

CONTRACT #5
RFS # 318.65-00606
FA # Pending
Edison # Pending

Finance & Administration
Health Care Finance &
Administration

VENDOR:
BlueCross Blue Shield of
Tennessee, Inc. (Cover
Tennessee Programs)



State of Tennessee
Department of Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville, Tennessee 37243

Bill Haslam
Governor

Mark A. Emkes
Commissioner

October 5, 2011

Ms. Leni Chick
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

RE: Department of Finance and Administrative
Division of Health Care Finance and Administration

Dear Ms. Chick:

The Department of Finance and Administration, Division of Health Care Finance and Administration, is submitting for consideration by the Fiscal Review Committee a non-competitive contract with BlueCross BlueShield of Tennessee, Inc. for the delivery of CoverTN, AccessTN and CoverKids (collectively Cover Tennessee) health plan services. There currently are three (3) existing contracts with BlueCross BlueShield of Tennessee to provide Cover Tennessee services which are being combined into one contract for the next two years. All of these contracts were competitively procured. The Cover Tennessee Program results from State law requiring provision of health care services to certain populations of the State, including CoverKids, which also is federally mandated. Upon implementation of the Health Care Reform law which becomes effective in 2014, the programs could become a candidate for extinction. This creates an uncertain future for these specialized programs which makes it difficult to successfully execute a traditional RFP process as potential bidders could not be certain the programs would exist over the term of the contract. If bidders did emerge, then the cost of the contract would likely increase as higher rates would be bid as a hedge against future uncertainty or risk. The intent of the State is to combine these three programs into one contract and continue with the current vendor for the next two years rather than competitively procure a new contract for services that may very well end once Health Care Reform is implemented. This contract is funded by the division of the cost among the State, the employee, and the employers.

The Division of Health Care Finance and Administration would greatly appreciate the consideration and approval of this contract by the Fiscal Review Committee.

Sincerely,



Casey Dungan
Chief Financial Officer

cc: Darin J. Gordon, Deputy Commissioner
Alma Chilton, Director of Contracts

Supplemental Documentation Required for
Fiscal Review Committee

*Contact Name:	Casey Dungan	*Contact Phone:	615-507-6482
*Original Contract Number:	N/A	*Original RFS Number:	N/A
Edison Contract Number: <i>(if applicable)</i>	N/A	Edison RFS Number: <i>(if applicable)</i>	31865-00606
*Original Contract Begin Date:	January 1, 2012	*Current End Date:	December 31, 2013
Current Request Amendment Number: <i>(if applicable)</i>	N/A		
Proposed Amendment Effective Date: <i>(if applicable)</i>	January 1, 2012 <i>(contract effective date)</i>		
*Department Submitting:	Finance and Administration		
*Division:	Health Care Finance and Administration		
*Date Submitted:	October 3, 2011		
*Submitted Within Sixty (60) days:	Yes		
<i>If not, explain:</i>	N/A		
*Contract Vendor Name:	BlueCross BlueShield of Tennessee, Inc.		
*Current Maximum Liability:	\$557,121,400.00		
*Current Contract Allocation by Fiscal Year: <i>(as Shown on Most Current Fully Executed Contract Summary Sheet)</i>			
FY: 2012	FY: 2013	FY: 2014	FY: FY FY
\$ 130,555,291.00	\$277,388,158.00	\$149,177,951.00	\$ \$ \$
*Current Total Expenditures by Fiscal Year of Contract: <i>(attach backup documentation from STARS or FDAS report)</i>			
FY: 2012	FY: 2013	FY: 2014	FY: FY FY
\$	\$	\$	\$ \$ \$
IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:		N/A New Contract	
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:		N/A New Contract	
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:		N/A New Contract	
*Contract Funding Source/Amount:	State:	\$258,711,640.00	Federal: \$298,409,760.00

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Fiscal Review Committee**

Interdepartmental:		<i>Other:</i>	
If " <i>other</i> " 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 Contract		
*What were the projected costs of the service for the entire term of the contract prior to contract award?	\$557,121,400.00 (Two Year Contract)		

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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.

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

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

Service Description	Amount Per Member Per Month (pmpm)
Cover Tennessee Health Plan Services	\$28.00/pmpm

The Contractor shall submit monthly invoices, 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 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.

C.3.1. 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). The Contractor shall understand that recovery of subrogation claims includes claims paid as a result of work related illnesses or injuries relative to worker's compensation claims.

C.3.2. State agrees that access fees required by the Contractor, and its licensees, for use of the BlueCard program by Members covered under the programs shall be deducted from the aggregate discount savings realized from the BlueCard Program with the savings balance accruing to the State. The maximum fees under the BlueCard program are as follows:

Type of Claim	State's cost per Claim
Professional Claim	\$6.00
Institutional Claim	\$6.00
Claim Based Access Fee	0.00% of the discount received from the Host Plan, if required.

Supplemental Documentation Required for Fiscal Review Committee

Maximum of \$2,000 per claim.

These BlueCard fees may be changed by the Blue Cross and Blue Shield Association; if changed, the Contractor shall provide the State with as much advance notice as is possible, but in no event less than thirty (30) calendar days.

All other fees related to the BlueCard Program, as described in Contract Attachment E BlueCard PPO Program shall be borne by the Contractor, and should not be charged separately to the State. The State is under no obligation for any fees or compensation under the BlueCard Program other than those contained in this Contract Section.

The Contractor shall provide the State with quarterly reports on the utilization of the BlueCard Program including claims paid, realized savings and BlueCard 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.

C.3.3. **Claims Funding.** Claims funding is separate from all other non-claims payments. Contractor shall submit invoices for claims that are to be funded within a week, as detailed in Contract Section A.22.2, on a weekly basis, as agreed to in writing by the Parties. The State shall make funds available to cover those claims payments within forty-eight (48) hours, and shall notify Contractor by email when those funds are available. Contract Section C.8 shall not apply to funding claims, except to the extent that such audit is regarding improper remuneration for claims under this Contract.

C.3.4. **Premium Equivalent Rebate.** If the State determines that a premium equivalent rebate is due to Members and Participating Employers, the State shall make funds available to the Contractor in order for the Contractor to administer this process and fund the rebates.

- a. The cost to administer this rebate shall not exceed \$200,000 annually.
- b. This cost is to cover the one-time initial set-up fee and all cost associated with issuing individual checks to Members and Participating Employers.
- c. The State shall provide such rebate funds five (5) business days before the Contractor issues checks to Members and Participating Employers, pursuant to Contract Section A.18.11.3.

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

Planned expenditures by fiscal year are those services itemized in Contract Section C.3 and on the attached Contract Summary sheet.

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.

The combination of the three existing Cover Tennessee programs will result in a savings to the State. There currently are three (3) existing individual contracts with BlueCross BlueShield of Tennessee to provide Cover Tennessee services which are being combined into one contract for the next two years. All of these contracts were competitively procured. Upon implementation

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of the Health Care Reform law which becomes effective in 2 years, the programs could become a candidate for extinction. This creates an uncertain future for these specialized programs which makes it difficult to successfully execute a traditional RFP process as potential bidders could not be certain the programs would exist over the term of the contract. If bidders did emerge, then the cost of the contract would likely increase as higher rates would be bid as a hedge against future uncertainty or risk. This contract is funded by the division of the cost among the State, the employee, and the employers.

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.

This non competitive contract represents the combination of three existing competitively procured contracts. The existing contracts have been re-negotiated to become an administrative services only contract which represents a savings to the state.

Non-Competitive Contract Request

NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant.
Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED

COMMISSIONER OF FINANCE & ADMINISTRATION

Request Tracking #	31865-00606	
1. Contracting Agency	Department of Finance and Administration Division of Health Care Finance and Administration	
2. Proposed Contractor	BlueCross BlueShield of Tennessee, Inc.	
3. Proposed Contract Period – with ALL options to extend exercised <i>The proposed contract start date shall follow the approval date of this request.</i>	24 months	
4. Maximum Contract Cost – with ALL options to extend exercised	\$557,121,400.00	
5. Office for Information Resources Endorsement – information technology (N/A to THDA)	x Not Applicable <input type="checkbox"/> Attached	
6. eHealth Initiative Support – health-related professional, pharmaceutical, laboratory, or imaging	x Not Applicable <input type="checkbox"/> Attached	
7. Human Resources Support – state employee training	x Not Applicable <input type="checkbox"/> Attached	
8. Has the contracting agency bought the subject service before?	<input type="checkbox"/> NO <input checked="" type="checkbox"/> YES, it was procured by... <input checked="" type="checkbox"/> RFP <input type="checkbox"/> Another Competitive Method <input type="checkbox"/> Non-Competitive Negotiation	
9. Service Description – brief <u>summary</u> only – do NOT restate the proposed scope of service	<p>This contract is for the delivery of CoverTN, AccessTN and CoverKids (collectively "Cover Tennessee") self-funded health plan services, including administrative services, provider network development and maintenance, eligibility and enrollment, premium equivalent billing and collections, case and care management, disease management, medical benefits, pharmacy benefits, behavioral health benefits customer service, claims adjudication and adjustment, appeals services and financial and program reporting for each of the three programs.</p>	
10. Explanation of Need for or Requirement Placed on the State to Acquire the Service	<p>Cover Tennessee is a result of State law providing health care services to certain populations of the State, including CoverKids, which also is federally mandated. Upon implementation of the Health Care Reform law which becomes effective in 2 years, the program could become a candidate for extinction. There currently are three (3) existing contracts with BlueCross BlueShield of Tennessee to provide Cover Tennessee services which are being combined into one contract for the next two years, however the payment structure is being changed to an administrative services only contract.</p>	

Request Tracking #	31865-00606
<p>11. Name & Address of the Contractor's Principal Owner(s) <i>- NOT required for a TN state education institution</i></p> <p>BlueCross BlueShield of Tennessee, inc. One Cameron Hill Circle Chattanooga, TN 37402</p>	
<p>12. Evidence Contractor's Experience & Length Of Experience Providing the Service</p> <p>BlueCross BlueShield of Tennessee has been centered on the health and well being of Tennesseans for more than 65 years. Currently they serve 3 million members in Tennessee and across the country. BCBST is an independent, not-for-profit, locally governed health plan company, positioned alongside Tennessee business customers and plan members, while also being part of the BlueCross BlueShield Association, a nationwide association of health care plans. Because of this, our plan members have access to the same quality health benefits while traveling or living out of state that they have while in Tennessee. BCBST currently serves as the competitively procured contractor for Cover Tennessee as well as Bureau of TennCare medical and behavioral health care services.</p>	
<p>13. Efforts to Identify Reasonable, Competitive, Procurement Alternatives</p> <p>BlueCross Blue Shield is the current vendor for all three Cover Tennessee programs. All of these contracts were competitively procured. The intent of the State is to combine these three programs into one contract and continue with the current vendor for the next two years rather than competitively procure a new contract for services that may very well end once Health Care Reform is implemented.</p>	
<p>14. Justification – specifically explain why non-competitive negotiation is in the best interest of the state</p> <p>The Cover Tennessee Program results from State law requiring provision of health care services to certain populations of the State, including CoverKids, which also is federally mandated. Upon implementation of the Health Care Reform law which becomes effective in 2 years, the programs could become a candidate for extinction. This creates an uncertain future for these specialized programs which makes it difficult to successfully execute a traditional RFP process as potential bidders could not be certain the programs would exist over the term of the contract. If bidders did emerge, then the cost of the contract would likely increase as higher rates would be bid as a hedge against future uncertainty or risk. There currently are three (3) existing contracts with BlueCross BlueShield of Tennessee to provide Cover Tennessee services which are being combined into one contract for the next two years. All of these contracts were competitively procured. The intent of the State is to combine these three programs into one contract and continue with the current vendor for the next two years rather than competitively procure a new contract for services that may very well end once Health Care Reform is implemented. This contract is funded by the division of the cost among the State, the employee, and the employers.</p>	
<p>Agency Head Signature and Date – <i>MUST be signed by the ACTUAL agency head as detailed on the current Signature Certification. Signature by an authorized signatory is acceptable only in documented exigent circumstances</i></p> <p><i>M. C. E. 9/29/14</i></p> <p style="text-align: right;"></p>	



CONTRACT

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

Begin Date January 1, 2012	End Date December 31, 2013	Agency Tracking # 31865-00606	Edison Record ID
Contractor Legal Entity Name BlueCross BlueShield of Tennessee, Inc.			Edison Vendor ID 0000091649

Service Caption (one line only)
Delivery of CoverTN Health Plan Services

Subrecipient or Vendor <input type="checkbox"/> Subrecipient <input checked="" type="checkbox"/> Vendor	CFDA # 93.767
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Funding —					
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2012	\$63,833,982.00	\$66,721,309.00			\$130,555,291.00
2013	\$128,987,935.00	\$148,400,223.00			\$277,388,158.00
2014	\$65,889,723.00	\$83,288,228.00			\$149,177,951.00
TOTAL:	\$258,711,640.00	\$298,409,760.00			\$557,121,400.00

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

Ownership/Control

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

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

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

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



OCR USE - FA

Speed Chart (optional)	Account Code (optional)	Contract #
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**CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
AND
BLUECROSS BLUESHIELD OF TENNESSEE, INC.**

This Contract, by and between the Department of Finance and Administration, Division of Health Care Finance and Administration, hereinafter referred to as the "State" and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the "Contractor," is for the delivery of CoverTN, AccessTN, and CoverKids (collectively, "Cover Tennessee") self-funded health plan services, including administrative services, provider network development and maintenance, eligibility and enrollment, premium equivalent billing and collection, utilization, case and care management, disease management, medical benefits, pharmacy benefits, behavioral health benefits customer service, claims adjudication and adjustment, appeals services, financial and program reporting for each of the three programs, as further defined in each program's separate Member Handbook and the "SCOPE OF SERVICES."

The Contractor is a not-for-profit corporation.

Contractor Place of Incorporation or Organization: Tennessee

Contractor Edison Registration ID: 91649

A. SCOPE OF SERVICES:

- A.1. The Contractor shall provide all service and deliverables as required, described, and detailed herein and shall meet all service and delivery timelines as specified by this Contract.

COVERKIDS SCOPE OF SERVICES

- A.2. The Contractor agrees to provide administrative services for the CoverKids self-funded plans for Members who elect to participate in the CoverKids program, which plans are administered by the Contractor in accordance with the terms of this Contract.

The Contractor is responsible for providing administrative claims processing services in accordance with the terms of the CoverKids plans. In (1) providing administrative claims adjudication services in accordance with the terms of the CoverKids plans, and (2) performing its duties and services as described in the CoverKids Member Handbook, and other duties specifically assumed by it pursuant to this Contract, Contractor shall adhere to its standard administrative policies and procedures, including without limitation medical policies, claims administration procedures, and provider reimbursement practices and grievance procedures. The Contractor does not assume any financial risk or obligation with respect to plan claims.

A.3. Definitions for the CoverKids Program

- A.3.1 "CHIPRA" is defined as the Children's Health Insurance Program Reauthorization Act, a federal law.
- A.3.2 "Eligible Individuals" are defined as persons who meet criteria for CoverKids eligibility established by the State within its statutory authority as of the effective date of this Contract.
- A.3.3 "Enrollment" is defined as the date Contractor determines that an applicant is eligible and enters the applicant's data into Contractor's core processing system.
- A.3.4 "Member" is defined as a CoverKids eligible individual who enrolled in the CoverKids plan administered by the Contractor.

- A.3.5. "Member Handbook" regardless of whether or not capitalized, shall mean the Member Handbook that is approved by the State for Members of the CoverKids program.
- A.3.6. "Group One Children" are 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. Also included in this group are children from families with incomes greater than 250% of FPL and who pay monthly premiums.
- A.3.7. "Group Two Children" are enrollees who are members of families below 150 percent of FPL as reported by the Eligibility Contractor to the Contractor for the coverage period.

