

CONTRACT #19
RFS # 318.65-00608
Edison # 39943

**Department of Finance and
Administration
Division of Health Care Finance
and Administration**

VENDOR:
**BlueCross BlueShield of
Tennessee, Inc.**



**STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243**

October 31, 2014

Senator Bill Ketron, Chairman
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: MCO Contract Amendments (Regional)
MCO Contract Amendments (Statewide)
Aon Consulting, Inc., #4
Health Management, Inc., #4
National Guardian Life Insurance Company, #5
BlueCross BlueShield of Tennessee, Inc. #1

Dear Chairman Ketron:

The Department of Finance and Administration, Division of Health Care Finance and Administration (HCFA), is submitting for consideration by the Fiscal Review Committee amendments to the regional Managed Care Organization (MCO) contracts. These contracts currently provide medical and behavioral health services to eligible TennCare enrollees. This proposed amendment is necessary to provide updated capitation rates for calendar year 2014 to reflect the implementation of the Primary Care Provider Enhanced Rate Payments as required by ACA. No additional funding is added to the contract to support the amended language. TennCare released a request for Proposal and new statewide contracts for managed care services have been identified and are currently preparing for implementation scheduled to begin January 1, 2015.

AMERIGROUP Tennessee, Inc., Amendment #19 - Middle
UnitedHealthCare Plan of the River Valley, Inc., Amendment #19- Middle
UnitedHealthCare Plan of the River Valley, Inc., Amendment #16 - West
Volunteer State Health Plan, Amendment #16 West
UnitedHealthCare Plan of the River Valley, Inc., Amendment #16 East
Volunteer State Health Plan, Amendment #16 East

The following new competitively procured MCOs for statewide medical and behavioral health services to TennCare enrollees were awarded in December, 2013. Since the January 1, 2014 contract start date, they have been undergoing a transition period from regional benefits to statewide, with actual delivery of services to begin January 1, 2015. This proposed amendment is necessary to provide specific language changes that have occurred since the contract was awarded, including changes regarding LTSS, Quality Oversight, minimum net worth requirements, CMS Health Insurer Fee requirements, and transportation clarifications. These amendments are language changes only and do not require additional funding nor a term extension.

Volunteer State Health Plan, Amendment #1
Unitedhealthcare Plan of the River Valley, Amendment #1
AMERIGROUP Tennessee, Amendment #1

Also submitted for review is amendment #36 to VSHP (TennCare Select), the current contractor providing a statewide network of medical and behavioral services for the TennCare program for children in State custody and other high risk populations. This proposed amendment is necessary to provide specific language changes including regarding LTSS, Quality Oversight, transportation clarifications, requirements regarding TCA 71-5-106 (r) for persons who are incarcerated, and term extension and funding for an additional year.

HCFA is also submitting amendment #4 to Aon Consulting, Inc., the competitively procured contract for actuarial services relevant to managed care organization rate structure in the TennCare program, as well as provision of federally required independent audits of Disproportionate Share Hospital (DSH) payments and actuarial services for the Cover Tennessee program. This amendment is necessary to provide sufficient funding to cover projected expenses for the remainder of the contract period of this competitively procured contract. The existing maximum liability and payment structure of this contract is based on hourly rates submitted in the competitive Cost Proposal.

Health Management Services, Inc. is the competitively procured contract for the provision of Third Party Liability recovery services. Per RFP and current contract language and associated rates, the Contractor is paid a percentage of all funds that are recovered on behalf of the state. This amendment provides continuation of services through term extension of the final one year period on this contract, at rates established in the RFP Cost Proposal. Additional funding is not being added to the contract at this time.

National Guardian Life Insurance is the current contractor for the provision of dental services for the Cover Kids program. This contract is being amended to extend the contract term for an additional six (6) month period of time and provide funding and rates for the continuation of dental services for this program until a new competitively procured contractor can assume delivery of services on July 1, 2015.

BlueCross BlueShield of Tennessee, Inc. is the current contractor for provision of CoverKids and AccessTN benefits. This amendment is necessary for the Contractor to transition AccessTN program members in order to provide services through policies of insurance for health insurance coverage for the program members who elect to participate in the AccessTN program. AccessTN members are typically suffering from high-risk, high-cost medical conditions. Transitioning members to individual coverage will also lower their out of pocket maximum, will allow members to stay on their same provider network, and will ensure members have minimum essential coverage to meet federal requirements. Current AccessTN coverage will not be designated minimum essential coverage after January 1, 2015.

The Department of Finance and Administration, Division of Health Care Finance and Administration, respectfully submits the above referenced contract amendments for consideration and approval 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

Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:			
*Contract Funding Source/Amount:			
State:	\$107,108,323.00	Federal:	\$274,948,486.00
<i>Interdepartmental:</i>		<i>Other:</i>	
If "other" please define:			
If "interdepartmental" 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>	
N/A			
Method of Original Award: <i>(if applicable)</i>		Non Competitive	
*What were the projected costs of the service for the entire term of the contract prior to contract award? How was this cost determined?		\$382,056,809.00	
*List number of other potential vendors who could provide this good or service; efforts to identify other competitive procurement alternatives; and the reason(s) a sole-source contract is in the best interest of the State.		This is an amendment to a non-competitive contract.	

BlueCross BlueShield of Tennessee, Inc.
Edison Contract ID: 39943
Vendor ID: 0000091649

CONTRACT EXPENDITURES BY FISCAL YEAR
(Payment Detail Attached)

FY2014	\$	73,162,273.11	
FY2015	\$	40,964,500.77	(Expenditures through October 17, 2014)
TOTAL	\$	114,126,773.88	

BlueCross BlueShield of Tennessee, Inc.

Edison Contract ID: 39943

Vendor ID: 0000091649

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2014	31865	00832311	010114-013114 CoverTnAdmin	1/8/2014	\$ 1,829,465.00
2014	31865	00832343	ACTN20140107	1/10/2014	\$ 6.00
2014	31865	00832343	ACTN20140107	1/10/2014	\$ 6.00
2014	31865	00832357	CVRK20140107	1/10/2014	\$ 36.00
2014	31865	00832343	ACTN20140107	1/10/2014	\$ 90.00
2014	31865	00832359	CVRK20140107TCS	1/10/2014	\$ 318.00
2014	31865	00832359	CVRK20140107TCS	1/10/2014	\$ 10,281.95
2014	31865	00832343	ACTN20140107	1/10/2014	\$ 18,257.19
2014	31865	00832343	ACTN20140107	1/10/2014	\$ 59,101.86
2014	31865	00832343	ACTN20140107	1/10/2014	\$ 233,807.68
2014	31865	00832357	CVRK20140107	1/10/2014	\$ 346,489.93
2014	31865	00832359	CVRK20140107TCS	1/10/2014	\$ 491,316.93
2014	31865	00836832	ACTN20140114	1/17/2014	\$ 6.00
2014	31865	00836832	ACTN20140114	1/17/2014	\$ 18.00
2014	31865	00836830	CVRK20140114	1/17/2014	\$ 42.00
2014	31865	00836832	ACTN20140114	1/17/2014	\$ 135.00
2014	31865	00836831	CVRK20140114TCS	1/17/2014	\$ 369.00
2014	31865	00836830	CVRK20140114	1/17/2014	\$ 691.11
2014	31865	00836831	CVRK20140114TCS	1/17/2014	\$ 17,567.14
2014	31865	00836832	ACTN20140114	1/17/2014	\$ 24,337.19
2014	31865	00836832	ACTN20140114	1/17/2014	\$ 24,522.37
2014	31865	00836832	ACTN20140114	1/17/2014	\$ 81,601.93
2014	31865	00836832	ACTN20140114	1/17/2014	\$ 101,519.55
2014	31865	00836832	ACTN20140114	1/17/2014	\$ 255,474.10
2014	31865	00836832	ACTN20140114	1/17/2014	\$ 344,528.48
2014	31865	00836830	CVRK20140114	1/17/2014	\$ 724,982.16
2014	31865	00836831	CVRK20140114TCS	1/17/2014	\$ 1,347,813.36
2014	31865	00840417	ACTN20140121	1/24/2014	\$ 12.00
2014	31865	00840417	ACTN20140121	1/24/2014	\$ 18.00
2014	31865	00840415	CVRK20140121	1/24/2014	\$ 57.00
2014	31865	00840417	ACTN20140121	1/24/2014	\$ 120.00
2014	31865	00840416	CVRK20140121TCS	1/24/2014	\$ 633.00
2014	31865	00840415	CVRK20140121	1/24/2014	\$ 5,258.86
2014	31865	00840416	CVRK20140121TCS	1/24/2014	\$ 19,737.90
2014	31865	00840417	ACTN20140121	1/24/2014	\$ 20,020.62
2014	31865	00840417	ACTN20140121	1/24/2014	\$ 102,705.66
2014	31865	00840417	ACTN20140121	1/24/2014	\$ 345,456.65
2014	31865	00840416	CVRK20140121TCS	1/24/2014	\$ 942,476.15
2014	31865	00840415	CVRK20140121	1/24/2014	\$ 1,159,081.09
2014	31865	00844533	ACTN20140128	1/31/2014	\$ 12.00

BlueCross BlueShield FY2014 (Continued)

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2014	31865	00844543	CVRK20140128	1/31/2014	\$ 39.00
2014	31865	00844533	ACTN20140128	1/31/2014	\$ 114.00
2014	31865	00844542	CVRK20140128TCS	1/31/2014	\$ 567.00
2014	31865	00844543	CVRK20140128	1/31/2014	\$ 4,773.32
2014	31865	00844533	ACTN20140128	1/31/2014	\$ 8,770.58
2014	31865	00844533	ACTN20140128	1/31/2014	\$ 10,123.33
2014	31865	00844542	CVRK20140128TCS	1/31/2014	\$ 14,534.64
2014	31865	00844533	ACTN20140128	1/31/2014	\$ 35,018.45
2014	31865	00844533	ACTN20140128	1/31/2014	\$ 44,682.50
2014	31865	00844533	ACTN20140128	1/31/2014	\$ 283,335.39
2014	31865	00844533	ACTN20140128	1/31/2014	\$ 290,252.89
2014	31865	00844543	CVRK20140128	1/31/2014	\$ 1,085,734.59
2014	31865	00844542	CVRK20140128TCS	1/31/2014	\$ 1,745,491.91
2014	31865	00844539	020114-022814 Cover TN Admi	2/3/2014	\$ 1,793,715.00
2014	31865	00848894	CVRK20140204	2/7/2014	\$ 30.00
2014	31865	00848897	ACTN20140204	2/7/2014	\$ 36.00
2014	31865	00848897	ACTN20140204	2/7/2014	\$ 114.00
2014	31865	00848895	CVRK20140204TCS	2/7/2014	\$ 393.00
2014	31865	00848894	CVRK20140204	2/7/2014	\$ 3,722.49
2014	31865	00848897	ACTN20140204	2/7/2014	\$ 7,167.57
2014	31865	00848895	CVRK20140204TCS	2/7/2014	\$ 8,449.00
2014	31865	00848897	ACTN20140204	2/7/2014	\$ 154,338.83
2014	31865	00848894	CVRK20140204	2/7/2014	\$ 677,394.65
2014	31865	00848895	CVRK20140204TCS	2/7/2014	\$ 928,263.36
2014	31865	00853894	ACTN20140211	2/14/2014	\$ 30.00
2014	31865	00853908	CVRK20140211	2/14/2014	\$ 66.00
2014	31865	00853894	ACTN20140211	2/14/2014	\$ 129.00
2014	31865	00853906	CVRK20140211TCS	2/14/2014	\$ 451.40
2014	31865	00853906	CVRK20140211TCS	2/14/2014	\$ 3,574.12
2014	31865	00853894	ACTN20140211	2/14/2014	\$ 7,568.62
2014	31865	00853894	ACTN20140211	2/14/2014	\$ 9,082.22
2014	31865	00853908	CVRK20140211	2/14/2014	\$ 9,749.00
2014	31865	00853894	ACTN20140211	2/14/2014	\$ 51,934.72
2014	31865	00853894	ACTN20140211	2/14/2014	\$ 56,524.58
2014	31865	00853894	ACTN20140211	2/14/2014	\$ 226,196.53
2014	31865	00853894	ACTN20140211	2/14/2014	\$ 252,558.54
2014	31865	00853908	CVRK20140211	2/14/2014	\$ 1,089,944.31
2014	31865	00853906	CVRK20140211TCS	2/14/2014	\$ 1,880,697.57
2014	31865	00858497	ACTN20140218	2/21/2014	\$ 6.00
2014	31865	00858495	CVRK20140218	2/21/2014	\$ 24.00
2014	31865	00858497	ACTN20140218	2/21/2014	\$ 162.00
2014	31865	00858494	CVRK20140218TCS	2/21/2014	\$ 396.00
2014	31865	00858495	CVRK20140218	2/21/2014	\$ 1,019.82

BlueCross BlueShield FY2014 (Continued)

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2014	31865	00858494	CVRK20140218TCS	2/21/2014	\$ 6,090.61
2014	31865	00858497	ACTN20140218	2/21/2014	\$ 15,947.52
2014	31865	00858497	ACTN20140218	2/21/2014	\$ 23,646.81
2014	31865	00858497	ACTN20140218	2/21/2014	\$ 191,341.21
2014	31865	00858495	CVRK20140218	2/21/2014	\$ 1,008,584.24
2014	31865	00858494	CVRK20140218TCS	2/21/2014	\$ 1,153,569.26
2014	31865	00863342	ACTN20140225	2/28/2014	\$ 6.00
2014	31865	00863342	ACTN20140225	2/28/2014	\$ 12.00
2014	31865	00863343	CVRK20140225	2/28/2014	\$ 75.00
2014	31865	00863342	ACTN20140225	2/28/2014	\$ 81.00
2014	31865	00863344	CVRK20140225TCS	2/28/2014	\$ 294.00
2014	31865	00863344	CVRK20140225TCS	2/28/2014	\$ 3,189.07
2014	31865	00863342	ACTN20140225	2/28/2014	\$ 4,273.48
2014	31865	00863342	ACTN20140225	2/28/2014	\$ 14,438.15
2014	31865	00863343	CVRK20140225	2/28/2014	\$ 24,312.72
2014	31865	00863342	ACTN20140225	2/28/2014	\$ 28,198.67
2014	31865	00863342	ACTN20140225	2/28/2014	\$ 40,043.96
2014	31865	00863342	ACTN20140225	2/28/2014	\$ 160,731.37
2014	31865	00863342	ACTN20140225	2/28/2014	\$ 249,345.51
2014	31865	00863343	CVRK20140225	2/28/2014	\$ 567,369.57
2014	31865	00863344	CVRK20140225TCS	2/28/2014	\$ 1,523,236.16
2014	31865	00868115	ACTN20140304	3/7/2014	\$ 12.00
2014	31865	00868115	ACTN20140304	3/7/2014	\$ 18.00
2014	31865	00868117	CVRK20140304	3/7/2014	\$ 33.00
2014	31865	00868115	ACTN20140304	3/7/2014	\$ 126.00
2014	31865	00868116	CVRK20140304TCS	3/7/2014	\$ 282.00
2014	31865	00868117	CVRK20140304	3/7/2014	\$ 607.57
2014	31865	00868116	CVRK20140304TCS	3/7/2014	\$ 1,387.54
2014	31865	00868115	ACTN20140304	3/7/2014	\$ 3,587.07
2014	31865	00868115	ACTN20140304	3/7/2014	\$ 60,493.71
2014	31865	00868115	ACTN20140304	3/7/2014	\$ 166,501.73
2014	31865	00868117	CVRK20140304	3/7/2014	\$ 647,540.61
2014	31865	00868116	CVRK20140304TCS	3/7/2014	\$ 947,089.33
2014	31865	00872588	030114-033114 Cover TN Admii	3/10/2014	\$ 2,041,875.00
2014	31865	00872644	ACTN20140311	3/14/2014	\$ 9.00
2014	31865	00872644	ACTN20140311	3/14/2014	\$ 18.00
2014	31865	00872642	CVRK20140311	3/14/2014	\$ 65.00
2014	31865	00872644	ACTN20140311	3/14/2014	\$ 246.00
2014	31865	00872640	CVRK20140311TCS	3/14/2014	\$ 321.00
2014	31865	00872642	CVRK20140311	3/14/2014	\$ 1,888.89
2014	31865	00872640	CVRK20140311TCS	3/14/2014	\$ 2,049.38
2014	31865	00872644	ACTN20140311	3/14/2014	\$ 7,674.20
2014	31865	00872644	ACTN20140311	3/14/2014	\$ 12,251.14

BlueCross BlueShield FY2014 (Continued)

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2014	31865	00872644	ACTN20140311	3/14/2014	\$ 33,741.91
2014	31865	00872644	ACTN20140311	3/14/2014	\$ 267,170.50
2014	31865	00872644	ACTN20140311	3/14/2014	\$ 285,689.00
2014	31865	00872642	CVRK20140311	3/14/2014	\$ 659,074.96
2014	31865	00872640	CVRK20140311TCS	3/14/2014	\$ 1,823,567.43
2014	31865	00877157	ACTN20140318	3/20/2014	\$ 6.00
2014	31865	00877160	CVRK20140318	3/20/2014	\$ 42.00
2014	31865	00877157	ACTN20140318	3/20/2014	\$ 57.00
2014	31865	00877157	ACTN20140318	3/20/2014	\$ 126.00
2014	31865	00877159	CVRK20140318TCS	3/20/2014	\$ 465.00
2014	31865	00877159	CVRK20140318TCS	3/20/2014	\$ 1,624.60
2014	31865	00877160	CVRK20140318	3/20/2014	\$ 5,229.72
2014	31865	00877157	ACTN20140318	3/20/2014	\$ 86,407.89
2014	31865	00877157	ACTN20140318	3/20/2014	\$ 364,765.19
2014	31865	00877160	CVRK20140318	3/20/2014	\$ 841,881.39
2014	31865	00877159	CVRK20140318TCS	3/20/2014	\$ 1,255,508.16
2014	31865	00881765	ACTN20140325	3/28/2014	\$ 9.00
2014	31865	00881765	ACTN20140325	3/28/2014	\$ 19.50
2014	31865	00881764	CVRK20140325	3/28/2014	\$ 60.00
2014	31865	00881765	ACTN20140325	3/28/2014	\$ 81.00
2014	31865	00881763	CVRK20140325TCS	3/28/2014	\$ 393.00
2014	31865	00881764	CVRK20140325	3/28/2014	\$ 6,364.87
2014	31865	00881763	CVRK20140325TCS	3/28/2014	\$ 7,141.47
2014	31865	00881765	ACTN20140325	3/28/2014	\$ 11,757.19
2014	31865	00881765	ACTN20140325	3/28/2014	\$ 15,058.69
2014	31865	00881765	ACTN20140325	3/28/2014	\$ 29,914.57
2014	31865	00881765	ACTN20140325	3/28/2014	\$ 41,334.42
2014	31865	00881765	ACTN20140325	3/28/2014	\$ 271,546.36
2014	31865	00881765	ACTN20140325	3/28/2014	\$ 338,891.70
2014	31865	00881764	CVRK20140325	3/28/2014	\$ 885,831.78
2014	31865	00881763	CVRK20140325TCS	3/28/2014	\$ 2,186,867.46
2014	31865	00886068	040114-043014 Cover TN Admii	4/2/2014	\$ 1,936,000.00
2014	31865	00886231	ACTN20140401	4/4/2014	\$ 3.00
2014	31865	00886246	CVRK20140401	4/4/2014	\$ 12.00
2014	31865	00886231	ACTN20140401	4/4/2014	\$ 17.25
2014	31865	00886231	ACTN20140401	4/4/2014	\$ 108.00
2014	31865	00886253	CVRK20140401TCS	4/4/2014	\$ 285.00
2014	31865	00886253	CVRK20140401TCS	4/4/2014	\$ 2,156.00
2014	31865	00886246	CVRK20140401	4/4/2014	\$ 6,083.48
2014	31865	00886231	ACTN20140401	4/4/2014	\$ 25,967.46
2014	31865	00886231	ACTN20140401	4/4/2014	\$ 28,293.17
2014	31865	00886231	ACTN20140401	4/4/2014	\$ 340,008.27
2014	31865	00886246	CVRK20140401	4/4/2014	\$ 607,627.71

BlueCross BlueShield FY2014 (Continued)

