Begin Date	MM/DD/CCYY format – i.e. 09/01/2004. This will represent the 1 st day of the month for which data is provided.	
3	Eligibility End Date	12	21	10	Date	Eligibility End Date	MM/DD/CCYY format – i.e. 09/30/2004 This will represent the last day of the month for which data is provided.	
4	Record Count	22	31	10	Numeric	Number of Records on File	The count of records provided in the data excluding the Trailer Record	
5	Filler	32	299	268	Character	Filler	Fill with Blanks	
6	Last Character	300	300	1	Character	Identification of last character in each row of data.	Hard Code 'Z'	

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a Medical claims file for plan participants administered through **<Data Supplier>**.

The data will be provided in a fixed-record length, ASCII file format. The data request consists of two layouts/records; A Medical Detail Record and a Trailer Record.

METHOD OF SUBMISSION

[To be determined] Medstat supports a number of file submission options including: FTP, Web Submission, as well as physical media.

FREQUENCY OF SUBMISSION

The data will be submitted to Medstat on a **<monthly/quarterly>** basis.

TIMING OF SUBMISSION

<Monthly/Quarterly> files should be submitted on or before the 15th of the month following the close of each **<month/quarter>**.

Data Type: Medical Claims / Encounter Records

Definitions:

- **Fee-for-service claims** – Claims records for services that result in direct payment to providers on a service-specific basis.
- **Encounter records** – Utilization records for services provided under capitation arrangements (i.e., plans in which a provider is paid based on the number of enrollees rather than the services rendered.) These records enable documentation of all services provided regardless of whether or not direct payment was made to the provider.
- **Facility Data** – Facility data includes all services rendered by an inpatient or outpatient facility. The basis for the requirements of facility data is the information found on the standard UB-92 claim form.
- **Professional Data** – Professional data includes all services rendered by a physician or other professional provider, including dental, vision and hearing. The basis for the requirements of professional data is the information found on the standard CMS-1500 claim form.
- **Fee-for-Service Equivalents** – Financial amounts for services rendered under a capitated arrangement found within encounter records.

Items for discussion

General

- If both fee-for-service claims and encounter records are included on the data file, Medstat will rely on the data supplier to explain how to differentiate them.
- Medstat prefers to receive the facility, professional and capitation data (if applicable) in one file. We will rely on the data supplier to explain how to differentiate facility, professional and capitation services in their data.
- If encounter records contain fee-for-service equivalents, it is essential for Medstat to understand which fields contain these amounts.
- Financial fields should be populated at the service line level, not at the claim level.
- Medstat will need to understand the circumstances under which claims are not paid on a line item basis. For example, situations where claims are paid on a per diem basis or paid based on a DRG.
- If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

Financial Fields

Medstat defines the relationship among financial fields as follows:

$$\begin{aligned} & \text{Charge Submitted} \\ - & \text{Not Covered Amount*} \\ = & \text{Charge Covered*} \\ - & \text{Discount Amount} \\ = & \text{Allowed Amount} \\ - & \text{Coinsurance} \\ - & \text{Copayment} \\ - & \text{Deductible} \\ - & \text{Penalty/Sanction} \\ - & \text{Amount*} \\ - & \text{Third Party Amount} \\ = & \text{Net Payment} \end{aligned}$$

*not required in standard data extract (desirable if available)

Corrections to paid claims

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Medstat defines these as follows:

Void/Replacement

A void is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it.

The original, void and replacement need not appear in the same file.

Example: After adjudication, a paid claim with a \$25 Copay and \$50 Net Pay, a correction was necessary. The correction contains a \$10 Copay and \$65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Void	-1	-75.00	-25.00	0.00	-50.00
Replacement	1	75.00	10.00	0.00	65.00

Adjustments

A financial adjustment is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well.

The original and adjustment need not appear in the same file.