A.4. Preferred Plan Organization Provider Network

- A.4.1. The Contractor shall maintain and administer one provider network covering the entire State of Tennessee service area for Members in accordance with this Contract. The Contractor further agrees 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/high 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 State of Tennessee in each network. As required by Contract Attachment A: Performance Guarantee # 7, the State shall monitor network access. When requested by the State, the Contractor shall, within ten (10) business days and in writing, report to the State any actions it intends to take to correct any deficiencies highlighted by the quarterly network reports.
- A.4.2. The Contractor shall 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.
- A.4.3. The Contractor shall report to the State within five (5) working days of the end of each Contract quarter 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.
- A.4.4. The Contractor shall take action to disenroll network primary care providers or hospital providers from networks that it uses to provide services to the CoverKids/CHIPRA program if such providers are terminated from Medicare, Medicaid, and SCHIP federal health care programs pursuant to Sections 6501 of the Affordable Care Act which amends section 1902 (a)(39) of the Social Security Act.
- A.4.5. The Contractor shall make a provider directory available electronically to Members. At the discretion of the State, the directory may include provider name, specialty, address and phone number and can be organized in geographic areas as small as counties.
- A.4.6. The Contractor shall maintain the capability to respond to inquiries from Members concerning participation by providers in the network, by specialty and by county. Such capability shall be by toll-free telephone and an up-to-date Internet based directory of providers that includes provider search capability.
- A.4.7. The Contractor shall ensure that CoverKids and its Members financially benefit from any contracts maintained between the Contractor and health care providers. All special pricing considerations and financial incentives shall accrue to CoverKids and its Members

through the provision of plan benefits or upon the use of the network in the event that the Member exceeds the annual benefit limit.

- A.4.8. The Contractor shall ensure that network health care providers only bill Members for applicable plan benefit co-payments and coinsurance amounts.
- A.4.9. The Contractor shall contract only with health care providers who are duly licensed to provide such medical services and shall have admitting privileges to participating hospitals/facilities if applicable. 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 on a continuous basis, appropriate provider credentialing that assures the quality of network providers. Re-credentialing of network providers must be performed at least every three years. In addition, the Contractor shall, on an ongoing basis, monitor its providers by checking the databases set forth in Attachment F. The Contractor shall also comply with any federal and state provider screening requirements.
- A.4.10. 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 plan benefit requirements. There must be provisions for face-to-face contact in addition to telephone and written contact between Contractor and network health providers. 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.
- A.4.11. 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.
- A.4.12. The Contractor shall require all network providers to file claims associated with their services directly with the Contractor on behalf of Members.
- A.4.13. The Contractor shall identify and sanction network providers who establish a pattern of referral to non-network providers.
- A.4.14. The Contractor will quarterly notify the State in writing prior to any adjustments to provider fee schedules, facility per diems, DRG payments, capitated arrangements, or other provider payment arrangements, and the manner in which such adjustments will impact the cost of claims payments for the CoverKids plan. As part of any changes in future provider reimbursement methods, the State would be willing to explore the use of any Contractor proposed methods of payment that include provider incentives based on valid and reliable performance measures in areas such as clinical performance, patient satisfaction, and use of information technology.

A.5. Benefit Design, ID Cards, Eligibility and Enrollment Services

- A.5.1. The Contractor shall be responsible for administering the plan benefits and exclusions as developed and approved by the State on the CoverKids plan effective date covered under this Contract. Any modification to services or benefits shall be implemented through a Contract amendment and shall be effective on January 1 of each Contract year.
- A.5.2. The Contractor shall develop a Member Handbook to be distributed to Members upon Enrollment. The Member Handbook must be CoverKids-specific and shall include benefits and exclusions. The State shall have the sole responsibility for and authority to clarify the CoverKids benefits available and described in the Member Handbook. 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 standard polices in adjudicating claims including medical necessity determination, and the Contractor shall advise the State in writing, as to the difference along with the Contractor's recommendation. Such matters as

determined by the State to have a significant impact on administration of plan benefits shall be resolved by the State.

- A.5.2.1 Member Handbooks shall include notice of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) and a complaint form on which to do so;
- A.5.2.2 Member Handbooks shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free.
- A.5.3. The Contractor shall develop an identification card and provide it to Members. Identification cards shall contain unique identifiers for each Member; such identifier shall NOT be the Member's federal Social Security Number. The State reserves the right to review and approve the identification card format prior to issuance for use. Contractor shall update enrollment and shall mail subscriber identification cards no later than fourteen (14) calendar days from Enrollment. The cost of these items shall be borne by the Contractor.
- A.5.4. The Contractor shall maintain an electronic data interface with the CoverKids Eligibility Contractor for the purpose of accessing eligibility and enrollment data.
- A.5.5. The Contractor shall review eligibility transactions that cannot be automatically handled by the Contractor's core processing system and work with the Eligibility Contractor to resolve any conflicts or inconsistencies identified. The Contractor shall provide the results of such manual processes to the State upon request.
- A.5.6. The Contractor shall confirm eligibility of each Member 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 Members and/or the provider(s).
- A.5.7. Maternity and Pregnancy-Related Services - Through CoverKids HealthyTNBabies (the State's Title XXI program), the State will provide health benefits coverage to eligible children under age nineteen (19), including unborn children, from conception to birth.
- A.6. **Premium Equivalent Billing, Collection and Termination for Non-Payment**
- A.6.1. The Contractor shall be capable of collecting the appropriate premium equivalent amounts from Members. Not all Members are required to remit premium equivalents: this is described in the Member Handbook.
- A.6.2. The Contractor shall maintain accurate records of earned and unearned premium equivalents received and premium equivalent refunds.
- A.6.3. The Contractor shall send billing statements to Members at their mailing address and collect all premium equivalent payments in a time and manner consistent with Contractor's standard administrative policy. Payment may be made by check mailed to Contractor's lockbox vendor or recurring bank draft. The Contractor shall not accept credit card or debit card payments.
- A.6.4. The Contractor shall report premium equivalents collected to the State on a monthly basis, and deposit all premium equivalent funds to the designated CoverKids account in a time and manner consistent with state policy and procedures.
- A.6.5. The Contractor shall implement a notification process concerning premium equivalents due on a monthly basis and a process to suspend and subsequently terminate coverage

for individuals who fail to pay the premium equivalent in a timely fashion. The process shall assure that:

- A.6.5.1. Premium equivalent billings are consistently generated on a date agreed upon by the State,
- A.6.5.2. Premium equivalents are due from Members by the first (1st) day of each month of Member coverage, unless mutually agreed upon by the Contractor and the State;
- A.6.5.3. Medical benefit payments are suspended when Members fail to pay premium equivalents by the due date designated;
- A.6.5.4. Members for whom a recurring bank draft payment is not received on the draft date due to lack of funds will be charged a fee;
- A.6.5.5. Members who do not remit premium equivalent payment in accordance with payment policies are promptly terminated effective to the last date for which premium equivalents were paid; and
- A.6.5.6. There is a reinstatement policy in place for Members who were terminated from CoverKids coverage due to failure to pay premium equivalents on a timely basis, subject to approval by the State.

The State may require no greater than four (4) notifications for the proper administration of premium equivalent payments and collection.

- A.6.6. The buy-in premium equivalent shall be established by the State.

A.7. **Medical and Care Management Services**

- A.7.1. The Contractor shall provide a medical and care management system designed to help individual Members 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 Members in need of inpatient care. The following services must be provided:
 - A.7.1.1. Identification of Members 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.
 - A.7.1.2. Concurrent review during the course of a Members' hospital inpatient stay, where qualified medical management personnel coordinate care with the hospital staff and Member's physicians. The process will review the continued hospitalization of Members and identify medical necessity for stays, as well as available alternatives.
 - A.7.1.3. Discharge planning, providing a process by which medical management staff work with the hospital, Member's physicians, family, and appropriate community resources to coordinate discharge and post-discharge needs of the Member. Prevention of readmission is also a goal of the discharge planning process.
 - A.7.1.4. Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for services provided.
 - A.7.1.5. The Contractor shall provide a written report to the State on a semiannual basis regarding Members' utilization of services and in addition, a written

report to the State, no less than annually, regarding the demonstrated effectiveness of the programs.

- A.7.2. 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 (1) business day for urgent requests upon receipt by the Contractor of all necessary information regarding the admission. Any appeals of requests for continued hospitalization denials must be promptly processed and involve physician-to-physician consultation.
- A.7.3. The Contractor shall maintain a case management/care management program for Members, utilizing procedures and criteria to prospectively and retrospectively identify Members who would benefit from case management/care management (CM) services. The process of care management shall be capable of identifying the level of a Member's health status through stratification of risk in order for Members 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 Member (wellness information through catastrophic case management). Contractor shall provide a written report to the State on a semiannual basis regarding the utilization of case management and care management services by the target population. The Contractor shall provide a written report, no less than annually, 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.
- A.7.4. The Contractor shall maintain an internal quality assurance program.
- A.7.4.1. The Contractor's 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 Health Plan Employer Data and Information Set (HEDIS) report card.
- A.7.4.2. The State may retain an independent External Quality Review Organizational (EQRO) contractor ("EQRO Contractor") to review compliance with 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 Children's Health Insurance Program Reauthorization Act (CHIPRA).
- 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.

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.

A.7.5. 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 Members 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:

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

A.7.5.1. 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 Members identified with the chronic condition.

A.7.5.2. The Contractor shall provide a written report to the State, no less than semiannually, detailing Member 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 Contract Section A.7.5.1.

A.7.5.3. The State reserves the authority 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 Members 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 Cover Tennessee 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, to programs providing this service.

A.7.6. 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.

A.7.6.1. The behavioral health management capabilities shall include the ability to:

A.7.6.1.1. Review proposed treatment plans.

A.7.6.1.2. Refer to a specialty provider network.

A.7.6.1.3. Provide case and care management services to Members and treatment providers.

A.7.6.1.4. Work actively with Community Mental Health Centers to enlist that resource as a set of network providers.

A.7.6.1.5. Assist in the co-management of medical and behavioral health and substance abuse.

A.7.6.2 Services provided by primary care pediatricians for the treatment and diagnosis of behavioral health issues for Members as recommended by the American Academy of Pediatrics shall be reimbursed at the applicable rates.

A.7.7 The Contractor shall comply with all applicable State and federal regulations regarding quality measure requirements.

ACCESSTN SCOPE OF SERVICES

A.8. The Contractor agrees to provide administrative services for the AccessTN self-funded plans for Members who elect to participate in the AccessTN program, which plans are administered by the Contractor in accordance with the terms of this Contract.

The Contractor is responsible for providing administrative claims processing services in accordance with the terms of the AccessTN plans. In (1) providing administrative claims adjudication services in accordance with the terms of the AccessTN plans, and (2) performing its duties and services as described in the AccessTN Member Handbook, and other duties specifically assumed by it pursuant to this Contract, Contractor shall adhere to its standard administrative policies and procedures, including without limitation medical policies, claims administration procedures, and provider reimbursement practices and grievance procedures. The Contractor does not assume any financial risk or obligation with respect to plan claims.

A.9. **Definitions for the AccessTN Program**

A.9.1 "Eligible Individuals" are defined as persons who meet criteria for AccessTN eligibility established by the AccessTN Board of Directors (Board) within its statutory authority, and may be modified by the Board, no more frequently than semiannually, with sixty (60) days notice to the Contractor

A.9.2 "Enrollment" is defined as the date Contractor determines that an applicant is eligible and enters the applicant's data into Contractor's core processing system.

A.9.3. "Member" is defined as an AccessTN eligible individual who enrolled in the plan administered by the Contractor.

A.9.4. "Member Handbook" regardless of whether or not capitalized, shall mean the Member Handbook that is approved by the State for Members of the AccessTN program.

A.9.5. "Premium Assistance" is the percentage of a qualified Member's premium equivalent that is funded by the State.

A.10. Preferred Plan Organization Provider Network

- A.10.1. The Contractor shall maintain and administer a provider network covering the entire State of Tennessee service area for Members in accordance with this Contract. The Contractor further agrees 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/high 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 State of Tennessee. As required by Contract Attachment A: Performance Guarantee # 7, the State shall monitor network access. When requested by the State, the Contractor shall, within ten (10) business days and in writing, report to the State any actions it intends to take to correct any deficiencies highlighted by the quarterly network reports.
- A.10.2. The Contractor shall 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.
- A.10.3. The Contractor shall report to the State within five (5) working days of the end of each Contract quarter 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.
- A.10.4. The Contractor shall make a provider directory available electronically to Members. At the discretion of the State, the directory may include provider name, specialty, address and phone number and can be organized in geographic areas as small as counties.
- A.10.5. The Contractor shall maintain the capability to respond to inquiries from Members concerning participation by providers in the network, by specialty and by county. Such capability shall be by toll-free telephone and an up-to-date Internet based directory of providers that includes provider search capability.
- A.10.6. The Contractor shall ensure that AccessTN and its Members financially benefit from any contracts maintained between the Contractor and health care providers. All special pricing considerations and financial incentives shall accrue to AccessTN and its Members through the provision of plan benefits or upon the use of the network in the event that the Member exceeds the annual benefit limit.
- A.10.7. The Contractor shall ensure that network health care providers only bill Members for applicable plan benefit co-payments and coinsurance amounts.
- A.10.8. The Contractor shall contract only with health care 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 on a continuous basis, appropriate provider credentialing that assures the quality of network providers. Re-credentialing of network providers must be performed at least every three (3) years.
- A.10.9. 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 AccessTN plan benefit requirements. There must be provisions for face-to-face contact in addition to telephone and written contact between Contractor and network health providers. 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.

- A.10.10. 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.
- A.10.11 The Contractor shall require all network providers to file claims associated with their services directly with the Contractor on behalf of Members.
- A.10.12. The Contractor shall identify and sanction network providers who establish a pattern of referral to non-network providers.
- A.10.13 The Contractor will quarterly notify the State in writing prior to any adjustments to provider fee schedules, facility per diems, DRG payments, capitated arrangements, or other provider payment arrangements, and the manner in which such adjustments will impact the cost of claims payments for AccessTN. As part of any changes in future provider reimbursement methods, the State would be willing to explore the use of any Contractor proposed methods of payment that include provider incentives based on valid and reliable performance measures in areas such as clinical performance, patient satisfaction, and use of information technology.

A.11. Benefit Design, ID Cards, Eligibility and Enrollment Services

- A.11.1. The Contractor shall be responsible for administering the AccessTN plan benefits and exclusions as developed and approved by the State on the AccessTN plan effective date covered under this Contract. Any modification to services or benefits shall be implemented through a Contract amendment and shall be effective on January 1 of each Contract year.
- A.11.2. The Contractor shall develop a Member Handbook to be distributed to Members upon Enrollment. The Member Handbook must be AccessTN-specific and shall include benefits and exclusions. The State shall have the sole responsibility for and authority to clarify the AccessTN benefits available and described in the Member Handbook. 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 standard policies in adjudicating claims including medical necessity determination, and the Contractor shall advise the State in writing, as to the difference along with the Contractor's recommendation. Such matters as determined by the State to have a significant impact on administration of plan benefits shall be resolved by the State.

One of the AccessTN plans offered by the State is a High Deductible Health Plan (HDHP), a type of plan that has a higher calendar year deductible than a typical health plan and intended to be eligible for use with a Health Savings Account (HSA). If choosing the HDHP option, a Member may qualify for tax savings by contributing to a HSA. An HSA is a personal tax-exempt trust or custodial account used to pay for qualified medical expenses, which is regulated by the Internal Revenue Service (IRS). The Parties expressly acknowledge and agree that (i) neither party will provide an HSA as part of the AccessTN HDHP option; (ii) neither party will provide a Member with tax advice; and (iii) Contractor does not make (and the State has not relied upon) any representation, warranty or statement regarding a Member's qualification for an HSA in conjunction with choosing the HDHP option

- A.11.3. The Contractor shall develop an identification card and provide it to Members. Identification cards shall contain unique identifiers for each Member; such identifier shall NOT be the Member's federal Social Security Number (SSN). The State reserves the right to review and approve the identification card format prior to issuance for use. Contractor shall update enrollment and shall mail subscriber identification cards no later than fourteen (14) calendar days from Enrollment. The cost of these items shall be borne by the Contractor.