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2014	31865	00886253	CVRK20140401TCS	4/4/2014	\$ 1,407,764.66
2014	31865	00890758	ACTN20140408	4/11/2014	\$ 3.75
2014	31865	00890761	CVRK20140408	4/11/2014	\$ 11.00
2014	31865	00890758	ACTN20140408	4/11/2014	\$ 90.00
2014	31865	00890760	CVRK20140408TCS	4/11/2014	\$ 342.00
2014	31865	00890760	CVRK20140408TCS	4/11/2014	\$ 4,238.71
2014	31865	00890758	ACTN20140408	4/11/2014	\$ 9,036.52
2014	31865	00890761	CVRK20140408	4/11/2014	\$ 10,741.88
2014	31865	00890758	ACTN20140408	4/11/2014	\$ 16,158.53
2014	31865	00890758	ACTN20140408	4/11/2014	\$ 20,409.45
2014	31865	00890758	ACTN20140408	4/11/2014	\$ 43,372.34
2014	31865	00890758	ACTN20140408	4/11/2014	\$ 182,275.41
2014	31865	00890758	ACTN20140408	4/11/2014	\$ 299,495.59
2014	31865	00890761	CVRK20140408	4/11/2014	\$ 530,014.64
2014	31865	00890760	CVRK20140408TCS	4/11/2014	\$ 2,099,626.03
2014	31865	00903000	CVRK20140422	4/28/2014	\$ 6.00
2014	31865	00902998	CVRK20140415	4/28/2014	\$ 12.00
2014	31865	00903008	ACTN20140415	4/28/2014	\$ 13.50
2014	31865	00903009	ACTN20140422	4/28/2014	\$ 18.00
2014	31865	00903008	ACTN20140415	4/28/2014	\$ 45.00
2014	31865	00903009	ACTN20140422	4/28/2014	\$ 72.00
2014	31865	00903001	CVRK20140422TCS	4/28/2014	\$ 78.00
2014	31865	00902999	CVRK20140415TCS	4/28/2014	\$ 189.00
2014	31865	00902998	CVRK20140415	4/28/2014	\$ 204.16
2014	31865	00902999	CVRK20140415TCS	4/28/2014	\$ 468.02
2014	31865	00903009	ACTN20140422	4/28/2014	\$ 1,911.56
2014	31865	00903000	CVRK20140422	4/28/2014	\$ 2,520.68
2014	31865	00903001	CVRK20140422TCS	4/28/2014	\$ 4,106.26
2014	31865	00903009	ACTN20140422	4/28/2014	\$ 9,254.54
2014	31865	00903009	ACTN20140422	4/28/2014	\$ 10,238.06
2014	31865	00903008	ACTN20140415	4/28/2014	\$ 11,396.30
2014	31865	00903008	ACTN20140415	4/28/2014	\$ 22,638.12
2014	31865	00903009	ACTN20140422	4/28/2014	\$ 23,047.43
2014	31865	00903009	ACTN20140422	4/28/2014	\$ 147,325.04
2014	31865	00903008	ACTN20140415	4/28/2014	\$ 178,768.59
2014	31865	00903009	ACTN20140422	4/28/2014	\$ 350,403.14
2014	31865	00902998	CVRK20140415	4/28/2014	\$ 422,624.31
2014	31865	00903000	CVRK20140422	4/28/2014	\$ 422,768.43
2014	31865	00902999	CVRK20140415TCS	4/28/2014	\$ 1,047,623.09
2014	31865	00903001	CVRK20140422TCS	4/28/2014	\$ 2,482,687.86
2014	31865	00903120	CVRK20140429	5/2/2014	\$ 12.00
2014	31865	00903127	ACTN20140429	5/2/2014	\$ 36.00
2014	31865	00903121	CVRK20140429TCS	5/2/2014	\$ 219.00

BlueCross BlueShield FY2014 (Continued)

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2014	31865	00903120	CVRK20140429	5/2/2014	\$ 377.32
2014	31865	00903127	ACTN20140429	5/2/2014	\$ 1,187.38
2014	31865	00903127	ACTN20140429	5/2/2014	\$ 1,653.11
2014	31865	00903121	CVRK20140429TCS	5/2/2014	\$ 5,144.83
2014	31865	00903120	CVRK20140429	5/2/2014	\$ 173,391.31
2014	31865	00903127	ACTN20140429	5/2/2014	\$ 177,305.70
2014	31865	00903121	CVRK20140429TCS	5/2/2014	\$ 1,299,373.47
2014	31865	00907496	ACTN20140506	5/9/2014	\$ 3.00
2014	31865	00907496	ACTN20140506	5/9/2014	\$ 6.00
2014	31865	00907496	ACTN20140506	5/9/2014	\$ 36.00
2014	31865	00907498	CVRK20140506TCS	5/9/2014	\$ 319.75
2014	31865	00907498	CVRK20140506TCS	5/9/2014	\$ 1,277.79
2014	31865	00907496	ACTN20140506	5/9/2014	\$ 1,508.72
2014	31865	00907499	CVRK20140506	5/9/2014	\$ 1,666.78
2014	31865	00907496	ACTN20140506	5/9/2014	\$ 6,663.90
2014	31865	00907496	ACTN20140506	5/9/2014	\$ 27,281.81
2014	31865	00907496	ACTN20140506	5/9/2014	\$ 44,901.52
2014	31865	00907499	CVRK20140506	5/9/2014	\$ 182,964.07
2014	31865	00907496	ACTN20140506	5/9/2014	\$ 288,336.34
2014	31865	00907496	ACTN20140506	5/9/2014	\$ 345,495.13
2014	31865	00907498	CVRK20140506TCS	5/9/2014	\$ 2,273,947.37
2014	31865	00912625	ACTN20140513	5/19/2014	\$ 6.00
2014	31865	00912622	CVRK20140513	5/19/2014	\$ 30.00
2014	31865	00912625	ACTN20140513	5/19/2014	\$ 86.00
2014	31865	00912621	CVRK20140513TCS	5/19/2014	\$ 323.00
2014	31865	00912625	ACTN20140513	5/19/2014	\$ 1,896.19
2014	31865	00912621	CVRK20140513TCS	5/19/2014	\$ 2,161.29
2014	31865	00912625	ACTN20140513	5/19/2014	\$ 4,160.82
2014	31865	00912622	CVRK20140513	5/19/2014	\$ 16,495.35
2014	31865	00912625	ACTN20140513	5/19/2014	\$ 87,494.26
2014	31865	00912622	CVRK20140513	5/19/2014	\$ 133,311.21
2014	31865	00912621	CVRK20140513TCS	5/19/2014	\$ 1,634,119.73
2014	31865	00916851	ACTN20140520	5/23/2014	\$ 66.00
2014	31865	00916866	CVRK20140520TCS	5/23/2014	\$ 324.00
2014	31865	00916851	ACTN20140520	5/23/2014	\$ 651.00
2014	31865	00916851	ACTN20140520	5/23/2014	\$ 1,299.34
2014	31865	00916851	ACTN20140520	5/23/2014	\$ 2,499.64
2014	31865	00916866	CVRK20140520TCS	5/23/2014	\$ 4,549.66
2014	31865	00916851	ACTN20140520	5/23/2014	\$ 49,535.91
2014	31865	00916851	ACTN20140520	5/23/2014	\$ 89,864.66
2014	31865	00916851	ACTN20140520	5/23/2014	\$ 158,114.58
2014	31865	00916866	CVRK20140520TCS	5/23/2014	\$ 2,056,387.13
2014	31865	00920848	050114-053114 Cover TN Admi	5/27/2014	\$ 1,918,922.50

BlueCross BlueShield FY2014 (Continued)

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2014	31865	00920917	060114-063014 CoverTN Admin	5/30/2014	\$ 1,904,155.00
2014	31865	00925234	CVRK20140528	6/2/2014	\$ 18.00
2014	31865	00925235	CVRK20140520	6/2/2014	\$ 18.00
2014	31865	00925231	ACTN20140528	6/2/2014	\$ 57.00
2014	31865	00925237	CVRK20140528TCS	6/2/2014	\$ 459.00
2014	31865	00925231	ACTN20140528	6/2/2014	\$ 948.80
2014	31865	00925237	CVRK20140528TCS	6/2/2014	\$ 2,930.10
2014	31865	00925234	CVRK20140528	6/2/2014	\$ 4,583.18
2014	31865	00925231	ACTN20140528	6/2/2014	\$ 8,708.54
2014	31865	00925231	ACTN20140528	6/2/2014	\$ 106,598.28
2014	31865	00925234	CVRK20140528	6/2/2014	\$ 233,529.06
2014	31865	00925237	CVRK20140528TCS	6/2/2014	\$ 1,425,729.98
2014	31865	00925293	ACTN20140603	6/6/2014	\$ 9.97
2014	31865	00925300	CVRK20140603	6/6/2014	\$ 12.00
2014	31865	00925293	ACTN20140603	6/6/2014	\$ 24.00
2014	31865	00925300	CVRK20140603	6/6/2014	\$ 308.66
2014	31865	00925301	CVRK20140603TCS	6/6/2014	\$ 557.00
2014	31865	00925301	CVRK20140603TCS	6/6/2014	\$ 4,228.14
2014	31865	00925293	ACTN20140603	6/6/2014	\$ 23,403.37
2014	31865	00925293	ACTN20140603	6/6/2014	\$ 67,695.83
2014	31865	00925293	ACTN20140603	6/6/2014	\$ 117,146.46
2014	31865	00925300	CVRK20140603	6/6/2014	\$ 123,323.71
2014	31865	00925301	CVRK20140603TCS	6/6/2014	\$ 2,254,986.60
2014	31865	00929035	CVRK20140610	6/13/2014	\$ 13.00
2014	31865	00929034	ACTN20140610	6/13/2014	\$ 51.00
2014	31865	00929034	ACTN20140610	6/13/2014	\$ 56.80
2014	31865	00929034	ACTN20140610	6/13/2014	\$ 106.13
2014	31865	00929036	CVRK20140610TCS	6/13/2014	\$ 363.00
2014	31865	00929035	CVRK20140610	6/13/2014	\$ 71,807.23
2014	31865	00929034	ACTN20140610	6/13/2014	\$ 73,015.37
2014	31865	00929036	CVRK20140610TCS	6/13/2014	\$ 1,138,384.53
2014	31865	00933371	CVRK20140617	6/20/2014	\$ 27.00
2014	31865	00933378	ACTN20140617	6/20/2014	\$ 108.00
2014	31865	00933378	ACTN20140617	6/20/2014	\$ 453.22
2014	31865	00933370	CVRK20140617TCS	6/20/2014	\$ 462.00
2014	31865	00933370	CVRK20140617TCS	6/20/2014	\$ 2,357.53
2014	31865	00933378	ACTN20140617	6/20/2014	\$ 23,829.31
2014	31865	00933378	ACTN20140617	6/20/2014	\$ 61,083.64
2014	31865	00933371	CVRK20140617	6/20/2014	\$ 76,774.59
2014	31865	00933378	ACTN20140617	6/20/2014	\$ 130,070.77
2014	31865	00933370	CVRK20140617TCS	6/20/2014	\$ 2,399,230.30
2014	31865	00937453	CVRK20140624	6/27/2014	\$ 21.00
2014	31865	00937454	ACTN20140624	6/27/2014	\$ 63.00

BlueCross BlueShield FY2014 (Continued)

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2014	31865	00937455	CVRK20140624TCS	6/27/2014 \$	182.42
2014	31865	00937455	CVRK20140624TCS	6/27/2014 \$	504.00
2014	31865	00937453	CVRK20140624	6/27/2014 \$	878.00
2014	31865	00937454	ACTN20140624	6/27/2014 \$	2,724.66
2014	31865	00937454	ACTN20140624	6/27/2014 \$	7,540.82
2014	31865	00937453	CVRK20140624	6/27/2014 \$	66,945.61
2014	31865	00937454	ACTN20140624	6/27/2014 \$	145,945.73
2014	31865	00937455	CVRK20140624TCS	6/27/2014 \$	1,450,837.23

Total FY 2014: **\$ 73,162,273.11**

Contract Expenditures by Fiscal Year (Continued)

BlueCross BlueShield - Edison Contract #39943

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2015	31865	00941839	070114-073114 CoverTN Admin	7/2/2014	\$ 1,876,545.00
2015	31865	00945992	CVRK20140703	7/8/2014	\$ 54.00
2015	31865	00945989	ACTN20140703	7/8/2014	\$ 57.00
2015	31865	00945991	CVRK20140703TCS	7/8/2014	\$ 642.00
2015	31865	00945991	CVRK20140703TCS	7/8/2014	\$ 1,714.17
2015	31865	00945992	CVRK20140703	7/8/2014	\$ 20,121.60
2015	31865	00945989	ACTN20140703	7/8/2014	\$ 25,514.75
2015	31865	00945989	ACTN20140703	7/8/2014	\$ 72,734.60
2015	31865	00945989	ACTN20140703	7/8/2014	\$ 76,002.82
2015	31865	00945991	CVRK20140703TCS	7/8/2014	\$ 2,197,848.31
2015	31865	00946041	ACTN20140708	7/11/2014	\$ 9.00
2015	31865	00946046	CVRK20140708	7/11/2014	\$ 12.00
2015	31865	00946041	ACTN20140708	7/11/2014	\$ 41.07
2015	31865	00946041	ACTN20140708	7/11/2014	\$ 45.00
2015	31865	00946041	ACTN20140708	7/11/2014	\$ 80.14
2015	31865	00946045	CVRK20140708TCS	7/11/2014	\$ 369.00
2015	31865	00946045	CVRK20140708TCS	7/11/2014	\$ 1,808.32
2015	31865	00946046	CVRK20140708	7/11/2014	\$ 18,089.25
2015	31865	00946041	ACTN20140708	7/11/2014	\$ 138,183.14
2015	31865	00946045	CVRK20140708TCS	7/11/2014	\$ 1,308,593.50
2015	31865	00950762	ACTN20140715	7/18/2014	\$ 6.00
2015	31865	00950761	CVRK20140715	7/18/2014	\$ 6.00
2015	31865	00950762	ACTN20140715	7/18/2014	\$ 10.18
2015	31865	00950762	ACTN20140715	7/18/2014	\$ 12.00
2015	31865	00950758	CVRK20140715TCS	7/18/2014	\$ 432.00
2015	31865	00950758	CVRK20140715TCS	7/18/2014	\$ 1,217.21
2015	31865	00950762	ACTN20140715	7/18/2014	\$ 71,263.31
2015	31865	00950762	ACTN20140715	7/18/2014	\$ 111,048.05
2015	31865	00950758	CVRK20140715TCS	7/18/2014	\$ 1,822,419.49
2015	31865	00954630	CVRK20140722	7/25/2014	\$ 15.00
2015	31865	00954628	ACTN20140722	7/25/2014	\$ 30.60
2015	31865	00954628	ACTN20140722	7/25/2014	\$ 57.00
2015	31865	00954629	CVRK20140722TCS	7/25/2014	\$ 495.00
2015	31865	00954630	CVRK20140722	7/25/2014	\$ 3,220.72
2015	31865	00954630	CVRK20140722	7/25/2014	\$ 55,905.56
2015	31865	00954628	ACTN20140722	7/25/2014	\$ 67,878.37
2015	31865	00954629	CVRK20140722TCS	7/25/2014	\$ 1,519,224.05
2015	31865	00958665	080114-083114 CoverTN Admin	7/28/2014	\$ 1,877,452.50
2015	31865	00958821	ACTN20140729	8/1/2014	\$ 6.00
2015	31865	00958821	ACTN20140729	8/1/2014	\$ 36.00
2015	31865	00958818	CVRK20140729TCS	8/1/2014	\$ 635.12
2015	31865	00958818	CVRK20140729TCS	8/1/2014	\$ 732.00

BlueCross BlueShield FY2015 (Continued)

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2015	31865	00958821	ACTN20140729	8/1/2014	\$ 3,218.72
2015	31865	00958821	ACTN20140729	8/1/2014	\$ 74,667.30
2015	31865	00958821	ACTN20140729	8/1/2014	\$ 237,528.58
2015	31865	00958818	CVRK20140729TCS	8/1/2014	\$ 2,163,276.51
2015	31865	00958820	CVRK20140729	8/4/2014	\$ 6.00
2015	31865	00958820	CVRK20140729	8/4/2014	\$ 12,913.79
2015	31865	00962964	ACTN20140805	8/8/2014	\$ 51.00
2015	31865	00962966	CVRK20140805TCS	8/8/2014	\$ 384.00
2015	31865	00962964	ACTN20140805	8/8/2014	\$ 658.68
2015	31865	00962964	ACTN20140805	8/8/2014	\$ 1,481.82
2015	31865	00962964	ACTN20140805	8/8/2014	\$ 91,406.91
2015	31865	00962966	CVRK20140805TCS	8/8/2014	\$ 1,512,152.46
2015	31865	00967277	CVRK20140812	8/15/2014	\$ 6.00
2015	31865	00967271	ACTN20140812	8/15/2014	\$ 15.00
2015	31865	00967277	CVRK20140812	8/15/2014	\$ 128.20
2015	31865	00967278	CVRK20140812TCS	8/15/2014	\$ 133.75
2015	31865	00967271	ACTN20140812	8/15/2014	\$ 77,076.21
2015	31865	00967271	ACTN20140812	8/15/2014	\$ 140,060.62
2015	31865	00967278	CVRK20140812TCS	8/15/2014	\$ 2,622,455.37
2015	31865	00971199	ACTN20140819	8/22/2014	\$ 51.00
2015	31865	00971317	CVRK20140819TCS	8/22/2014	\$ 615.00
2015	31865	00971199	ACTN20140819	8/22/2014	\$ 1,448.36
2015	31865	00971199	ACTN20140819	8/22/2014	\$ 71,709.06
2015	31865	00971317	CVRK20140819TCS	8/22/2014	\$ 1,510,487.72
2015	31865	00975469	ACTN20140826	8/29/2014	\$ 6.00
2015	31865	00975469	ACTN20140826	8/29/2014	\$ 6.00
2015	31865	00975466	CVRK20140826	8/29/2014	\$ 12.00
2015	31865	00971318	CVRK20140819	8/29/2014	\$ 18.00
2015	31865	00975469	ACTN20140826	8/29/2014	\$ 96.00
2015	31865	00975469	ACTN20140826	8/29/2014	\$ 309.46
2015	31865	00975467	CVRK20140826TCS	8/29/2014	\$ 628.00
2015	31865	00975467	CVRK20140826TCS	8/29/2014	\$ 980.79
2015	31865	00975469	ACTN20140826	8/29/2014	\$ 36,115.70
2015	31865	00975466	CVRK20140826	8/29/2014	\$ 37,584.03
2015	31865	00975469	ACTN20140826	8/29/2014	\$ 112,717.93
2015	31865	00975444	090114-093014 CoverTN Admin	8/29/2014	\$ 1,919,885.00
2015	31865	00975467	CVRK20140826TCS	8/29/2014	\$ 2,476,203.32
2015	31865	00979591	ACTN20140902	9/5/2014	\$ 6.00
2015	31865	00979592	CVRK20140902	9/5/2014	\$ 6.00
2015	31865	00979591	ACTN20140902	9/5/2014	\$ 69.00
2015	31865	00979592	CVRK20140902	9/5/2014	\$ 168.26
2015	31865	00979593	CVRK20140902TCS	9/5/2014	\$ 209.60
2015	31865	00979593	CVRK20140902TCS	9/5/2014	\$ 417.00

BlueCross BlueShield FY2015 (Continued)

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2015	31865	00979592	CVRK20140902	9/5/2014	\$ 8,233.85
2015	31865	00979591	ACTN20140902	9/5/2014	\$ 56,411.39
2015	31865	00979593	CVRK20140902TCS	9/5/2014	\$ 1,915,428.52
2015	31865	00983918	CVRK20140909	9/12/2014	\$ 24.00
2015	31865	00983912	ACTN20140909	9/12/2014	\$ 51.00
2015	31865	00983918	CVRK20140909	9/12/2014	\$ 161.56
2015	31865	00983919	CVRK20140909TCS	9/12/2014	\$ 372.00
2015	31865	00983912	ACTN20140909	9/12/2014	\$ 3,883.54
2015	31865	00983919	CVRK20140909TCS	9/12/2014	\$ 6,427.99
2015	31865	00983918	CVRK20140909	9/12/2014	\$ 47,103.29
2015	31865	00983912	ACTN20140909	9/12/2014	\$ 73,656.04
2015	31865	00983912	ACTN20140909	9/12/2014	\$ 109,093.36
2015	31865	00983919	CVRK20140909TCS	9/12/2014	\$ 2,575,687.98
2015	31865	00987635	ACTN20140916	9/19/2014	\$ 39.00
2015	31865	00987632	CVRK20140916TCS	9/19/2014	\$ 282.00
2015	31865	00987632	CVRK20140916TCS	9/19/2014	\$ 2,468.68
2015	31865	00987628	CVRK20140916	9/19/2014	\$ 10,062.37
2015	31865	00987635	ACTN20140916	9/19/2014	\$ 42,011.16
2015	31865	00987632	CVRK20140916TCS	9/19/2014	\$ 1,456,286.02
2015	31865	00991745	ACTN20140923	9/26/2014	\$ 66.00
2015	31865	00991745	ACTN20140923	9/26/2014	\$ 186.48
2015	31865	00991748	CVRK20140923TCS	9/26/2014	\$ 211.05
2015	31865	00991748	CVRK20140923TCS	9/26/2014	\$ 399.00
2015	31865	00991745	ACTN20140923	9/26/2014	\$ 77,847.43
2015	31865	00991745	ACTN20140923	9/26/2014	\$ 122,113.57
2015	31865	00991748	CVRK20140923TCS	9/26/2014	\$ 2,452,030.62
2015	31865	00995873	100114-103114 CoverTN Admin	10/1/2014	\$ 1,888,342.50
2015	31865	00996023	CVRK20140930	10/3/2014	\$ 17.00
2015	31865	00996019	ACTN20140930	10/3/2014	\$ 45.00
2015	31865	00996021	CVRK20140930TCS	10/3/2014	\$ 439.00
2015	31865	00996021	CVRK20140930TCS	10/3/2014	\$ 707.19
2015	31865	00996019	ACTN20140930	10/3/2014	\$ 2,879.55
2015	31865	00996019	ACTN20140930	10/3/2014	\$ 59,520.69
2015	31865	00996021	CVRK20140930TCS	10/3/2014	\$ 1,528,268.77
2015	31865	01000314	CVRK20141007	10/10/2014	\$ 7.00
2015	31865	01000310	ACTN20141007	10/10/2014	\$ 57.00
2015	31865	01000312	CVRK20141007TCS	10/10/2014	\$ 445.00
2015	31865	01000312	CVRK20141007TCS	10/10/2014	\$ 2,545.97
2015	31865	01000310	ACTN20141007	10/10/2014	\$ 53,073.03
2015	31865	01000310	ACTN20141007	10/10/2014	\$ 165,109.67
2015	31865	01000312	CVRK20141007TCS	10/10/2014	\$ 2,335,490.43