Example: After a claim was adjudicated with a \$25 Copay and \$50 Net Pay, it was discovered that there should have been a \$10 Copay and \$65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Adjustment	0	0	-15.00	0.00	15.00

Facility Record Content

- The standard UB-92 claim form contains both information that pertains to the entire claim and single service/procedure within the claim.
- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim).
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

Example: One facility claim with three service lines:

Claim-Level Information			Service-Level Detail			
Claim ID	Prov ID	Prov Type	Line Nbr	Rev Cd	Svc Cnt	Net Pay
11111	121212121	25	1	120	2	2000.00
11111	121212121	25	2	250	1	100.00
11111	121212121	25	3	720	10	1532.00

Professional Record Content

- Medstat does not store separate header/claim-level and detail/service-level information for professional claims. Medstat requires the following:
- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim.)
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

Example: One professional claim with two service lines:

Claim-Level Information			Service-Level Detail			
Claim ID	Prov ID	Prov Type	Line Nbr	Proc Cd	Svc Cnt	Net Pay
13331	621262121	51	1	99201	1	100.00
13331	621262121	51	2	99175	1	150.00

Denied Claims

Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Medstat defines denied claims as follows:

- Fully denied claim - The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- Partially denied claim – The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

Data Type: Capitation Data

Definition

- 1 Capitation data contains information regarding payments made to a physician, facility or other provider for a pre-determined set of services, regardless if the services are rendered to the enrollee. When services are rendered, an encounter record will be found in the medical claims data.

Items for Discussion

- Person-level information is preferred; such as, one record contains payment information per person per month
- Provider detail information is also preferred

DATA FORMATTING

Character Fields

- Includes A - Z (lower or upper case), 0 – 9, and spaces
- Left justified, right blank/space filled
- Unrecorded or missing values in character fields are blank/spaces

Numeric Fields

- All numeric fields should be right-justified and left zero-filled.
- Unrecorded or missing values in numeric fields should be set to zero.

Financial Fields

- All financial fields should be right-justified and left zero-filled.
- Medstat prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example, the data string "1234567" would represent \$12,345.67. Please do not include an actual decimal point in the data.
- Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal) and left zero-filled.

Medical Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Medstat Fields							
1	Adjustment Type Code	1	1	1	Character	Client-specific code for the claim adjustment type	Adjustment Type values will be identified in the Data Dictionary .
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
3	Bill Type Code UB	12	14	3	Character	The UB-92 standard code for the billing type, indicating type of facility, bill	Bill Type values will be identified in the Data Dictionary .
4	Capitated Service Indicator	15	15	1	Character	An indicator that this service (encounter record) was capitated	Applicable field values are “Y” for Capitated services and “N” for non-cap services.
5	Charge Submitted	16	25	10	Numeric	The submitted or billed charge amount	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
6	Claim ID	26	40	15	Character	The client-specific identifier of the claim.	
7	Claim Type Code	41	42	2	Numeric	Client-specific code for the type of claim	Claim Type Codes will be identified in the Data Dictionary .
8	Co-Insurance	43	52	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
9	Copayment	53	62	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
10	Date of Birth	63	72	10	Date	The birth date of the person.	MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned

29	Diagnosis Code 13 UB	189	193	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
30	Discharge Status Code UB	194	195	2	Numeric	The UB-92 standard patient status code, indicating disposition at the time of billing.	
31	Discount	196	205	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.	Format 9(7)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
32	Family ID	206	214	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.	The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
33	Gender Code	215	215	1	Character	The member's gender code.	"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
34	Line Number	216	217	2	Numeric	The detail line number for the service on the claim	
35	Net Payment	218	227	10	Numeric	The actual check amount for the record	Format 9(7)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
36	Network Paid Indicator	228	228	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level	"Y" or "N"
37	Network Provider Indicator	229	229	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs	"Y" or "N"
38	Ordering Provider ID	230	242	13	Character	The ID number of the provider who referred the patient or ordered the test or procedure.	The ID should be the physician's Federal Tax ID (TIN).
39	PCP Responsibility Indicator	243	243	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.	
40	Place of Service Code	244	245	2	Character	Client-specific code for the place of service.	Place of Service values will be identified in the Data Dictionary.
41	Procedure Code	246	250	5	Character	The procedure code for the service record.	CPT/HCPCS codes.
42	Procedure Code UB Surg 1	251	255	5	Character	The primary surgical procedure code (1) on the facility claim.	ICD-9 Surgical procedure codes.