- A.11.4. The Contractor shall conduct an annual plan re-enrollment period for the AccessTN Members. This shall occur every November, as agreed to by the Parties. If instructed in writing by the State, Contractor shall suspend this requirement.
- A.11.4.1. At each plan re-enrollment, Members may switch plan designs, upon following the re-enrollment rules as stated in the Member Handbook.
- A.11.4.2. Upon a Member's request, Contractor will mail Member a change form.
- A.11.5. The Contractor shall print the application and information brochure detailing coverage options for the plan. The Contractor shall produce sufficient copies of the application form and brochure to meet information requests and inquiries by the public.
- A.11.6. The Contractor shall assess whether all potential applicants meet the requirements for enrollment in the plan according to the eligibility and enrollment requirements in place as of the effective date of this Contract.
- A.11.7. The Contractor shall utilize the following process for enrollment. The Contractor shall review each application for the requirements specified in the AccessTN regulations or as instructed by the State and shall determine if the applicant is eligible to be a Member in the plan.
- A.11.7.1. Beginning on the date the Contractor receives an application, the Contractor shall have fourteen (14) calendar days in which to make a disposition on the application. Disposition shall mean determination that the applicant does not qualify, approve the application, or inform the applicant that additional information is needed to complete the application.
- A.11.7.2. If the application is determined to be incomplete, the Contractor will mail the applicant a letter informing the applicant that (i) the application is incomplete and has been declined and (ii) additional information may be provided to reopen and complete the application if provided within thirty (30) days of the date of the letter. The Contractor shall give the applicant thirty (30) days, plus a fifteen (15) day grace period, in which to provide the information necessary to complete the application. If information sufficient to complete the application is not received within such forty-five (45) day period, the Contractor shall close the application and the applicant must reapply for the program, including filling out and submitting a new application and paying any applicable application fee.
- A.11.7.3. The Contractor shall send a letter to the applicant including an appropriate explanation of the eligibility determination and information about the appeal procedures if the applicant is found to be ineligible for AccessTN.
- A.11.7.4. The Contractor shall determine which provision or provisions of the plan regulations apply to the applicant if the applicant is found to be eligible for the plan.
- A.11.7.5. Eligible Members who (i) had existing prior qualifying health coverage and (ii) applied to the AccessTN program within sixty-three (63) days of losing such other coverage, and whose complete applications have been approved, shall begin coverage on the first day after the date such Member's prior coverage ended.
- A.11.7.6. Coverage for all other eligible Members, whose complete applications are approved on or before the fifteenth (15th) of the month, shall begin on the first (1st) day of the next month. Coverage for Members whose complete applications are approved after the fifteenth (15th) of the month will begin on the first (1st) day of the second (2nd) month.

A.11.8. Maternity and Pregnancy-Related Services - Through CoverKids HealthyTNBabies (the State's Title XXI program), the State will provide health insurance to AccessTN members ineligible for maternity services, including unborn children, from conception to birth.

A.12. Premium Equivalent Billing, Collection and Termination for Non-Payment

- A.12.1. The Contractor shall be capable of collecting the appropriate premium equivalent amounts from Members. The State will establish a schedule of premium equivalent amounts based upon age, tobacco use and body mass index (BMI), involving no more than ten (10) age based levels.
- A.12.2. The Contractor shall maintain accurate records of earned and unearned premium equivalents received and premium equivalent refunds.
- A.12.3. The Contractor shall send billing statements to Members at their mailing address and collect all premium equivalent payments in a time and manner consistent with Contractor's standard administrative policy. Payment may be made by check mailed to Contractor's lockbox vendor or recurring bank draft. The Contractor shall not accept credit card or debit card payments.
- A.12.4. The Contractor shall report premium equivalents collected to the State on a monthly basis, and deposit all premium equivalent funds to the designated AccessTN account in a time and manner consistent with State policy and procedures.
- A.12.5. The Contractor shall implement a notification process concerning premium equivalents due on a monthly basis and a process to suspend and subsequently terminate coverage for individuals who fail to pay the premium equivalent in a timely fashion. The process shall assure that:
 - A.12.5.1. Premium equivalent billings are consistently generated on a date agreed upon by the State;
 - A.12.5.2. Premium equivalents are due from Members by the first (1st) day of each month of Member coverage, unless mutually agreed upon by the Contractor and the State;
 - A.12.5.3. Medical benefit payments are suspended during the grace period when Members fail to pay premium equivalents by the due date designated;
 - A.12.5.4. Medical benefits are terminated in accordance with the Contractor's standard corporate processes when Members fail to pay premium equivalents by the due date designated;
 - A.12.5.5. Pharmacy benefits are terminated in accordance with the Contractor's standard corporate processes when Members fail to pay premium equivalents by the due date designated;
 - A.12.5.6. Members for whom a recurring bank draft payment is not received on the draft date due to lack of funds will be charged a fee;
 - A.12.5.7. Members who do not remit premium equivalent payment in accordance with payment policies are promptly terminated effective to the last date for which premium equivalents were paid; and
 - A.12.5.8. There is a reinstatement policy in place for Members who were terminated from AccessTN coverage due to failure to pay premium equivalents on a timely basis, subject to approval by the State.

The State may require no greater than four (4) notifications for the proper administration of premium equivalent payments and collection.

A.12.6. The Contractor shall not be responsible for the determination of the availability of Premium Assistance or any funds related to such Premium Assistance. The State shall annually verify Member eligibility for Premium Assistance. At Contract implementation, the State shall report to the Contractor the Premium Assistance percentages for Members enrolled in AccessTN. The State shall report to the Contractor, no more frequently than monthly, changes to the Premium Assistance percentages for Members enrolled in AccessTN.

A.12.6.1. The Contractor shall update changes to a Member's level of Premium Assistance based on the information from the State through its annual re-verification process and as communicated to the Contractor no more frequently than monthly, as indicated in Contract Section A.12.6.

A.12.7. The Contractor shall report directly to the State the amount of the State's premium equivalent liability in accordance with the premium assistance percentage reported to the Contractor by the State. The Contractor's premium assistance report to the State shall occur on a monthly basis and shall accommodate the AccessTN billing cycle.

A.13. **Medical and Care Management Services**

A.13.1. The Contractor shall provide a medical and care management system designed to help individual Members 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 Members in need of inpatient care. The following services must be provided:

A.13.1.1. Identification of Members 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.

A.13.1.2. Concurrent review during the course of a Member's hospital inpatient stay, where qualified medical management personnel coordinate care with the hospital staff and Member's physicians. Process will review the continued hospitalization of Members and identify medical necessity for stays, as well as available alternatives.

A.13.1.3. Discharge planning, providing a process by which medical management staff work with the hospital, Member's physicians, family, and appropriate community resources to coordinate discharge and post-discharge needs of the Member. Prevention of readmission is also a goal of the discharge planning process.

A.13.1.4. Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for services provided.

The Contractor shall provide a written report to the State on a semiannual basis regarding Members' utilization of services, and, in addition, a written report to the State, no less than annually, regarding the demonstrated effectiveness of the programs.

A.13.2. 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 of requests for continued hospitalization denials must be promptly processed and involve physician-to-physician consultation.

- A.13.3. The Contractor shall maintain a case management/care management program for Members, utilizing procedures and criteria to prospectively and retrospectively identify Members who would benefit from case management/care management (CM) services. The process of care management shall be capable of identifying the level of a Member's health status through stratification of risk in order for Members 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 Member (wellness information through catastrophic case management). Contractor shall provide a written report to the State, on a semiannual basis, regarding the utilization of case management and care management services by the target population. The Contractor shall provide a written report, no less than annually, 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.
- A.13.4. The Contractor shall maintain an internal quality assurance program. The Contractor's 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 Health Plan Employer Data and Information Set (HEDIS) report card.
- A.13.5. 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: congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes and asthma. The Contractor shall provide these disease management programs to optimize the health status of Members 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:
- A Population identification process;
 - Evidence-based practice guidelines;
 - Collaborative practice models to include physician and support service providers;
 - Patient self-management education (may include primary prevention, behavior modification programs, compliance/surveillance);
 - Process and outcomes measurement, evaluation, and management; and
 - Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).
- A.13.5.1. 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 Members identified with the chronic condition.
- A.13.5.2. The Contractor shall provide a written report to the State, no less than semiannually, detailing Member 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 Contract Section A.13.5.1.

- A.13.5.3. The State reserves the authority 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 Members 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 Cover Tennessee 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 to programs providing this service.
- A.13.6. 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.
 - A.13.6.1. The behavioral health management capabilities shall include the ability to:
 - A.13.6.1.1. Review proposed treatment plans.
 - A.13.6.1.2. Refer to a specialty provider network.
 - A.13.6.1.3. Provide case and care management services to Members and treatment providers.
 - A.13.6.1.4. Work actively with Community Mental Health Centers to enlist that resource as a set of network providers.
 - A.13.6.1.5. Assist in the co-management of medical and behavioral health and substance abuse.
 - A.13.6.2. Services provided by primary care pediatricians for the treatment and diagnosis of behavioral health issues for Members as recommended by the American Academy of Pediatrics shall be reimbursed at the applicable rates.

COVERTN SCOPE OF SERVICES

- A.14. The Contractor agrees to provide administrative services for the limited health benefit program known as CoverTN. This program is a limited benefit plan, and is not intended to be comprehensive in nature. The benefits for the CoverTN program shall be capped at a maximum annual benefit limit of \$25,000 per year. Individuals who reach the annual benefit maximum during the year are responsible for all expenses exceeding \$25,000 until the next plan year begins. Members exceeding the \$25,000 annual benefit maximum will continue to receive network discounts on their medical services and prescription drugs when they use network providers and pharmacies. The State shall have no risk for services provided or received in excess of the annual benefit maximum.

The Contractor is responsible for providing administrative claims processing services in accordance with the terms of the CoverTN plans. In (1) providing administrative claims adjudication services in accordance with the terms of the plan, and (2) performing its duties and services as described in the Member Handbook for each plan, and other duties specifically assumed by it pursuant to this Contract, the Contractor shall adhere to its standard administrative policies and procedures, including without limitation medical policies, claims administration procedures, and provider reimbursement practices and grievance procedures. The Contractor does not assume any financial risk or obligation with respect to plan claims.

A.15. Definitions for the CoverTN Program

- A.15.1. "Eligible Individuals" are defined as persons who meet criteria for CoverTN eligibility established by the State within its statutory authority.
- A.15.2. "Enrollment" is defined as the date Contractor enters an eligible person into Contractor's core processing system.
- A.15.3. "Member" is defined as a CoverTN individual and/or spouse who enrolled in the limited benefit plan administered by the Contractor.
- A.15.4. "Member Handbook" regardless of whether or not capitalized, shall mean the Member Handbook that is approved by the State for Members of the CoverTN program.
- A.15.5. "Qualifying Event" is defined as an event that qualifies an eligible individual to enroll in the CoverTN Program outside of the Initial Enrollment Period or the Open Enrollment Period, including but not limited to: (a) Marriage; (b) Death of a spouse; (c) Divorce or annulment; (d) Involuntary loss of health insurance coverage; (e) Spouse becoming entitled to Medicare; or (f) Meeting the six (6) month go-bare requirement.
- A.15.6. "Participating Employer" is defined as an employer that has been determined by the State to be eligible to participate in CoverTN and has enrolled in the CoverTN program.
- A.15.7. "Subscriber" is defined as an enrolled person in the CoverTN program who is an employee of a Participating Employer, an employee of a non-participating employer, or a person between jobs. It does not include the spouse of an employee or a person between jobs.

A.16. Preferred Plan Organization Provider Network

- A.16.1. The Contractor shall maintain and administer a provider network covering the entire State of Tennessee service area for Members in accordance with this Contract. The Contractor further agrees 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), 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 State of Tennessee. As required by Contract Attachment A: Performance Guarantee # 7, the State shall monitor network access. When requested by the State, the Contractor shall, within ten (10) business days and in writing, report to the State any actions it intends to take to correct any deficiencies highlighted by the quarterly network reports.
- A.16.2. The Contractor shall report to the State within five (5) working days of the end of each Contract quarter 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.
- A.16.3. The Contractor shall make a provider directory available electronically to Members. At the discretion of the State, the directory may include provider name, specialty, address and phone number and can be organized in geographic areas as small as counties.
- A.16.4. The Contractor shall maintain the capability to respond to inquiries from Members concerning participation by providers in the network, by specialty and by county. Such capability shall be by toll-free telephone and an up-to-date Internet based directory of providers that includes provider search capability.
- A.16.5. The Contractor shall ensure that CoverTN and its Members financially benefit from any contracts maintained between the Contractor and health care providers. All special pricing considerations and financial incentives shall accrue to CoverTN and its Members through the provision of plan benefits or upon the use of the network in the event that the Member exceeds the annual benefit limit(s).

- A.16.6. The Contractor shall ensure that network health care providers only bill Members for applicable plan benefit co-payments.
- A.16.7. The Contractor shall contract only with health care 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 on a continuous basis, appropriate provider credentialing that assures the quality of network providers. Re-credentialing of network providers must be performed at least every three years.
- A.16.8. 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 plan benefit requirements. There must be provisions for face-to-face contact in addition to telephone and written contact between Contractor and network health providers. 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.
- A.16.9. 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.
- A.16.10 The Contractor shall require all network providers to file claims associated with their services directly with the Contractor on behalf of Members.
- A.16.11The Contractor shall identify and sanction network providers who establish a pattern of referral to non-network providers.
- A.16.12.The Contractor shall notify the State in writing, on a quarterly basis, prior to any adjustments to provider fee schedules, facility per diems, Diagnostic Related Grouping (DRG) payments, capitated arrangements, or other provider payment arrangements, and the manner in which such adjustments will impact the cost of claims payments for CoverTN. As part of any changes in future provider reimbursement methods, the State would be willing to explore the use of any Contractor proposed methods of payment that include provider incentives based on valid and reliable performance measures in areas such as clinical performance, patient satisfaction, and use of information technology.
- A.17. Benefit Design, ID Cards, Eligibility and Enrollment Services**
- A.17.1. The Contractor shall be responsible for administering the CoverTN plan benefits and exclusions as developed and approved by the State on the CoverTN plan effective date covered under this Contract. Any modification to services or benefits shall be implemented through a Contract amendment and shall be effective on January 1 of each Contract year.
- A.17.2. The Contractor shall develop a Member Handbook to be distributed to Members upon Enrollment. The Member Handbook must be CoverTN-specific and shall include benefits and exclusions. The State shall have the sole responsibility for and authority to clarify the CoverTN benefits available and described in the Member Handbook. 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 standard polices in adjudicating claims including medical necessity determination, and the Contractor shall advise the State in writing, as to the difference along with the Contractor's recommendation. Such matters as determined by the State to have a significant impact on administration of plan benefits shall be resolved by the State.
- A.17.3. The Contractor shall develop an identification card and provide it to Members. Identification cards shall contain unique identifiers for each Member; such identifier shall

NOT be the Member's federal Social Security Number. The State reserves the right to review and approve the identification card format prior to issuance for use. Contractor shall update enrollment and shall mail Member identification cards no later than fourteen (14) calendar days from Enrollment. The cost of these items shall be borne by the Contractor.