BlueCross BlueShield FY2015 (Continued)

Fiscal Year	Unit	Voucher ID	Invoice	Pymt Date	Sum Amount
2015	31865	01004209	ACTN20141014	10/17/2014	\$ 3.00
2015	31865	01004211	CVRK20141014	10/17/2014	\$ 6.00
2015	31865	01004210	CVRK20141014TCS	10/17/2014	\$ 12.40
2015	31865	01004209	ACTN20141014	10/17/2014	\$ 45.00
2015	31865	01004210	CVRK20141014TCS	10/17/2014	\$ 397.00
2015	31865	01004209	ACTN20141014	10/17/2014	\$ 787.03
2015	31865	01004209	ACTN20141014	10/17/2014	\$ 67,690.30
2015	31865	01004210	CVRK20141014TCS	10/17/2014	\$ 1,520,137.36

Total FY 2015: **\$ 40,964,500.77**

Amendment Request

Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprrs.Agsprsr@tn.gov

APPROVED

CHIEF PROCUREMENT OFFICER

DATE

Request Tracking #	31865-00608	
1. Procuring Agency	Department of Finance and Administration Division of Health Care Finance and Administration	
2. Contractor	BlueCross BlueShield of Tennessee, Inc.	
3. Contract #	39943	
4. Proposed Amendment #	1	
5. Edison ID #	39943	
6. Contract Begin Date	January 1, 2014	
7. Current Contract End Date – with ALL options to extend exercised	December 31, 2015	
8. Proposed Contract End Date – with ALL options to extend exercised	December 31, 2015	
9. Current Maximum Contract Cost – with ALL options to extend exercised	\$382,056,809.00	
10. Proposed Maximum Contract Cost – with ALL options to extend exercised	\$382,056,809.00	
11. Office for Information Resources Pre-Approval Endorsement Request – information technology service (N/A to THDA)	x Not Applicable <input type="checkbox"/> Attached	
12. eHealth Pre-Approval Endorsement Request – health-related professional, pharmaceutical, laboratory, or imaging	x Not Applicable <input type="checkbox"/> Attached	
13. Human Resources Pre-Approval Endorsement Request – state employee training service	x Not Applicable <input type="checkbox"/> Attached	
14. Explanation Need for the Proposed Amendment		
<p>This amendment is necessary for the Contractor to transition AccessTN program members in order to provide services through policies of insurance for health insurance coverage for the program Members who elect to participate in the AccessTN program. AccessTN members are typically suffering from high-risk, high-cost medical conditions. Through this contract, the State shall secure health insurance coverage at the Silver Level for AccessTN members. This Silver Level plan selected from the Contractor shall be referred to as the "State-designated plan". Silver-level coverage</p>		

Request Tracking #	31865-00608
provides comparable benefits to AccessTN coverage, lower out-of-pocket limits, and eliminates maximum annual benefit limits and maximum lifetime limits that are present in AccessTN coverage	
<p>15. 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>16. Evidence Contractor's Experience & Length Of Experience Providing the Goods or Services</p> <p>BlueCross Blue Shield 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 that they have in Tennessee. BCBST has successfully implemented and managed not only the health care services for Cover Tennessee, but also has been a partner with TennCare in providing medical and behavioral services to eligible TennCare enrollees since 2008.</p>	
<p>17. Efforts to Identify Reasonable, Competitive, Procurement Alternatives</p> <p>This is a program amendment language change to existing contract. This amendment does not provide for term extension nor funding increase.</p>	
<p>18. Justification</p> <p>The AccessTN Board of Directors voted on September 16, 2014, to transition the state's high-risk pool members to a state-designated, individual, silver-level plan effective January 1, 2015. Transitioning AccessTN members into individual coverage will give members access to more comprehensive benefits. AccessTN members are currently subject to maximum annual benefit limits and maximum lifetime limits that are not included in individual market plans. Transitioning members to individual coverage will also lower their out of pocket maximum, will allow members to stay on their same provider network, and will ensure members have minimum essential coverage to meet federal requirements. Current AccessTN coverage will not be designated minimum essential coverage after January 1,2015. The Division of Health Care Finance and Administration respectfully requests approval of this amendment request.</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 circumstances</i></p> <p> 10/31/2014</p>	

**AMENDMENT #1 TO CONTRACT #39943
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
AND
BLUECROSS BLUESHIELD OF TENNESSEE, INC.**

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, hereinafter referred to as the "State" or "HCFA" and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the "Contractor." For good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

1. Delete the first paragraph of the Contract in its entirety and replace with the following:

This Contract, by and between the Department of Finance and Administration, Division of Health Care Finance and Administration (HCFA), hereinafter referred to as the "State" or "HCFA" and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the "Contractor," is for the delivery of AccessTN policies of insurance, and CoverKids (collectively, "Cover Tennessee") self-funded health plan services, including administrative services, provider network development and maintenance, 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 programs, as further defined in each program's separate Member Handbook and the "SCOPE OF SERVICES."

2. Delete Contract Section A.3.4 in its entirety and replace with the following:

A.3.4 "CoverKids Member" is defined as a CoverKids eligible individual who enrolled in the CoverKids plan administered by the Contractor.

3. Delete Contract Sections A.8. and A.9 in their entirety and replace with the following:

A.8 The Contractor agrees to provide services through policies of insurance for health insurance coverage for the AccessTN program for individuals who elect to participate in the AccessTN program. AccessTN Members are typically suffering from high-risk, high-cost medical conditions. Through this Contract, the State shall secure health insurance coverage at the Silver Level for AccessTN members. The State shall select a Silver Level plan that does not exceed the maximum monthly member premium per member rate specified in Contact Section C.3.d.. This Silver Level plan selected from the Contractor shall be referred to as the "State-Designated Plan". Silver-level coverage provides comparable benefits to AccessTN coverage, lower out-of-pocket limits, and eliminates maximum annual benefit limits and maximum lifetime limits that are present in AccessTN coverage.

A.8.1. The Contractor is responsible for providing services in accordance with the terms of the State-Designated Plan and as otherwise described in this Contract. The Contractor shall adhere to its standard administrative policies and procedures, including without limitation medical policies, claims administration procedures, member materials including ID cards and member handbooks, provider reimbursement practices and grievance procedures.

- A.8.2. The State will pay the entire monthly premium for the State-Designated Plan for each AccessTN Member directly to the Contractor as long as such AccessTN Members remain financially eligible for AccessTN. Financial eligibility will continue to be determined by the State. The Contractor will be required to refund premiums paid on behalf of an AccessTN Member who has been determined by the State to be ineligible for the program and the Contractor was properly notified by the State of the ineligibility prior to the premium being paid. Contractor will not be required to refund premiums paid on behalf of an AccessTN Member who is determined by the State to have been ineligible for periods for which premiums have already been paid. Premium rates for AccessTN Members will vary based on the AccessTN Member's age, geographic area, and tobacco use status, however, the monthly member premium per member shall not exceed the maximum monthly rate specified in Contact Section C.3.d.
- A.8.3. The Contractor shall ensure continuity of care and provide transition planning, when necessary and in a timely manner, for AccessTN Members transitioning December 31, 2014 to the State-Designated Plan.
- A.8.4. The Contractor shall be responsible for enrolling AccessTN Members into the State-Designated Plan in a process and timeline agreed to by the Contractor and the State.
- A.8.5. The Contractor shall provide to the State a monthly reconciliation report including (i) such member identification elements as member name, member ID number, date of birth, member address, final premium amount, coverage period, and tobacco use, or other member identification elements reasonably determined by the State, and (ii) premiums paid by the State for each AccessTN Member enrolled during the applicable month. The monthly reconciliation report shall be submitted by Contractor to the State within five business (5) days following receipt by Contractor of premium payment from the State.
- A.8.6. An ACH account established by the State to provide bank account drafts monthly will be used to facilitate enrollment of AccessTN Members into the State- Designated Plan. The Contractor shall act as a broker and enroll the AccessTN Members on behalf of the State into the State-Designated Plan.

The Contractor shall enter the State's ACH account number and routing number into the AccessTN Member's account during the member enrollment process. Monthly premiums will be debited each month separately for all active AccessTN Members. The ACH account will be reconciled by the State each month to active AccessTN Members.

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.
- A.9.2 "Enrollment" is defined as the date the Contractor enters the applicant's data into Contractor's core processing system.
- A.9.3. "AccessTN Member" is defined as an AccessTN eligible individual who is enrolled in the State-Designated Plan purchased from the Contractor.

A.9.4. "Member Handbook" regardless of whether or not capitalized, shall mean the Member Handbook that is supplied to AccessTN Members.

A.9.5. "Vital Documents" - Vital Documents may include, but are not limited to, consent and complaint forms, intake forms with the potential for important consequences, notices pertaining to the reduction, denial, delay, suspension or termination of services, certain critical outreach documents (i.e. case management and Population Health documents). At a minimum, all Vital Documents shall be available in the Spanish language.

A.9.6. "Silver Level Qualified Health Plan" - Coverage providing an actuarial value of 70 percent. Actuarial value reflects the average share of medical spending that is paid by the plan for a standard population, as opposed to out of pocket by the consumer in copays and deductibles.

4. Contract Sections A.10 – A.13 are deleted in their entirety and intentionally left blank.
5. Contract Section A.14 and the Heading preceding it are deleted in their entirety and replaced with the following:

APPLICABLE TO COVERKIDS SERVICES ONLY

A.14. The language in this section of the Contract is applicable to only to the CoverKids Program.

6. Contract Sections A.15.14 and A.15.15. are deleted in their entirety and replaced with the following:

A.15.14. BlueCard Program. The Contractor shall provide access to providers outside Tennessee to CoverKids Members, in certain situations, through the BlueCard program. This program is described in greater detail in Attachment E of this Contract.

A.15.15. New York Surcharge. If a CoverKids 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 CoverKids Member received services through the BlueCard and Program. The Contractor shall complete any reports that may be due, unless the State directs otherwise.

7. Contract Sections A.15.18. and A.15.19. are deleted in their entirety and replaced with the following:

A.15.18. In the event that a CoverKids Member is determined to be retroactively eligible for Medicaid, CoverKids eligibility will be terminated on the day before Medicaid eligibility begins. The Contractor will recoup payments to providers when periods of concurrent eligibility are determined.

8. Contract Section A.16.2.1. is deleted in its entirety and replaced with the following:

A.16.2.1. Claims Adjudication Reports. The Contractor shall provide the following reports to the State concerning claims adjudication for the CoverKids program:

9. Contract Section A.16.5 and A.16.6 are deleted in their entirety and replaced with the following:

A.16.5. The State will not hold the Contractor responsible for claims payments 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.16.6. The Contractor shall maintain a year to date calculation of all copayments (including medical and vision services, dental services and prescription drugs) required by CoverKids Members, accumulate the amounts by family units and advise the family by explanation of benefits (EOB) when the covered members of the family have assumed copayments equal to 5 percent (5%) of the allowable family income. The EOB will be in a form and substance approved by the State. When the family has reached this threshold, none of the CoverKids Members will be responsible for copays for the balance of the calendar year and provider payments shall be adjusted accordingly.

10. Contract Section A.17.1 is deleted in its entirety and replaced with the following:

A.17.1. 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 CoverKids program. 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, the expense of administration, the paid and incurred losses for the year and any other business conducted on behalf of the program and requested by the State, for each month, 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.

11. Contract Section A.17.4 is deleted in its entirety and replaced with the following:

A.17.4. The Contractor shall retain and maintain all records and documents in any way relating to the CoverKids program 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.

12. Contract Section A.18.4.1 is deleted in its entirety and replaced with the following:

A.18.4.1. The State appeals process is available to CoverKids 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 staff in the research and development of appeals.

13. Contract Section A.18.9 is deleted in its entirety and replaced with the following:
 - A.18.9. The Contractor shall maintain program-dedicated Internet pages for CoverKids Members and AccesTN Members, providing information on eligibility, benefits and enrollment. Information contained at this web site shall be subject to the review and approval of the State.
14. The first paragraph of Contract Section A.18.11 is deleted in its entirety and replaced with the following:
 - A.18.11. With regard to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Prospective Payments.
15. Contract Section A.18.12 is deleted in its entirety and replaced with the following:
 - A.18.12 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.
16. The first paragraph of Contract Section A.19.2 is deleted in its entirety and replaced with the following:
 - A.19.2. The State has selected Contractor's pharmacy program for CoverKids 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. Rebates are based on the pharmaceutical usage by CoverKids Members and are a percentage of the Rebate received by the PBM.
17. Contract Sections A.20.3 and A.20.4 are deleted in their entirety and replaced with the following:
 - A.20.3. The Contractor shall provide the State with a GeoNetworks® report showing service and geographic access in accordance with Contract Attachment A: Performance Guarantees. 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 Contractor shall submit a written plan of action to correct said deficiencies within the timeframe established by the State.
 - A. 20.4. In accordance with the requirements set forth in 42 U.S.C. § 300kk, the Contractor must develop and maintain the ability to collect and report, to the extent practicable, data on race, ethnicity, sex, primary language, and disability status for members and from members' parents or legal guardians if members are minors or legally incapacitated individuals, in a form and manner as prescribed by HCFA. In collecting this data the Contractor shall use the Office of Management and Budget (OMB) standards, at a minimum, for race and ethnicity measures. Race and

Ethnic Standards established for Federal Statistics and Administrative Reporting include the following categories as defined by the OMB:

A.20.4.1.Race – American Indian or Alaska Native, Asian, black or African American, native Hawaiian or other Pacific Islander, white;

A.20.4.2. Ethnicity – Hispanic or Latino, Not Hispanic or Latino.

18. The first paragraph of contract Section A.20.5 is deleted in its entirety and replaced with the following:

A.20.5. The Contractor is required to transmit CoverKids program enrollment data monthly and medical and prescription drug claims monthly to the Division of Health Care Finance and Administration, Office of Healthcare Informatics (HCI), until all claims incurred during the term of this Contract have been paid. Data shall be submitted in the format approved by the State. 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).

19. Contract Section A.21.2 is deleted in its entirety.

20. The following is added as Contract Sections C.3.c.and C.3.d:

c.. Effective January 1, 2015, the Contractor shall be compensated for said units, milestones, or increments of service based upon the following payment rates applicable to the CoverKids Program:

Service Description	Amount Per Member Per Month (PMPM)
CoverKids	\$27.50 PMPM

The State shall compensate the Contractor by the 5th business day of each month for the Contractor's satisfactory performance of all services outlined in this Contract, at the PMPM and other service based rates indicated, based upon the number of CoverKids Members certified by the State to the Contractor. The payment to the Contractor shall be equal to the number of CoverKids enrollees certified by the State, multiplied by the administrative fee for the appropriate enrollee category. The actual amount owed the Contractor for each CoverKids enrollee shall be determined by dividing the appropriate monthly administrative fee by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the CoverKids enrollee was enrolled in the plan.

The Contractor agrees the State may retroactively recoup Administrative Fee payments for deceased CoverKids enrollees. Retroactive recoupment will be deducted from the monthly payment for the following month. Payments may be recouped back to the date of death. This is the only provision whereby the State may retroactively recoup administrative fee payments from the Contractor for enrollees retroactively terminated from CoverKids.

(1) Subrogation Recoveries (CoverKids Only). 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 outside subrogation attorneys. 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.

(2) (CoverKids Only) State agrees that access fees required by the Contractor, and its licensees, for use of the BlueCard program by CoverKids 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 Attachment E BlueCard Program – CoverKids Only 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.

(3) Claims Funding (CoverKids Only). 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.16.2, on a weekly basis, as agreed to in writing by the State and the Contractor. The State shall make funds available to cover those claims payments within forty-eight (48) hours. 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.

d. Effective January 1, 2015, the following payment structures regarding AccessTN monthly premium for State-Designated Plan shall apply for the approximately 445 remaining AccessTN members. The State agrees to pay the premiums in a method established by the State and acceptable to the Contractor:

Service Description	Amount
Monthly Member premium for State-Designated Plan (not to exceed 445 AccessTN Members at varying rates based on age, geographic area and tobacco use status).	\$700.00 Maximum Per Member/Per Month Premium Rate (not to exceed \$3,738,000.00 annually)

(1) An ACH account established by the State to provide bank account drafts monthly will be used to facilitate enrollment of AccessTN Members into the State-Designated Plan. The Contractor shall act as a broker and enroll the AccessTN Members on behalf of the State into the State-Designated Plan.

(2) The Contractor shall enter the State's ACH account number and routing number into the AccessTN Member's account during the member enrollment process. Monthly premiums would then be debited each month separately for all active AccessTN Members. The ACH account would be reconciled by the State each month to active Access TN Members.

21. The first paragraph of Contract Section C.5 is deleted in its entirety and replaced with the following:

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.

22. Contract Section E.2 is deleted in its entirety and replaced with the following:

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
310 Great Circle Road, 2W
Nashville, Tennessee 37243
Telephone: (615) 741-9750
Fax: (615) 741-0028
Bo.irvin@tn.gov

The Contractor:
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, Tennessee 37402
Attn: Melissa Scissom
COO – CoverTennessee
Telephone: 423.535.8356
Fax: 423.591.9111

With a Copy to:
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, Tennessee 37402
Attn: General Counsel
Telephone: 423.535.7665
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.

23. The first sentence of Contract Section E.23 is deleted and replaced with the following:

E.23 Non-Discrimination Compliance Requirements -CoverKids Only (refer to Contract Section E.33 for AccessTN Only Non-Discrimination Compliance Requirements)

24. The first sentence of Contract Section E.24 is deleted and replaced with the following:

E.24. Non- Discrimination Compliance Reports –CoverKids Only

25. The following are added as Contract Sections E.33, E.34, and E.35.

E.33. Nondiscrimination Compliance Requirements – AccessTN Only

The Contractor shall comply with all applicable federal and state civil rights laws, regulations, rules, and policies and Contract Section D.7 of this Contract. The Parties acknowledge that a premium differential based on the Patient Protection and Affordable Care Act's permitted rating factors is not considered to be discrimination.

a. In order to demonstrate compliance with the applicable federal and State civil rights laws and regulations, which may include, but are not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Age Discrimination Act of 1975 the Contractor shall designate a staff person to be responsible for nondiscrimination compliance.

b. The Contractor's Nondiscrimination Compliance Coordinator ("NCC") shall be responsible for compliance with the nondiscrimination requirements set forth in this Contract. The Contractor does not have to require that civil rights compliance be the sole function of the designated NCC staff member. The Contractor's AccessTN NCC may be the NCC for the Contractor's Medicaid/CHIP programs or receive assistance from the Medicaid/CHIP NCC. However, the Contractor shall identify the designated NCC staff member to HCFA by name.

c. The Contractor shall report to HCFA, in writing, to the attention of the HCFA Director of Non-Discrimination Contract Compliance, within ten (10) calendar days of the commencement of any period of time that the Contractor does not have a designated staff person for nondiscrimination compliance. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported in writing to HCFAs within ten (10) calendar days of assuming the duties of the NCC.

(1) The Contractor's NCC currently has, or shall develop within thirty (30) days of the implementation of this Contract, a nondiscrimination training plan, and shall provide a copy of such training plan to HCFA on an annual basis and upon request. This training plan may be the same plan the Contractor uses for its Medicaid/CHIP programs or may be based off of that plan. If needed, the NCC may request an extension of time for this due date. Thereafter, this training plan shall be updated as needed to conform to changes in Federal and State law and provided to HCFA as set forth above.