43	Procedure Modifier Code 1	256	257	2	Character	The 2-character code of the first procedure code modifier on the professional claim	
44	Provider ID	258	270	13	Character	The identifier for the provider of service.	This must be the federal tax ID in order to use the standard hospital identifier lookup (UNIHOSP)
45	Provider Type Code Claim	271	273	3	Numeric	Client-specific code for the provider type on the claim record	Provider Type codes are further defined in the Data Dictionary
46	Provider Zip Code	274	278	5	Numeric	The 5-digit zip code corresponding to the Provider ID	Provider Location zip code
47	Revenue Code UB	279	282	4	Numeric	The CMS standard revenue code from the facility claim	This field must be at the service/detail level.
48	Third Party Amount	283	292	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
49	Units of Service	293	296	4	Numeric	Client-specific quantity of services or units	
50	Provider Name	297	326	30	Character	The description or name corresponding to the Provider ID.	
51	Financial Cost Amount	327	336	10	Numeric	The amount of payments contributing to total cost of coverage, but received as a standard claim.	Format 9(7)v99 (2 – digit, implied decimal) Usually used for capitation payments.
52	Capitation Type Code	337	338	2	Numeric	Client-specific code for the type of capitation payment	
53	Funding Type Code	339	340	2	Numeric	Specifies whether the claim was paid under a fully or self-funded arrangement	"S" = Self-funded "F" = Fully-funded
54	Account Structure	341	348	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Additional fields may be added to the layout if there is more than one component of the account structure.
55	Provider NPI Number	349	358	10	Character	The National Provider ID number for the provider.	
56	Provider Address 1	359	408	50	Character	The current street address1 of the provider of service.	
57	Provider Address 2	409	458	50	Character	The current street address2 of the provider of service.	
58	HRA Amount	459	458	10	Numeric	The amount paid from the HRA as a result of this claim.	
58	Filler1	469	599	131	Character	Reserved for future use	Fill with blanks
59	Record Type	600	600	1	Character	Record Type Identifier	Hard Code 'D'

Medical Detail – Trailer Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instruction/Notes
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2004. This will represent the 1 st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2004 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data excluding the Trailer Record
4	Total Net Payments	31	44	14	Numeric	Total Net Payments on File	The sum of Net Payments provided on the file.
5	Filler	45	599	555	Character	Filler	Fill with Blanks
6	Record Type	600	600	1	Character	Record Type Identifier	Hard Code 'T'

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a Prescription Drug claims file for plan participants administered through **<Data Supplier>**.

The data will be provided in a fixed-record length, ASCII file format. The data request consists of two layouts/records; A Drug Detail Record and a Trailer Record.

METHOD OF SUBMISSION

[To be determined] Medstat supports a number of file submission options including: FTP, Web Submission, as well as physical media.

FREQUENCY OF SUBMISSION

The data will be submitted to Medstat on a **<monthly/quarterly>** basis.

TIMING OF SUBMISSION

<Monthly/Quarterly> files should be submitted on or before the 15th of the month following the close of each **<month/quarter>**.

Data Type: Drug Claims

Definitions:

- Prescription drug data are claim records for services that result in direct payment to a pharmacy on a service-specific (for example, prescription-specific) basis.

Items for discussion

6 General

- If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

Financial Fields

Medstat defines the relationship among financial fields as follows:

- Charge Submitted
- Not Covered Amount*
- = Charge Covered*
- Discount Amount
- = Allowed Amount
- Coinsurance
- Copayment
- Deductible
- Penalty/Sanction Amount*
- Third Party Amount
- = **Net Payment**

*not required in standard data extract (desirable if available)

Corrections to paid claims

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Medstat defines these as follows:

Void/Replacement

A void is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it.

The original, void and replacement need not appear in the same file.

Example: After adjudication, a paid claim with a \$25 Copay and \$50 Net Pay, a correction was necessary. The correction contains a \$10 Copay and \$65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Void	-1	-75.00	-25.00	0.00	-50.00
Replacement	1	75.00	10.00	0.00	65.00

Adjustments

A financial adjustment is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well.

The original and adjustment need not appear in the same file.

