CONTRACT #9
RFS # 318.65-00346
Edison # 34942

Finance and Administration
Health Care Finance and Administration

VENDOR:
Magellan Medicaid Administration, Inc.

TN Division of
Health Care Finance & Administration

March 31, 2016

Mark White, Chairman
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: Cognosante, LLC - Amendment #2
Magellan Medicaid Administration, Inc. – Amendment #2
Principle Valuation, LLC – Amendment #1

Dear Chairman White:

The Department of Finance and Administration, Division of Health Care Finance and Administration (HCFA), is submitting for consideration by the Fiscal Review Committee amendment #2 to Cognosante, LLC (Edison 37266). This competitively procured contract is for the provision of Independent Validation and Verification (IV&V) services including (1) IV&V Medicaid and Eligibility expertise in support of the TEDS project from startup throughout the project lifecycle; (2) To maintain and leverage valuable resources with Eligibility, Medicaid, and TN specific intellectual capacity that are currently working on the project and will provide continuity to ensure the project progresses as expeditiously as possible, (3) to address the need for Medicaid and Eligibility expertise and resource capacity of IV&V services to support the most timely and highest quality implementation of the TEDS system required to adequately serve the State's Medicaid population, and (4) add in the IV&V functions required by CMS associated with the MMIS IV&V. The payment structure for this contract is a combination of monthly and hourly rates for staff with expertise in IV&V to support the State and other designated contractors and vendors that TennCare will engage for the improved TEDS project outcome. This amendment is necessary to provide adequate funding to support these ongoing functions and also to exercise optional term extension at optional year rates.

Additionally, we are submitting for consideration amendment #2 to Magellan Medicaid Administration, Inc., the competitively procured contractor for the provision of the State of Tennessee TennCare Pharmacy Benefits Manager. These services include a Point-of-Sale (POS) pharmacy claims processing system with prospective drug utilization review (DUR), retrospective drug utilization review (Retro-DUR), and reporting and adjudication capabilities, as well as the CoverRx program members that were added to this contract in March, 2015. This amendment is necessary to extend the term of this contract for the first term extension option as stated in the Request for Proposal as well as in the current contract language, as well as funding added to support the required activities of the pharmacy term extension. The TennCare rates mirror the rates submitted in the RFP Cost Proposal, however, due to less than anticipated volume in the CoverRx program, Magellan has reduced their rates for the CoverRx program, which is reflected in the amendment.

Finally, HCFA is submitting amendment #1 to Principle Valuation, LLC, the competitively procured contract for the provision of a comprehensive independent real estate appraisal for each current Medicaid-certified nursing facility in the state and for any new Medicaid-certified facility which is established in Tennessee prior to December 31, 2018. Once appraisals began and after discussions with the nursing facility industry and the vendor, it was agreed that in order to design a nursing facility payment model that would equitably treat all facilities, both old and new, the Contractor would need to perform additional work to calculate facility depreciation values. This amendment is necessary to establish an hourly rate to reimburse the contractor for these additional necessary tasks, projected to be 400 hours of analysis, as well as provide increase to the maximum liability in the amount of $40,000 for the duration of the contract.

HCFA 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

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Alma Chilton	*Contact Phone:	615-507-6384
*Presenter's name(s):	Casey Dungan		
Edison Contract Number: *(if applicable)*	#34942	RFS Number: *(if applicable)*	
*Original or Proposed Contract Begin Date:	December 20, 2012	*Current or Proposed End Date:	May 31, 2016
Current Request Amendment Number: *(if applicable)*		2	
Proposed Amendment Effective Date: *(if applicable)*		May 31, 2016	
*Department Submitting:		Department of Finance and Administration	
*Division:		Division of Health Care Finance & Administration	
*Date Submitted:		March 31, 2016	
*Submitted Within Sixty (60) days:		Yes	
If not, explain:		N/A	
*Contract Vendor Name:		Magellan Medicaid Administration, Inc.	
*Current or Proposed Maximum Liability:		$61,659,020.00	
*Estimated Total Spend for Commodities:			

*Current or Proposed Contract Allocation by Fiscal Year:
(as Shown on Most Current Fully Executed Contract Summary Sheet)

FY: 2013	FY: 2014	FY: 2015	FY: 2016	FY	FY
$ 1,574,983.50	$ 19,523,141.15	$21,175,447.35	$19,385,448.00	$	$

*Current Total Expenditures by Fiscal Year of Contract:
(attach backup documentation from Edison) **Attached**

FY: 2013	FY: 2014	FY: 2015	FY:2016	FY	FY
$1,041,780.51	$14,656,830.64	$15,908,642.40	$12,141,310.54 **(thru 2/16)**	$	$

IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:	Sufficient funding is included in the contract maximum liability to cover all possible payments. This contract allocation includes monthly fixed amounts as well as optional percentage rates, including percentage of supplemental rebate, and payments based on percentage of Third Party Liability recovery. Any unspent dollars in a FY roll forward in this contract to be available for payments for remainder of contract.
IF surplus funds have been carried forward, please give the reasons and provide the authority for the	This contract payment methodology is based on rates submitted in competitive Cost Proposal. The maximum liability is calculated by FY to include the fixed rates in addition to projected percentage

Supplemental Documentation Required for Fiscal Review Committee

carry forward provision:	payments. All unused funds for a Fiscal Year roll forward for availability throughout the term of the contract.
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:	N/A

*Contract Funding Source/Amount:			
State:	$31,985,011.00	Federal:	$29,674,009.00
Interdepartmental:		*Other*:	
If "*other*" please define:			
If "*interdepartmental*" please define:			

Dates of All Previous Amendments or Revisions: *(if applicable)*	Brief Description of Actions in Previous Amendments or Revisions: *(if applicable)*
Amendment #1 - 09/2014	Roll in the CoverRx Program in to existing pharmacy contract.

Method of Original Award: *(if applicable)*	RFP
*What were the projected costs of the service for the entire term of the contract prior to contract award? How was this cost determined?	$59,348,018.00 for the base period. Amendment #1 moved the CoverRx population into this contract. RFP Cost Proposal
*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 contract was competitively procured. There were 4 proposers to this RFP. Magellan won the award based on highest combined experience/technical and cost proposals.
Provide information on the circumstances and status of any disciplinary action taken or pending against the vendor during the past 5 years with state agencies/ departments, professional organizations, or through any legal action.	No disciplinary actions identified.
In addition, please provide any information regarding the due diligence that the Department has taken to ensure that the	HCFA googled this contractor and did not identify any illegal activity. Language in the contract requires

vendor is not or has not been involved in any circumstances related to illegal activity, including but not limited to fraud.	immediate notification to the state regarding illegal activity or fraud if discovered during the term of this Contract.

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00346	34942		01

Contractor Legal Entity Name	Edison Vendor ID
Magellan Medicaid Administration, Inc.	0000041004

Amendment Purpose & Effect(s)

Update Scope and Payment Terms to include CoverRx

Amendment Changes Contract End Date: ☐ YES x NO **End Date:** May 31, 2016

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$2,311,002.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2013	$787,491.75	$787,491.75			$1,574,983.50
2014	$9,761,570.57	$9,761,570.58			$19,523,141.15
2015	$11,273,491.68	$9,901,955.67			$21,175,447.35
2016	$10,162,457.00	$9,222,991.00			$19,385,448.00
TOTAL:	**$31,985,011.00**	**$29,674,009.00**			**$61,659,020.00**

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

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.

Speed Chart (optional)	Account Code (optional)

CPO USE

Magellan Medicaid Administration, Inc.
Edison Contract ID: 34942
Vendor #: 0000041004

CONTRACT EXPENDITURES BY FISCAL YEAR
(Payment Detail Attached)

FY 2013	$1,041,780.51	
FY 2014	$14,656,830.64	
FY 2015	$15,908,642.40	
FY 2016	$12,141,310.54	(Expenditures through February, 2016)
TOTAL	$43,748,564.09	

Magellan Medicaid Administration, Inc.
Edison Contract ID: 34942
Vendor ID: 0000041004

FY 2013 Payments

Fiscal Year	Unit	Voucher ID	Invoice	Date	Sum Amount
2013	31865	00790523	PH-1507	10/25/2013	$79,997.01
2013	31865	00790526	PH-1488	10/25/2013	$961,783.50

Total FY 2013: **$1,041,780.51**

FY 2014 Payments

Fiscal Year	Unit	Voucher ID	Invoice	Date	Sum Amount
2014	31865	00790524	PH-1540	10/25/2013	$177,464.17
2014	31865	00790527	PH-1531	10/25/2013	$974,131.89
2014	31865	00790525	PH-1551	10/25/2013	$974,983.50
2014	31865	00836777	PH-1594	1/15/2014	$250,569.94
2014	31865	00836779	PH-1625	1/15/2014	$279,975.99
2014	31865	00836774	PH-1595	1/15/2014	$974,983.50
2014	31865	00836776	PH-1566	1/16/2014	$193,808.80
2014	31865	00836773	PH-1573	1/16/2014	$974,983.50
2014	31865	00848903	PH-1653	2/7/2014	$238,327.69
2014	31865	00848902	PH-1630	2/7/2014	$974,983.50
2014	31865	00903018	PH-1676	4/30/2014	$262,769.51
2014	31865	00903017	PH-1699	4/30/2014	$288,927.32
2014	31865	00903007	PH-1673	5/2/2014	$933,183.50
2014	31865	00903015	PH-1691	5/2/2014	$968,083.50
2014	31865	00920918	PH-1737	6/4/2014	$700,835.11
2014	31865	00920919	PH-1761	6/4/2014	$335,680.08
2014	31865	00920856	PH-1714	6/6/2014	$974,983.50
2014	31865	00903017	PH-1699	6/6/2014	$303,828.97
2014	31865	00925289	PH-1780	6/9/2014	$974,983.50
2014	31865	00937318	PH-1793	7/2/2014	$355,414.85
2014	31865	00967176	PH-1811	8/14/2014	$974,483.50
2014	31865	00967179	PH-1821	8/14/2014	$295,324.71
2014	31865	00967180	PH-1833	8/14/2014	$998,322.67
2014	31865	00967181	PH-1844	8/14/2014	$275,797.44