- A.17.4. The Contractor shall conduct an annual open enrollment for CoverTN plans. This shall occur every October, as agreed to by the Parties. If instructed by the State, Contractor shall suspend this requirement. At each open enrollment (a) current employees of Participating Employers (and their spouses) may enroll in CoverTN; (b) Spouses of enrolled Subscribers may enroll in CoverTN; and (c) Subscribers may change plans.
- A.17.5. The Contractor shall assess whether all potential enrollees meet the requirements for enrollment in the plan according to the eligibility and enrollment requirements in place as of the effective date of this Contract.
- A.17.6. Individuals may apply for CoverTN as indicated in the Member Handbook.
- A.17.7. The Contractor shall utilize the following process for enrollment. The Contractor shall review each enrollment form or change form for the requirements specified in the plan or as instructed by the State, and shall determine if the potential enrollee is eligible to be a Member in the plan.
 - A.17.7.1. If the enrollment or change form is determined to be incomplete, the Contractor will attempt to contact the potential enrollee or employer by phone. If information sufficient to complete the enrollment or change form is not received as agreed in writing by the Contractor and the State, the Contractor shall decline the request and send a letter to the potential enrollee including an appropriate explanation of the eligibility determination and information about the appeal procedures.
 - A.17.7.2. Coverage for eligible Members who are enrolled on or before the fifteenth (15th) of the month, shall begin on the first (1st) day of the next month. Coverage for Members whose complete applications are approved after the fifteenth (15th) of the month will begin on the first (1st) day of the second (2nd) month.
- A.17.8. Maternity and Pregnancy-Related Services - Through CoverKids (the State's Title XXI program), the State will provide health insurance to eligible children under age nineteen (19), including unborn children, from conception to birth.
 - A.17.8.1. Subject to the disenrollment provisions, Members who become pregnant may remain enrolled in CoverTN but will receive maternity benefits and pregnancy-related services through CoverKids (or TennCare, if the Member is eligible for TennCare).
 - A.17.8.2. The Contractor shall not cover prenatal care, services that are related to the pregnancy or to conditions that could complicate pregnancy, or labor and delivery. Instead, the CoverKids (or TennCare) program will provide these maternity and pregnancy-related services for all pregnant women in CoverTN.
 - A.17.8.3. The Contractor shall provide pregnant Members any services that are covered by the Contractor but are not covered through CoverKids (or TennCare), subject to the Contractor's service limitations. Within the Contractor's service limitations, the Contractor shall cover one (1) office visit to confirm pregnancy.
 - A.17.8.4. The Contractor shall provide Covered Services (as defined by the Contractor and subject to the Contractor's service limitations) to female Members after delivery unless these services are provided through CoverKids or TennCare.

A.18. Premium Equivalent Billing, Collection and Termination for Non-Payment

- A.18.1. The Contractor shall be capable of collecting the appropriate premium equivalent amounts from Participating Employers and Subscribers. Participating Employers will be required to withhold their employees' share through a payroll deduction and make payment on behalf of their employees. Premium equivalent obligations shall be established in accordance with the following:
- A.18.1.1. For employees of Participating Employers who are residents of Tennessee:
 - A.18.1.1.1. The State pays one-third of the total premium equivalent;
 - A.18.1.1.2. The employer pays at least one-third of the total premium equivalent; and
 - A.18.1.1.3. The employee (through a payroll deduction) pays the remaining portion of the premium equivalent.
 - A.18.1.2. For spouses of employees of Participating Employers who are residents of Tennessee:
 - A.18.1.2.1. The State pays one-third of the total premium equivalent;
 - A.18.1.2.2. The employer may pay a portion of the spouse's premium equivalent; and
 - A.18.1.2.3. The employee (through a payroll deduction) pays the remaining portion of the premium equivalent.
 - A.18.1.3. For employees of Participating Employers who are not residents of Tennessee (and their spouses), the State will not pay one-third of the total premium. The Participating Employer and/or the Subscriber shall be responsible for payment of the total premium equivalent.
 - A.18.1.4. For all other Subscribers and their spouses:
 - A.18.1.4.1. The State pays one-third of the total premium equivalent; and
 - A.18.1.4.2. The Subscriber pays the remaining portion of the premium equivalent.
- A.18.2. The Contractor shall maintain accurate records of earned and unearned premium equivalents received and premium equivalent refunds.
- A.18.3. The Contractor shall send billing statements to Participating Employers and Subscribers at their mailing address.
- A.18.3.1. The Contractor shall send billing statements to Participating Employers at their mailing address and collect premium equivalent payments electronically through recurring bank draft.
 - A.18.3.2. The Contractor shall send billing statements to Subscribers and collect all premium equivalent payments in a time and manner consistent with Contractor's standard administrative policy. Payment may be made by check mailed to Contractor's lockbox vendor or recurring bank draft. The Contractor shall not accept credit card or debit card payments.
- A.18.4. The Contractor shall report premium equivalents collected to the State on a monthly basis, and deposit all premium equivalent funds to the designated CoverTN account in a time and manner consistent with State policy and procedures.
- A.18.5. The Contractor shall implement a notification process concerning premium equivalents due on a monthly basis and a process to suspend and subsequently terminate coverage for Participating Employers and Subscribers who fail to pay premium equivalents in a timely fashion. The process shall assure that:

- A.18.5.1. For Participating Employers, the process shall assure that:
- A.18.5.1.1 Premium equivalent billings are consistently generated on a date agreed upon by the State,
 - A.18.5.1.2 Premium equivalents are drafted from the Participating Employer's bank account on the 1st day of each month of Member coverage, unless mutually agreed upon by the Contractor and the State,
 - A.18.5.1.3 Medical benefit payments are suspended when Participating Employers fail to pay premium equivalents by the due date designated,
 - A.18.5.1.4 Participating Employers for whom a recurring bank draft payment is not received on the draft date due to lack of funds will be charged a fee.
 - A.18.5.1.5 Participating Employers who do not remit premium equivalent payment in accordance with payment policies are promptly terminated effective to the last date for which premium equivalents were paid, and
 - A.18.5.1.6 Employees of a former Participating Employer that no longer participates due to non-payment of the employee and employer share of the premium equivalent shall be allowed to continue participation in CoverTN as a Subscriber.
- A.18.5.2 For Subscribers, the process shall assure that:
- A.18.5.2.1 Premium equivalent billings are consistently generated on a date agreed upon by the State,
 - A.18.5.2.2 Premium equivalents are due from Subscribers by the 1st day of each month of Member coverage, unless mutually agreed upon by the Contractor and the State,
 - A.18.5.2.3 Medical benefit payments are suspended when Subscribers fail to pay premium equivalents by the due date designated,
 - A.18.5.2.4 Subscribers for whom a recurring bank draft payment is not received on the draft date due to lack of funds will be charged a fee.
 - A.18.5.2.5 Subscribers who do not remit premium equivalent payment in accordance with payment policies are promptly terminated effective to the last date for which premium equivalents were paid, and
 - A.18.5.2.6 There is a reinstatement policy in place for Subscribers or their spouses who were terminated from CoverTN coverage due to failure to pay premium equivalents on a timely basis, subject to approval by the State.
- A.18.5.3. The State may require no greater than four (4) notifications for the proper administration of premium equivalent payments and collection.
- A.18.6. The Contractor shall require that premium equivalent payments made by Participating Employers be made electronically through bank draft.
- A.18.7. The Contractor shall report directly to the State the amount of the State's premium equivalent liability (i.e., reports the State's liability for its third of the CoverTN premium equivalent). Contractor's premium equivalent report to the State shall occur on a monthly basis and shall accommodate the CoverTN billing cycle.

- A.18.8. The Contractor shall disenroll a Member from CoverTN, and terminate the Member from the CoverTN program, if the Member (a) moves out of state and does not work for a Participating Employer, (b) is a non-resident and no longer works for a Participating Employer, (c) is enrolled in either Medicare or Medicaid (except for a CoverTN pregnant woman enrolled in TennCare Medicaid), (d) dies, or (e) upon the State's determination, in writing to the Contractor, that the Member is no longer eligible for the CoverTN program. If the Contractor becomes aware that a Member has moved out of state, is enrolled in either Medicare or Medicaid, or died, the Contractor shall issue a disenrollment notice and disenroll the Member unless the Contractor receives an attestation from the Member refuting the basis for disenrollment.
- A.18.9. The Contractor shall allow employees of Participating Employers and their spouses to continue enrollment in CoverTN if (a) the employee loses coverage as a result of the Participating Employer not paying the required premium: (b) the Member no longer works for the Participating Employer: or (c) the employer no longer participates with CoverTN.
- A.18.10. The Contractor shall allow spouses of Subscribers to continue enrollment in CoverTN if (a) he/she legally separates from or divorces the Subscriber: (b) the Subscriber becomes incapacitated or disabled or dies: or (c) the Subscriber qualifies for Medicare or other insurance.
- A.18.11. Premium Equivalent Rebate. At the direction of the State, and occurring no more frequently than annually, the Contractor shall administer a process to provide an annual premium equivalent rebate to each Member enrolled in CoverTN as of the last day of the Plan year with a minimum of six (6) months of coverage. The Contractor shall also administer a process to provide an annual premium equivalent rebate to each Participating Employer enrolled in CoverTN as of the last day of the Plan year with no look-back period.
- A.18.11.1. Thirty (30) days after the end of each calendar year, the Contractor will provide the State with a report of Members and Participating Employers enrolled in CoverTN as of the last day of the calendar year.
- A.18.11.2. The State will determine if a premium equivalent rebate is applicable and the amount of the premium equivalent rebate based on the information provided by the Contractor. If applicable, the State will advise the Contractor of the amount of the rebate and will provide funds for such rebate pursuant to Contract Section C.3.4.
- A.18.11.3. The Contractor will issue checks and mail to Members and Participating Employers along with a letter from the State.
- A.18.11.4. If the State determines that a premium equivalent rebate is due to Members and Participating Employers for Plan year 2013, it will separately contract with Contractor to administer this rebate in 2014.

A.19. Medical and Care Management Services

- A.19.1. The Contractor shall provide a medical and care management system designed to help individual Members 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 and other levels of care as necessary. The Contractor must have in place an effective process that identifies and manages those Members in need of inpatient care. The following services must be provided:
- A.19.1.1. Identification of Members 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.

- A.19.1.2. Concurrent review during the course of a patient's hospital inpatient stay, where qualified medical management personnel coordinate care with the hospital staff and Members' physicians. The process will review the continued hospitalization of Members and identify medical necessity for stays, as well as available alternatives.
- A.19.1.3. 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 Member. Prevention of readmission is also a goal of the discharge planning process.
- A.19.1.4. Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for the service.

The Contractor shall provide a written report to the State on a semiannual basis regarding Member utilization of services and in addition, a written report to the State, no less than annually, regarding the demonstrated effectiveness of the programs.

- A.19.2. The aforementioned services should be included as required and appropriate for hospital admissions. 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 of requests for continued hospitalization denials must be promptly processed and involve physician-to-physician consultation.
- A.19.3. The Contractor shall maintain an internal quality assurance program. The Contractor's 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 Health Plan Employer Data and Information Set (HEDIS) report card.
- A.19.4. As part of its medical management activities, the Contractor shall notify Members and providers regarding the extent of available benefits.

SCOPE APPLICABLE TO ALL THREE PROGRAMS

- A.20. The language in this section of the Contract is applicable to all three Cover Tennessee program services contained in this Contract, with the exception of program specific language as noted that may only apply to one or more of the programs.
- A.21. **Claims Adjudication and Adjustment**
 - A.21.1. The Contractor shall by the Contract start date, establish administrative claim processing and payment functions on behalf of the State from receipt of both paper and electronic claims, through final payment or denial on a fully automated claim adjudication system in a timely and accurate manner and all other necessary functions to assure timely adjudication of claims and payment of benefits to Members.
 - A.21.2. The Contractor shall ensure the claims processing function is operated and maintained in an efficient and effective manner. The system shall have at a minimum the following capabilities:
 - A.21.2.1 automated eligibility verification that coverage has not terminated on the date of eligible service;
 - A.21.2.2 benefit plan information stored on the system;

- A.21.2.3. automatic calculation of copayments and out-of-pocket limits;
 - A.21.2.4. identification and collection of claim overpayments; and
 - A.21.2.5. automated tracking of internal limits.
- A.21.3. The Contractor shall be responsible for making available information relating to the proper manner of submitting a claim for benefits to the plan and distributing forms upon which claim submissions shall be made, or making provision for the acceptance and processing of electronically-filed claims.
- A.21.4. The Contractor shall process all benefit claims in strict accordance with the Member Handbook and its clarifications and revisions.
- A.21.5. The Contractor shall, upon payment of a claim, provide an Explanation of Benefits (EOB) notice to the Member. The EOB shall include the name of the patient, the provider, the date(s) of service, payments to the provider and the patient's liability.
- A.21.6. Claims Payments Adjustments.
- A.21.6.1. Whenever the Contractor becomes aware that a claims payment to a provider or Member is less than the amount to which the provider or Member is entitled under the terms of the applicable Cover Tennessee program, the Contractor shall promptly adjust the underpayment to reflect the proper amount that should be remitted.
 - A.21.6.2. Whenever the Contractor becomes aware of an overpayment under the applicable Cover Tennessee program, the Contractor shall make a diligent attempt to recover such overpayment, in accordance with its customary administrative procedures. In the event any part of an overpayment is recovered, the applicable Cover Tennessee program will receive a credit from the Contractor. The Contractor shall not be required to institute any legal proceeding to recover such overpayment. The Contractor may use its reasonable judgment to compromise and settle overpayments. The Contractor is not liable for interest on recovered overpayments.
 - A.21.6.2.1. If a claim payment was made for services rendered through the BlueCard program, Contractor has no obligation to attempt to collect claim payments that were for less than Fifty (\$50) dollars, or in accordance with stated limits in effect at the Host Plan location.
 - A.21.6.2.2. The Contractor will assume liability for an unrecovered overpayment only if and when it is determined that:
 - a. the overpayment was caused by an act or omission of Contractor that (1) was not taken at the express direction of the State, and (2) did not meet the standard of care set out in this Contract;
 - b. all reasonable means of recovery under the circumstances have been exhausted; or
 - c. the State did not direct the Contractor not to recover the overpayment.
 - A.21.6.2.3. Except in cases of fraud committed by the provider, the Contractor cannot, under Tennessee State law, recover overpayments from providers more than eighteen (18) months after the date that Contractor paid the claim submitted by the provider.

A.21.6.2.4. In no event does Contractor have an obligation to recover on liability for overpayments of claims that were adjudicated for payment more than three (3) years before the overpayment is discovered.

A.21.6.3. The Parties acknowledge that the State may not contact network providers directly regarding rates.

A.21.6.4. If a Member is also covered by Medicare, Contractor must coordinate with Medicare in adjusting claims according to the Medicare Secondary Payor rules, and the rules regarding Cross Over Claims. This may delay finalization of a claim, depending on when data is received from Medicare regarding the claim. If Medicare is primary, the Contractor will adjudicate the Member's benefit based on the Medicare allowed amount.

A.21.7. The Contractor shall ensure that the majority of 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.

A.21.8. 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 and The Health Information Technology for Economic and Clinical Health Act (HITECH Act). Said standards shall include the requirements specified under each of the following HIPAA and HITECH subsections:

HIPAA 5010 Electronic Transactions and Code Sets	National Individual Identifier
Privacy	Claims attachments
Security	National Health Plan Identifier
National Provider Identifier	Compliance
National Employer Identifier	Enforcement

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 and HITECH. The Contractor must have a disaster recovery plan for restoring the application software and current master files and for hardware backup if the production systems are destroyed.

A.21.9. To maintain the privacy of protected health information, the Contractor shall provide to the State a method of securing email for daily communications between the Department of Finance and Administration and the Contractor.

A.21.10. The Contractor shall institute subrogation based on a mutually agreeable process between the Contractor and the State. Such process shall include:

A.21.10.1 A defined process for the recovery of monies received through subrogation;

A.21.10.2. Notification, upon request by the State, of the status of cases under review for subrogation and

A.21.10.3. Identification to the State of all subrogation subcontractors and, upon request by the State, copies of said subcontracts.

A.21.10.4. Additional information regarding the retention of administrative fees by the Contractor is included in Section C.3 of this Contract.