Example: After a claim was adjudicated with a \$25 Copay and \$50 Net Pay, it was discovered that there should have been a \$10 Copay and \$65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Adjustment	0	0	-15.00	0.00	15.00

Denied Claims

Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Medstat defines denied claims as follows:

- Fully denied claim - The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- Partially denied claim – The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

DATA FORMATTING

Character Fields

- Includes A - Z (lower or upper case), 0 – 9, and spaces
- Left justified, right blank/space filled
- Unrecorded or missing values in character fields are blank/spaces

Numeric Fields

- All numeric fields should be right-justified and left zero-filled.
- Unrecorded or missing values in numeric fields should be set to zero.

Financial Fields

- All financial fields should be right-justified and left zero-filled.
- Medstat prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example, the data string "1234567" would represent \$12,345.67. Please do not include an actual decimal point in the data.
- Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal) and left zero-filled.

Drug Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Medstat Fields							
1	Adjustment Type Code	1	1	1	Character	Client-specific code for the claim adjustment type	Adjustment Type values will be identified in the Data Dictionary .
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.	Format 9(7)v99 (2 – digit, implied decimal)
3	Capitated Service Indicator	12	12	1	Character	An indicator that this service (encounter record) was capitated	Applicable field values are "Y" for Capitated services and "N" for non-cap services.
4	Charge Submitted	13	22	10	Numeric	The submitted or billed charge amount	Format 9(7)v99 (2 – digit, implied decimal)
5	Claim ID	23	37	15	Character	The client-specific identifier of the claim.	
6	Claim Type Code	38	39	2	Numeric	Client-specific code for the type of claim	Claim Type Codes will be identified in the Data Dictionary .
7	Co-Insurance	40	49	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal)
8	Copayment	50	59	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal)
9	Date of Birth	60	69	10	Date	The birth date of the person.	MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
10	Date of Service	70	79	10	Date	The date of service for the drug claim.	MM/DD/CCYY format
11	Date Paid	80	89	10	Date	The date the claim or data record was paid.	MM/DD/CCYY format This is the check date.

12	Days Supply	90	93	4	Numeric	The number of days of drug therapy covered by the prescription.	
13	Deductible	94	103	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.	Format 9(7)v99 (2 – digit, implied decimal)
14	Dispensing Fee	104	113	10	Numeric	An administrative fee charged by the pharmacy for dispensing the prescription.	Format 9(7)v99 (2 – digit, implied decimal)
15	Family ID	114	122	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.	The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
16	Formulary Indicator	123	123	1	Character	An indicator that the prescription drug is included in the formulary.	"Y" or "N"
17	Gender Code	124	124	1	Character	The member's gender code.	"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
18	Ingredient Cost	125	134	10	Numeric	The charge or cost associated with the pharmaceutical product.	Format 9(7)v99 (2 – digit, implied decimal)
19	Metric Quantity Dispensed	135	145	11	Numeric	The number of units dispensed for the prescription drug claim, as defined by the NCPDP (National Council for Prescription Drug Programs) standard format.	
20	NDC Number Code	146	156	11	Character	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.	Please leave out the dashes.
21	Net Payment	157	166	10	Numeric	The actual check amount for the record	Format 9(7)v99 (2 – digit, implied decimal)
22	Network Paid Indicator	167	167	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level.	"Y" or "N"
23	Network Provider Indicator	168	168	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs.	"Y" or "N"
24	Ordering Provider ID	169	181	13	Character	The ID number of the provider who prescribed the drug.	The ID should be the physician's Federal Tax ID (TIN).