Total FY 2014: **$14,656,830.64**

FY 2015 Payments

Fiscal Year	Unit	Voucher ID	Invoice	Date	Sum Amount
2015	31865	00995845	PH-1862	10/3/2014	$998,222.67
2015	31865	00995854	PH-1875	10/7/2014	$277,922.91
2015	31865	01004166	PH-1907	10/17/2014	$288,816.51
2015	31865	01004165	PH-1891	10/20/2014	$996,322.67
2015	31865	01016692	PH-1935	11/14/2014	$286,725.94
2015	31865	01016691	PH-1925	11/14/2014	$998,322.67
2015	31865	01051593	PH-1970	1/14/2015	$992,622.67
2015	31865	01055521	PH-1983	1/16/2015	$322,486.96
2015	31865	01055524	PH-1985	1/16/2015	$998,322.67
2015	31865	01058596	PH-2010	1/27/2015	$250,428.04
2015	31865	01084003	PH-2038	3/12/2015	$273,629.80
2015	31865	01084002	PH-2028	3/16/2015	$992,322.67
2015	31865	01099765	PH-2062	4/3/2015	$133,770.00
2015	31865	01103801	PH-2061	4/9/2015	$133,770.00
2015	31865	01107469	PH-2052	4/17/2015	$998,122.67
2015	31865	01107467	PH-2053	4/20/2015	$284,082.81
2015	31865	01111469	PH-2104	4/30/2015	$133,770.00
2015	31865	01122649	PH-2078	5/20/2015	$995,822.67
2015	31865	01122662	PH-2101	5/21/2015	$232,208.24
2015	31865	01122663	PH-2081	5/21/2015	$285,997.57
2015	31865	01122664	PH-2100	5/21/2015	$998,322.67
2015	31865	01130364	PH-2128	6/3/2015	$133,770.00
2015	31865	01137711	PH-2151	6/30/2015	$133,770.00
2015	31865	01148778	PH-2154	7/10/2015	$191,747.74
2015	31865	01148780	PH-2125	7/10/2015	$224,035.67
2015	31865	01148781	PH-2124	7/10/2015	$991,822.67
2015	31865	01148779	PH-2152	7/10/2015	$998,322.67
2015	31865	01152907	PH-2162	7/30/2015	$136,846.00
2015	31865	01203938	PH-2174	10/9/2015	$1,022,362.00
2015	31865	01203939	PH-2175	10/9/2015	$203,952.84

Total FY 2015: **$15,908,642.40**

FY 2016 Payments

Fiscal Year	Unit	Voucher ID	Invoice	Date	Sum Amount
2016	31865	01177369	PH-2202	8/28/2015	$136,846.00
2016	31865	01203935	PH-2251	10/9/2015	$136,846.00
2016	31865	01203937	PH-2198	10/9/2015	$365,212.56
2016	31865	01203936	PH-2197	10/9/2015	$1,019,762.00
2016	31865	01207495	PH-2247	10/21/2015	$1,026,362.00
2016	31865	01211274	PH-2254	10/21/2015	$393,303.83
2016	31865	01211410	PH-2276	11/2/2015	$136,846.00
2016	31865	01225888	PH-2317	12/1/2015	$136,846.00
2016	31865	01232587	PH-2284	12/9/2015	$354,653.02
2016	31865	01232586	PH-2272	12/9/2015	$1,021,862.00
2016	31865	01246121	PH-2352	12/31/2015	$136,846.00
2016	31865	01253944	PH-2349	1/20/2016	$301,717.17
2016	31865	01253936	PH-2315	1/20/2016	$328,851.21
2016	31865	01253930	PH-2314	1/20/2016	$1,020,462.00
2016	31865	01253943	PH-2348	1/20/2016	$1,022,362.00
2016	31865	01260645	PH-2383	2/5/2016	$136,846.00
2016	31865	01278062	PH-2411	3/3/2016	$136,846.00
2016	31865	01282233	PH-2378	3/7/2016	$1,020,762.00
2016	31865	01282234	PH-2379	3/7/2016	$334,360.45
2016	31865	Pending	PH-2407	Pending	$1,022,362.00
2016	31865	Pending	PH-2414	Pending	$362,662.87
2016	31865	Pending	PH-2456	Pending	$136,846.00
2016	31865	Pending	PH-2450	Pending	$1,022,362.00
2016	31865	Pending	PH-2451	Pending	$429,485.43