- A.21.11 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 determine both prospectively and retroactively the medical necessity of treatments and their associated claims.
- A.21.12. The Contractor shall have a process in place based on the most appropriate up-to-date clinical and pharmacological information for determining those procedures and services that are considered experimental/investigative.
- A.21.13. If the Contractor terminates a Member retroactively, the Contractor shall initiate the recovery of any claims paid on behalf of such affected Member during the period covering the retroactivity. The Contractor shall use its standard commercial process to retroactively terminate Members' coverage. Upon request, the Contractor shall provide the State with a report of all overpayment recoveries initiated during the previous calendar year, including dollar amounts initiated, recovered, and not recovered, and whether such amounts are for medical or pharmacy claims.
- A.21.14. BlueCard Program. The Contractor shall provide access to providers outside Tennessee to Members, in certain situations, through the BlueCard and BlueCard PPO program. This program is described in greater detail in Attachment E of this Contract.
- A.21.15. New York Surcharge. If a Member receives services from a New York state hospital (or other diagnostic facility), the New York Surcharge will be built into the claim submitted by the Host Plan, which will submit payment of the New York Surcharge as if it had been incurred by the Host Plan directly. The New York Surcharge will be handled this way regardless of whether or not the Member received services through the BlueCard PPO Program. The Contractor shall complete any reports that may be due, unless the State directs otherwise.
- A.21.16. The Contractor shall assist the State in identifying fraud and perform fraud investigations of Members and providers, in consultation with the State, for the purpose of recovery of overpayments due to fraud. The Contractor shall provide all documentation, records, and data to the Tennessee Office of Inspector General for the purpose of investigating suspected fraud and abuse cases. Reviews must include all possible actions necessary to locate and investigate cases of potential, suspected, or known fraud and abuse. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall inform the Department of Finance and Administration, Division of Health Care Finance and Administration, the Bureau of TennCare, the Division of State Audit within the Office of the Comptroller of the Treasury, and the State of Tennessee Office of Inspector General. The State shall review the information and inform the Contractor whether it wishes the Contractor to:
- A.21.16.1. discontinue further investigation if there is insufficient justification; or
 - A.21.16.2. continue the investigation and report back to the Department of Finance and Administration, the Office of the Inspector General and the Division of State Audit; or
 - A.21.16.3. continue the investigation with the assistance of the Division of State Audit; or
 - A.21.16.4. discontinue the investigation and turn the Contractor's findings over to the Division of State Audit or the Office of Inspector General for its investigation.
 - A.21.16.5. Cooperation – The Contractor and its Providers, Subcontractors, and/or employees and consultants shall cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview the Contractor and its Providers, subcontractors, and/or employees and consultants, including, but not limited to, those with expertise in the

administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

- A.21.16.6. Internal controls - The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities. The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including, but not limited to, Sections 1128, 1156, and 1902(a) (68) of the Social Security Act.
- A. 21. 17. The Contractor agrees to abide by the false claims laws, regulations and program instructions that apply to it. The Contractor understands that claims payments by the State is conditioned upon the claims and the underlying transactions complying with such laws, regulations, and program instructions, including, but not limited to, the federal anti-kickback statute and the Stark law. The Contractor understands and agrees that the claims it submits to the State constitutes a certification that it has complied with all applicable laws, regulations and program instructions, including, but not limited to, the federal anti-kickback statute and the Stark law, in connection with such claims and the services provided thereunder. Contractor understands the payment it receives is made from federal and State funds and that any falsification, or concealment of a material fact related to obtaining State payment, may be prosecuted under federal and State laws. Therefore, the Contractor has the full responsibility to ensure the accuracy of claims submitted for reimbursement and maintain necessary records to support justifications of claims submitted.
- A. 21.18. **For the AccessTN Program Only:** The Contractor shall have in place a process providing for the coordination of benefits based on AccessTN as the payor of last resort, with the exception of TennCare. In the event a Member is covered by both AccessTN and TennCare, AccessTN will be primary as to TennCare.
- A.21.19 **For the CoverKids Program Only:** In the event that a CoverKids Member is determined to be retroactively eligible for Medicaid, CoverKids enrollment will be terminated on the last day of the month in which the Medicaid eligibility is identified. The Contractor will not recoup payments to providers when periods of concurrent eligibility are determined.
- A.22. **Claims Payment and Reconciliation Process**
- A.22.1. 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 Contract. For the purposes of this Contract, claims funding is not a part of Contractor's compensation.
- A.22.2. On a mutually acceptable day of each week, 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 Automated Clearing House (ACH), provided the Contractor's payment process includes timely delivery of checks and settlement of ACH transactions. The Contractor shall notify the State of the week's funding requirement amount in a manner mutually agreed to by both Parties. The funding option for the State shall include an ACH credit of funds to the Contractor's designated bank account. The Contractor acknowledges and agrees that since the State intends to fund payments within one day 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.

- A.22.2.1 Claims Adjudication Reports. The Contractor shall provide the following reports to the State concerning claims adjudication for the Cover Tennessee programs:
 - A.22.2.1.1. A Related Provider Payment Report, submitted quarterly, that lists all related providers and subcontractors to whom Contractor has made payments during the previous quarter, and the payment amounts.
 - A.22.2.1.2. A Claims Invoice, submitted weekly, to notify the State of the amount to be paid to providers at least forty-eight (48) hours in advance of distribution of provider checks.
 - A.22.2.1.3. A Check Register Report with the weekly Invoice to support the payments to be released to providers.
 - A.22.2.1.4. A Claims Data Extract, submitted within eight (8) calendar days after the Contractor's request of the funds which shall be generated from the claims processing system, supporting the release of provider payments.
 - A.22.2.1.5. A Reconciliation Report, submitted within eight (8) days of the Claims Data Extract for the total paid amounts of the funds to be released for payment to providers, supporting the claims data extract, and the encounter data submissions for the relevant adjudication cycle.
- A.22.3. The Contractor acknowledges the State will monitor and age the outstanding check and ACH balance and the Contractor agrees, upon request of the State, to conduct a review and/or cancel-reissue of stale dated outstanding items. At the specific request of the State, the Contractor shall provide in an electronic file, in a format mutually agreed to by the Parties, information which provides payment information (whether by check or ACH) and claim numbers for outstanding unclaimed payments to providers.
- A.22.4. 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. The Contractor shall repay the State the amount of any such overpayment within thirty (30) calendar days of discovery of the overpayment. The Contractor agrees to assist in identifying fraud and make reasonable efforts, in consultation with the State, to recover overpayments due to fraud. The State will not hold the Contractor responsible for overpayments caused by the State's errors 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 Contract Section does not require the Contractor to become a party to any legal proceeding as a result thereof.
- A.22.5. **For the CoverKids Program Only:** The State will not hold the Contractor responsible for premium equivalent or claims payments caused by the State's errors, errors committed by the Eligibility 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 Contract Section does not require the Contractor to become a party to any legal proceeding as a result thereof.
- A.22.6. **For the CoverKids Program Only:** The Contractor shall maintain a year to date calculation of all copayments (including medical and vision services, dental services and prescription drugs) required by Members, 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 Members 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.

A.23. Financial Tracking and Reporting

- A.23.1. 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 Cover Tennessee programs. 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. The Contractor at a minimum will be responsible for determining net written and earned premium equivalents, the expense of administration, the paid and incurred losses for the year and any other business conducted on behalf of the programs and requested by the State, for each quarter and calendar year. Such information shall be reported to the State and to the State of Tennessee Comptroller of the Treasury in a form and manner prescribed by the Commissioner of Finance and Administration.
- A.23.2. The Contractor will maintain a general ledger and supporting accounting records and systems for the programs that are adequate to meet the needs of an insurance carrier of comparable size. This will include, but is not limited to:
 - A.23.2.1. preparation and reconciliation of monthly financial statements on a cash basis in a format prescribed by the State; and
 - A.23.2.2. preparation of accrual based quarterly financial statements prepared in accordance with statutory and/or generally accepted accounting principles prescribed.
- A.23.3. The Contractor shall establish and maintain a management information reporting system that provides enrollment utilization, claims reporting, and administrative services data to the State.
- A.23.4. The Contractor shall retain and maintain all records and documents in any way relating to the Cover Tennessee programs for three (3) 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 programs are to be retained for the entire time provided under this Contract Section.

A.24. General Administration

- A.24.1. The Contractor shall establish and provide a customer service operation that is available to Members from at least 8:00 a.m. to 6:00 p.m. EST. Monday through Friday (excluding holidays). The customer service operation should also include a state-wide, toll-free customer service line equipped with an automated voice response system that Members can access directly twenty-four (24) hours a day, 7 days a week, to request and receive service authorizations or other pertinent data. The toll-free customer service line shall be capable of handling calls from callers with Limited English Proficiency as well as calls from members who are hearing impaired.
- A.24.2. The Contractor shall also establish and maintain a dedicated state-wide toll-free fax number for applicants to submit enrollment, and claim materials, as well as supporting documents. This toll-free fax number must receive application materials on a secured fax server. Claim forms (if required) must be mailed to Members within two (2) business days from the date of request.
- A.24.3. The Contractor shall provide a customer service operation that includes:

- A.24.3.1. Qualified staff available to answer questions on benefits, benefit levels, and claims procedures. Disabled individuals must be provided adequate access to the customer service system;
 - A.24.3.2. A toll-free line abandon rate not to exceed five percent (5%) of incoming calls (or the Contractor's standard abandon rate, if so specified) in a calendar month. The abandon rate percentage shall be calculated using the hourly abandon rate averaged on a monthly basis;
 - A.24.3.3. A toll-free busy rate not to exceed five percent (5%) of incoming calls (or the Contractor's standard busy rate, if so specified) in any calendar month. The busy rate percentage shall be calculated using the hourly busy rate averaged on a monthly basis, and
 - A.24.3.4. 85 percent (85%) of an incoming call live voice answer rate calls on the toll-free line will be answered by a live voice within thirty (30) seconds in accordance with Attachment A: Performance Guarantee #4 (or the Contractor's standard live response rate and time period, if so specified) in each calendar month. Calls placed on hold within thirty (30) seconds (or the Contractor's response time period) of being answered by a live voice will not be considered to meet this "live voice" performance standard. Nothing herein shall prevent the Contractor from allowing calls to go to voicemail because of peak call times and absentees.
- A.24.4. The Contractor shall maintain a formal grievance procedure, by which Members and providers may appeal: decisions regarding benefits administration; medical necessity determinations; and disputes arising from the utilization management program. The State reserves the authority to review the procedure and make recommendations, where appropriate.
- A.24.4.1. **For the CoverKids Program Only:** The State appeals process is available to Members 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.
- A.24.5. The Contractor shall respond to all inquiries in writing from the State within ten (10) business days 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.
- A.24.6. 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 a Product Manager to interface directly with the State on external as well as internal and administrative functions. Said designee shall be responsible for the coordination and operation for all aspects of the Contract.
- A.24.7. The Contractor, at the request of either party, shall meet with representatives of the State periodically, but no less than quarterly, to discuss any problems and/or progress on matters outlined by the State. The Contractor shall have in attendance, when requested by the State, a Product Manager and representatives from its organizational units required to respond to topics indicated by the State's agenda. The Contractor shall provide information to the State concerning its efforts to develop cost containment mechanisms and improve administrative activities, as well as trends in the provision of group health care benefits. The Contractor shall also provide information to the State regarding the administration of the benefit, eligibility determination and enrollment,

internal procedures for billing and reconciliation of transactions and the provision of health care treatment and other administrative matters.

A.24.8. The Contractor shall assist the State, if requested, in the education and dissemination of information regarding the Plan options. This assistance may include but not be limited to:

A.24.8.1. written information;

A.24.8.2. audio/video presentations;

A.24.8.3. attendance at meetings, workshops, and conferences; and

A.24.8.4. training of State staff and the Department of Finance and Administration staff, as may be necessary, on Contractor's administrative and benefits procedures.

A.24.9. The Contractor shall maintain program-dedicated Member Internet pages, providing information on eligibility, premium equivalents, benefits and enrollment. Information contained at this web site shall be subject to the review and approval of the Department of Finance and Administration.

A.24.10. **For the CoverKids and AccessTN Programs Only:** The Contractor shall perform Member 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 Parties and shall involve a statistically valid random sample of Members. The Contractor shall use the CAHPS survey methodology approved by NCQA. Based upon the results of the survey, the Parties shall jointly develop an action plan to correct problems or deficiencies identified through this activity.

A.24.11. **For the CoverKids Program Only:** With regard to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Prospective Payments.

A.24.11.1. At the end of thirty (30) days following the end of each calendar quarter during the term of this Contract, 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 CHIPRA. 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.

A.24.11.2. 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.

A.24.11.3. 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.

- A.24.11.4. The State may request, and upon request the Contractor shall provide assistance with claims incurred at an 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.
 - A.24.11.5. For purposes of Contract Section A.24.11., 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. The 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.
 - A.24.11.6. Any obligations imposed on the Contractor for purposes of Contract Section A.24.11 shall not survive beyond the termination of this Contract and all such obligations hereunder shall be deemed complete and fulfilled upon the termination of this Contract.
- A.24.12 **For the CoverKids Program Only:** The Contractor shall meet and confer at least once each calendar year through its regularly-scheduled provider workshops with various pediatric providers, including pediatricians and children's hospitals in the State, and representatives of pediatric associations to discuss plan operations and network participation issues. The State shall be provided an opportunity to attend and observe the Contractor's workshop.
- A.25. **Pharmacy**
- A.25.1. The Contractor shall provide the following required programs and service components for the retail and mail order pharmacy benefits.
 - A.25.1.1. Administrative and Account Management Support
 - A.25.1.1.1. Collaborate with the State in proactively identifying opportunities to improve the quality of service, cost effectiveness and operational efficiency of the pharmacy benefits.
 - A.25.1.1.2. Provide quarterly reviews of pharmacy network adequacy, program performance, service levels and other factors that focus on managing pharmacy benefit cost.
 - A.25.1.2. Retail and Mail Order Claims Adjudication
 - A.25.1.2.1. Adjudicate and process all electronic point of sale and paper retail and mail order pharmacy claims incurred during the term of the Contract in strict accordance with the Member Handbook.
 - A.25.1.2.2. Maintain an integrated retail and mail order electronic point-of-sale claims system that shall have edits to verify eligibility, covered drug benefits, and claim accuracy. Mail order facilities shall have the capacity to process the volume of Member prescriptions.
 - A.25.1.2.3. Make efforts to recover overpayments and reimburse underpayments to the State in accordance with applicable law and any applicable State policies regarding the collection of overpayment and reimbursement of underpayment.
 - A.25.1.2.4. 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.

A.25.1.2.5. Provide a web site for Members providing access to pharmacy 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 Members to access their pharmacy claims.

A.25.1.3. Retail Network:

A.25.1.3.1. Provide a comprehensive network with Member access to retail pharmacies, which contractually agree through point-of-sale electronic transmission to verify eligibility, submit Member 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.

A.25.1.3.2. Provide participating pharmacies with a toll-free telephone service number.

A.25.1.3.3. Maintain a pharmacy audit program in order to ensure pharmacy compliance with the program.

A.25.1.4. Formulary/Preferred Drug List (PDL) and Utilization Review:

A.25.1.4.1. Implement and maintain a Formulary/ PDL for the retail and mail order program as outlined in the Member Handbook. Changes in the formulary shall be approved and communicated to the State and affected Members no less than 30 calendar days prior to change implementation date.

A.25.1.4.2. 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:

- Drug to drug interaction
- Duplicate therapy
- Known drug sensitivity
- Over utilization
- Maximum daily dosage
- Early refill indicators
- Suspected fraud

A.25.1.4.3. Provide for clinical pharmacist follow-up to dispensers and prescribers in order to share relevant information from the drug utilization review analysis.

A.25.1.4.4. 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.

A.25.1.4.5. Have the ability to lock a Member suspected of abusing the system into just one network pharmacy.

A.25.1.5. Therapeutic Substitution and Generic Dispensing Program

A.25.1.5.1. 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. Results of the program should be reported to the State on an annual basis.

A.25.1.5.2. 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 Members. Results of the program should be reported to the State on annual basis.

A.25.1.5.3. Maintain a communication plan by which notification will be made to affected Members when the most frequently utilized brand name medications lose their patent classification and become available as a generic equivalent.