25	PCP Responsibility Indicator	182	182	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.	
26	Provider ID	183	195	13	Character	The identifier for the provider of service.	This must be the National Association of Boards of Pharmacy (NABP) number.
27	Rx Dispensed as Written Code	196	196	1	Character	The NCPDP (National Council for Prescription Drug Programs) industry standard code that indicates how the product was dispensed.	
28	Rx Mail or Retail Code	197	197	1	Numeric	The Medstat standard code indicating the purchase place of the prescription.	"M" for Mail, "R" for Retail
29	Rx Payment Tier	198	198	1	Character	Client-specific description for the payment tier of the drug claim.	Data Supplier will help Medstat understand which fields to use in order to set this field for the customer. Examples of Rx Payment Tier are as follows: 1. Generic 2. Brand Formulary 3. Brand Non Formulary
30	Rx Refill Number	199	202	4	Numeric	A number indicating the original prescription or the refill number.	This is the refill number, not the number of refills remaining.
31	Sales Tax	203	212	10	Numeric	The amount of sales tax applied to the cost of the prescription.	Format 9(7)v99 (2 – digit, implied decimal)
32	Third Party Amount	213	222	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).	Format 9(7)v99 (2 – digit, implied decimal)
33	Discount	223	232	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.	Format 9(7)v99 (2 – digit, implied decimal)
34	Provider NPI Number	233	242	10	Numeric	The National Provider Identifier for the pharmacy.	
35	Funding Type Code	243	244	2	Numeric	Specifies whether the claim was paid under a fully or self-funded arrangement	"S" = Self-funded "F" = Fully-funded
36	Account Structure	245	252	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Additional fields may be added to the layout if there is more than one component of the account structure.
37	HRA Amount	253	262	10	Numeric	The amount paid from the HRA to pay the provider.	
38	Filler1	263	399	147	Character	Reserved for future use	Fill with blanks
39	Record Type	400	400	1	Character	Record Type Identifier	Hard Code 'D'

Drug Detail – Trailer Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instruction/Notes
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2004. This will represent the 1 st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2004 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data excluding the Trailer Record
4	Total Net Payments	31	44	14	Numeric	Total Net Payments on File	The sum of Net Payments provided on the file.
5	Filler	45	399	355	Character	Filler	Fill with Blanks
6	Record Type	400	400	1	Character	Record Type Identifier	Hard Code 'T'

Contract Attachment E

BLUECARD PPO PROGRAM

- E.1 This Attachment describes the general operation of the BlueCard/BlueCard PPO Program and describes the responsibilities of Contractor and State in relation to methods of paying claims and the fees and allowances resulting from administration of the BlueCard/BlueCard PPO Program. Contractor is referred further in this Attachment as a "Home Plan."
- E.1.1 Like all BlueCross and BlueShield Licensees, Contractor participates in a program called "BlueCard." Whenever Members access health care services outside the geographic area Contractor serves ("Service Area,") the claim for those services may be processed through BlueCard and presented to Contractor for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies.")
- E.1.2 Under BlueCard, when Members receive covered health care services within the geographic area served by an on-site BlueCross and/or BlueShield Licensee ("Host Plan,") Contractor remains responsible to State for fulfilling Contractor's Contract obligations. However, the Host Plan will be responsible, in accordance with applicable BlueCard Policies, if any, only for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of BlueCard are described generally below.
- E.2 Liability Calculation Method Per Claim. The calculation of Members' liability on claims for covered health care services incurred outside Contractor's Service Area and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price Contractor pays the Host Plan.
- E.2.1 The calculation of State's liability on claims for covered health care services incurred outside Contractor's Service Area and processed through BlueCard will be based on the negotiated price Contractor pays the Host Plan.
- E.2.2 Methods used to determine a negotiated price will vary among Host Plans, depending on the terms of each Host Plan's provider contracts. The negotiated price that Contractor pays a Host Plan on a health care claim processed through BlueCard may represent:
- E.2.2.1 the actual price the Host Plan paid to the health care provider ("Actual Price"); or
- E.2.2.2 an estimated price, determined by the Host Plan in accordance with BlueCard Policies, based on the Actual Price adjusted to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Plan's health care providers, or one or more particular providers ("Estimated Price"); or
- E.2.2.3 an average price, determined by the Host Plan in accordance with BlueCard Policies, based on a billed charges discount representing the Host Plan's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of the Host Plan's health care providers, or for a specified group of providers ("Average Price.") An Average Price may result in greater variation to the Member and the State from the Actual Price than would an Estimated Price.
- E.2.3 Host Plans using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively adjust the Estimated Price or Average Price to correct for overestimation or underestimation of past prices. However, this prospective adjustment will not affect the amount the Member and State pay, which BlueCard defines as a final price.
- E.2.4 Use of the Estimated Price or Average Price calculation method may result in the Host Plan's holding some portion of the amount the State pays in a variance account, pending settlement with the Host Plan's participating providers. Since all amounts paid are final, the funds held in a variance account (if any) do not belong to the State. These funds are eventually exhausted by provider settlements and through prospective adjustment to the negotiated prices.
- E.2.5 Statutes in a few states may require a Host Plan either to:

- E.2.5.1 use a basis for calculating Member liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim; or
- E.2.5.2 add a surcharge.
- E.2.6 If any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Contractor would then calculate Member liability and the State's liability for any covered health care services consistent with the applicable state statute in effect at the time the Member received those services.
- E.3 Return of Overpayments. Under BlueCard, recoveries from a Host Plan or its participating providers can come from anti-fraud and abuse audits, provider audits, credit balance audits, utilization review refunds, and unsolicited refunds, among other sources. Host Plans may use third parties to assist in discovering or collecting recovery amounts. The third party's fees are netted against the recovery. Recovery amounts, net of fees (if any), will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by claim or prospective basis.
- E.4 BlueCard Fees and Compensation. The State understands and agrees:
- E.4.1 to pay certain fees and compensation to Contractor, as contained in Section C.12 of the contract, which Contractor is obligated under BlueCard to pay to the Host Plan, to the BlueCross BlueShield Association ("BCBSA,") or to BlueCard vendors, unless our contract obligations to the State require those fees and compensation to be paid only by Contractor; and
- E.4.2 that BCBSA may revise fees and compensation under the BlueCard program from time to time without the State's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard. Contractor will notify the State as soon as practicable if these fees and compensation arrangements are modified.
- E.4.3 Some of these fees and compensation arrangements are charged each time a claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Some of these claim-based fees, such as the access fee and the administrative expense allowance fee, may be passed on to the State as an additional claim liability.
- E.4.4 Other fees include, but are not limited to, an 800 number fee and a fee for providing PPO provider directories. If you do not have a complete listing, or want an updated listing of these types of fees or the amount of these fees paid directly by the State, you should contact Contractor. All such applicable fees are listed in Section C of this Contract.
- E.4.5 The claim-based access fee, if one is charged, will not exceed 6.60% for 2010 (and 6.12% for 2011) of the discount received from the Host Plan on such claim, or no more than \$2,000 per claim.
- E.5 The BlueCard/BlueCard PPO Program provides that Contractor or other Home Plan must pay the Host Plan an Administrative Expense allowance for each Original Claim that the Host Plan processes. The amount of the Administrative Expense Allowance is determined according to the terms of the BlueCard/BlueCard PPO Policies and Procedures and varies according to the type of claim processed. Current Administrative Expense Allowance charges are as follows:

Type of Claim	State's cost per Claim	
	2010	2011
Professional Claim	\$5.00	\$5.00
Institutional Claim	\$11.00	\$11.00

- E.6 A Host Plan can charge an Access Fee only if the Host Plan's contract with the provider requires that the provider accept the payment rate negotiated by the Host Plan as payment in full for the services provided. The provider cannot seek to recover from the Member any amount above the Host Plan's payment rate except for applicable deductibles and copayments. When a Host Plan charges an Access Fee, the Host Plan certifies that it has an enforceable agreement with the provider that holds the Member harmless from balance billing and that the Host Plan will enforce such agreement.

E.7 Through the BlueCard Worldwide Program, Members also have access to a participating hospital network and referrals to doctors in major travel destinations throughout the world. When Members need to locate a hospital or doctor, they can call 1.800.810.BLUE, or call collect at 1.804.673.1177; they can also visit the web site <https://international.worldaccess.com/bcbsa/index.asp?page=login>, or they can call Contractor. When Members need inpatient medical care, they should call the BlueCard Worldwide Service Center, who will refer them to a participating hospital. Members will only be responsible for the Plan's usual out-of-pocket expense (i.e., non-covered expenses, deductible, copayment and/or coinsurance). In an emergency, Members should go to the nearest hospital. The BlueCard Worldwide Service Center will also provide referrals to doctors, but Members will have to pay the provider and then file the claim for reimbursement. The administrative costs charged by the BlueCard Worldwide Program will be passed on to the State when they are received by Contractor.