The NCC shall be responsible for making nondiscrimination training available to all Contractor staff on an annual basis. The Contractor shall be able to show documented proof that the training was made available to the Contractor's staff.

(2) The Contractor shall, at a minimum, emphasize nondiscrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.

(3) The Contractor shall keep such records as may be necessary in order to submit timely, complete and accurate compliance reports that may be requested by the U.S. Department of Health and Human Services ("HHS"), HCFA, and the Tennessee Human Rights Commission ("THRC") or their designees. If requested, the information shall be provided in a format and timeframe specified by HHS, HCFA, or THRC. The requested information may be necessary to enable HHS, HCFA, or THRC to ascertain whether the Contractor is complying with the applicable civil rights laws. For example, the Contractor should have available data showing the manner in which services are or will be provided by the program in question, and related data necessary for determining whether any persons are or will be denied such services on the basis of prohibited discrimination. Further examples of data that could be requested can be found at 45 C.F.R. § 80.6 and 28 C.F.R. § 42.406.

(4) The Contractor shall permit access as set forth in the applicable civil rights laws, such as, 45 C.F.R. § 80.6 to HHS, HCFA, and THRC or their designees during normal business hours to such of its books, records, accounts, and other sources of information, and its facilities as may be pertinent to ascertain whether the Contractor is complying with the applicable civil rights laws.

(5) The Contractor shall make available to AccessTN Members and other interested persons information regarding the provisions of the applicable civil rights laws as set forth in the implementing regulations, including 45 C.F.R. § 80.6 and 45 C.F.R. § 84.8. For example, a notification shall state, where appropriate, that the Contractor does not discriminate in admission or access to, or treatment or employment in, its programs or activities. The notification shall also include an identification of the responsible employee designated for its nondiscrimination compliance. This notice shall be considered a vital document and shall be available at a minimum in the English and Spanish languages.

(6) The Contractor shall use and have available to AccessTN Members or other complainants AccessTN's discrimination complaint form located at the following link: http://www.covertn.gov/web/access_fair_treatment.html. The discrimination complaint form shall be provided to AccessTN Members and complainants upon request and on the Contractor's website. This complaint form shall be considered a vital document and shall be available at a minimum in the English and Spanish languages.

When requests for assistance to file a discrimination complaint are made by an AccessTN Member, and the Contractor is aware that the individual requesting the assistance is an AccessTN Member or a representative of an AccessTN member, the Contractor shall assist these individuals with submitting complaints to HCFA. The Contractor shall inform its employees about how to assist AccessTN Members and their representatives with obtaining discrimination complaint forms and assistance with submitting the forms to HCFA.

(7) Written materials provided to AccessTN Members shall ensure effective communication with Limited English Proficiency ("LEP") individuals and disabled/handicapped individuals at no expense to the member and/or the member's representative, and shall meet the standards set forth in the applicable civil rights laws and guidance. Effective Communication may be achieved by providing auxiliary aids or services, including, Braille and large print and shall be based on the needs of the individual and/or the individual's representative. Written materials sent to AccessTN Members shall include a number individuals can call free of charge for such language assistance. This information shall be considered a vital document and shall be available at a minimum in the English and Spanish languages.

(8) Written materials provided to AccessTN Members that are considered to be vital documents shall be translated and available to each AccessTN LEP group in accordance with the applicable standards set forth below:

(a) If the LEP group constitutes five percent (5%) or 1,000, whichever is less, of the AccessTN Member population, vital documents shall be translated into that LEP language. Translation of other documents, if needed, can be provided orally; or

(b) If there are fewer than fifty (50) persons in a member population language group that reaches the five percent (5%) trigger in (a), the Contractor shall inform those members that it does not provide written translation of the vital documents but provides written notice in that primary language of the right to receive competent oral interpretation of those written member materials, free of cost.

d. The Contractor shall submit the following nondiscrimination compliance deliverables to HCFA as follows:

- (1) Annually, HCFA shall provide the Contractor with a Nondiscrimination Compliance Questionnaire. The Contractor shall answer the questions contained in the Compliance Questionnaire and submit the completed Questionnaire to HCFA within ninety (90) days of the end of the calendar year with any requested documentation, which shall include, the Contractor's Assurance of Nondiscrimination. The signature date of the Contractor's Nondiscrimination Compliance Questionnaire shall be the same as the signature date of the Contractor's Assurance of Nondiscrimination. The Contractor's Nondiscrimination Compliance Questionnaire may be part of the same Questionnaire submitted for the Contractor's Medicaid/CHIP programs. However, certain information may need to be designated as belonging to the Contractor's Medicaid and CHIP programs. The Nondiscrimination Compliance Questionnaire deliverables shall be in a format specified by HCFA.
- (2) As part of the requested documentation for the Nondiscrimination Compliance Questionnaire, the Contractor shall submit copies of its nondiscrimination policies and procedures that demonstrate nondiscrimination in the provision of its services. These policies shall include topics, such as, the provision of language assistance services for LEP individuals and those requiring effective communication assistance in alternative formats, and providing assistance to individuals with disabilities. Any nondiscrimination policies and procedures that are specific to AccessTN Members shall be prior approved in writing by HCFA.
- (3) Also as part of the requested documentation for the Nondiscrimination Compliance Questionnaire the Contractor shall include a report that lists all language assistance services used by the Contractor in providing services to individuals who have LEP or that need communication assistance in an alternative formats. The report shall contain the names of the Contractor's language assistance service providers, the languages that interpretation and translation services are available in, the hours the language assistance services are available, and the numbers individuals call to access language assistance services.

e. Discrimination Complaint Investigations. All discrimination complaints against the Contractor and its employees shall be resolved according to the provisions of the below subsections:

- (1) Discrimination Complaints against the Contractor and/or Contractor's Employees. When complaints concerning alleged acts of discrimination committed by the Contractor and/or its employees related to the provision of and/or access to HCFA covered services are reported to the Contractor, the Contractor's NCC shall send such complaints within two (2) business days of receipt to HCFA. HCFA shall investigate and resolve all alleged acts of discrimination committed by the Contractor and/or its employees. The Contractor shall cooperate with HCFA during the investigation and resolution of such complaints. HCFA reserves the right to request that the Contractor's NCC assist with conducting the initial investigations and to suggest resolutions of alleged discrimination complaints. If HCFA requests that the Contractor's NCC assist HCFA with conducting the initial investigation, the Contractor's NCC within five (5) business days from the date of the request shall start the initial investigation. The Contractor's NCC shall provide HCFA with all requested information, including but not limited to, the identity of the party filing the complaint; the complainant's relationship to the Contractor; the circumstances of the complaint; date complaint filed; and the Contractor's suggested resolution. HCFA shall review the Contractor's initial investigations and determine the appropriate resolutions for the complaints as set forth in subsection b below. During the complaint investigation, the Contractor shall have the opportunity to provide HCFA with any information that is relevant to the complaint investigation. Any documentation or materials related to such investigation shall be considered confidential and not subject to disclosure to any third party, unless disclosure is otherwise required by law.
- (2) Corrective Action Plans to Resolve Discrimination Complaints. If a discrimination complaint against the Contractor or its employees is determined by HCFA to be valid, HCFA shall, at its option, either (i) provide the Contractor with a corrective action plan to resolve the complaint, or (ii) request that the Contractor submit a proposed corrective action plan to HCFA for review and approval that specifies what actions the Contractor proposes to take to resolve the discrimination complaint. Upon provision of the corrective action plan to Contractor by HCFA, or approval of the Contractor's proposed corrective action plan by HCFA, the Contractor shall implement the approved corrective action plan to resolve the discrimination complaint. HCFA, in its sole discretion, shall determine when a satisfactory discrimination complaint resolution has been reached and shall notify Contractor of the approved resolution. A discrimination complaint resolution corrective action plan may consist of approved nondiscrimination training on relevant discrimination topics. Prior to use, the nondiscrimination training material shall be reviewed and approved by HCFA. Time periods for the implementation of the corrective action plan nondiscrimination training shall be designated by HCFA.

E.34. Access TN Only - As a party to this Contract, the Contractor hereby acknowledges its designation as a covered entity and/or business associate under the HIPAA regulations and agrees to comply with all applicable HIPAA and HITECH (hereinafter "HIPAA/HITECH") regulations. In accordance with HIPAA/HITECH regulations, the Contractor shall, at a minimum:

- a. Comply with requirements of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic

and Clinical Health Act of 2009 (HITECH), including, but not limited to, the transactions and code sets, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data sharing agreements required under the regulations;

b. Transmit/receive from/to its providers, subcontractors, clearinghouses and HCFA all transactions and code sets required by the HIPAA/HITECH regulations in the appropriate standard formats, utilizing appropriate and adequate safeguards, as specified under the law and as directed by HCFA so long as HCFA direction does not conflict with the law;

c. Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA/HITECH standards, that it will be in breach of this Contract and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between HCFA and the Contractor and between the Contractor and its providers and/or subcontractors to a halt, if for any reason the Contractor cannot meet the requirements of this Section, HCFA may terminate this Contract in accordance with the Business Associate Agreement ancillary to this Contract;

d. Ensure that Protected Health Information (PHI) exchanged between the Contractor and HCFA is used only for the purposes of treatment, payment, or health care operations and health oversight and its related functions. All PHI not transmitted for these purposes or for purposes allowed under the federal HIPAA/HITECH regulations shall be de-identified to secure and protect the individual enrollee's PHI;

e. Report to HCFA's Privacy Office without unreasonable delay and no later than 60 days from the discovery of any use or disclosure of PHI in violation of this Contract by the Contractor, its officers, directors, employees, subcontractors or agents or by a third party to which the Contractor disclosed PHI;

f. Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the Contractor pursuant to this Section;

g. Make an enrollee's PHI accessible within a reasonable period to HCFA upon request by HCFA;

h. Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA/HITECH regulations upon request;

i. Create and adopt policies and procedures to periodically audit adherence to all HIPAA/HITECH regulations, and for which Contractor acknowledges and promises to perform, including but not limited to, the following obligations and actions:

j. Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of HCFA agrees to use reasonable and appropriate safeguards to protect the PHI;

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

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

E.35. Notification of Breach - AccessTN Only - The Contractor shall notify HCFA's Privacy Office without unreasonable delay and no later than 60 days after becoming aware of any incident, that represents unauthorized access, use or disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained or held by the Contractor, including any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the Contractor's system. This includes, but is not limited to, loss or suspected loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and/or disks.

a. The Contractor shall use the Loss Worksheet located at http://www.tn.gov/HCFA/forms/phi_piiworksheet.pdf to quickly gather and organize information about the incident. The Contractor must provide HCFA with timely updates as any additional information about the loss of PHI/PII becomes available.

b. If the Contractor experiences a loss or breach of said data, HCFA will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the Contractor shall bear any costs associated with the notice or any mitigation.

c. The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services and identify theft safeguards for individuals that are deemed to be part of a potential or actual disclosure. The Contractor shall bear the costs of notification to individuals having PHI/PII involved in a potential or actual disclosure, including individual notice and/or public notice and all other costs associated with the provision of safeguard services.

26. Contract Attachment A is deleted in its entirety and replaced with new Attachment A, attached hereto.

27. Contract Attachment B is deleted in its entirety and replaced with the new attachment B attached hereto.

28. Contract Attachment D is deleted in its entirety.

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

Amendment Effective Date. The revisions set forth herein shall be effective December 31, 2014. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

CONTRACTOR SIGNATURE

DATE

**PRINTED NAME AND TITLE OF CONTRACTOR
SIGNATORY (ABOVE)**

DATE

**DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION:**

LARRY B. MARTIN , COMMISSIONER

DATE

ATTACHMENT A
Effective January 1, 2015

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. In addition to the specific performance assessments below, the State reserves the right to assess a general performance assessment of five hundred dollars (\$500) per calendar day for each day that the Contractor fails to comply with the provisions and requirements of this Contract. The damage that may be assessed shall be \$500 per calendar day for each separate failure to comply with the Contract, plus, if applicable, an additional \$500 per calendar day for each affected member.

AccessTN

1. Protected Health Information Security	
Guarantee	Ensure that all State data containing protected health information (PHI), as defined in HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5 on the HHS Web site which compromises the security or privacy of protected health information (See ancillary Business Associate Agreement executed between the parties)
Definition	The Contractor shall take all necessary steps to secure all protected health information as prescribed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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 specified by the Secretary of Health and Human Services under Public Law 115 and according to the Business Associate Agreement.
Assessment	Should the above standard not be met, an assessment of (\$500) per recipient per occurrence may be assessed, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those State recipients whose PHI was placed at risk by Contractor's failure to comply with the terms of this Contract, the Contractor shall be liable for all costs associated with the provision of such safeguard services.
Compliance Report	Contractor shall issue an annual statement attesting to compliance. In the event of a breach of PHI security, the Contractor shall without unreasonable delay and no later than 60 days file a report with the HCFA Privacy Office containing the details of the breach as previously set forth in this contract via the PHI/PII Loss Worksheet. All required follow up reports from the Contractor will be timely submitted to the HCFA Privacy Office as directed.

CoverKids

2. Claims Payment Dollar Accuracy	
Guarantee	The average monthly financial accuracy of claims payments will be 97% upon initial submission.
Definition	Percentage of total claims paid accurately for each month
Assessment	\$5,000 for each full percentage point accuracy is below 97% for each month
Compliance report	The Compliance Report is the monthly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results monthly. Performance will be reconciled annually.

3. Timely Claims Processing	
Guarantee	90% of non-investigated (clean) claims (for which no further written information or substantiation is required in order to make payment) are paid within fourteen (14) calendar days of the receipt of claim 96% of all claims are processed within thirty (30) calendar days
Definition	Percentage of clean electronic claims paid within 14 calendar days of receipt of claim, for each month Percentage of claims paid within 30 calendar days of receipt of claim, for each month
Assessment	\$10,000 for each month determined not to be in compliance
Compliance report	The Compliance Report is the monthly internal audit performed by the Contractor on a statistically valid sample. The Contractor shall measure and report results monthly. Performance will be reconciled annually.
4. Telephone Response Time/Call Answer Timeliness - Member Services	
Guarantee	Eighty-five percent (85%) of incoming Member services calls will be answered by a Member Services representative within 30 seconds or the prevailing benchmark established by NCQA
Definition	Telephone Response Time is defined as the number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period
Assessment	\$25,000 for each full percentage point below the 85% threshold for calls answered within 30 seconds 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. Telephone Response Time/Call Answer Timeliness – Provider Services Line	
Guarantee	Eighty-five percent (85%) of incoming Provider Services calls will be answered by a Provider Services representative within 30 seconds or the prevailing benchmark established by NCQA
Definition	Telephone Response Time is defined as the number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period
Assessment	\$25,000 for each full percentage point below the 85% threshold for calls answered within 30 seconds 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.
6. Telephone Response Time/Call Answer Timeliness – Utilization Management (UM) Line	
Guarantee	Eighty-five percent (85%) of incoming Utilization Management calls will be answered by a Utilization Management representative within 30 seconds or the prevailing benchmark established by NCQA
Definition	Telephone Response Time is defined as the number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period
Assessment	\$25,000 for each full percentage point below the 85% threshold for calls answered within 30 seconds 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.
7. Telephone Response Time/Call Answer Timeliness – NurseTriage/Nurse Advice Line	
Guarantee	Eighty-five percent (85%) of incoming NurseTriage/Nurse Advice calls will be answered by a NurseTriage/Nurse Advice representative within 30 seconds or the prevailing benchmark established by NCQA
Definition	Telephone Response Time is defined as the number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period
Assessment	\$25,000 for each full percentage point below the 85% threshold for calls answered within 30 seconds 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.

8. Telephone Call Abandonment Rate (Unanswered calls) – Member Services Line	
Guarantee	Less than 5% of telephone calls are abandoned by the Member Services Line
Definition	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period.
Assessment	\$25,000 for each full percentage point above 5% for calls abandoned before being answered by a live voice. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal Member Services telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
9. Telephone Call Abandonment Rate (Unanswered calls) – Provider Services Line	
Guarantee	Less than 5% of telephone calls are abandoned by the Provider Services Line
Definition	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period.
Assessment	\$25,000 for each full percentage point above 5% for calls abandoned before being answered by a live voice. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal Provider Services telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
10. Telephone Call Abandonment Rate (Unanswered calls) –UM Line	
Guarantee	Less than 5% of telephone calls are abandoned by the UM Line
Definition	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period.
Assessment	\$25,000 for each full percentage point above 5% for calls abandoned before being answered by a live voice. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal UM telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
11. Telephone Call Abandonment Rate (Unanswered calls) – Nurse Triage/Nurse Advice Line	
Guarantee	Less than 5% of telephone calls are abandoned by the Nurse Triage/Nurse Advice Line
Definition	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period.
Assessment	\$25,000 for each full percentage point above 5% for calls abandoned before being answered by a live voice. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal Nurse Triage/Nurse Advice telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
12. Distance from Provider to Member	
Guarantee	In accordance with this Contract, including all attachments.
Definition	Distance from provider to member is defined by travel distance as measured by GeoAccess.
Assessment	\$25,000 if any of the listed standards are not met, either individually or in combination, on a monthly basis; The liquidated damage may be lowered to \$5,000 in the event that the Contractor provides a corrective action plan that is accepted by HCFA.
Compliance report	The monthly Provider Enrollment file sent to the State will determine if the GeoAccess is met on a monthly basis.
13. Provider Satisfaction	
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, throughout the year, and report annually. 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.
14. Member Satisfaction	
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	\$10,000 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.
15. External Quality Review Organization (EQRO) - Provider Network Documentation	
Guarantee	Each monthly Provider Enrollment file should have 100% of providers with a signed provider agreement with the Contractor.
Definition	Executed contract is a signed provider agreement with a provider to participate in the Contractor's network as a contract provider.
Assessment	\$1,000 for each provider for which the Contractor cannot provide a signature page from the provider agreement between the provider and the Contractor
Compliance report	Compliance report is the monthly Provider Enrollment File and provider agreement signature page, upon request from HCFA.
16. External Quality Review Organization (EQRO) - Specialist Provider Network	
Guarantee	1. Physician Specialists: Executed specialty physician contracts in all areas required by this Agreement for the following specialists: allergy; cardiology; dermatology; endocrinology; gastroenterology; general surgery; nephrology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; psychiatry (child/adolescent); and urology 2. Essential Hospital Services: Executed contract with at least one (1) tertiary care center for each essential hospital service 3. Center of Excellence for People with AIDS: Executed contract with at least two (2) Center of Excellence for AIDS. 4. Center of Excellence for Behavioral Health: Executed contract with all COEs for Behavioral Health.
Definition	Executed contract is a signed provider agreement with a provider to participate in the Contractor's network as a contract provider.
Assessment	\$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis.
Compliance report	Compliance report is the monthly Provider Enrollment File.
17. External Quality Review Organization (EQRO) Provider Data Validation – Provider Participation Accuracy	
Guarantee	As validated by the State's EQRO vendor quarterly, Contractor shall have at least 90% of listed providers confirm participation in the Contractor's network.
Definition	A statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the Contractor's network
Assessment	\$25,000 per quarter if less than 90% of providers confirm participation. The liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by HCFA, or may be waived by HCFA if the Contractor submits sufficient documentation to demonstrate 90% of providers in the sample are participating
Compliance report	Compliance report is the quarterly EQRO Provider Data Validation report.
18. External Quality Review Organization (EQRO) Provider Data Validation – Provider Information Accuracy	
Guarantee	As validated by the State's EQRO vendor quarterly, Contractor shall have data for no more than 10% of listed providers is incorrect for each data element.
Definition	Data for no more than 10% of a statistically valid sample of participating providers on the most recent monthly provider enrollment is incorrect for each element as determined by HCFA
Assessment	\$5,000 per quarter if data for more than 10% but fewer than 31% of providers is incorrect for each