Total FY 2016: **$12,141,310.54**

cy16-6551

Amendment Request

This request form is not required for amendments to grant contracts. Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@tn.gov

APPROVED

Kevin C. Bartels for Michael F. Perry

Digitally signed by Kevin C. Bartels for Michael F. Perry
DN: cn=Kevin C. Bartels for Michael F. Perry, o=CPO, ou, email=Kevin.C.Bartels@tn.gov, c=US
Date: 2016.03.29 16:16:32 -05'00'

CHIEF PROCUREMENT OFFICER **DATE**

Agency request tracking #	**31865-00346**
1. Procuring Agency	**Department of Finance and Administration Division of Health Care Finance and Administration**
2. Contractor	**Magellan Medicaid Administration, Inc.**
3. Edison contract ID #	**34942**
4. Proposed amendment #	**2**
5. Contract's Effective Date	**December 20, 2012**
6. Current end date	**May 31, 2016**
7. Proposed end date	**May 31, 2017**
8. Current Maximum Liability or Estimated Liability	**$ 61,659,020.00**
9. Proposed Maximum Liability or Estimated Liability	**$ 72,615,595.00**
10. Office for Information Resources Pre-Approval Endorsement Request *– information technology service (N/A to THDA)*	**x Not Applicable ☐ Attached**
11. eHealth Pre-Approval Endorsement Request *– health-related professional, pharmaceutical, laboratory, or imaging*	**x Not Applicable ☐ Attached**
12. Human Resources Pre-Approval Endorsement Request *– state employee training service*	**x Not Applicable ☐ Attached**

13. Explain why the proposed amendment is needed

Magellan Medicaid Administration, Inc. is the competitively procured contractor for the provision of the State of Tennessee TennCare Pharmacy Benefits Manager. These services include a Point-of-Sale (POS) pharmacy claims processing system with prospective drug utilization review (DUR), retrospective drug utilization review (Retro-DUR), and reporting and adjudication capabilities, as well as the CoverRx program members that were added to this contract in March, 2015. This amendment is necessary to extend the term of this contract for the first term extension option as stated in the Request for Proposal as well as in the current contract language. The TennCare rates mirror the rates submitted in the RFP Cost Proposal, however, due to less than

Agency request tracking #	31865-00346

anticipated volume in the CoverRx program, Magellan has reduced their rates for the CoverRx program, which is reflected in the amendment, as well as funding added to support the required activities of the pharmacy term extension.

14. If the amendment involves a change in Scope, describe efforts to identify reasonable, competitive, procurement alternatives to amending the contract.

Contract scope is modified by updating supplemental rebate language. This is a clarification of existing language and would not substantiate re-procurement.

Signature of Agency head or authorized designee, title of signatory, and date (the authorized designee may sign his or her own name if indicated on the Signature Certification and Authorization document)

Larry B. Martin/CD 3/24/2016

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00346	34942		02

Contractor Legal Entity Name	Edison Vendor ID
Magellan Medicaid Administration, Inc.	0000041004

Amendment Purpose & Effect(s)

Extends Term and Increases Maximum Liability

Amendment Changes Contract End Date: ☒ YES ☐ NO **End Date:** May 31, 2017

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$ 10,956,575.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2013	$787,491.75	$787,491.75			$1,574,983.50
2014	$9,761,570.57	$9,761,570.58			$19,523,141.15
2015	$11,273,491.68	$9,901,955.67			$21,175,447.35
2016	$10,162,457.00	$9,222,991.00			$19,385,448.00
2017	$6,318,245.00	$4,638,330.00			$10,956,575.00
TOTAL:	**$38,303,256.00**	**$34,312,339.00**			**$72,615,595.00**

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

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.

Speed Chart (optional)	Account Code (optional)
TN00000318 TN00000311	70803000

CPO USE

AMENDMENT #2
OF CONTRACT #34942
BETWEEN THE STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
AND
MAGELLAN MEDICAID ADMINISTRATION, 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 (HCFA), hereinafter referred to as the "State" or "TennCare," or "HCFA" and Magellan Medicaid Administration, 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. Contract Section A.4.5.2 d is deleted in its entirety and replaced with the following:

   A.4.5.2.d. On an annual basis the percentage of effectiveness of the supplemental rebate program shall be measured against the Contractors response to the RFP as stipulated in Contract Section C.3. The Contractor shall be allowed a two percent (2%) deviation from its response. For example, if the Contractor bid six percent (6%) for supplemental rebate percentage, the allowable range shall be four to eight percent (4 - 8%). Rebates shall be calculated on the basis of any rebates obtained outside of the OBRA rebates. Failure to achieve supplemental rebate within this range will result in liquidated damages as set forth in Attachment C. Annually, if the Contractor exceeds the upper figure of the allowed supplemental rebate percentage range they shall receive an annual incentive based on the following table:

Exceed by less than one percent (1%)	One hundred thousand dollars ($100,000)
Exceed by more than or equal to one percent (1%), but less than two percent (2%)	One hundred thousand dollars ($100,000)
Exceed by more than or equal to two percent (2%), but less than three percent (3%)	One hundred thousand dollars ($100,000)
Exceed by more than or equal to three percent (3%)	One hundred thousand dollars ($100,000)

2. Contract Section A.33 is deleted in its entirety and replaced with the following:

   A.33. The Contractor shall setup and configure the current eRebate™ system to handle drug rebate administration for the CoverRx Program to support the CorverRx rebate for diabetic supplies, insulins and albuterol HFA products-The Contractor shall manage and assume all of the same responsibilities for the CoverRx Program that are currently being performed for TennCare, including contracting for a CoverRx rebate for diabetic supplies, insulins and albuterol HFA products and submitting the manufacturer contracts to CoverRx for review, rebate invoicing, payment posting, and dispute resolution processes.

3 Contract Section B.1 is deleted in its entirety and replaced with the following:

B.1. This Contract shall be effective for the period beginning December 20, 2012, and ending on May 31, 2017. Actual delivery of services shall begin on June 1, 2013 after completion of transition, should one be necessary, and completion of readiness review. 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.

4. Contract Section C.1 is deleted in its entirety and replaced with the following:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Seventy-Two Million Six Hundred Fifteen Thousand Five Hundred Ninety Five Dollars ($72,615,595.00). The payment rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

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

5. Contract Section C.3.b.(8) and C.3.b.(9) are deleted in their entirety and replaced with the following:

(8) Should the contract be amended for extension of services for the period of June 1, 2016 through May 31, 2017, the following Monthly Administration rates for the CoverRx Program shall apply:

Service Description	**Amount** (per compensable increment)
Monthly CoverRx Administrative Fee (June 1, 2016 – May 31, 2017)	$131,243.00 Per month

(9) Should the contract be amended for extension of services for the period of June 1, 2017 through May 31, 2018, the following Monthly Administration rates for the CoverRx Program shall apply:

Service Description	**Amount** (per compensable increment)

Monthly CoverRx Administrative Fee (June 1, 2017 – May 31, 2018)	$131,243.00 Per month

6. Contract Sections C.3.c and C.3.d are deleted in their entirety and replaced with the following:

c. Rebate Incentive - Per Section A.4.5.2., Annual Rebates for each year of the contract shall be calculated on the basis of any rebates obtained outside of the OBRA rebates. Annually, if the Contractor exceeds the upper figure of the allowed supplemental rebate percentage range they shall receive an annual incentive based on the following table:

Exceed by less than one percent (1%)	One hundred thousand dollars ($100,000)
Exceed by more than or equal to one percent (1%), but less than two percent (2%)	One hundred thousand dollars ($100,000)
Exceed by more than or equal to two percent (2%), but less than three percent (3%)	One hundred thousand dollars ($100,000)
Exceed by more than or equal to three percent (3%)	One hundred thousand dollars ($100,000)

d. Rebate Incentive - Per Section A.4.5.2., Annual Rebates for each year of the contract shall be calculated on the basis of any rebates obtained outside of the OBRA rebates. The Table below lists the Contractor's Annual Allowed Supplemental Percentage for each year of the contract:

	June 1, 2013- May 31, 2014	June 1, 2014- May 31, 2015	June 1, 2015- May 31, 2016	June 1, 2016- May 31, 2017	June 1, 2017- May 31, 2018
Annual Allowed Supplemental Rebate Percentage	7.45%	7.13%	4.00%	3.35%	3.20%

7. Contract Attachment C is amended by deleting Performance Measure items A.4.5.2, A.18.2, A.18.3, A.18.5, A.19.2, and A.29.3 in their entirety and replacing with the following:

A.4.5.2 Supplemental Rebate Incentive	On an annual basis the percentage of effectiveness of the supplemental rebate	For example, if the Contractor bids six percent (6%) for supplemental rebate percentage	Not to exceed $100,000 annually