A.25.2. The State has selected Contractor's pharmacy program for Members. Contractor's Pharmacy Benefits Manager (PBM) has access to Rebates from pharmaceutical manufacturers. "Rebates" are any reimbursement, incentive payment, pricing concession, or other discount that the PBM accepts or receives under contract with pharmaceutical manufacturers based on volume of certain pharmaceutical products. Each group's (such as CoverTN, AccessTN or CoverKids) Rebates are based on the pharmaceutical usage by that group's Members, and are a percentage of the Rebate received by the PBM.

A.25.2.1. The PBM retains five percent (5%) of the Rebates it receives to cover its administration costs.

A.25.2.2. Remit to the State no less than quarterly a credit to the State's invoice for all Pharmacy Rebates obtained on behalf of the State due to the use of pharmaceuticals by Members of the State-sponsored plans for the Rebates remitted during the claim period ending six (6) months prior to the Rebate payment date.

A.25.2.3. Sometimes, the PBM will remit a Rebate to Contractor based on an estimate. When this occurs, the PBM will retain a portion of the estimated Rebate (the "Withhold Account") until the pharmaceutical manufacturer remits the Rebate to the PBM. The PBM will conduct an annual detailed reconciliation that compares the amount of the Rebate requested with the Rebate received from the pharmaceutical manufacturer.

A.25.2.4. At the end of the annual settlement process between Contractor and the PBM, any money in the Withhold Account will be released to the State.

A.25.3. The Contractor shall provide the following Pharmacy Rebates and Audits:

A.25.3.1. Upon thirty (30) days advance written notice by the State, and with execution of any applicable third party confidentiality agreements, submit to examination and audit of applicable pharmacy benefit data by the State, including manufacturer rebate contracts and rebate payments, 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.25.3.2. Upon thirty (30) days advance written notice by the State, and with the execution of any applicable third party confidentiality agreements, provide full disclosure of rebates received by the Contractor, its affiliates, subsidiaries, or subcontractors on behalf of the State, including line item detail by National Drug Code number and line item detail by pharmaceutical manufacturer

showing actual cost remitted and other related claim and financial information as needed to satisfy the scope of the audit. The Contractor will, upon request by the State, disclose to the State's authorized independent auditor (experienced in conducting pharmacy rebate audits) any administrative fees or other reimbursements received in connection with any rebates, discounts, fee reductions, incentive programs, or the like received by Contractor as a result of the drug manufacturer payments which include volume of pharmaceutical use by or on behalf of the State. In addition, Contractor will, upon request by the State, disclose fees or other reimbursements received in connection with any grants, educational programs or other incentive programs received by the Contractor on behalf of the State.

- A.25.3.3. With the execution of any applicable third party confidentiality agreements, provide at any time, upon thirty (30) days advance written notice from the State, access to audit the pharmacy rebate program, including but not limited to rebate contracts, special discounts, fee reductions, incentive programs or the like with pharmacy manufactures and program financial records as necessary to perform accurate and complete audit of rebates received by the State. At the State's discretion, the State's authorized independent auditor (experienced in conducting rebate audits) may perform such audit. The State is responsible for the cost of its authorized third party representatives for such audits. If the outcome of the audit results in an amount due to the State, payment of such settlement will be made within thirty (30) days of the Contractor's receipt of the final audit report.

A.26. Data and Specific Reporting Requirements

- A.26.1. The Contractor shall 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 sixty (60) days from the date of creation.
- A.26.2. The Contractor shall 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.
- A.26.3. The Contractor shall quarterly provide the State with a GeoNetworks© report showing service and geographic access (see Contract Attachment A: Performance Guarantee #7). The State shall review the network structure and shall inform the Contractor in writing of any deficiencies the State considers to deny reasonable access to health care. The State and Contractor shall then mutually develop a plan of action to correct said deficiencies within sixty (60) days.
- A.26.4. The Contractor is required to transmit Cover Tennessee program enrollment data monthly and medical and prescription drug claims quarterly to the Department of Finance and Administration's health care decision support services (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).
- A.26.4.1. For each quarter of the Contract term, and any extensions thereof, claims data must meet the established quality standards (see Contract Attachment A: Performance Guarantee #8), as determined by the State's healthcare claims data management vendor.

- A.26.4.2. The Contractor will work with the State's DSS vendor to identify a data format similar to the format detailed in Attachment D for these transmissions, and is responsible for the cost incurred by the DSS vendor to develop, test and implement conversion programs for the Contractor's claims data. The State's DSS vendor currently charges a maximum of \$30,000 per new contractor. Furthermore, the Contractor will pay during the full term of this Contract all applicable fees as assessed by the State's DSS vendor related to any data formats changes, which are Contractor-initiated or are due to meeting compliance with new regulations. 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.
- A.26.4.3. Claims data are to be securely submitted to the State's health and decision support system vendor no later than the last day of the month following the end of each calendar quarter (see Contract Attachment A: Performance Guarantee #10).
- A.26.5. The Contractor shall submit Management Reports as required by the State in electronic format of the type, at the frequency, and containing the detail described in Attachment B, Management Reporting Requirements.
- A.26.6. The Contractor may produce additional reports, and may conduct programming related to such reports, as mutually agreed upon by the Contractor and the State. Requests for additional reports shall be approved in writing by both the Contractor and the State in advance of the development of such reports.
- A.27. Services Provided by the State**
- A.27.1. The State shall fund applicable accounts from which the Contractor will make claims payments during the term of the Contract, and for the thirteen (13) months following its termination, for care and treatment services delivered within the term of the Contract.
- A.27.2. The State and the CoverKids Eligibility Contractor shall facilitate the enrollment of pregnant CoverTN and AccessTN women into other state programs, including CoverKids, so that they can receive maternity and pregnancy-related services.
- A.28. Effect of Termination**
- A.28.1. The terms and conditions set forth herein shall be of no further force or effect if this Contract is terminated, except as follows:
- A.28.1.1. The Parties' rights and obligations intended to survive termination of this Contract, including Contract Section E.7, shall continue in effect notwithstanding its termination.
- A.28.1.2. Termination of this Contract, except as provided to the contrary herein, shall not affect the rights, obligations and liabilities of the Parties arising out of transactions occurring prior to termination.
- A.28.1.3. 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 ("Runout claims") with no additional administrative cost to the State. "Run out claims" refers to those claims for Covered Services, performed prior to the termination of this Contract, but not yet paid and/or not submitted for payment to Contractor prior to the termination of this Contract. These claims shall be administered as any other claim handled during the term of the Contract, and shall be subject to the same restrictions. The claims run out period shall extend through the final day of the thirteenth (13th) month following Contract termination. The State

remains liable to fund all claims adjudicated by Contractor during this time period.

- A.28.1.4. Upon conclusion of any program under this Contract, or in the event of a program's 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 while the program was operating through this Contract ("Runout claims") with no additional administrative cost to the State for that program. "Run out claims" refers to those claims for Covered Services, performed prior to the termination of the program, but not yet paid and/or not submitted for payment to Contractor prior to the termination of the program. These claims shall be administered as any other claim handled during the term of the program, and shall be subject to the same restrictions. The claims run out period shall extend through the final day of the thirteenth (13th) month following program termination. The State remains liable to fund all claims adjudicated by Contractor during this time period.
- A.28.2. Upon cancellation or termination of the Contract for any reason, the Contractor shall submit to the State a roster of Members who are, at the date termination is effective:
 - A.28.2.1. receiving CM services, together with all the identifying information and conditions that make the Members' care appropriate for CM; and
 - A.28.2.2. receiving disease management services, together with all the identifying information and conditions that make the Members' enrollment in the specified disease management program appropriate.
- A.28.3. Upon cancellation or termination of any program governed by this Contract for any reason, the Contractor shall submit to the State a roster of Members who are, at the date termination is effective:
 - A.28.3.1. receiving CM services through that program, together with all the identifying information and conditions that make the Members' care appropriate for CM; and
 - A.28.3.2. receiving disease management services through that program, together with all the identifying information and conditions that make the Members' enrollment in the specified disease management program appropriate.
- A.28.4. 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. Use of the data by Contractor after termination shall be governed by the terms of the Business Associate Agreement.
- A.28.5. Should the State terminate one or more than one program for any reason, the notice requirements of Contract Sections E.20 and E.21 are applicable.

B. CONTRACT TERM

- B.1. Term. This Contract shall be effective for the period beginning January 1, 2012, and ending on December 31, 2013. The Contractor hereby acknowledges and affirms that the State shall have no obligation for services rendered by the Contractor which were not performed within this specified contract period.
- B.2. Term Extension. The State reserves the right to extend this Contract for an additional period or periods of time representing increments of no more than one year and a total contract term of no more than three (3) years, provided that the State notifies the Contractor in writing of its intent to do so at least two hundred seventy days (270) prior to the Contract expiration date. Such an extension of the Contract term shall be effected

prior to the current contract expiration date by means of a Contract amendment. If a term extension necessitates additional funding beyond that which was included in the original Contract, an increase of the State's maximum liability will also be effected through Contract amendment, and shall be based upon payment rates provided in the original Contract.

C. PAYMENT TERMS AND CONDITIONS

C.1 Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Five Hundred Fifty-Seven Million One Hundred Twenty-One Thousand Four Hundred Dollars (\$557,121,400.00). The payment rates in Contract Section C.3 shall constitute the entire compensation due the Contactor for all service and Contractor obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the payment rates detailed in Contract 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. If a program or programs is/are terminated or re-opened, the monthly payment rate stated below will be renegotiated in good faith by the Parties and reflected in an amendment.

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

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

Service Description	Amount Per Member Per Month (pmpm)
Cover Tennessee Health Plan Services	\$28.00/pmpm

The Contractor shall submit monthly invoices, 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

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.

C.3.1. 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). The Contractor shall understand that recovery of subrogation claims includes claims paid as a result of work related illnesses or injuries relative to worker’s compensation claims.

C.3.2. State agrees that access fees required by the Contractor, and its licensees, for use of the BlueCard program by Members covered under the programs shall be deducted from the aggregate discount savings realized from the BlueCard Program with the savings balance accruing to the State. The maximum fees under the BlueCard program are as follows:

Type of Claim	State’s cost per Claim
Professional Claim	\$6.00
Institutional Claim	\$6.00
Claim Based Access Fee	0.00% of the discount received from the Host Plan, if required. Maximum of \$2,000 per claim.

These BlueCard fees may be changed by the Blue Cross and Blue Shield Association; if changed, the Contractor shall provide the State with as much advance notice as is possible, but in no event less than thirty (30) calendar days.

All other fees related to the BlueCard Program, as described in Contract Attachment E BlueCard PPO Program shall be borne by the Contractor, and should not be charged separately to the State. The State is under no obligation for any fees or compensation under the BlueCard Program other than those contained in this Contract Section.

The Contractor shall provide the State with quarterly reports on the utilization of the BlueCard Program including claims paid, realized savings and BlueCard 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.

C.3.3. Claims Funding. Claims funding is separate from all other non-claims payments. Contractor shall submit invoices for claims that are to be funded within a week, as detailed in Contract Section A.22.2, on a weekly basis, as agreed to in writing by the Parties. The State shall make funds available to cover those claims payments within forty-eight (48) hours, and shall notify Contractor by email when those funds are available. Contract Section C.8 shall not apply to funding claims, except to the extent that such audit is regarding improper remuneration for claims under this Contract.

C.3.4 Premium Equivalent Rebate. If the State determines that a premium equivalent rebate is due to Members and Participating Employers, the State shall make funds available to the Contractor in order for the Contractor to administer this process and fund the rebates.

- a. The cost to administer this rebate shall not exceed \$200,000 annually.
- b. This cost is to cover the one-time initial set-up fee and all cost associated with issuing individual checks to Members and Participating Employers.
- c. The State shall provide such rebate funds five (5) business days before the Contractor issues checks to Members and Participating Employers, pursuant to Contract Section A.18.11.3.

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 Contract 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:

Cover Tennessee Programs
 2600 WRS Tennessee Towers
 312 Rosa L Parks Avenue
 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: Division of Health Care 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) only be submitted for completed service and shall not include any charge for future work;
 - (3) not include sales tax or shipping charges; and
 - (4) initiate the timeframe for payment (and any discounts) only when the State is in receipt of the invoice, and the invoice meets the minimum requirements of this Contract Section C.5.
- C.6. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice, or matter in relation thereto. A payment by the State shall not be construed as acceptance of any part of the work or service provided or as approval of any amount invoiced.
- C.7. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute proper remuneration for compensable services.
- C.8. Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the state of Tennessee any amounts which are or shall become due and payable to the state of Tennessee by the Contractor.
- C.9. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following documentation properly completed.
- a. The Contractor shall complete, sign, and present to the State an "Authorization Agreement for Automatic Deposit (ACH Credits) Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once said form is received by the State, all payments to the Contractor, under this or any other contract the Contractor has with the state of Tennessee shall be made by Automated Clearing House (ACH).
 - b. The Contractor shall complete, sign, and present to the State a "Substitute W-9 Form" provided by the State. The taxpayer identification number detailed by said form must agree with the Contractor's Federal Employer Identification Number or Tennessee Edison Registration ID referenced in this Contract.

D. STANDARD TERMS AND CONDITIONS

- D.1. Required Approvals. The State is not bound by this Contract until it is signed by the Contract Parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).
- D.2. Modification and Amendment. This Contract may be modified only by a written amendment signed by all Parties hereto and approved by both the officials who approved the base Contract and, depending upon the specifics of the Contract as amended, any additional officials required by Tennessee laws and regulations (said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

- D.3. Termination for Convenience. The State may terminate this Contract without cause for any reason. Said termination shall not be deemed a breach of contract by the State. The State shall give the Contractor at least two hundred seventy (270) days written notice before the effective termination date. The Contractor shall be entitled to compensation for satisfactory, authorized service completed as of the termination date, but in no event shall the State be liable to the Contractor for compensation for any service which has not been rendered. Upon such termination, the Contractor shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.
- D.4 Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to immediately terminate the Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.
- D.5. Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, each shall contain, at a minimum, sections of this Contract below pertaining to "Conflicts of Interest," "Nondiscrimination," and "Records" (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime Contractor and shall be responsible for all work performed.
- D.6. Conflicts of Interest. The Contractor warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed relative to this Contract.

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

- D.7. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Contractor shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.
- D.8. Prohibition of Illegal Immigrants. The requirements of *Tennessee Code Annotated*, Section 12-4-124, *et seq.*, addressing the use of illegal immigrants in the performance of any Contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.
- a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the

performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment C, 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 Contract Section will be subject to the sanctions of *Tennessee Code Annotated*, Section 12-4-124, *et seq.* for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a Contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a Contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Contract.
 - e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.
- D.9. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.
- D.10. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.
- D.11. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.
- D.12. Strict Performance. Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the Parties hereto.

D.13. Independent Contractor. The Parties hereto, in the performance of this Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly acknowledged by the Parties hereto that such Parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

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

D.14. State Liability. The State shall have no liability except as specifically provided in this Contract.

D.15. Force Majeure. The obligations of the Parties to this Contract are subject to prevention by causes beyond the Parties' control that could not be avoided by the exercise of due care including, but not limited to, natural disasters, riots, wars, epidemics, or any other similar cause.

D.16. State and Federal Compliance. The Contractor shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.

D.17. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising 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.

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:

Bo Irvin, Executive Director
Cover Tennessee Programs
2600 WRS Tennessee Towers
312 Rosa L Parks Avenue
Nashville, Tennessee 37243-1102
Telephone: (615) 741-9750
Fax: (615) 253-8556
Bo.irvin@tn.gov

The Contractor:

Amy Bercher, Product Manager
BlueCross BlueShield of Tennessee, Inc.
One Cameron Hill Circle
Chattanooga, TN 37402
Amy_Bercher@bcbst.com
Telephone: 423.535.5983
Fax: 423.591.9111

With a Copy to:

Attention: Deputy General Counsel
BlueCross BlueShield of Tennessee, Inc.
One Cameron Hill Circle
Chattanooga, TN 37402
Tena_Roberson@bcbst.com
Telephone: 423.535.5158
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 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 (hereafter referenced as “Performance Guarantee Assessments”, (as contained in **Contract Attachment A: Performance Guarantees**) — In the event of a Breach, the State may assess Performance Guarantee Assessments. The State shall notify the Contractor of amounts to be assessed. 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 Attachment A: Performance Guarantee Assessments, and agrees 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 Performance Guarantee Assessments 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 Performance Guarantee Assessment amounts are in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or other Contract Section of this Contract.