	<p>data element \$25,000 per quarter if data for more than 30% of providers is incorrect for each data element The \$25,000 liquidated damage may be lowered to \$5,000 in the event that the Contractor provides a corrective action plan that is accepted by HCFA, or may be waived by HCFA if the Contractor submits sufficient documentation</p>	
Compliance report	Compliance report is the quarterly EQRO Provider Data Validation report.	
19. Claims Data Quality		
Guarantee	Claims Data Quality is measured by HCI. The Contractor's quarterly data submission to HCI 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 ANY of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Compliance report	Compliance Report consists of the Quarterly Data Quality report provided by HCI. Performance measured and reported quarterly; reconciled annually.)	
20. Member Handbooks and Member ID Card Distribution		
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 \$5,000 per year in which the standard is not met.	
Compliance report	Compliance Report submitted by the Contractor. Performance is measured, reported, and reconciled annually.	
21. Submission of Monthly Data to Data Management Vendor		
Guarantee	Monthly claims data will be submitted by the Contractor to HCI no later than the 5th day of the month following the end of each calendar month.	
Definition	Monthly claims data are received by the HCI no later than the 5th day of the month following the end of each calendar month.	
Assessment	Failure to submit monthly claims data no later than the 5th day of the month following the end of each month will result in an assessment of \$100 per day for the first and second business days past the compliance date, and \$500 for each business day thereafter, to a maximum of \$3,000 per quarter.	
Compliance report	Compliance reporting submitted by the State's analytic division upon receipt of monthly claims data. Performance is measured and reported monthly, reconciled annually.	
22. Requirements for Implementing On Request Reports (ORR) and Corrective Action Plans (CAP)		
Guarantee	<p>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.</p> <p>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.</p> <p>Each approved CAP will have a deadline by which the Contractor must fully implement the required actions.</p>	
Definition	<p>On Request Report (ORR) shall mean a request by HCFA 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.</p> <p>Corrective Action Plan (CAP) means a plan of action proposed by the Contractor, at HCFA's request, to remedy a deficiency in Contractor's performance under this Contract. HCFA must approve each proposed CAP before it is implemented by the Contractor. The Contractor shall implement each approved CAP within the time specified by HCFA. HCFA, in its sole discretion, will determine when the approved CAP has been successfully implemented.</p>	
Assessment	<p>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.</p> <p>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 HCFA.</p>	

	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.
23. Protected Health Information Security	
Guarantee	Ensure that all State data containing protected health information (PHI), as defined in HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5 on the HHS Web site which compromises the security or privacy of protected health information (See ancillary Business Associate Agreement executed between the parties)
Definition	The Contractor shall take all necessary steps to secure all protected health Information as prescribed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) ,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 specified by the Secretary of Health and Human Services under Public Law 115 and according to the Business Associate Agreement.
Assessment	Should the above standard not be met, an assessment of (\$500) per recipient per occurrence may be assessed, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those State recipients whose PHI was placed at risk by Contractor's failure to comply with the terms of this Contract, the Contractor shall be liable for all costs associated with the provision of such safeguard services.
Compliance report	Contractor shall issue a quarterly statement attesting to compliance. In the event of a breach of PHI security, the Contractor shall immediately file a report with the HCFA Privacy Office containing the details of the breach. All required follow up reports from the Contractor will be timely submitted to the HCFA Privacy Office as directed.
24. Prevention of PHI Disclosure to Third Party	
Guarantee	Ensure to seek express written approval from the State, including the execution of the appropriate agreements to effectuate transfer and exchange of State recipient PHI or State confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party for any purpose other than the purpose of this Contract. (See ancillary Business Associate Agreement executed between the parties)
Definition	Prior to the disclosure of any State recipient PHI or State confidential information that is outside the scope of this contract to a third party, the Contractor must seek express written approval from the HCFA Privacy Office.
Assessment	Should the above standard not be met, an assessment of (\$500) per recipient per occurrence may be assessed.
Compliance report	After the transfer of the approved PHI, Contractor shall notify the HCFA Privacy Office of the successful transfer of the PHI and provide documentation that the approved process for the transfer was followed.
25. Prevention of PHI Information to Third Party Beyond U.S. Boundaries	
Guarantee	Ensure prevention of use or disclosure of State recipient data or State confidential data in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States (See ancillary Business Associate Agreement executed between the parties)

Definition	No State recipient data or State confidential data is permitted to be used or disclosed by any third party outside of the boundaries and jurisdiction of the United States. The Contractor is responsible to take all necessary steps to prevent a breach of this requirement.
Assessment	Should the above standard not be met, an assessment of (\$1,000) per recipient per occurrence may be assessed.
Compliance report	Contractor shall issue a quarterly statement attesting to compliance. In the event of a breach of this guarantee, the Contractor shall immediately file a report with the HCFA Privacy Office containing the details of the breach. All required follow up reports from the Contractor will be timely submitted to the HCFA Privacy Office as directed.

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	CoverKids Only	Monthly
Monthly Enrollment Report	Detail breakout of enrollment	CoverKids Only	Monthly
Enrollment by County and Region	Enrollment by County and Region	CoverKids Only	Monthly
Care Management Monthly Summary Report	Reports touch and engagement rates, case distribution, closure reasons and cases by phase for DM and CM	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
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	Quarterly thru run-out
Ownership and Control Interest Statement and	Includes, but is not limited to, the percentage of	CoverKids only	Monthly

Criminal Information Report – only for the pharmacies in the CoverKids Program	Disclosure Forms that have been verified as accurate and complete and the percentage remaining to be verified.		
5% Annual Member Cost Sharing Report	Identifies CoverKids members who may reach their 5% annual cost sharing maximum limit	CoverKids only	Quarterly



GENERAL ASSEMBLY OF THE STATE OF TENNESSEE
FISCAL REVIEW COMMITTEE

320 Sixth Avenue, North – 8th Floor
NASHVILLE, TENNESSEE 37243-0057
615-741-2564

Sen. Bill Ketron, Chairman

Senators

Douglas Henry Reginald Tate
Brian Kelsey Ken Yager
Steve Southerland
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*

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Jeremy Faison Mark Pody
Brenda Gilmore David Shepard
Matthew Hill Tim Wirgau
Charles Sargent, *ex officio*
Speaker Beth Harwell, *ex officio*

M E M O R A N D U M

TO: Mike Perry, Chief Procurement Officer
 Department of General Services

FROM: Senator Bill Ketron, Chairman BK
 Representative Mark White, Vice-Chairman MW

DATE: November 13, 2013

SUBJECT: **Contract Comments**
 (Fiscal Review Committee Meeting 11/12/13)

RFS# 318.65-00608 (Edison # Pending)

Department: Finance and Administration

Division: Health Care Finance and Administration/ Bureau of TennCare

Vendor: BlueCross BlueShield of Tennessee, Inc.

Summary: The proposed two-year contract is for the delivery of CoverKids and AccessTN, part of the “Cover Tennessee” program for self-funded health plan services. The proposed contract has a term beginning January 1, 2014, and ending December 31, 2015.

Proposed maximum liability: \$382,056,809

After review, the Fiscal Review Committee voted to recommend approval of the contract.

cc: The Honorable Darin Gordon, Deputy Commissioner



**STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243**

October 31, 2013

Lucian Geise, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: Managed Care Contract Amendments (7)
BlueCross Blue Shield – Cover Tennessee Contract
Policy Studies, Inc, Amendment #9 – Cover Tennessee Contract

Dear Mr. Geise:

The Department of Finance and Administration, Division of Health Care Finance and Administration (HCFA), is submitting for consideration by the Fiscal Review Committee amendments to the Managed Care Organization (MCO) contracts. These contracts provide medical and behavioral health services to eligible TennCare enrollees. The proposed amendments contain language changes regarding the role of the Fiscal Employer Agent, the Supports Broker, and the MCO for CHOICES members participating in Consumer Direction, as well as clarifications regarding the CHOICES program and updates the contract to include current capitation rates. The term for the East/West and Volunteer State Health Plan - TennCare Select contracts have been extended and funding added to all amendments to support the continuation of services through current end date. TennCare has released a Request for Proposal to competitively procure statewide MCO contracts with a projected award date of late December.

Volunteer State Health Plan – TennCare Select
AMERIGROUP Tennessee, Inc
UnitedHealthCare Plan of the River Valley, Inc. – Middle
UnitedHealthCare Plan of the River Valley, Inc. – West
Volunteer State Health Plan – West
UnitedHealthCare Plan of the River Valley, Inc. – East
Volunteer State Health Plan – East

In addition to the MCO amendments, HCFA is submitting amendment #9 to Policy Studies, Inc., the competitively procured contract for eligibility determination, application processing, applicant outreach and enrollee retention services for the CoverKids program. The eligibility determination services provided by this Contractor will be transitioning through Calendar year 2014 to the new competitively procured TennCare Eligibility Determination System (TEDS). This amendment provides a mechanism for the State to ensure the continuation of eligibility services for an additional period of time to allow sufficient time for transition to TEDS.

Page 2
Mr. Lucien Giese
October 31, 2013

Additionally, we are submitting a new contract with BlueCross Blue Shield for the delivery of CoverKids and AccessTN, collectively "Cover Tennessee," the self-funded health plan services. These services include 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 both programs. The Cover Tennessee Program results from State law requiring provision of health care services to certain populations of the State, including AccessTN (state high risk pool) and CoverKids (federal Children's Health Insurance Program).

The Department of Finance and Administration, Division of Health Care Finance and Administration, respectfully submits the above referenced amendments and new contract for consideration and approval 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:	507-6482
*Original Contract Number:		*Original RFS Number:	31865-00608
Edison Contract Number: <i>(if applicable)</i>		Edison RFS Number: <i>(if applicable)</i>	
*Original Contract Begin Date:	January 1, 2014	*Current End Date:	December 31, 2015
Current Request Amendment Number: <i>(if applicable)</i>	NEW CONTRACT		
Proposed Amendment Effective Date: <i>(if applicable)</i>	January 1, 2014		
*Department Submitting:	Finance and Administration		
*Division:	Health Care Finance and Administration		
*Date Submitted:	October 31, 2013		
*Submitted Within Sixty (60) days:	Yes		
<i>If not, explain:</i>			
*Contract Vendor Name:	BlueCross BlueShield of Tennessee, Inc.		
*Current Maximum Liability:	\$382,056,809.00		
*Current Contract Allocation by Fiscal Year: <i>(as Shown on Most Current Fully Executed Contract Summary Sheet)</i> NEW CONTRACT			
FY: 2014	FY: 2015	FY: 2016	
\$84,739,877.00	\$180,845,736.00	\$116,471,196.00	
*Current Total Expenditures by Fiscal Year of Contract: <i>(attach backup documentation from EDISON report)</i>			
FY: 2014	FY: 2015	FY: 2016	FY: 2017
			\$
IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:		N/A	
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:		N/A	
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:		N/A	
*Contract State:	\$107,108,323.00	Federal:	\$274,948,486.00

Supplemental Documentation Required for
Fiscal Review Committee

Funding Source/Amount:				
Interdepartmental:			<i>Other:</i>	
If "other" please define:				
Dates of All Previous Amendments or Revisions: <i>(if applicable)</i>		Brief Description of Actions in Previous Amendments or Revisions: <i>(if applicable)</i>		
N/A				
Method of Original Award: <i>(if applicable)</i>		Non Competitive		
*What were the projected costs of the service for the entire term of the contract prior to contract award?		\$386,056,809.00		

Supplemental Documentation Required for Fiscal Review Committee

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

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

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	\$27.50 PMPM

For AccessTN Only-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 each month for the Contractor's satisfactory performance of 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.

For CoverKids Only- The State shall compensate the Contractor by the 5th business day of each month for the Contractor's satisfactory performance of all services outlined in this Contract, at the PMPM and other service based rates indicated, based upon the number of Members certified by the State to the Contractor. The payment to the Contractor shall be equal to the number of enrollees certified by the State, multiplied by the administrative fee for the appropriate enrollee category. The actual amount owed the Contractor for each enrollee shall be determined by dividing the appropriate monthly administrative fee by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the enrollee was enrolled in the plan.

The Contractor agrees the State may retroactively recoup Administrative Fee payments for deceased enrollees. Retroactive recoupment will be deducted from the monthly payment for the following month. Payments may be recouped back to the date of death. This is the only provision whereby the State may retroactively recoup administrative fee payments from the Contractor for enrollees retroactively terminated from CoverKids.

Supplemental Documentation Required for Fiscal Review Committee

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 outside subrogation attorneys. 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 D BlueCard PPO Program – AccessTN Only and Attachment E BlueCard Program – CoverKids Only 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.16.2, 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. 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.

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.

There are no savings to be realized by entering into this contract. The Cover Tennessee Program results from State law requiring provision of health care services to certain populations of the State, including AccessTN (state high risk pool) and CoverKids (federal Children's Health Insurance Program-CHIP).

Supplemental Documentation Required for
Fiscal Review Committee

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.

The Cover Tennessee program currently has a contract with BCBST to provide these contracted services which was originally procured by Requests for Proposal, the State's competitive procurement process. Since one of the three Cover Tennessee programs (CoverTN) is ending in its entirety, and would have logistically required substantial amendment deletions in the existing contract, it was determined that a new contract would be a clearer, more concise method to move forward with these required services. For the services required to be provided by the Contractor in administering this contract, the per member per month (PMPM) rate is the same rate currently being paid for these services, there is no increase. In determining the maximum liability for this contract (which includes the administrative PMPM rate above and the reimbursement for medical, pharmacy and behavioral health claims), the amount was based on prior claims experience and projected cost for the duration of this contract.

Special 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@tn.gov.

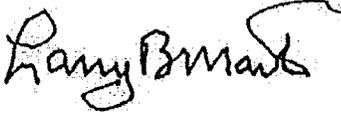
APPROVED

Michael F. Remy/cs

Chief Procurement Officer

Request Tracking #	31865-00608
1. Contracting Agency	Department of Finance and Administration Division of Health Care Finance and Administration
2. Type of Contract	<input checked="" type="checkbox"/> Non-Competitive <input type="checkbox"/> No Cost <input type="checkbox"/> Revenue
3. Requestor Contact Information	Casey Dungan 507-6482
4. Date Requested	October 25, 2013
5. Brief Service Caption	Delivery of CoverKids and AccessTN Health Plan Services
6. Proposed Contractor	BlueCross BlueShield of Tennessee, Inc.
7. 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
8. Maximum Contract Cost – with ALL options to extend exercised	\$ 382,056,809.00
9. Office for Information Resources Endorsement – information technology (N/A to THDA)	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached
10. eHealth Initiative Support – health-related professional, pharmaceutical, laboratory, or imaging	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached
11. Human Resources Support – state employee training	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached
12. Has the contracting agency procured 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"/> Non-Competitive Negotiation <input type="checkbox"/> Another Competitive Method	
13. Will the State incur any substantial cost as a result of the	<input type="checkbox"/> NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> Not Applicable

Request Tracking #	31865-00608
subject agreement? (For No Cost or Revenue Contracts <u>only</u>)	
14. Will the State also contract with other parties interested in entering substantially the same agreement?	X NO <input type="checkbox"/> YES
15. Description of Product/Services Contractor Will Provide: This contract is for the delivery of CoverKids and AccessTN, collectively "Cover Tennessee, the self-funded health plan services. Those services include 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 both programs.	
16. Is this product/service currently available on a statewide contract? X NO <input type="checkbox"/> YES	
If YES, please explain why the current statewide contract is not being used for this procurement.	
17. Summary of State Responsibilities Under Proposed Contract (For No Cost and Revenue Contracts <u>only</u>)	
18. Explanation of Need for or Requirement Placed on the State to Acquire the Service: The Cover Tennessee Program results from State law requiring provision of health care services to certain populations of the State, including AccessTN (state high risk pool) and CoverKids (federal Children's Health Insurance Program-CHIP).	
19. Proposed Contract Impact on Current State Operations: The contract provides medical services to the populations of AccessTN and CoverKids as mandated by federal and state law.	
20. Justification - Specifically explain why the procurement method being requested is required. The Cover Tennessee Program results from State law requiring provision of health care services to certain populations of the State, including AccessTN (state high risk pool) and CoverKids (federal Children's Health Insurance Program). The Cover Tennessee program currently has a contract with BCBST to provide these contracted services which was originally procured by Requests for Proposal, the State's competitive procurement process. Since one of the three Cover Tennessee programs (CoverTN) is ending in its entirety, and would have logistically required substantial amendment deletions in the existing contract, it was determined that a new contract would be a clearer, more concise method to move forward with these required services.	
21. Contractor Selection Process and Efforts to Identify Reasonable, Competitive, Procurement Alternatives The Cover Tennessee program currently has a contract with BCBST to provide these contracted services which was originally procured by Requests for Proposal, the State's competitive procurement process. Since one of the three Cover Tennessee programs (CoverTN) is ending in its entirety, and would have logistically required substantial amendment deletions in the existing contract, it was determined that a new contract would be a clearer, more concise method to move forward with these required services.	
22. Name & Address of the Contractor's Principal Owner(s) - NOT required for a TN state education institution BlueCross BlueShield of Tennessee, Inc. One Cameron Hill Circle Chattanooga, TN 37402	
23. Evidence of Contractor's Experience & Length Of Experience Providing the Service 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 that they have in Tennessee. BCBST has	

Request Tracking #	31865-00608
successfully implemented and managed not only the health care services for Cover Tennessee, but also has been a partner with TennCare in providing medical and behavioral services to eligible TennCare enrollees since 2008.	
24. Was there an initial government estimate?	<input checked="" type="checkbox"/> NO <input type="checkbox"/> YES
25. Cost Determination Used- How did agency arrive at the price? For the services required to be provided by the Contractor in administering this contract, the per member per month (PMPM) rate is the same rate currently being paid for these services, there is no increase. In determining the maximum liability for this contract (which includes the administrative PMPM rate above and the reimbursement for medical, pharmacy and behavioral health claims), the amount was based on prior claims experience and projected cost for the duration of this contract.	
26. Documentation of Discussions with Contractor- BCBST is currently under contract with Cover Tennessee for the provision of health related services for the eligible Cover Tennessee populations. Discussions took place to ensure that eligible members would continue to have access to a robust statewide network of providers at the same administrative rate.	
27. Explanation of Fair and Reasonable Price- Explain why price is fair and reasonable under the circumstances: There is no increase from the prior year for the administrative PMPM rate to the contractor.	
<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 style="text-align: right;"></p> <p style="text-align: right;">CD</p>	



CONTRACT

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

Begin Date January 1, 2014	End Date December 31, 2015	Agency Tracking # 31865-00608	Edison Record ID 39943
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Contractor Legal Entity Name BlueCross BlueShield of Tennessee, Inc.	Edison Vendor ID 0000091649
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Service Caption (one line only)
Delivery of CoverKids and AccesTN 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
2014	\$23,818,825.00	\$60,921,052.00			\$84,739,877.00
2015	\$50,825,261.00	\$130,020,475.00			\$180,845,736.00
2016	\$32,464,237.00	\$84,006,959.00			\$116,471,196.00
TOTAL:	\$107,108,323.00	\$274,948,486.00			\$382,056,809.00

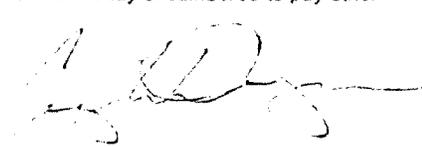
American Recovery and Reinvestment Act (ARRA) Funding: YES NO

Ownership/Control

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

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

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

<p>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.</p> 	<p>OCR 1 - FA</p>
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Speed Chart (optional)	Account Code (optional)
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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 (HCFA), hereinafter referred to as the "State" or "HCFA" and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the "Contractor," is for the delivery of AccessTN, and CoverKids (collectively, "Cover Tennessee") self-funded health plan services, including administrative services, provider network development and maintenance, 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 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 the Contractor 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 one hundred fifty percent (150%) and two hundred fifty percent (250%) of the federal poverty level (FPL) as reported by the State to the Contractor for the coverage period.
- A.3.7. "Group Two Children" are enrollees who are members of families below one hundred fifty percent (150%) of FPL as reported by the State to the Contractor for the coverage period.
- A.3.8. Vital Documents - Vital Documents may include, but are not limited to, consent and complaint forms, intake and application forms with the potential for important consequences, notices pertaining to the reduction, denial, delay, suspension or termination of services, certain critical outreach documents (i.e. case management and Population Health documents) and any other documents designated by the State. At a minimum, all Vital Documents shall be available in the Spanish language.

A.4. 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 Guarantees, CoverKids section, the State shall monitor network access. When requested by the State, the Contractor shall, within sixty (60) calendar days (unless otherwise informed by the state) and in writing, report to the State any actions it intends to take to correct any deficiencies highlighted by the monthly 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. 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) business 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 Section 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.
- A.4.9. Contractor will only contract with providers who have a valid TennCare Medicaid ID. Contractor shall rely on Tennessee's Medicaid program screening of providers to satisfy the requirements of 42 CFR 455.410. Contractor shall require its providers to screen their employees monthly to ensure that the employees are not excluded from participation in Federal healthcare programs. This monthly screen requirement may be met by screening which may be required of providers contracted under other parts of the Tennessee Medicaid program. For pharmacies, the Contractor will have its pharmacy benefits manager (PBM) submit a list of the PBM's in-state pharmacies to HCFA. 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 (3) years.
- 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.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.5.2.3 Member Handbooks shall include all member rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Contractor's Notice of Privacy Practices.
- 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 State 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 State 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, 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. **Medical and Care Management Services**

- A.6.1. 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.6.1.1. 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.6.1.2. 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.6.1.3. 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.6.1.4. Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for services provided.
 - A.6.1.5. 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.6.2. 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.6.3. 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.6.4. The Contractor shall maintain an internal quality assurance program.
- A.6.4.1. 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.6.4.2. 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) calendar 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) calendar 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.6.4.3. The Contractor shall meet a benchmark of ninety percent (90%) or above accuracy of the provider data validation information submitted to the State in accordance with Attachment A: Performance Guarantees, CoverKids section, in a form and manner to be determined by HCFA.
- A.6.5. 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:
- (1) A Population identification process;
 - (2) Evidence-based practice guidelines;
 - (3) Collaborative practice models to include physician and support service providers;
 - (4) Patient self-management education (may include primary prevention, behavior modification programs, compliance/surveillance);
 - (5) Process and outcomes measurement, evaluation, and management; and
 - (6) Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).
- A.6.5.1. 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.6.5.2. 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.6.5.1.