	program shall be measured against the Contractors response to the RFP. The Contractor shall be allowed a two percent (2%) deviation from its response.	in the RFP, the allowable range shall be four to eight percent (4% - 8%).	
A.19.2 CoverRx Eligibility Determination	For no less than ninety-five percent (95%) of new participants, a determination of eligibility will be made within five (5) working days of receipt of a completed application.	Determination of eligibility is defined as assessing whether or not an individual applicant meets the State's eligibility criteria for participation in CoverRx. A completed application is defined as one in which the applicant has provided the required data fields and supporting documentation.	One thousand ($1,000) dollars per month for every month out of compliance.
A.19.3 CoverRx Participant Communication Materials	Participant enrollment cards, descriptive booklets, and provider directories will be distributed to no less than ninety-five percent (95%) of new participants within one (1) week of enrollment. Performance will be based on an annual average.	Participant Communication Materials are any written materials developed and/or distributed by the Contractor which can be used by the participant to access, understand, clarify or make decisions concerning CoverRx.	Two thousand ($2,000) per year in which the standard is not met.
A.19.5 Annual Verification of CoverRx Participant Eligibility	Annual verification of participant eligibility, for no less than ninety-five percent (95%) of participants, shall occur within thirty (30) days of each participant's anniversary date.	Verification of participant eligibility is defined as assessing whether or not an individual applicant continues to meet the State's eligibility criteria for participation in CoverRx based on updated participant information that has been submitted by the participant to the Contractor.	One thousand ($1,000) dollars per month for every month out of compliance.
A.20.2 CoverRx Network Access	Within 90 days of CoverRx program implementation, 95% of all CoverRx participants will have access to at least one (1) retail pharmacist within thirty (30) miles of participants' residence.	The Contractor's provider and facility network will assure the access standard is met as measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis.	Five hundred dollars $500 for each week beyond the first 90 days of program implementation that the defined access standard is not met.
A.30.3 CoverRx Mail Order Turn-Around	All completed and fillable mail order prescriptions must be dispensed and shipped with a maximum turnaround time no greater than forty-eight (48) hours.	Mail order turnaround is measured from the time a prescription or refill request is received by the mail order pharmacy to the time it leaves the mail order pharmacy and mailed to the participant. Completed and fillable	One thousand dollars ($1,000) per month for each month the Contractor is five (5) full percentage points below one hundred percent (100%) compliance.

		prescriptions are those that require no intervention before they can be properly and/or accurately filled. (e.g. follow-up with participants or providers, for any reason)	

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 May 31, 2016. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

MAGELLAN MEDICAID ADMINISTRATION, INC.:

SIGNATURE **DATE**

PRINTED NAME AND TITLE OF SIGNATORY (above)

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

Larry B. Martin, Commissioner **DATE**

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*

Rep. Mark White, Vice-Chairman
Representatives
Jeremy Faison, Joe Pitts
Brenda Gilmore, Mark Pody
Matthew Hill, David Shepard
Pat Marsh, Tim Wirgau
Charles Sargent, *ex officio*
Speaker Beth Harwell, *ex officio*

MEMORANDUM

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

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

DATE: August 26, 2014

SUBJECT: Contract Comments
(Fiscal Review Committee Meeting 8/25/2014)

RFS# 318.65-00346 (Edison # 34942)
Department: Finance and Administration
Division: Health Care Finance and Administration/Bureau of TennCare
Vendor: Magellan Medicaid Administration, Inc.
Summary: The vendor is responsible for the provision of an online Point-of-Sale (POS) pharmacy claims processing system. The proposed amendment revises the scope of services; increases maximum liability by $2,311,002; revises payment methodology to include rates for the CoverRx Program; and updates Attachments A, C, and D.
Current maximum liability: $59,348,018
Proposed maximum liability: $61,659,020

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

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

July 1, 2014

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

Attention: Ms. Leni Chick

RE: Magellan Medicaid Administration, Inc. – Amendment #1

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 amendment #1 to Magellan Medicaid Administration, Inc., HCFA's competitively procured contract for Pharmacy Benefits Management (PBM) for the TennCare population. The existing Pharmacy Management contract for the HCFA CoverRx Program is ending December 31, 2014. This amendment is adding the CoverRx population of approximately 47,000 eligible CoverRx participants aged 19 – 64, needing access to prescription drugs for acute care and ongoing disease management into the Magellan contract. Due to Magellan's existing capabilities to support approximately 1.2 million TennCare enrollees, we believe that the CoverRx program will benefit from being added to the larger TennCare patient base population. The PBM will be able to leverage the size of the contract when administering the program with drug manufacturers, and the state will get the benefit of the vendor attending to the CoverRx program as part of a larger contract, including cost savings and improved service through reduced administrative overhead, competitive pricing, and program analytics.