The State may continue to assess Performance Guarantee Assessments 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 Performance Guarantee Assessments before availing itself of any other remedy. The State may choose to discontinue Performance Guarantee Assessments 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 Performance Guarantee Assessments previously assessed 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 Performance Guarantee Assessment amounts, as applicable, against the Contractor for any failure to perform which ultimately results in a Partial Default with said Performance Guarantee Assessment amounts to cease when said Partial Default is effective. Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor

agrees to cooperate fully with the State in the event a Partial Default is taken

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

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

E.5. **Partial Takeover.** The State may, at its convenience and without cause, exercise a partial takeover of any service which the Contractor is obligated to perform under this Contract, including but not limited to any service which is the subject of a subcontract between Contractor and a third party, although the Contractor is not in Breach (hereinafter referred to as "Partial Takeover"). Said Partial Takeover shall not be deemed a Breach of Contract by the State. Contractor shall be given at least 30 days prior written notice of said Partial Takeover with said notice to specify the area(s) of service the State will assume and the date of said assumption. Any Partial Takeover by the State shall not alter in any way Contractor's other obligations under this Contract. The State may withhold from amounts due the Contractor the amount the Contractor would have been paid to deliver the service as determined by the State. The amounts shall be withheld effective as of the date the State assumes the service. Upon Partial Takeover, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.6. **Workpapers Subject to Review.** The Contractor shall make all audit, accounting, or financial analysis workpapers, notes, and other documentation available for review by the Comptroller of the Treasury or his representatives, upon request, during normal working hours either while the analysis is in progress or subsequent to the completion of this Contract.

E.7. **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 Contract 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 Contract Section shall survive the termination of this Contract.

E.8. HIPAA and HITECH Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA) and their accompanying regulations, and as amended.

- a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and HITECH and their accompanying regulations, and shall comply with all applicable HIPAA and HITECH requirements in the course of this Contract including but not limited to the following:
 1. Compliance with the Privacy Rule, Security Rule, Notification Rule;
 2. The creation of and adherence to sufficient Privacy and Security Safeguards and Policies;
 3. Timely Reporting of Violations in the Access, Use and Disclosure of PHI; and
 4. Timely Reporting of Privacy and/or Security Incidents.
- b. Contractor warrants that it shall cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and HITECH and their accompanying regulations, in the course of performance of the Contract so that both Parties will be in compliance with HIPAA and HITECH.
- c. The State and the Contractor shall sign documents, including but not limited to business associate agreements, as required by HIPAA and HITECH and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA and HITECH. .

E.9. Tennessee Consolidated Retirement System. The Contractor acknowledges and understands that, subject to statutory exceptions contained in Tennessee Code Annotated, Section 8-36-801, et. seq., the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any

superseded system administered by TCRS, or of any local retirement fund established pursuant to Tennessee Code Annotated, Title 8, Chapter 35, Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor, if a retired member of TCRS, may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the period of this Contract.

- E.10. 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.11. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity as required by federal and State law.

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

- E.12. Annual Report and Audit. The Contractor shall prepare and submit, within nine (9) months after the close of the reporting period, an annual report of its activities funded under this Contract to the commissioner or head of the contracting agency, the Tennessee Comptroller of the Treasury, and the Commissioner of Finance and Administration. The annual report for any Contractor that receives five hundred thousand dollars (\$500,000) or more in aggregate federal and state funding for all its programs shall include audited financial statements. All books of account and financial records

shall be subject to annual audit by the Tennessee Comptroller of the Treasury or the Comptroller's duly appointed representative. When an audit is required, the Contractor may, with the prior approval of the Comptroller, engage a licensed independent public accountant to perform the audit. The audit contract between the Contractor and the licensed independent public accountant shall be on a contract form prescribed by the Tennessee Comptroller of the Treasury. Any such audit shall be performed in accordance with generally accepted government auditing standards, the provisions of OMB Circular A-133, if applicable, and the Audit Manual for Governmental Units and Recipients of Grant Funds published by the Tennessee Comptroller of the Treasury. The Contractor shall be responsible for reimbursement of the cost of the audit prepared by the Tennessee Comptroller of the Treasury, and payment of fees for the audit prepared by the licensed independent public accountant. Payment of the audit fees of the licensed independent public accountant by the Contractor shall be subject to the provisions relating to such fees contained in the prescribed contract form noted above. Copies of such audits shall be provided to the designated cognizant state agency, the State Contracting Department, the Tennessee Comptroller of the Treasury, and the Department of Finance and Administration and shall be made available to the public.

E.13. Prohibited Advertising. The Contractor shall not refer to this Contract or the Contractor's relationship with the State hereunder in commercial advertising in such a manner as to state or imply that the Contractor or the Contractor's services are endorsed. It is expressly understood and agreed that the obligations set forth in this section shall survive the termination of this Contract in perpetuity.

E.14. Public Accountability. If the Contractor is subject to *Tennessee Code Annotated*, Title 8, Chapter 4, Part 4 or if this Contract involves the provision of services to citizens by the Contractor on behalf of the State, the Contractor agrees to establish a system through which recipients of services may present grievances about the operation of the service program, and the Contractor shall display in a prominent place, located near the passageway through which the public enters in order to receive services pursuant to this Contract, a sign at least twelve inches (12") in height and eighteen inches (18") in width stating:

NOTICE: THIS AGENCY IS A RECIPIENT OF TAXPAYER FUNDING. IF YOU OBSERVE AN AGENCY DIRECTOR OR EMPLOYEE ENGAGING IN ANY ACTIVITY WHICH YOU CONSIDER TO BE ILLEGAL, IMPROPER, OR WASTEFUL, PLEASE CALL THE STATE COMPTROLLER'S TOLL-FREE HOTLINE: 1-800-232-5454

E.15. Lobbying. The Contractor certifies, to the best of its knowledge and belief, that:

- a. No federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- b. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this contract, grant, loan, or cooperative agreement, the Contractor shall complete

and submit Standard Form-LLL, ``“Disclosure Form to Report Lobbying,” in accordance with its instructions.

- c. The Contractor shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into and is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, *U.S. Code*.

- E.16. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Contractor to the State.

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

- E.17. Disclosure of Personal Identity and Protected Health Information. The Contractor shall report to the State any instances of unauthorized disclosure of confidential information that come to the attention of the Contractor. Any such report shall be made by the Contractor immediately upon becoming aware of the disclosure. within twenty-four (24) hours after the instance has come to the attention of the Contractor. The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services and identity theft safeguards for individuals that are deemed to be part of a potential disclosure. The Contractor shall bear the cost of notification to individuals having personal identity and protected health information involved in a potential disclosure event, including individual letters and/or public notice.

- E.18. Federal Funding Accountability and Transparency Act (FFATA). This Contract requires the Contractor to provide supplies and/or services that are funded in whole or in part by federal funds that are subject to FFATA. The Contractor is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the Contractor provides information to the State as required.

The Contractor shall comply with the following:

- a. Reporting of Total Compensation of the Contractor’s Executives.
 - (1) The Contractor shall report the names and total compensation of each of its five most highly compensated executives for the Contractor’s preceding completed fiscal year, if in the Contractor’s preceding fiscal year it received:

- i. 80 percent or more of the Contractor's annual gross revenues from federal procurement contracts and federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and
- ii. \$25,000,000 or more in annual gross revenues from federal procurement contracts (and subcontracts), and federal financial assistance subject to the Transparency Act (and subawards); and
- iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/excomp.htm>).

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

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

- i. Salary and bonus.
- ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
- iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.
- iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
- v. Above-market earnings on deferred compensation which is not tax qualified.
- vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds \$10,000.

- b. The Contractor must report executive total compensation described above to the State by the end of the month during which this Contract is awarded.
- c. If this Contract is amended to extend its term, the Contractor must submit an executive total compensation report to the State by the end of the month in which the amendment to this Contract becomes effective.
- d. The Contractor will obtain a Data Universal Numbering System (DUNS) number and maintain its DUNS number for the term of this Contract. More information about obtaining a DUNS Number can be found at: <http://fedgov.dnb.com/webform/>

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

- E.19. Use of Names and Service Marks. Contractor is allowed to use the State's name on I.D. cards and other forms necessary to implement this Contract, and to promote the State's relationship with Contractor to potential or existing providers. Contractor shall not use the State's name for any other purpose without the prior written consent of the State.

The names, logos, symbols, trademarks, trade names, and service marks of Contractor, whether presently existing or hereafter established, are the sole property of Contractor and Contractor retains the right to the use and control thereof. The State shall not use Contractor's name, logos, symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of Contractor and shall cease any such usage immediately upon written notice by Contractor or upon termination of this Contract, whichever is sooner.

The names, logos, symbols, trademarks, trade names, and service marks of Blue Cross and Blue Shield Association, whether presently existing or hereafter established, are the sole property of Blue Cross and Blue Shield Association and Blue Cross and Blue Shield Association retains the right to the use and control thereof. The State shall not use Blue Cross and Blue Shield Association's name, logos, symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of Blue Cross and Blue Shield Association and shall cease any such usage immediately upon written notice by Blue Cross and Blue Shield Association or upon termination of this Contract, whichever is sooner.

- E.20. Termination of Program for Convenience. A program under this Contract may be terminated by either party by giving written notice to the other, provided that the State shall give said notice to the Contractor at least Two Hundred and Seventy (270) days before the effective date of termination, and the Contractor shall give said notice to the State at least Two Hundred and Seventy (270) days before the effective date of termination.

a. 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.

b. 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.

c. In the event of disagreement, the Contractor may file a claim with the Tennessee Claims Commission in order to seek redress.

- E.21. Termination of Program for Cause. If the Contractor fails to properly perform specific program obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of a specific program included in this Contract, the State shall have the right to immediately terminate the Program 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. If the State terminates a program for cause, that will not be cause for the State to terminate any other program under the Contract.

- E.22. Non-Discrimination Compliance Requirements – for CoverKids only.

- a. The Contractor shall comply with Contract Section D.7 of this Contract regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.
- b. In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Church Amendments (42 U.S.C. 300a 7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110 161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209), the Contractor shall designate a staff person to be responsible for non-discrimination compliance as required in Contract Section E.22.j. This person shall develop a Contractor non-discrimination compliance training plan within thirty (30) days of Contract implementation, to be approved by CoverKids. This person shall be responsible for the provision of instruction regarding the plan to all Contractor staff within sixty (60) days of Contract implementation and for the provision of instruction regarding the plan to providers and direct service subcontractors within ninety (90) days of Contract implementation. The Contractor shall be able to show documented proof of such instruction.
- c. The Contractor's non-discrimination compliance plan shall include written policies and procedures that demonstrate non-discrimination in the provision of services to members. The policy shall also demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring communication assistance in alternative formats. These policies and procedures shall be prior approved in writing by CoverKids.
- d. The Contractor shall, at a minimum, emphasize non-discrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.
- e. The Contractor shall ask all staff to provide their race or ethnic origin and sex. The Contractor is required to request this information from all Contractor staff. Contractor staff response is voluntary. The Contractor is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts.
- f. The Contractor shall ask all providers for their race or ethnic origin. Provider response is voluntary. The Contractor is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the Contractor's provider network or in determination of compensation amounts.
- g. The Contractor shall track and investigate all complaints alleging discrimination filed by employees, enrollees, providers and subcontractors related to the provision of and/or access to CoverKids covered services provided by the Contractor. The Contractor shall track and investigate all complaints alleging discrimination filed by employees (when the complaint is related to the CoverKids program), enrollees, providers and subcontractors in which discrimination is alleged. The Contractor shall track, at a minimum, the following elements: identity of the party filing the complaint; the complainant's relationship to the Contractor; the circumstances of the complaint; date complaint filed; Contractor's resolution, date of resolution; and name of Contractor staff person responsible for adjudication of the complaint.

- h. The Contractor shall develop and have available a standardized complaint form to provide to a complainant upon request. This complaint form shall be in a format specified by CoverKids.
- i. The Contractor shall report on non-discrimination activities as described in this Contract Section.
- j. The Contractor shall designate a staff person to serve as the Contractor's Non-discrimination Compliance Coordinator. This person shall be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), *the Church Amendments (42 U.S.C. 300a 7)*, *Section 245 of the Public Health Service Act (42 U.S.C. 238n.)*, and *the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110 161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209)* on behalf of the Contractor. The Contractor shall report to CoverKids, in writing, to the attention of the Director of Non-Discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the commencement of any period of time that the Contractor does not have a designated staff person for non-discrimination compliance. The Contractor shall report to CoverKids at such time that the function is redirected.

E.23. Non-Discrimination Compliance Reports – For CoverKids Only.

- a. On an annual basis the Contractor shall submit a copy of the Contractor's non-discrimination policy that demonstrates non-discrimination in the provision of services to members. The policy shall also demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring communication assistance in alternative formats. This shall include a report that lists all interpreter/translator services used by the Contractor in providing services to members with Limited English Proficiency or that need communication assistance in an alternative format. The listing shall identify the provider by full name, address, phone number, languages spoken, and hours services are available.
- b. The Contractor shall submit an annual Summary Listing of Servicing Providers. The listing shall include, at a minimum, provider name, address, race or ethnic origin, language spoken other than English and shall be sorted by provider type (e.g., pediatrician, surgeon, etc.). The Contractor shall use the following race or ethnic origin categories: American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin as indicated by CoverKids.
- c. The Contractor shall annually submit its Non-Discrimination Compliance Plan and Assurance of Non-Discrimination to CoverKids. **The signature date of the Contractor's Plan shall coordinate with the signature date of the Contractor's Assurance of Non-Discrimination.**
- d. The Contractor shall submit a quarterly Non-discrimination Compliance Report which shall include the following:
 - (1) A summary listing totaling the number of supervisory personnel by race or ethnic origin and sex. This report shall provide the number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnicity as indicated by CoverKids and number of female supervisors who are White, Black (not of Hispanic origin), American

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

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

E.24. The State acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Contractor and that neither the Blue Cross Blue Shield 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.

On behalf of itself and its Members, the State hereby 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.

E.25. Disclosure of Ownership and Control Interest Statement and Criminal Information – For CoverKids Only. Federal Regulations in 42 C.F.R. § 457.935 and Medicare, Medicaid, and SCHIP federal health care programs pursuant to Sections 6501 [*et seq.*] of the Affordable Care Act, which amends § 1902 (a)(39) of the Social Security Act, requires that the CoverKids/CHIPRA program monitor the payments of Federal funds to Providers. CoverKids has chosen to implement these federal requirements by use of a Disclosure of Ownership and Control Interest Statement and Criminal Information form the (CoverKids Provider Disclosure Form and/or the Bureau of TennCare Ownership and Disclosure Form; collectively, the "Disclosure Form") to collect the information required in 42 C.F.R. § 455 *et seq.*, as well as other information deemed necessary by the State. The Disclosure Form must be submitted to the Contractor by the Provider as follows:

- a. At the time a Provider is initially enrolled by CoverKids or its Contractor;
- b. At the time a Provider is being re-accredited by CoverKids or its Contractor;
- c. At the time a Provider is being reenrolled by CoverKids or its Contractor;
- d. Whenever there is a change in ownership of a Provider;
- e. Whenever there is a material change in the information required by the Disclosure Form; or

f. Upon request by CoverKids, a federal or state agency, or the Contractor.

Providers shall return the original Disclosure Form to the Contractor. Providers should retain a copy for their files. Failure to provide the Disclosure Form as required above, or to accurately supply the required information, may lead to sanctions and exclusion from federal healthcare programs including "CoverKids".