A.6.5.3. 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.6.6. 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.6.6.1. The behavioral health management capabilities shall include the ability to:

A.6.6.1.1. Review proposed treatment plans.

A.6.6.1.2. Refer to a specialty provider network.

A.6.6.1.3. Provide case and care management services to Members and treatment providers.

A.6.6.1.4. Work actively with Community Mental Health Centers to enlist that resource as a set of network providers.

A.6.6.1.5. Assist in the co-management of medical and behavioral health and substance abuse.

A.6.6.2. 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.6.7. The Contractor shall comply with all applicable State and federal regulations regarding quality measure requirements.

A.7. Payment Reform Initiative

The Contractor agrees to implement retrospective episode based reimbursement and patient centered medical home (PCMH) strategies consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by HCFA. This includes:

Using a the retrospective administrative process that is aligned with the model designed by HCFA;

Implementing key design choices as directed by HCFA, including the definition of each episode and definition of quality measures;

Delivering performance reports with same appearance and content as those designed by the State / payer coalition;

Implementation at a pace dictated by the State, likely three to five (3-5) new episodes per calendar quarter with appropriate lead time to allow payers and provider contracting;



Participate in a State-led process to design and launch new episodes, including the seeking of clinical input from payer medical teams and clinical leaders throughout Tennessee.

The Contractor shall implement State Budget Reductions and Payment Reform Initiatives, including retrospective episode based reimbursement, as described by HCFA. The Contractor's failure to implement State Budget Reductions and/or Payment Reform Initiatives as described by HCFA may, at the discretion of HCFA, result in the Contractor forfeiting savings that would have been realized based on the timely implementation of these measures, including the forfeiture of recoupment from providers.

ACCESSTN SCOPE OF SERVICES

A.8 The Contractor agrees to provide administrative services for the AccessTN self-funded plan for Members who elect to participate in the AccessTN program, which plan is 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 plan. In (1) providing administrative claims adjudication services in accordance with the terms of the AccessTN plan, 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 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) calendar days notice to the Contractor.

A.9.2 "Enrollment" is defined as the date the 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.9.6. "Vital Documents" - Vital Documents may include, but are not limited to, consent and complaint forms, intake and application forms with the potential for important consequences, notices pertaining to the reduction, denial, delay, suspension or termination of services, certain critical outreach documents (i.e. case management and Population Health documents) and any other documents designated by the State. At a minimum, all Vital Documents shall be available in the Spanish language.

A.10. 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 Guarantees, AccessTN section, 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) business 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 material 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. 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.

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. The cost of these items shall be borne by the Contractor.

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:

- i. A Population identification process;
- ii. Evidence-based practice guidelines;
- iii. Collaborative practice models to include physician and support service providers;
- iv. Patient self-management education (may include primary prevention, behavior modification programs, compliance/surveillance);
- v. Process and outcomes measurement, evaluation, and management; and
- vi. 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, if achievable, 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 physicians for the treatment and diagnosis of behavioral health issues for Members as recommended by the American Medical Association shall be reimbursed at the applicable rates.



SCOPE APPLICABLE TO BOTH PROGRAMS

- A.14. The language in this section of the Contract is applicable to both Cover Tennessee programs' 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.15. Claims Adjudication and Adjustment**
- A.15.1. 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.15.2. 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.15.2.1 automated eligibility verification that coverage has not terminated on the date of eligible service;
 - A.15.2.2 benefit plan information stored on the system;
 - A.15.2.3 automatic calculation of copayments and out-of-pocket limits;
 - A.15.2.4 identification and collection of claim overpayments; and
 - A.15.2.5 automated tracking of internal limits.
- A.15.3. 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.15.4. The Contractor shall process all benefit claims in strict accordance with the Member Handbook and its clarifications and revisions.
- A.15.5. 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.15.6. Claims Payments Adjustments.
- A.15.6.1. 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.15.6.2. Whenever the Contractor becomes aware of an overpayment under the applicable Cover Tennessee program, the Contractor shall promptly issue a credit to the applicable program.
 - A.15.6.2.1. 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.15.6.2.2. 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.15.6.2.3. 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.15.6.3. The Parties acknowledge that the State may not contact network providers directly regarding rates.

A.15.6.4. 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.15.7. 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.15.8. 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.15.9. 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 State and the Contractor.

A.15.10. The Contractor shall institute subrogation based on a mutually agreeable process between the Contractor and the State. Such process shall include:

A.15.10.1 A defined process for the recovery of monies received through subrogation;

A.15.10.2. Notification, upon request by the State, of the status of cases under review for subrogation and

A.15.10.3. Identification to the State of all subrogation subcontractors and, upon request by the State, copies of said subcontracts.

A.15.10.4. Additional information regarding the retention of administrative fees by the Contractor is included in Section C.3 of this Contract.

A.15.11 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.15.12. 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.15.13. 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 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.15.14. BlueCard Program. The Contractor shall provide access to providers outside Tennessee to Members, in certain situations, through the BlueCard PPO (AccessTN) and BlueCard (CoverKids) program. This program is described in greater detail in Attachment D and Attachment E of this Contract.
- A.15.15. 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 and BlueCard PPO Program. The Contractor shall complete any reports that may be due, unless the State directs otherwise.
- A.15.16. The Contractor shall assist the State in identifying fraud and assist with fraud investigations of Members and providers, including pharmacies, 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 HCFA Office of Program Integrity and the Division of State Audit within the Office of the Comptroller of the Treasury for the purpose of investigating suspected fraud and abuse cases in a form and manner described by the State. The State shall review the information and inform the Contractor whether it wishes the Contractor to:
- A.15.16.1. discontinue further investigation if there is insufficient justification; or
 - A.15.16.2. continue the investigation and report back to HCFA, the Office of the Inspector General or the Division of State Audit; or
 - A.15.16.3. continue the investigation with the assistance of the Division of State Audit; or
 - A.15.16.4. 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.15.16.5. 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.15.16.6. Internal controls - The Contractor shall create a Fraud and Abuse Compliance plan in a form and manner subject to review by HCFA. The Contractor shall have adequate staffing and resources to investigate potential fraud and abuse 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.15.17. 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.15.18. **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.15.19. **For the CoverKids Program Only:** In the event that a CoverKids Member is determined to be retroactively eligible for Medicaid, CoverKids eligibility will be terminated on the day before Medicaid eligibility begins. The Contractor will recoup payments to providers when periods of concurrent eligibility are determined.

A.16. Claims Payment and Reconciliation Process

- A.16.1. The 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.16.2. On a mutually acceptable day of each week, the State shall reimburse 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 by submitting a Claims Invoice in a manner mutually agreed to by both Parties. The State shall reimburse the Contractor using an ACH credit of funds to the Contractor's designated bank account within forty eight (48) hours of the timely receipt of the Claims Invoice. The Contractor acknowledges and agrees that the State shall not maintain a separate bank account or an escrow account with the Contractor or to otherwise pre-fund an account.
- A.16.2.1. Claims Adjudication Reports. The Contractor shall provide the following reports to the State concerning claims adjudication for the Cover Tennessee programs:
- A.16.2.1.1. 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.16.2.1.2. A Weekly Medical Adjudicated Claims Summary Report, a Weekly Medical Adjudicated Claims Detail Report and a Weekly Medical Adjudicated Claims Detail file, submitted each Tuesday, to notify the State of the amount paid to providers during the prior week, to be paid



to the Contractor within forty-eight (48) hours of the timely receipt of the Claims Invoice.

A.16.2.1.3. A Bi-Weekly Pharmacy Adjudicated Claims Summary Report, a Bi-Weekly Pharmacy Adjudicated Claims Detail Report and a Bi-Weekly Pharmacy Adjudicated Claims Detail file, submitted each Tuesday, to notify the State of the amount paid to the Contractor's Pharmacy Benefits Manager (PBM) during the prior week, to be paid to the Contractor within forty-eight (48) hours of the timely receipt of the Claims invoice.

A.16.2.1.4. A Monthly Invoice Summary that summarizes the weekly payments by program.

A.16.3. 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.16.4 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 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.16.5. **For the CoverKids Program Only:** The State will not hold the Contractor responsible for claims payments 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.16.6. **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 explanation of benefits (EOB) when the covered members of the family have assumed copayments equal to 5 percent (5%) of the allowable family income. The EOB 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.

A.17. **Financial Tracking and Reporting**

A.17.1. 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 (AccessTN Only), 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 month, 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.17.2. 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.17.2.1. preparation and reconciliation of monthly financial statements on a cash basis in a format prescribed by the State; and
 - A.17.2.2. preparation of accrual based quarterly financial statements prepared in accordance with statutory and/or generally accepted accounting principles prescribed.
- A.17.3. 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.17.4. 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.18. General Administration

- A.18.1. 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 and speech impaired.
- A.18.2. 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.18.3. The Contractor shall provide a customer service operation that includes:
 - A.18.3.1. 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.18.3.2. A toll-free line abandon rate not to exceed five percent (5%) of incoming calls. The abandon rate percentage shall be assessed in accordance with Contract Attachment A: Performance Guarantees, CoverKids section; and
 - A.18.3.3. 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 Guarantees (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.18.4. 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.18.4.1. **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 staff in the research and development of appeals.
- A.18.5. The Contractor shall respond to all inquiries in writing from the State within ten (10) business days, unless otherwise specifically stated in the contract, e.g., Notification of Provisional or Actual Breach, 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.18.6. 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 an individual 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.18.7. 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, the Contractor's executive level individual 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.18.8. 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.18.8.1. written information;
 - A.18.8.2. audio/video presentations;
 - A.18.8.3. attendance at meetings, workshops, and conferences; and
 - A.18.8.4. training of State staff, as may be necessary, on Contractor's administrative and benefits procedures.
- A.18.9. 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 State.
- A.18.10. 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.18.11. For the CoverKids Program Only: With regard to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Prospective Payments.

A.18.11.1. 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.18.11.2. 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.18.11.3. 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.18.11.4. 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.18.11.5. For purposes of Contract Section A.18.11., 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.18.11.6. Any obligations imposed on the Contractor for purposes of Contract Section A.18.11 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.18.12 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.19. Pharmacy



A.19.1. The Contractor shall provide the following required programs and service components for the retail and mail order pharmacy benefits.

A.19.1.1. Administrative and Account Management Support

A.19.1.1.1. Collaborate with the State in proactively identifying opportunities to improve the quality of service, cost effectiveness and operational efficiency of the pharmacy benefits.

A.19.1.1.2. Provide quarterly reviews of pharmacy network adequacy, program performance, service levels and other factors that focus on managing pharmacy benefit cost.

A.19.1.2. Retail and Mail Order Claims Adjudication

A.19.1.2.1. 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.19.1.2.2. 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.19.1.2.3. 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.19.1.2.4. 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.19.1.2.5. 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.19.1.3. Retail Network:

A.19.1.3.1. 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.19.1.3.2. Provide participating pharmacies with a toll-free telephone service number.

A.19.1.3.3. Maintain a pharmacy audit program in order to ensure pharmacy compliance with the program.

A.19.1.4. Formulary/Preferred Drug List (PDL) and Utilization Review:

A.19.1.4.1. 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 thirty (30) calendar days prior to change implementation date.

A.19.1.4.2. 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:

- a) Drug to drug interaction
- b) Duplicate therapy
- c) Known drug sensitivity
- d) Over utilization
- e) Maximum daily dosage
- f) Early refill indicators
- g) Suspected fraud

A.19.1.4.3. Provide for clinical pharmacist follow-up to dispensers and prescribers in order to share relevant information from the drug utilization review analysis.

A.19.1.4.4. 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.19.1.4.5. Have the ability to lock a Member suspected of abusing the system into just one network pharmacy.

A.19.1.5. Therapeutic Substitution and Generic Dispensing Program

A.19.1.5.1. 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.19.1.5.2. 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.19.1.5.3. 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.19.2. 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 (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.19.2.1. Remit to the State no less than quarterly 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 eight (8) months prior to the Rebate payment date.



A.19.3. The Contractor shall provide the following Pharmacy Rebates and Audits:

A.19.3.1. 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 (3) 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.19.3.2. 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.19.3.3. 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.20. Data and Specific Reporting Requirements

A.20.1. 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, electronic and physical intrusion, 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 thirty (30) days from the date of creation.

A.20.2. The Contractor shall reconcile, within ten (10) business days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

A.20.3. The Contractor shall provide the State with a GeoNetworks© report showing service and geographic access in accordance with Contract Attachment A: Performance Guarantees (AccessTN section and CoverKids section). 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 Contractor shall submit a written plan of action to correct said deficiencies within the timeframe established by the State.

A. 20.4. **For the CoverKids Program Only:** In accordance with the requirements set forth in 42 U.S.C. § 300kk, the Contractor must develop and maintain the ability to collect and report, to the extent practicable, data on race, ethnicity, sex, primary language, and disability status for members and from members' parents or legal guardians if members are minors or legally incapacitated individuals, in a form and manner as prescribed by HCFA. In collecting this data the Contractor shall use the Office of Management and Budget (OMB) standards, at a minimum, for race and ethnicity measures. Race and Ethnic Standards established for Federal Statistics and Administrative Reporting include the following categories as defined by the OMB:

A.20.4.1. Race – American Indian or Alaska Native, Asian, black or African American, native Hawaiian or other Pacific Islander, white;

A.20.4.2. Ethnicity – Hispanic or Latino, Not Hispanic or Latino.

A.20.5. The Contractor is required to transmit Cover Tennessee program enrollment data monthly and medical and prescription drug claims monthly to the Division of Health Care Finance and Administration, Office of Healthcare Informatics (HCI), until all claims incurred during the term of this Contract have been paid. Data shall be submitted in the format approved by the State. 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.20.5.1. For each quarter of the Contract term, and any extensions thereof, claims data must meet the established quality standards in accordance with Contract Attachment A: Performance Guarantees as determined by the State.

A.20.5.2. The Contractor will work with HCI to identify a data format approved by the State for these transmissions, and is responsible for the cost incurred by the State to develop, test and implement conversion programs for the Contractor's claims data. Furthermore, the Contractor will pay during the full term of this Contract all applicable fees as assessed by the State 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 State efforts to correct Contractor data quality errors that occur during the term of this Contract.

A.20.5.3. Claims data are to be securely submitted to HCI no later than the 5th day of the month following the end of each calendar month in accordance with Contract Attachment A: Performance Guarantees

A.20.6. The Contractor shall submit Management Reports as required by the State, including but not limited to Attachment B, Management Reporting Requirements, in electronic format of the type, at the frequency, and containing the detail approved by the State.

A.20.7. 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.21. **Services Provided by the State**

A.21.1. 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.21.2. The State shall facilitate the enrollment of pregnant AccessTN women into other State programs, including CoverKids, so that they can receive maternity and pregnancy-related services.

A.22. Effect of Termination

A.22.1. The terms and conditions set forth herein shall be of no further force or effect if this Contract is terminated, except as follows:

A.22.1.1. 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.22.1.2. 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.22.1.3. 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.22.1.4. 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.22.2. 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.22.2.1. receiving CM services, together with all the identifying information and conditions that make the Members' care appropriate for CM; and

A.22.2.2. 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.22.3. 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.22.3.1. receiving CM services through that program, together with all the identifying information and conditions that make the Members' care appropriate for CM; and
- A.22.3.2. 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.22.4. 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.22.5. Should the State terminate one or more than one program for any reason, the notice requirements of Contract Sections E.21 and E.22 are applicable.

B. CONTRACT TERM

- B.1. Term. This Contract shall be effective for the period beginning January 1, 2014, and ending on December 31, 2015. 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 (1) year and a total contract term of no more than two (2) 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 Three Hundred Eighty-Two Million Fifty-Six Thousand Eight Hundred Nine Dollars (\$382,056,809.00). The payment rates in Contract Section C.3 shall constitute the entire compensation due the Contractor 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	\$27.50 PMPM

For AccessTN Only-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 each month for the Contractor's satisfactory performance of 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.

For CoverKids Only- The State shall compensate the Contractor by the 5th business day of each month for the Contractor's satisfactory performance of all services outlined in this Contract, at the PMPM and other service based rates indicated, based upon the number of Members certified by the State to the Contractor. The payment to the Contractor shall be equal to the number of enrollees certified by the State, multiplied by the administrative fee for the appropriate enrollee category. The actual amount owed the Contractor for each enrollee shall be determined by dividing the appropriate monthly administrative fee by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the enrollee was enrolled in the plan.

The Contractor agrees the State may retroactively recoup Administrative Fee payments for deceased enrollees. Retroactive recoupment will be deducted from the monthly payment for the following month. Payments may be recouped back to the date of death. This is the only provision whereby the State may retroactively recoup administrative fee payments from the Contractor for enrollees retroactively terminated from CoverKids.

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 outside subrogation attorneys. 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 D BlueCard PPO Program – AccessTN Only and Attachment E BlueCard Program – CoverKids Only 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.16.2, 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. 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.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 (AccessTN only) 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
310 Great Circle Road – 2W
Nashville, Tennessee 37243
 - 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 Public Chapter No. 878 and Tennessee Executive Order 41, 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 section will be subject to the sanctions of Tennessee Public Chapter No. 878 and Tennessee Executive Order 41, *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.

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
310 Great Circle Road, 2W
Nashville, Tennessee 37243
Telephone: (615) 741-9750
Fax: (615) 741-0028
Bo.irvin@tn.gov

The Contractor:

Stephani Ryan,
Chief Operating Officer-Cover Tennessee
BlueCross BlueShield of Tennessee, Inc.
3200 West End Avenue,
Suite 305
Nashville, TN 37203
Stephani_Ryan@bcbst.com
Telephone: 615-386-8544
Fax: 615-760-8766

With a Copy to:

Attention: General Counsel
BlueCross BlueShield of Tennessee, Inc.
One Cameron Hill Circle
Chattanooga, TN 37402
Tony_Hullender@BCBST.com
Telephone: 423.535.7665
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 business 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.

Failure to comply may result in actual damages that the State incurs as a result of the breach and Performance Guarantees in Attachment A.

- 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. As a party to this Contract, the Contractor hereby acknowledges its designation as a covered entity and/or business associate under the HIPAA regulations and Omnibus Rule effective September 23, 2013, and agrees to comply with all applicable HIPAA and HITECH (hereinafter "HIPAA/HITECH") regulations. In accordance with HIPAA/HITECH regulations, the Contractor shall, at a minimum:
- a. Comply with requirements of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), including, but not limited to, the transactions and code sets, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data sharing agreements required under the regulations;
 - b. Transmit/receive from/to its providers, subcontractors, clearinghouses and HCFA all transactions and code sets required by the HIPAA/HITECH regulations in the appropriate standard formats, utilizing appropriate and adequate safeguards, as specified under the law and as directed by HCFA so long as HCFA direction does not conflict with the law;
 - c. Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA/HITECH standards, that it will be in breach of this Contract and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between HCFA and the Contractor and between the Contractor and its providers and/or subcontractors to a halt, if for any reason the Contractor cannot meet the requirements of this Section, HCFA may terminate this Contract in accordance with the Business Associate Agreement ancillary to this Contract;
 - d. Ensure that Protected Health Information (PHI) exchanged between the Contractor and HCFA is used only for the purposes of treatment, payment, or health care operations and health oversight and its related functions. All PHI not transmitted for these purposes or for purposes allowed under the federal HIPAA/HITECH regulations shall be de-identified to secure and protect the individual enrollee's PHI;



- e. Report to HCFA's Privacy Office immediately upon becoming aware of any use or disclosure of PHI in violation of this Contract by the Contractor, its officers, directors, employees, subcontractors or agents or by a third party to which the Contractor disclosed PHI;
- f. Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the Contractor pursuant to this Section;
- g. Make available to HCFA enrollees the right to amend their PHI in accordance with the federal HIPAA regulations. The Contractor shall also send information to enrollees educating them of their rights and necessary steps in this regard;
- h. Make an enrollee's PHI accessible to HCFA immediately upon request by HCFA;
- i. Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA/HITECH regulations upon request;
- j. Create and adopt policies and procedures to periodically audit adherence to all HIPAA/HITECH regulations, and for which Contractor acknowledges and promises to perform, including but not limited to, the following obligations and actions:
- k. Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of HCFA agrees to use reasonable and appropriate safeguards to protect the PHI.
- l. If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with this Section of this Contract. The Contractor shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement. The Contractor shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, the Contractor shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which cannot feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;
- m. Implement all appropriate administrative, physical and technical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Contract and, including, but not limited to, privacy, security and confidentiality requirements in 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164;
- n. Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;
- o. Create and implement policies and procedures to address present and future HIPAA/HITECH regulatory requirements as needed, including, but not limited to: use and disclosure of data, including genetic information; de-identification of data;



minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint;

- p. Provide an appropriate level of training to its staff and employees regarding HIPAA/HITECH-related policies, procedures, enrollee rights and penalties prior to the HIPAA/HITECH implementation deadlines and at appropriate intervals thereafter;
- q. Track training of Contractor staff, employees and subcontractors and maintain signed acknowledgements by staff, employees and subcontractors of the Contractor's HIPAA/HITECH policies;
- r. Be allowed to use and receive information from HCFA where necessary for the management and administration of this Contract and to carry out business operations where permitted under the regulations;
- s. Be permitted to use and disclose PHI for the Contractor's own legal responsibilities;
- t. Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by Contractor employees and other persons, including subcontractors, performing work for the Contractor to have only minimum necessary access to PHI/PII within their organization;
- u. Continue to protect and secure PHI/PII relating to enrollees who are deceased for fifty (50) years following the enrollee's date of death;
- v. Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations;
- w. Make available PHI in accordance with 45 C.F.R. 164.524, including making an electronic record available if the record is maintained electronically;
- x. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. 164.526; and
- y. Obtain a third (3rd) party certification of their HIPAA transaction compliance within ninety (90) calendar days upon request by HCFA.