The Department of Finance and Administration, Division of Health Care Finance and Administration, respectfully submits the above referenced contract amendment 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:	Alma Chilton	*Contact Phone:	615-507-6384
*Presenter's name(s):	Casey Dungan		
Edison Contract Number: *(if applicable)*	#34942	RFS Number: *(if applicable)*	
*Original or Proposed Contract Begin Date:	December 20, 2012	*Current or Proposed End Date:	May 31, 2016
Current Request Amendment Number: *(if applicable)*		1	
Proposed Amendment Effective Date: *(if applicable)*		September 1, 2014	
*Department Submitting:		Department of Finance and Administration	
*Division:		Division of Health Care Finance & Administration	
*Date Submitted:		July 1, 2014	
*Submitted Within Sixty (60) days:		Yes	
If not, explain:		N/A	
*Contract Vendor Name:		Magellan Medicaid Administration, Inc.	
*Current or Proposed Maximum Liability:		$59,348,018.00	
*Estimated Total Spend for Commodities:			

*Current or Proposed Contract Allocation by Fiscal Year:
(as Shown on Most Current Fully Executed Contract Summary Sheet)

FY: 2013	FY: 2014	FY: 2015	FY: 2016	FY	FY
$ 1,574,983.50	$ 19,523,141.15	$19,803,911.35	$18,445,982.00	$	$

*Current Total Expenditures by Fiscal Year of Contract:
(attach backup documentation from Edison) **Attached**

FY: 2013	FY: 2014	FY:	FY:	FY	FY
$1,041,780.51	$13,383,210.53 **(through May 2014)**	$	$	$	$

IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:	Sufficient funding is included in the contract maximum liability to cover all possible payments. This contract allocation includes monthly fixed amounts as well as optional percentage rates, including percentage of supplemental rebate, and payments based on percentage of Third Party Liability recovery. Any unspent dollars in a FY roll forward in this contract to be available for payments for remainder of contract.
IF surplus funds have been carried forward, please give the reasons and provide the authority for the	This contract payment methodology is based on rates submitted in competitive Cost Proposal. The maximum liability is calculated by FY to include

Supplemental Documentation Required for Fiscal Review Committee

carry forward provision:	the fixed rates in addition to projected percentage payments. All unused funds for a Fiscal Year roll forward for availability throughout the term of the contract.		
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:	N/A		
*Contract Funding Source/Amount:			
State:	$29,674,009.	Federal:	$29,674,009.00
Interdepartmental:		*Other*:	
If "*other*" please define:			
If "*interdepartmental*" please define:			
Dates of All Previous Amendments or Revisions: *(if applicable)*	Brief Description of Actions in Previous Amendments or Revisions: *(if applicable)*		
N/A			
Method of Original Award: *(if applicable)*	RFP		
*What were the projected costs of the service for the entire term of the contract prior to contract award? How was this cost determined?	$59,348,018.00 RFP Cost Proposal		
*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 contract was competitively procured. There were 4 proposers to this RFP. Magellan won the award based on highest combined experience/technical and cost proposals.		

Magellan Medicaid Administration, Inc.
Edison Contract ID: 34942
Vendor #: 0000041004

CONTRACT EXPENDITURES BY FISCAL YEAR
(Payment Detail Attached)

FY 2013	**$1,041,780.51**	
FY 2014	**$13,383,210.53**	(Expenditures through May, 2014)
TOTAL	**$14,424,991.04**	

Magellan Medicaid Administration, Inc.
Edison Contract ID: 34942
Vendor ID: 0000041004

FY 2013 Payments

Fiscal Year	Unit	Voucher ID	Invoice	Date	Sum Amount
2013	31865	00790523	PH-1507	10/25/2013	$79,997.01
2013	31865	00790526	PH-1488	10/25/2013	$961,783.50

Total FY 2013: **$1,041,780.51**

FY 2014 Payments

Fiscal Year	Unit	Voucher ID	Invoice	Date	Sum Amount
2014	31865	00790524	PH-1540	10/25/2013	$177,464.17
2014	31865	00790527	PH-1531	10/25/2013	$974,131.89
2014	31865	00790525	PH-1551	10/25/2013	$974,983.50
2014	31865	00836777	PH-1594	1/15/2014	$250,569.94
2014	31865	00836779	PH-1625	1/15/2014	$279,975.99
2014	31865	00836774	PH-1595	1/15/2014	$974,983.50
2014	31865	00836776	PH-1566	1/16/2014	$193,808.80
2014	31865	00836773	PH-1573	1/16/2014	$974,983.50
2014	31865	00848903	PH-1653	2/7/2014	$238,327.69
2014	31865	00848902	PH-1630	2/7/2014	$974,983.50
2014	31865	00903018	PH-1676	4/30/2014	$262,769.51
2014	31865	00903017	PH-1699	4/30/2014	$288,927.32
2014	31865	00903007	PH-1673	5/2/2014	$933,183.50
2014	31865	00903015	PH-1691	5/2/2014	$968,083.50
2014	31865	00920918	PH-1737	6/4/2014	$700,835.11
2014	31865	00920919	PH-1761	6/4/2014	$335,680.08
2014	31865	00920856	PH-1714	6/6/2014	$974,983.50
2014	31865	00903017	PH-1699	6/6/2014	$303,828.97
2014	31865	00925289	PH-1780	6/9/2014	$974,983.50
2014	31865	00937318	PH-1793	Pending	$355,414.85
2014	31865	Pending	PH-1811	Pending	$974,983.50
2014	31865	Pending	PH-1821	Pending	$295,324.71