Beginning on January 31, 2012, the Contractor shall submit a monthly Ownership and Control Interest Statement and Criminal Information Report to CoverKids that shall include, but is not limited to, the percentage of Disclosure Forms that have been verified as accurate and complete and the percentage remaining to be verified. In addition, CoverKids reserves the right to request a complete listing of the Providers who have not complied with the request to submit a Disclosure Form. The collection and review of the Disclosure Forms shall be accomplished as follows for the following Provider Categories:

Category 1 - Existing Providers (Providers already enrolled with the Contractor prior to January 1, 2012) with no TennCare contract:

- Contractor shall collect Disclosure Forms by January 2, 2012.
- The Disclosure Forms for the top 50% (fifty percent) of the Providers who bill the most claims to the CoverKids program and are not enrolled in TennCare shall be categorized as either: 1) accurate and complete; or 2) inaccurate and incomplete by April 30, 2012.
- The Disclosure Forms for the remaining 50% (fifty percent) of the billing Providers for the CoverKids program shall be categorized as either: 1) accurate and complete; or 2) inaccurate and incomplete by July 31, 2012.

Category 2 - Existing Providers with a TennCare contract: Disclosure Forms shall be verified as accurate and complete by January 2, 2012.

Category 3 - Newly contracting Providers: Disclosure Forms collected and verified as accurate and complete at the time the Provider contract is signed.

This Disclosure Form must be submitted at the time a Provider is initially enrolling, or is being re-accredited, or being reenrolled by CoverKids or its Contractor, or whenever there is a change in ownership of a Provider, a material change in the information required by this form, and/or upon request by CoverKids, federal and state agencies, or the Contractor.

- E.26. The State may, at its discretion, require the Contractor to submit additional On Request Reports (ORR). If the State requests any revisions to an ORR already submitted, the Contractor shall make the changes and resubmit the ORR, according to the time period and format required by the State. Unless otherwise indicated the Contractor shall submit ORRs within ten (10) business days from the date of the request. The State may require an approved Corrective Action Plan (CAP) to remedy any defects in performance of contract requirements that were revealed through an ORR. It is in the sole discretion of the State as to whether or not Performance Guarantee Assessments shall be imposed according to Attachment A, Item #12.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Contractor Signature

DATE

J.D. HICKEY, SENIOR VICE PRESIDENT

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY

DEPARTMENT OF FINANCE AND ADMINISTRATION

DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION:

MARK A. EMKES, COMMISSIONER

DATE

Contract Attachment A 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. Any penalty will be assessed annually.

1. Claims Payment Dollar Accuracy – Applies to CoverTN, CoverKids and AccesTN	
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	\$1,000 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 - Applies to CoverTN, CoverKids and AccesTN	
Guarantee	The average quarterly processing accuracy will be 95% or higher.
Definition	Claims Processing Accuracy is defined as the absolute number of Member claims with no in processing or procedural errors, divided by the total number of Member claims within the audit sample. <u>This excludes financial errors.</u>
Assessment	\$1,000 for each full percentage point below 95%, 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 - Applies to CoverTN, CoverKids and AccesTN	
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): \$1,000 for each full percentage point below the required minimum standard of 90% within 14 days. Quarterly Guarantee. All Claims: \$1,000 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 - Applies to CoverTN, CoverKids and AccesTN	
Guarantee	Eighty-five percent (85%) of incoming Member services calls will be answered by a Member Services representative within 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 percentage point below the 85% threshold for calls answered within 30 second or less. 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. Provider Satisfaction - Applies to CoverKids only	
Guarantee	The Contractor shall conduct a provider satisfaction survey of physicians and hospitals, following approval by the State of the form, content, and proposed administration of the survey, each October or November. The survey shall include each of the Children’s Hospitals in Tennessee, the top 15 percent

	of facilities based upon inpatient days for the first six months of the calendar year (excluding the Children's Hospitals) and the pediatrician IPA who request participation in the annual survey.	
Definition	Completion of the survey.	
Assessment	Assessment \$2,500 annually if not complete and all elements provided by the end of January of each year.	
Compliance Report	A written report summarizing the survey methods and results.	
6. Member Satisfaction - Applies to CoverKids and AccesTN only		
Guarantee	The level of overall customer satisfaction, as measured annually by a State approved Member Satisfaction survey(s), will be equal to or greater than 90% for all years of the Contract term.	
Definition	Member Satisfaction will be measured utilizing the most current National Committee on Quality Assurance (NCQA) Adult Member Satisfaction Survey question that measures overall satisfaction.	
Assessment	\$3,000 for failure to attain a 90% satisfaction level for each year of the Contract term. Satisfaction will be indicated by each neutral and each better than neutral response.	
Compliance report	The Compliance Report is the Contractor's results from National Committee Quality Assurance (NCQA) annual Adult Member Satisfaction Survey. Performance will be measured, reported, and reconciled annually.	
7. Provider/Facility Network Accessibility - Applies to CoverTN, CoverKids and AccesTN		
Guarantee	As measured by the GeoNetworks [®] Provider & Facility Network Accessibility Analysis, the Contractor's provider and facility network will assure that 95% of all Members will have the Access Standard indicated.	
Definition	Provider Group	Access Standard
	PCPs (Endocrinologists, Pediatricians, Internal Medicine, General or Family Practitioners)	2 physicians within 20 miles
	Acute Care Hospitals	1 facility within 30 miles
	Pediatric Specialists (CoverKids only)	5 physicians within 100 miles
Assessment	\$1,000 if either of the characteristics of the network analysis are below the performance measure, as measured quarterly each year of the Contract.	
Compliance report	Compliance report is the quarterly GeoNetworks Analysis submitted by Contractor. The Quarterly guarantee is measured, reported and reconciled annually.	
8. Claims Data Quality - Applies to CoverTN, CoverKids and AccesTN		
Guarantee	Claims Data Quality is measured by the State's Claims Data Management vendor (Thomson-Reuters). The Contractor's quarterly data submission to Thomson-Reuters must meet the following Data Quality measures.	
Definition	<i>Measure</i>	<i>Benchmark</i>
	Gender	Data missing for <= (less than or equal to) 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 Thomson-Reuters Quarterly Data Quality report provided by Thomson-Reuters. Performance measured and reported (by Thomson-Reuters) quarterly; reconciled annually.)	
9. Member Handbooks and Member ID Card Distribution - Applies to CoverTN, CoverKids and AccesTN		
Guarantee	Member Handbooks and Member ID cards must be distributed (defined as "mailed") to a minimum of 95% of Members within 14 calendar days of Enrollment.	
Definition	The actual distribution to a minimum of 95% of Members by the specified dates.	
Assessment	Should the above standard not be met, the total amount shall be \$3,000 per year in which the standard	

	is not met.
Compliance report	Compliance Report submitted by Contractor. Performance is measured, reported, and reconciled annually.
10. Submission of Quarterly Data to Data Management Vendor - Applies to CoverTN, CoverKids and AccessTN	
Guarantee	Quarterly claims data will be submitted by the Contractor to the state's data management vendor (Thomson-Reuters) no later than the last day of the month following the end of each calendar quarter.
Definition	Quarterly claims data are received by Thomson-Reuters 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 \$3,000 per quarter.
Compliance report	Compliance reporting submitted by Thomson-Reuters upon receipt of quarterly claims data. Performance is measured and reported quarterly, reconciled annually.
11. Disease Management Program – Applies to AccessTN	
Guarantee	Maintain a compliant disease management program for each calendar year of the contract and provide a written report detailing Member participation semiannually and a written report detailing the results of the program evaluation annually.
Definition	Each disease management program shall have 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 Members identified with the chronic condition.
Assessment	\$5,000 for each semiannual report not submitted detailing Member participation. \$10,000 for each annual report not submitted detailing the results of the program evaluation.
Compliance report	Submitted by the Contractor, subject to examination of program content and participation by the State or the State's designee.
12. Requirements for Implementing On Request Reports (ORR) and Corrective Action Plans (CAP)	
Guarantee	Each ORR will have a deadline of ten (10) business days from the date of the ORR by which it will be due unless the ORR specifies a different delivery deadline. Each request for a CAP will have a deadline of ten (10) business days from the date of the request for CAP by which it will be due unless the CAP request specifies a different delivery deadline. Each approved CAP will have a deadline by which the Contractor must fully implement the required actions.
Definition	On Request Report (ORR) shall mean a request by Cover Tennessee for information pertaining to the fulfillment of the terms of this Contract by Contractor that is not otherwise listed in Attachment B to this Contract. Corrective Action Plan (CAP) means a plan of action proposed by the Contractor, at Cover Tennessee's request, to remedy a deficiency in Contractor's performance under this Contract. Cover Tennessee must approve each proposed CAP before it is implemented by the Contractor. The Contractor shall implement each approved CAP within the time specified by Cover Tennessee. Cover Tennessee, in its sole discretion, will determine when the approved CAP has been successfully implemented.
Assessment	A performance guarantee assessment of One Hundred Dollars (\$100) per business day may be made against the Contractor for each business day that the ORR is late. A performance guarantee assessment of One Hundred Dollars (\$100) per business day may be made against the Contractor for each business day that the CAP has not been received by Cover Tennessee. A performance guarantee assessment of One Hundred Dollars (\$100) per business day may be made against the Contractor for each business day that the approved CAP is not fully implemented.
Compliance Report	Incorporated into the approved CAP.

**Contract Attachment B
Management Reporting Requirements**

The Contractor shall submit Management Reports by which the State can assess the programs' 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 A (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) Management Reports

Report Name	Description	Program(s)	Frequency
Utilization and Cost Surveillance Report	Provides cost and utilization data for each major type of service	All Programs	Monthly
New Member Go-Bare Discrepancy Report	Identifies new Members who may have had coverage through Contractor during the three or six month go-bare period. Used to identify potential misrepresentation.	All Programs	Monthly
Division of Health Care Finance and Administration Enrollment Report	Report of all current Members. State matches against the public sector enrollment files for program integrity.	CoverTN and AccessTN only	Monthly
Monthly Enrollment Report	Detail breakout of enrollment	All Programs	Monthly
Enrollment by County and Region	Enrollment by County and Region	All Programs	Monthly
Care Management Monthly Summary Report	Reports touch and engagement rates, case distribution, closure reasons and cases by phase for DM and CM	AccessTN and CoverKids only	Monthly
Premium Exposure Report	Average Premium Equivalent and Premium Assistance calculated based on rates x exposure	AccessTN only	Monthly
Paid Premium Assistance Report	Reports the State's liability for Premium Assistance. Includes retroactivity.	AccessTN Only	Monthly

AccessTN Proactive Maternity Report	Identifies AccessTN women who (1) are qualified for AccessTN under regular eligibility, (2) have been enrolled for less than 12 months, and (3) have filed a claim with a diagnosis code related to pregnancy. Used for outreach for HealthyTNBabies.	AccessTN only	Monthly
CoverTN Proactive Maternity Report	Identifies CoverTN women who have filed a claim with a diagnosis code related to pregnancy. Used for outreach for HealthyTNBabies.	CoverKids only	Monthly
Existing Member Data Match Report	Identifies CoverKids members who may potentially have other coverage with Contractor. Used for State and Eligibility Contractor.	CoverKids only	Monthly
State Premium Equivalent Report	Reports the State's liability for its third of the CoverTN premium equivalent.	CoverTN only	Monthly
Deceased Member Report	Identifies CoverKids members who have a claim with a diagnosis code that indicates that the member is or became deceased.	CoverKids only	Quarterly
CoverTN Pregnant Woman claims data	Identifies the total amount of claims paid on CoverTN pregnant women that had a short enrollment time span while enrolled in HealthyTNBabies program.	CoverKids only	Annually
Ownership and Control Interest Statement and Criminal Information Report – only for the CoverKids Program	Includes, but is not limited to, the percentage of Disclosure Forms that have been verified as accurate and complete and the percentage remaining to be verified.	CoverKids only	Monthly

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	FA-
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.

CONTRACTOR SIGNATURE

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

PRINTED NAME AND TITLE OF SIGNATORY

DATE OF ATTESTATION

**CONTRACT ATTACHMENT D
DECISION SUPPORT SERVICES (DSS) DATA FORMATS
STANDARD ELIGIBILITY FILE LAYOUT
DESCRIPTION/GENERAL INFORMATION**

This interface is designed to produce a monthly eligibility file for Members administered through Contractor.

The data will be provided in a fixed-record length, ASCII file format.

The 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, the DSS vendor 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

As agreed to by DSS vendor and the Parties to this Contract.

FREQUENCY OF SUBMISSION

The data will be submitted to the DSS vendor 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.

DATA FORMATTING

The file layout table shall be provided in an agreed upon format and approved by the State.

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STANDARD MEDICAL CLAIMS FILE LAYOUT

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a Medical claims file for Members administered through Contractor.

The data will be provided in a fixed-record length, ASCII file format.

METHOD OF SUBMISSION

As agreed to by DSS vendor and the Parties to this Contract.

FREQUENCY OF SUBMISSION

The data will be submitted to DSS vendor on a quarterly basis.

TIMING OF SUBMISSION

Quarterly files should be submitted on or before the last day of the month following the close of each quarter.

DATA FORMATTING

The file layout table shall be provided in an agreed upon format and approved by the State.

**TR STANDARD DRUG FILE LAYOUT
DESCRIPTION/GENERAL INFORMATION**

This interface is designed to produce a Prescription Drug claims file for Members administered through the Contractor.

METHOD OF SUBMISSION

As agreed to by DSS vendor and the Parties to this Contract.

FREQUENCY OF SUBMISSION

The data will be submitted to the DSS vendor on a quarterly basis.

TIMING OF SUBMISSION

Quarterly files should be submitted on or before the last day of the month following the close of each quarter.

DATA FORMATTING

The file layout table shall be provided in an agreed upon format and approved by the State.

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 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 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 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. State understands and agrees:
 - E.4.1. to pay certain fees and compensation to Contractor, as contained in Contract Section C.3.2. 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. The 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 Contract Section A of this Contract.

- E.4.5. The claim-based access fee, if one is charged, will not exceed 0.00% 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
Professional Claim	\$6.00
Institutional Claim	\$6.00

*Large Group Locations are defined as: (1) Accounts having 1,000 or more, up to 9,999, Subscribers in a PPO product with 20 or more Subscribers residing in a single Host Plan Service Area; or (2) Accounts having 10,000 or more Subscribers in a PPO product.

- 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.

ATTACHMENT F

Name of Database	How often we review (Weekly, Monthly, Quarterly, Yearly)	Name of individual/Department responsible	How do we complete? (Manual verification or Systematically)	Comments
EPLS (Excluded Parties List System)	<ul style="list-style-type: none"> Quarterly via Homeland tracker Prior to contracting at preapp Monthly review of excluded providers 	Credentialing Dept/ Homeland Tracker	Systematically identify possible matches, then manually update Cactus and/or Facets Manual for excluded providers every month.	Also see Homeland Tracker below EPLS-GSA https://www.epls.gov/
GSA (General Services Administration)	See EPLS			This is the government agency responsible for EPLS
FEPOC (Federal Employee Operations Center) – OPM	Monthly via Enclarity and also quarterly file from FEPOC Quarterly as received	Provider Data Management/ Credentialing	Systematically and manual	
HIPDB (Health Integrity Protection Data Bank)	With Pre-app	Credentialing	Systematically submitted from and received to Cactus.	
OIG (Office of Inspector General)	See LEIE – Monthly review	Credentialing/ Provider	Systematically	OIG – LEIE http://exclusions.oig.hhs.gov/ Par and Non par providers
LEIE (List of Excluded Individuals/Entities)	Prior to initial credentialing, at 36 month recredentialing, and quarterly for credentialed providers	Credentialing, also Homeland Tracker for par and nonpar providers	Systematically identify possible matches, then manually update Cactus and/or Facets	OIG – LEIE http://exclusions.oig.hhs.gov/
TN Department of Health Disciplinary Reports	Monthly for credentialed providers (contiguous states, TN, GA, KY, AL, AR, KY, MS, MO & VA	Credentialing	Manually	