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

- E.10. HCFA and the Contractor are "information holders" as defined in Tenn. Code Ann. § 47-18-2107. In the event of a breach of the security of Contractor's information system, as defined by Tenn. Code Ann. § 47-18-2107, the Contractor shall indemnify and hold HCFA harmless for expenses and/or damages related to the breach. Such obligations shall include, but not be limited to, mailing notifications to affected enrollees. Substitute notice to written notice, as defined by Tenn. Code Ann. § 47-18-2107(e)(2)and(3), shall only be permitted with HCFA's express written approval. The Contractor shall notify HCFA's Privacy Office immediately upon becoming aware of any security incident that would constitute a "breach of the security of the system" as defined in Tenn. Code Ann. § 47-18-2107.



- E.11. Notification of Breach and Notification of Provisional Breach - The Contractor shall notify HCFA's Privacy Office immediately upon becoming aware of any incident, either confirmed or provisional, that represents or may represent unauthorized acquisition, access, use or disclosure of encrypted or unencrypted computerized data that may materially compromise the security, confidentiality, or integrity of enrollee PHI maintained or held by the Contractor, including any unauthorized acquisition of enrollee PHI by an employee, subcontractor, or otherwise authorized user of the Contractor's system. This includes, but is not limited to, loss or suspected loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and/or disks.
- a. The Contractor shall utilize the Loss Worksheet located at http://www.tn.gov/tenncare/forms/phi_piiworksheet.pdf to quickly gather and organize information about the incident. The Contractor must provide HCFA with timely updates as any additional information about the loss of PHI/PII becomes available.
 - b. If the Contractor experiences a loss or breach of said data, HCFA will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the Contractor shall bear any costs associated with the notice or any mitigation.
 - c. The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services and identify theft safeguards for individuals that are deemed to be part of a potential or actual disclosure. The Contractor shall bear the cost of notification to individuals having PHI/PII involved in a potential or actual disclosure, including individual notice and/or public notice.
- E.12. 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.13. 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.14. 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.15. Prohibited Advertising. The Contractor shall not refer to this Contract or the Contractor's relationship with the State hereunder in commercial advertising in such a manner as to state or imply that the Contractor or the Contractor's services are endorsed. It is expressly understood and agreed that the obligations set forth in this section shall survive the termination of this Contract in perpetuity.

- E.16. 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.17. 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.18. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Contractor to the State.

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

- E.19. 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/execomp.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.20. 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

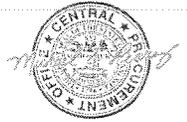


relationship with Contractor to potential or existing providers. Contractor shall not use the State's name for any other purpose without the prior written consent of the State.

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.21. 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.22 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.23 Non-Discrimination Compliance Requirements
- 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 the applicable federal and State civil rights laws and regulations, which may include, but are not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III 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. This person shall develop a Contractor non-discrimination compliance training plan within thirty (30) days of Contract implementation, to be approved by the State. 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 language assistance services to members. The policy shall also demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring effective communication assistance in alternative formats, such as, auxiliary aids. These policies and procedures shall be prior approved in writing by the State.
 1. The Contractor's providers and subcontractors shall have written procedures for the provision of language assistance services to members and/or the member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats, such as, auxiliary aids to any member and/or the member's representative who needs such services, including but not limited to, members with Limited English Proficiency and individuals with disabilities.
- 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. Discrimination Complaints against the Contractor and/or Contractor's Employees. When complaints concerning alleged acts of discrimination committed by the Contractor and/or its employees related to the provision of and/or access to Cover Tennessee covered services are reported to the Contractor, the Contractor's nondiscrimination compliance officer shall send such complaints within two (2) business days of receipt to Cover Tennessee. Cover Tennessee shall investigate and resolve all alleged acts of discrimination committed by the Contractor and/or its employees. The Contractor shall assist Cover Tennessee during the investigation and resolution of such complaints. Cover Tennessee reserves the right to request that the Contractor's nondiscrimination compliance officer assist with conducting the initial investigations and to suggest resolutions of alleged discrimination complaints. If a request for assistance with an initial investigation is made by Cover Tennessee, the Contractor's nondiscrimination compliance officer shall provide Cover Tennessee with all requested information, including but not limited to, the identity of the party filing the complaint; the complainant's relationship to the Contractor; the circumstances of the complaint; date complaint filed; and the Contractor's suggested resolution. Cover Tennessee shall review the Contractor's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section f.2 below.



- (1) Discrimination Complaints against the Contractor's Providers, Provider's Employees and/or Provider's Subcontractors. Should complaints concerning alleged acts of discrimination committed by the Contractor's providers, provider's employees and/or subcontractors related to the provision of and/or access to Cover Tennessee covered services be reported to the Contractor, the Contractor's nondiscrimination compliance officer shall inform Cover Tennessee of such complaints within two (2) business days from the date Contractor learns of such complaints. If Cover Tennessee requests that the Contractor's nondiscrimination compliance officer assist Cover Tennessee with conducting the initial investigation, the Contractor's nondiscrimination compliance officer within five (5) business days from the date of the request shall start the initial investigation. Once an initial investigation has been completed, the Contractor's nondiscrimination compliance officer shall report his/her determinations to Cover Tennessee. At a minimum, the Contractor's nondiscrimination compliance officer's report shall include the identity of the party filing the complaint; the complainant's relationship to the Contractor; the circumstances of the complaint; date complaint filed; and the Contractor's suggested resolution. Cover Tennessee shall review the Contractor's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section f.2 below. Cover Tennessee reserves the right to investigate and resolve all complaints concerning alleged acts of discrimination committed by the Contractor's providers, and subcontractors.
 - (2) Plans to Resolve Discrimination Complaints. If a discrimination complaint against the Contractor, Contractor's employees, Contractor's providers, Contractor's provider's employees, or Contractor's subcontractors is determined by Cover Tennessee to be valid, Cover Tennessee shall, at its option, either (i) provide the Contractor with a plan to resolve the complaint, or (ii) request that the Contractor submit a proposed plan to Cover Tennessee for review and approval that specifies what actions the Contractor proposes to take to resolve the discrimination complaint. Upon provision of the plan to Contractor by Cover Tennessee, or approval of the Contractor's proposed plan by Cover Tennessee, the Contractor shall implement the approved plan to resolve the discrimination complaint. Cover Tennessee, in its sole discretion, shall determine when a satisfactory discrimination complaint resolution has been reached and shall notify Contractor of the approved resolution. A discrimination complaint resolution plan may consist of approved nondiscrimination training on relevant discrimination topics. Prior to use, the nondiscrimination training material shall be reviewed and approved by Cover Tennessee. Time periods for the implementation of the plan's nondiscrimination training shall be designated by Cover Tennessee.
- g. 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 the State. This complaint form shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages. When requests for assistance to file a discrimination complaint are made by enrollees, the Contractor shall assist the enrollees with submitting complaints to Cover Tennessee. In addition, the Contractor shall inform its employees, providers, and subcontractors how to assist Cover Tennessee enrollees with obtaining discrimination complaint forms and assistance from the Contractor with submitting the forms to Cover Tennessee and the Contractor. The Contractor's providers and subcontractors shall agree to cooperate with Cover Tennessee and the Contractor during discrimination complaint investigations.
 - h. All Vital Documents shall be translated and available in Spanish. Within ninety (90) calendar days of notification from Cover Tennessee, all Vital Documents shall be translated and available to each Limited English Proficiency group that constitutes five



percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered.

- i. All written member materials shall notify members that language assistance services such as oral interpretation for any language and auxiliary aids or services are available at no expense to them and how to access those services;
- j. All written member materials shall ensure effective communication with disabled/handicapped persons at no expense to the member and/or the member's representative. Effective Communication may be achieved by providing auxiliary aids or services, including, but may not be limited to: Braille, large print and audio and shall be based on the needs of the individual member and/or the member's representative. The Contractor and its providers and direct service subcontractors shall be required to comply with the Americans with Disabilities Act of 1990 in the provision of auxiliary aids and services to members and/or the member's representative to achieve effective communication. In the event that the provision of auxiliary aids and services to a member and/or the member's representative is not readily achievable by the Contractor's providers or direct service subcontractors, the Contractor shall provide the member and/or the member's representative with the auxiliary aid or service that would result in effective communication with the member and/or the member's representative;
- k. The Contractor shall develop written policies and procedures for the provision of language assistance services, which includes, but is not limited to interpreter and translation services and effective communication assistance in alternative formats, such as, auxiliary aids to any member or the member's representative who needs such services. The Contractor shall provide language and cultural competence training to subcontractors and contracted providers which shall include the potential impact of linguistic and cultural barriers on utilization, delivering services in a culturally competent manner to all members, quality and satisfaction with care and how and when to access interpreter services and to promote their appropriate use during the medical encounter.
- l. The Contractor shall provide language assistance services, including but not limited to interpreter and translation services and effective communication assistance in alternative formats, such as, auxiliary aids free of charge to members and/or the member's representative.
- m. Interpreter services should be available in the form of in-person interpreters, telephone interpretation language line services, sign language or access to telephonic assistance, such as the Telecommunications Relay Services (TRS).
- n. The Contractor shall report on non-discrimination activities as described in this Contract Section and in Section E.24.
- o. The Contractor shall report to the State, in writing, to the attention of the HCFA 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 the State at such time that the function is redirected.



E.24 Non-Discrimination Compliance Reports

- 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 language assistance services for members with Limited English Proficiency and those requiring effective communication assistance in alternative formats, such as auxiliary aids. 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 effective communication assistance in an alternative format, such as, auxiliary aids. The listing shall identify the provider by full name, address, phone number, languages spoken, and hours services are available.
- b. Annually, Cover Tennessee shall provide the Contractor with a Nondiscrimination Compliance Plan Template. The Contractor shall answer the questions contained in the Compliance Plan Template and submit the completed Compliance Plan to Cover Tennessee within ninety (90) days of the end of the calendar year with any requested documentation, which shall include, but is not limited to, the Assurance of Nondiscrimination. The signature date of the Contractor's Plan shall coordinate with the signature date of the Contractor's Assurance of Non-Discrimination. These deliverables shall be in a format specified by Cover Tennessee.
- c. 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 the State 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 the State;
 - (2) A listing of all discrimination complaints filed by employees, members, providers and subcontractors in which discrimination is alleged related to the provision of and/or access to Cover Tennessee 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 effective communication assistance services. The report shall list the member, the member's identification number, the requested service, the date of the request, the date the service was provided and the name of the service provider.

E.25 **For CoverKids Only:** Disclosure of Ownership and Control Interest Statement and Criminal Information – 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 Pharmacies. CoverKids has chosen to implement these federal requirements by use of a Disclosure of Ownership and Control Interest Statement and Criminal Information form (CoverKids Pharmacy 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 Pharmacy as follows:

- a. At the time a Pharmacy is initially enrolled by CoverKids or its Contractor;
- b. At the time a Pharmacy is being re-accredited by CoverKids or its Contractor;
- c. At the time a Pharmacy is being reenrolled by CoverKids or its Contractor;
- d. Whenever there is a change in ownership of a Pharmacy;
- 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.

Pharmacies shall return the original Disclosure Form to the Contractor. Pharmacies 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."

- E.26. 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.27. 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 Contract Attachment A: Performance Guarantees.

- E.28. Social Security Administration (SSA) Required Provisions for Data Security (for CoverKids Only). The Contractor shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act (FISMA) of 2002 (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology (NIST) guidelines. In addition, the Contractor shall have in place administrative, physical, and technical safeguards for data.

- a. In order to meet certain requirements set forth in the State's Computer Matching and Privacy Protection Act Agreement (CMPPA) with the SSA, the Parties acknowledge that this Section shall be included in all agreements executed by or on behalf of the State. The Parties further agree that FISMA and NIST do not apply in



the context of data use and disclosure under this Agreement as the Parties shall neither use nor operate a federal information system on behalf of a federal executive agency. Further, NIST is applicable to federal information systems; therefore, although encouraged to do so, the State, its contractors, agents and providers are not required to abide by the NIST guidelines, except to the extent they are required to do so by IRC Publication 1075 with regard to eligibility and verification FTI information.

- b. The Contractor shall not duplicate in a separate file or disseminate, without prior written permission from HCFA, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the Cover Tennessee program. Should the Contractor propose a redisclosure of said data, the Contractor must specify in writing to HCFA the data the Contractor proposes to redisclose, to whom, and the reasons that justify the redisclosure. HCFA will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the Cover Tennessee program.
- c. The Contractor agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.
- d. The Contractor shall provide a current list of the employees of such contractor with access to SSA data and provide such lists to HCFA upon request.
- e. The Contractor shall restrict access to the data obtained from HCFA to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Contract. The Contractor shall not further duplicate, disseminate, or disclose such data without obtaining HCFA's prior written approval.
- f. The Contractor shall ensure that its employees:
 - (1) properly safeguard PHI/PII furnished by HCFA under this Contract from loss, theft or inadvertent disclosure;
 - (2) understand that they are responsible for safeguarding this information at all times, regardless of whether or not the Contractor employee is at his or her regular duty station;
 - (3) ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;
 - (4) send emails containing PHI/PII only if encrypted or if to and from addresses that are secure; and,
 - (5) limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

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

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



If the Contractor experiences a loss or breach of said data, HCFA will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the Contractor shall bear any costs associated with the notice or any mitigation.

The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services and identify theft safeguards for individuals that are deemed to be part of a potential or actual disclosure. The Contractor shall bear the cost of notification to individuals having PHI/PII involved in a potential or actual disclosure, including individual notice and/or public notice.

h. HCFA may immediately and unilaterally suspend the data flow under this Contract, or terminate this Contract, if HCFA, in its sole discretion, determines that the Contractor has: (1) made an unauthorized use or disclosure of HCFA SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Contract.

i. Legal Authority – Federal laws and regulations giving SSA the authority to disclose data to HCFA and HCFA's authority to collect, maintain, use and share data with Contractor is protected under federal law for specified purposes.

i. Definitions

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

E.29 Medicaid and CHIP – The Contractor must provide safeguards that restrict the use or disclosure of information concerning members and beneficiaries to purposes directly connected with the administration of the plan:



- i. Purposes directly related to the administration of Medicaid and CHIP includes:
- (a) establishing eligibility;
 - (b) determining the amount of medical assistance;
 - (c) providing services for beneficiaries; and,
 - (d) conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to Medicaid or CHIP administration.
- ii. The Contractor must have adequate safeguards to assure that—
- (a) Information is made available only to the extent necessary to assist in the valid administrative purposes of those receiving the information, and information received under 26 USC section 6103(l) is exchanged only with parties authorized to receive that information under that section of the Code; and,
 - (b) the information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.
- iii. The Contractor must have criteria that govern the types of information about members and beneficiaries that are safeguarded. This information must include at least--
- (a) Names and addresses;
 - (b) Medical services provided;
 - (c) Social and economic conditions or circumstances;
 - (d) Contractor evaluation of personal information;
 - (e) Medical data, including diagnosis and past history of disease or disability; and
 - (f) Any information received for verifying income eligibility and amount of medical assistance payments, including income information received from SSA or the Internal Revenue Service,
 - (g) Any information received for verifying income eligibility and amount of medical assistance payments
 - (h) Income information received from SSA or the Internal Revenue Service must be safeguarded according to Medicaid and CHIP requirements
 - (i) Any information received in connection with the identification of legally liable third party resources.
 - (j) Social Security Numbers.
- iv. The Contractor must have criteria approved by HCFA specifying
- (a) the conditions for release and use of information about members and beneficiaries;
 - (b) Access to information concerning members or beneficiaries must be restricted to persons or Contractor representatives who are subject to standards of confidentiality that are comparable to those of HCFA.
 - (c) The Contractor shall not publish names of members or beneficiaries.
 - (d) The Contractor shall obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment to an authorized individual or entity;
 - (e) If, because of an emergency situation, time does not permit obtaining consent before release, the Contractor shall notify HCFA, the family or individual immediately after supplying the information.
 - (f) The Contractor's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.
 - (g) The Contractor shall notify HCFA of any requests for information on members or beneficiaries by other governmental bodies, the courts or law



- enforcement officials ten (10) days prior to releasing the requested information.
- (h) If a court issues a subpoena for a case record or for any Contractor representative to testify concerning an member or beneficiary, the Contractor must notify HCFA at least ten (10) days prior to the required production date so HCFA may inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information, effective until Jan. 1, 2014.
- (i) The Contractor shall not request or release information to other parties to verify income, eligibility and the amount of assistance under Medicaid or CHIP, prior to express approval from HCFA.

E. 30. Sensitive Data Related to Substance Abuse and Mental Health Treatment Enrollee Records.

Enrollee records related to substance abuse and mental health treatment are subject to the Substance Abuse and Mental Health Services Act (SAMHSA). This federal law prohibits re-disclosure without written consent. Note that a general written consent (including a HIPAA-compliant authorization) is not sufficient. The following language must be included with such records if Contractor discloses the records to another party:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 42 C.F.R. § 2.32

E. 31. Federal Tax Information (FTI).

Any FTI made available shall be used only for the purpose of carrying out the provisions of this Agreement. Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this Agreement. Inspection by or disclosure to anyone other than an officer of employer of the Grantee is strictly prohibited.

Failure to comply with federal regulations regarding HIPAA/HITECH, SSA, Medicaid, CHIP, SAMHSA, and FTI data may result in criminal and civil fines and penalties.

E. 32. Tennessee Department of Revenue Registration. The Contractor shall be registered with the Department of Revenue for the collection of Tennessee sales and use tax. This registration requirement is a material requirement of this Contract.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

	11-18-13
CONTRACTOR SIGNATURE	DATE
SCOTT C. PIERCE	11-18-13
PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (ABOVE)	DATE



DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION:

Larry B. Martin /cd
LARRY B. MARTIN, COMMISSIONER

11/19/2013
DATE



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. In addition to the specific performance assessments below, the State reserves the right to assess a general performance assessment of five hundred dollars (\$500) per calendar day for each day that the Contractor fails to comply with the provisions and requirements of this Contract. The damage that may be assessed shall be \$500 per calendar day for each separate failure to comply with the Contract, plus, if applicable, an additional \$500 per calendar day for each affected member.

AccessTN

1. Claims Payment Dollar Accuracy	
Guarantee	The average quarterly financial accuracy for claims payments will be 99% or higher.
Definition	Claims Payment Dollar Accuracy is defined as the absolute value of financial errors divided by the total paid value of Contractor audited dollars paid.
Assessment	\$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	
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	
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	
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 full 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		
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, throughout the year and report annually.	
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		
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		
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
Assessment	\$1,000 if either of the characteristics of the network analysis is 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		
Guarantee	Claims Data Quality is measured by the Division of Health Care Finance and Administration, Office of Healthcare Informatics (HCI). The Contractor's quarterly data submission to the HCI must meet the following Data Quality measures.	



Definition	Measure	Benchmark
	Gender	Data missing for \leq (less than or equal to) 3% of claims
	Date of birth	Data missing for \leq 3% of claims
	Outpatient diagnosis coding	Data invalid or missing for \leq 5% of outpatient claims
	Outpatient provider type missing	Data missing for \leq 1.5% of outpatient claims
Assessment	\$2500 if ANY of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Compliance Report	Compliance Report consists of the Quarterly Data Quality report provided by the HCI. Performance measured and reported quarterly; reconciled annually.)	
9. Member Handbooks and Member ID Card Distribution		
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 Monthly Data to Data Management Vendor		
Guarantee	Monthly claims data will be submitted by the Contractor to HCI no later than the 5th day of the month following the end of each calendar month.	
Definition	Monthly claims data are received by HCI no later than the 5th day of the month following the end of each calendar month.	
Assessment	Failure to submit monthly claims data no later than the 5th day of the month following the end of each month will result in an assessment of \$100 per day for the first and second business days past the compliance date, and \$500 for each business day thereafter, to a maximum of \$3,000 per quarter.	
Compliance Report	Compliance reporting submitted by HCI upon receipt of monthly claims data. Performance is measured and reported monthly, reconciled annually.	
11. Disease Management Program		
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, if achievable, 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	<p>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.</p> <p>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.</p> <p>Each approved CAP will have a deadline by which the Contractor must fully implement the required actions.</p>
Definition	<p>On Request Report (ORR) shall mean a request by HCFA 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.</p> <p>Corrective Action Plan (CAP) means a plan of action proposed by the Contractor, at HCFA's request, to remedy a deficiency in Contractor's performance under this Contract. HCFA must approve each proposed CAP before it is implemented by the Contractor. The Contractor shall implement each approved CAP within the time specified by HCFA. HCFA, in its sole discretion, will determine when the approved CAP has been successfully implemented.</p>
Assessment	<p>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.</p> <p>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 HCFA.</p> <p>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.</p>
Compliance Report	Incorporated into the approved CAP.
13. Protected Health Information Security	
Guarantee	<p>Ensure that all State data containing protected health information (PHI), as defined in HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5 on the HHS Web site which compromises the security or privacy of protected health information (See ancillary Business Associate Agreement executed between the parties)</p>
Definition	<p>The Contractor shall take all necessary steps to secure all protected health Information as prescribed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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 specified by the Secretary of Health and Human Services under Public Law 115 and according to the Business Associate Agreement.</p>
Assessment	<p>Should the above standard not be met, an assessment of (\$500) per recipient per occurrence may be assessed, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those State recipients whose PHI was placed at risk by Contractor's failure to comply with the terms of this Contract, the Contractor shall be liable for all costs associated with the provision of such safeguard services.</p>



Compliance Report	Contractor shall issue a quarterly statement attesting to compliance. In the event of a breach of PHI security, the Contractor shall immediately file a report with the HCFA Privacy Office containing the details of the breach as previously set forth in this contract via the PHI/PII Loss Worksheet All required follow up reports from the Contractor will be timely submitted to the HCFA Privacy Office as directed.
14. Prevention of PHI Disclosure to Third Party	
Guarantee	Ensure to seek express written approval from the State, including the execution of the appropriate agreements to effectuate transfer and exchange of State recipient PHI or State confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party for any purpose other than the purpose of this Contract. (See ancillary Business Associate Agreement executed between the parties)
Definition	Prior to the disclosure of any State recipient PHI or State confidential information that is outside the scope of this contract to a third party, the Contractor must seek express written approval from the HCFA Privacy Office.
Assessment	Should the above standard not be met, an assessment of (\$500) per recipient per occurrence may be assessed.
Compliance Report	After the transfer of the approved PHI, Contractor shall notify the HCFA Privacy Office of the successful transfer of the PHI and provide documentation that the approved process for the transfer was followed.
15. Prevention of PHI Information to Third Party Beyond U.S. Boundaries	
Guarantee	Ensure prevention of use or disclosure of State recipient data or State confidential data in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States absent express approval from HCFA. (See ancillary Business Associate Agreement executed between the parties)
Definition	No State recipient data or State confidential data is permitted to be used or disclosed by any third party outside of the boundaries and jurisdiction of the United States, absent express approval by HCFA. The Contractor is responsible to take all necessary steps to prevent a breach of this requirement.
Assessment	Should the above standard not be met, an assessment of (\$1,000) per recipient per occurrence may be assessed.
Compliance Report	Contractor shall issue a quarterly statement attesting to compliance. In the event of a breach of this guarantee, the Contractor shall immediately file a report with the HCFA Privacy Office containing the details of the breach. All required follow up reports from the Contractor will be submitted timely to the HCFA Privacy Office as directed.

CoverKids

16. Claims Payment Dollar Accuracy	
Guarantee	The average monthly financial accuracy of claims payments will be 97% upon initial submission.
Definition	Percentage of total claims paid accurately for each month
Assessment	\$5,000 for each full percentage point accuracy is below 97% for each month
Compliance report	The Compliance Report is the monthly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results monthly. Performance will be reconciled annually.



17. Timely Claims Processing	
Guarantee	90% of non-investigated (clean) claims (for which no further written information or substantiation is required in order to make payment) are paid within fourteen (14) calendar days of the receipt of claim 96% of all claims are processed within thirty (30) calendar days
Definition	Percentage of clean electronic claims paid within 14 calendar days of receipt of claim, for each month Percentage of claims paid within 30 calendar days of receipt of claim, for each month
Assessment	\$10,000 for each month determined not to be in compliance
Compliance report	The Compliance Report is the monthly internal audit performed by the Contractor on a statistically valid sample. The Contractor shall measure and report results monthly. Performance will be reconciled annually.
18. Telephone Response Time/Call Answer Timeliness - Member Services	
Guarantee	Eighty-five percent (85%) of incoming Member services calls will be answered by a Member Services representative within 30 seconds or the prevailing benchmark established by NCQA
Definition	Telephone Response Time is defined as the number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period
Assessment	\$25,000 for each full percentage point below the 85% threshold for calls answered within 30 seconds 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.
19. Telephone Response Time/Call Answer Timeliness – Provider Services Line	
Guarantee	Eighty-five percent (85%) of incoming Provider Services calls will be answered by a Provider Services representative within 30 seconds or the prevailing benchmark established by NCQA
Definition	Telephone Response Time is defined as the number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period
Assessment	\$25,000 for each full percentage point below the 85% threshold for calls answered within 30 seconds 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.
20. Telephone Response Time/Call Answer Timeliness – Utilization Management (UM) Line	
Guarantee	Eighty-five percent (85%) of incoming Utilization Management calls will be answered by a Utilization Management representative within 30 seconds or the prevailing benchmark established by NCQA
Definition	Telephone Response Time is defined as the number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period
Assessment	\$25,000 for each full percentage point below the 85% threshold for calls answered within 30 seconds 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.
21. Telephone Response Time/Call Answer Timeliness – NurseTriage/Nurse Advice Line	
Guarantee	Eighty-five percent (85%) of incoming NurseTriage/Nurse Advice calls will be answered by a NurseTriage/Nurse Advice representative within 30 seconds or the prevailing benchmark established by NCQA
Definition	Telephone Response Time is defined as the number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation)



	during the measurement period
Assessment	\$25,000 for each full percentage point below the 85% threshold for calls answered within 30 seconds 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.
22. Telephone Call Abandonment Rate (Unanswered calls) – Member Services Line	
Guarantee	Less than 5% of telephone calls are abandoned by the Member Services Line
Definition	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period.
Assessment	\$25,000 for each full percentage point above 5% for calls abandoned before being answered by a live voice. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal Member Services telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
23. Telephone Call Abandonment Rate (Unanswered calls) – Provider Services Line	
Guarantee	Less than 5% of telephone calls are abandoned by the Provider Services Line
Definition	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period.
Assessment	\$25,000 for each full percentage point above 5% for calls abandoned before being answered by a live voice. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal Provider Services telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
24. Telephone Call Abandonment Rate (Unanswered calls) – UM Line	
Guarantee	Less than 5% of telephone calls are abandoned by the UM Line
Definition	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period.
Assessment	\$25,000 for each full percentage point above 5% for calls abandoned before being answered by a live voice. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal UM telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
25. Telephone Call Abandonment Rate (Unanswered calls) – Nurse Triage/Nurse Advice Line	
Guarantee	Less than 5% of telephone calls are abandoned by the Nurse Triage/Nurse Advice Line
Definition	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period.
Assessment	\$25,000 for each full percentage point above 5% for calls abandoned before being answered by a live voice. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal Nurse Triage/Nurse Advice telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
26. Distance from Provider to Member	
Guarantee	In accordance with this Contract, including all attachments.
Definition	Distance from provider to member is defined by travel distance as measured by GeoAccess.
Assessment	\$25,000 if any of the listed standards are not met, either individually or in combination, on a monthly basis; The liquidated damage may be lowered to \$5,000 in the event that the Contractor



	provides a corrective action plan that is accepted by HCFA.
Compliance report	The monthly Provider Enrollment file sent to the State will determine if the GeoAccess is met on a monthly basis.
27. Provider Satisfaction	
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, throughout the year, and report annually. 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.
28. Member Satisfaction	
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	\$10,000 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.
29. External Quality Review Organization (EQRO) - Provider Network Documentation	
Guarantee	Each monthly Provider Enrollment file should have 100% of providers with a signed provider agreement with the Contractor.
Definition	Executed contract is a signed provider agreement with a provider to participate in the Contractor's network as a contract provider.
Assessment	\$1,000 for each provider for which the Contractor cannot provide a signature page from the provider agreement between the provider and the Contractor
Compliance report	Compliance report is the monthly Provider Enrollment File and provider agreement signature page, upon request from HCFA.
30. External Quality Review Organization (EQRO) - Specialist Provider Network	
Guarantee	<p>1. Physician Specialists: Executed specialty physician contracts in all areas required by this Agreement for the following specialists: allergy; cardiology; dermatology; endocrinology; gastroenterology; general surgery; nephrology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; psychiatry (child/adolescent); and urology</p> <p>2. Essential Hospital Services: Executed contract with at least one (1) tertiary care center for each essential hospital service</p> <p>3. Center of Excellence for People with AIDS: Executed contract with at least two (2) Center of Excellence for AIDS.</p> <p>4. Center of Excellence for Behavioral Health:</p> <p>Executed contract with all COEs for Behavioral Health.</p>
Definition	Executed contract is a signed provider agreement with a provider to participate in the Contractor's network as a contract provider.
Assessment	\$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis.



Compliance report	Compliance report is the monthly Provider Enrollment File.	
31. External Quality Review Organization (EQRO) Provider Data Validation – Provider Participation Accuracy		
Guarantee	As validated by the State's EQRO vendor quarterly, Contractor shall have at least 90% of listed providers confirm participation in the Contractor's network.	
Definition	A statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the Contractor's network	
Assessment	\$25,000 per quarter if less than 90% of providers confirm participation. The liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by HCFA, or may be waived by HCFA if the Contractor submits sufficient documentation to demonstrate 90% of providers in the sample are participating	
Compliance report	Compliance report is the quarterly EQRO Provider Data Validation report.	
32. External Quality Review Organization (EQRO) Provider Data Validation – Provider Information Accuracy		
Guarantee	As validated by the State's EQRO vendor quarterly, Contractor shall have data for no more than 10% of listed providers is incorrect for <u>each</u> data element.	
Definition	Data for no more than 10% of a statistically valid sample of participating providers on the most recent monthly provider enrollment is incorrect for <u>each</u> element as determined by HCFA	
Assessment	<p>\$5,000 per quarter if data for more than 10% but fewer than 31% of providers is incorrect for each data element</p> <p>\$25,000 per quarter if data for more than 30% of providers is incorrect for each data element</p> <p>The \$25,000 liquidated damage may be lowered to \$5,000 in the event that the Contractor provides a corrective action plan that is accepted by HCFA, or may be waived by HCFA if the Contractor submits sufficient documentation</p>	
Compliance report	Compliance report is the quarterly EQRO Provider Data Validation report.	
33. Claims Data Quality		
Guarantee	Claims Data Quality is measured by HCI. The Contractor's quarterly data submission to HCI 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 ANY of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Compliance report	Compliance Report consists of the Quarterly Data Quality report provided by HCI. Performance measured and reported quarterly; reconciled annually.)	
34. Member Handbooks and Member ID Card Distribution		
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 \$5,000 per year in which the standard is not met.	
Compliance report	Compliance Report submitted by the Contractor. Performance is measured, reported, and reconciled annually.	
35. Submission of Monthly Data to Data Management Vendor		



Guarantee	Monthly claims data will be submitted by the Contractor to HCI no later than the 5th day of the month following the end of each calendar month.
Definition	Monthly claims data are received by the HCI no later than the 5th day of the month following the end of each calendar month.
Assessment	Failure to submit monthly claims data no later than the 5th day of the month following the end of each month will result in an assessment of \$100 per day for the first and second business days past the compliance date, and \$500 for each business day thereafter, to a maximum of \$3,000 per quarter.
Compliance report	Compliance reporting submitted by the State's analytic division upon receipt of monthly claims data. Performance is measured and reported monthly, reconciled annually.
36. 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 HCFA 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 HCFA's request, to remedy a deficiency in Contractor's performance under this Contract. HCFA must approve each proposed CAP before it is implemented by the Contractor. The Contractor shall implement each approved CAP within the time specified by HCFA. HCFA, 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 HCFA. 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.
37. Protected Health Information Security	
Guarantee	Ensure that all State data containing protected health information (PHI), as defined in HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5 on the HHS Web site which compromises the security or privacy of protected health information (See ancillary Business Associate Agreement executed between the parties)
Definition	The Contractor shall take all necessary steps to secure all protected health Information as prescribed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 specified by the Secretary of Health and Human Services under Public Law 115 and according to the Business Associate Agreement.
Assessment	Should the above standard not be met, an assessment of (\$500) per recipient per occurrence may be assessed, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those State recipients whose PHI was placed at



	risk by Contractor's failure to comply with the terms of this Contract, the Contractor shall be liable for all costs associated with the provision of such safeguard services.
Compliance report	Contractor shall issue a quarterly statement attesting to compliance. In the event of a breach of PHI security, the Contractor shall immediately file a report with the HCFA Privacy Office containing the details of the breach. All required follow up reports from the Contractor will be timely submitted to the HCFA Privacy Office as directed.
38. Prevention of PHI Disclosure to Third Party	
Guarantee	Ensure to seek express written approval from the State, including the execution of the appropriate agreements to effectuate transfer and exchange of State recipient PHI or State confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party for any purpose other than the purpose of this Contract. (See ancillary Business Associate Agreement executed between the parties)
Definition	Prior to the disclosure of any State recipient PHI or State confidential information that is outside the scope of this contract to a third party, the Contractor must seek express written approval from the HCFA Privacy Office.
Assessment	Should the above standard not be met, an assessment of (\$500) per recipient per occurrence may be assessed.
Compliance report	After the transfer of the approved PHI, Contractor shall notify the HCFA Privacy Office of the successful transfer of the PHI and provide documentation that the approved process for the transfer was followed.
39. Prevention of PHI Information to Third Party Beyond U.S. Boundaries	
Guarantee	Ensure prevention of use or disclosure of State recipient data or State confidential data in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States (See ancillary Business Associate Agreement executed between the parties)
Definition	No State recipient data or State confidential data is permitted to be used or disclosed by any third party outside of the boundaries and jurisdiction of the United States. The Contractor is responsible to take all necessary steps to prevent a breach of this requirement.
Assessment	Should the above standard not be met, an assessment of (\$1,000) per recipient per occurrence may be assessed.
Compliance report	Contractor shall issue a quarterly statement attesting to compliance. In the event of a breach of this guarantee, the Contractor shall immediately file a report with the HCFA Privacy Office containing the details of the breach. All required follow up reports from the Contractor will be timely submitted to the HCFA Privacy Office as directed.



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	Both 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.	Both 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.	AccessTN only	Monthly
Monthly Enrollment Report	Detail breakout of enrollment	Both Programs	Monthly
Enrollment by County and Region	Enrollment by County and Region	Both Programs	Monthly
Care Management Monthly Summary Report	Reports touch and engagement rates, case distribution, closure reasons and cases by phase for DM and CM	Both Programs	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	AccessTN only	Monthly



	retroactivity.		
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
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
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	Quarterly thru run-out
Ownership and Control Interest Statement and Criminal Information Report – only for the pharmacies in 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
5% Annual Member Cost Sharing Report	Identifies CoverKids members who may reach their 5% annual cost sharing maximum limit	CoverKids only	Quarterly



ATTACHMENT C

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	39943
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.

SCOTT C. PIERCE

PRINTED NAME AND TITLE OF SIGNATORY

11-18-13

DATE OF ATTESTATION



ATTACHMENT D

BLUECARD PPO PROGRAM (AccessTN ONLY)

- D.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."
- D.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.")
- D.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.
- D.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.
- D.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.
- D.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:
- D.2.2.1. the actual price the Host Plan paid to the health care provider ("Actual Price"); or
- D.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
- D.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.



- D.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.
- D.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.
- D.2.5. Statutes in a few states may require a Host Plan either to:
 - D.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
 - D.2.5.2. add a surcharge.
- D.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.
- D.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.
- D.4. BlueCard Fees and Compensation. State understands and agrees:
 - D.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
 - D.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.
 - D.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.
 - D.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.

- D.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.
- D.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.

- D.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.
- D.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 E

BLUECARD PROGRAM (CoverKids ONLY)

- E.1. This Attachment describes the general operation of the BlueCard 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 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



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 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 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 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 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 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

GENERAL ACCESS STANDARDS (CoverKids Only)

In general, Contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum, this shall include:

1. Primary Care Physician or PCP Extender (Nurse Practitioner or Physician Assistant)
 - (a) Distance Rural: 30 miles
 - (b) Distance Urban: 20 miles
 - (c) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
2. Specialty Care and Emergency Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed thirty (30) days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed forty-five (45) minutes.
3. Hospitals

Transport distance will be the usual and customary, not to exceed thirty (30) miles, except in rural areas where access distance may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.
4. General Optometry Services:
 - (a) Transport distance will be the usual and customary, not to exceed thirty (30) miles, except in rural areas where community standards and documentation shall apply.
 - (b) Appointment/Waiting Times: Usual and customary not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care. Waiting times shall not exceed 45 minutes.
5. All other services not specified here shall meet the usual and customary standards for the community as determined by HCFA.



HCFA will evaluate the need for further action when the above standards are not met. At its sole discretion HCFA may elect one of three options: (1) HCFA may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the Contractor's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If HCFA determines the Contractor's response demonstrates existence of alternate measures or unique market conditions, HCFA may elect to request periodic updates from the Contractor regarding efforts to address such conditions.

The Contractor shall not refuse to credential and contract with a qualified provider, on the sole basis of the network already meeting the contractual distance accessibility standard, if there is a subset of enrollees in the proposed service area that must travel beyond the average standard to access care.



ATTACHMENT G

**ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES
(CoverKids Only)**

The Contractor shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members. For the purpose of assessing behavioral health provider network adequacy, HCFA will evaluate the Contractor's provider network relative to the requirements described below.

Access to Behavioral Health Services

The Contractor shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The Contractor shall have provider agreements with providers of the services listed in the table below and meet the geographic and time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Travel distance does not exceed 60 miles for at least 75% of CHILD members and does not exceed 90 miles for at least 90% of CHILD members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization	Travel distance does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	The Contractor shall contract with at least one (1) provider of service Region for CHILD members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours

HCFA will evaluate the need for further action when the above standards are not met. At its sole discretion HCFA may elect one of three options: (1) HCFA may request a Corrective Action



Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the Contractors network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If HCFA determines the Contractor's response demonstrates the existence of alternate measures or unique market conditions, HCFA may elect to request periodic updates from the Contractor regarding efforts to address such conditions.

The Contractor shall not refuse to credential and contract with a qualified provider, on the sole basis of the network already meeting the contractual distance accessibility standard, if there is a subset of enrollees in the proposed service area that must travel beyond the average standard to access care.



ATTACHMENT H

**SPECIALTY NETWORK STANDARDS
(CoverKids Only)**

The Contractor shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (pregnant women/unborn child and children). For the purpose of assessing specialty provider network adequacy, HCFA will evaluate the Contractor’s provider network relative to the requirements described below. A provider is considered a “specialist” if he/she has a provider agreement with the Contractor to provide specialty services to members.

Access to Specialty Care

The Contractor shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

(1) The Contractor shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (child and adolescent) and Urology; and

(2) The following access standards are met:

- o Travel distance does not exceed 60 miles for at least 75% of members and
- o Travel distance does not exceed 90 miles for ALL members

Availability of Specialty Care

The Contractor shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its members. To account for variances in HCFA enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the Contractor must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers statewide was compared to the size of the population. The Contractor shall have a sufficient number of provider agreements with each type of specialist served to ensure that the number of members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000



Specialty	Number of Non-Dual Members
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Psychiatry (adult)	25,000
Psychiatry (child & adolescent)	150,000
Urology	30,000

HCFA will evaluate the need for further action when the above standards are not met. At its sole discretion HCFA may elect one of three options: (1) HCFA may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the Contractor's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If HCFA determines the Contractor's response demonstrates existence of alternate measures or unique market conditions, HCFA may elect to request periodic updates from the Contractor regarding efforts to address such conditions

The Contractor shall not refuse to credential and contract with a qualified provider, on the sole basis of the network already meeting the contractual distance accessibility standard, if there is a subset of enrollees in the proposed service area that must travel beyond the average standard to access care.