Total FY 2014: **$13,383,210.53**

Amendment Request

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

APPROVED	
CHIEF PROCUREMENT OFFICER	DATE

Request Tracking #	**31865-00346**
1. Procuring Agency	**Department of Finance and Administration Division of Health Care Finance and Administration (HCFA)**
2. Contractor	**Magellan Medicaid Administration, Inc.**
3. Contract #	**34942**
4. Proposed Amendment #	**1**
5. Edison ID #	**34942**
6. Contract Begin Date	**December 20, 2012**
7. Current Contract End Date *– with ALL options to extend exercised*	**May 31, 2016**
8. Proposed Contract End Date *– with ALL options to extend exercised*	**May 31, 2016**
9. Current Maximum Contract Cost *– with ALL options to extend exercised*	**$ 59,348,018.00**
10. Proposed Maximum Contract Cost *– with ALL options to extend exercised*	**$61,659,020.00**
11. Office for Information Resources Pre-Approval Endorsement Request *– information technology service (N/A to THDA)*	**X Not Applicable ☐ Attached**
12. eHealth Pre-Approval Endorsement Request *– health-related professional, pharmaceutical, laboratory, or imaging*	**X Not Applicable ☐ Attached**
13. Human Resources Pre-Approval Endorsement Request *– state employee training service*	**X Not Applicable ☐ Attached**

14. Explanation Need for the Proposed Amendment

This amendment is needed because the current CoverRx contract for Pharmacy Benefits Management (PBM) ends December 31, 2014 and HCFA is charged with providing a contract for administrative services for the State's pharmacy assistance program. CoverRx provides limited pharmacy assistance through retail or mail order to eligible participants enrolled in the State's Department of Mental Health and Substance Abuse Services Safety Net program and for other eligible adults ages 19–64, needing access to prescription drugs for acute care and ongoing disease management. Magellan Medicaid

Request Tracking #	31865-00346

Administration, Inc. is the competitively procured contractor for provision of the State of Tennessee TennCare Pharmacy Benefits Manager. These services include a Point-of-Sale (POS) pharmacy claims processing system with prospective drug utilization review (DUR), retrospective drug utilization review (Retro-DUR), and reporting and adjudication capabilities. Due to Magellan's existing capabilities to support approximately 1.2 million TennCare enrollees, it has been determined to be in the best interest and most cost effective to the State to add the approximately 47,000 CoverRx members to those TennCare enrollees already being served by this Contractor. This Contract is responsible for all aspects of member enrollment, including the management of the enrollment process, and the production and distribution of enrollment documents, including enrollment letters, welcome kits, and benefit identification cards. The Contractor shall support the development and production of standard operational and ad hoc reports for the enrollment management process.

15. Name & Address of the Contractor's Principal Owner(s)
– NOT required for a TN state education institution

Timothy P. Nolan, President

Magellan Medicaid Administration, Suite 500

Glen Allen, VA 23060

16. Evidence Contractor's Experience & Length Of Experience Providing the Goods or Services

Magellan Medicaid Administration, Inc. is a leading provider of Medicaid pharmacy services for health plans and States nationwide. They have more than 40 years of Medicaid-specific experience and knowledge from serving over half the nation's programs, to provide solutions that help health plans and States better manage their Medicaid pharmacy spend to lower total health care costs and improve quality of care. As a part of Magellan Health Services, a specialty health care management company and leader in behavioral health, they understand that Medicaid beneficiaries have unique challenges, often with higher incidence of mental health-related issues, diabetes and asthma. They use their extensive knowledge and experience to maximize the effectiveness of pharmacotherapy while minimizing cost. Due to the fact that Medicaid keeps changing, Magellan has proven to be a responsive Medicaid pharmacy expert that will change with the program. TennCare released an RFP for Pharmacy Benefits Management services in 2012 and Magellan, having had the highest combined technical/experience and cost scores of 4 proposers, was awarded the contract with a three year term, with two optional years available.

17. Efforts to Identify Reasonable, Competitive, Procurement Alternatives

Magellan Medicaid Administration, Inc. is the competitively procured contractor for the provision of the State of Tennessee TennCare Pharmacy Benefits Manager. These services include a Point-of-Sale (POS) pharmacy claims processing system with prospective drug utilization review (DUR), retrospective drug utilization review (Retro-DUR), and reporting and adjudication capabilities. With Magellan, the state gets the additional benefit of PBM staff on site working through pharmacy claims issues for a population similar to members served in the CoverRx program. We believe this will provide a benefit to CoverRx members and the pharmacies that serve these members. It will also benefit state staff who can meet with on-site staff to resolve any issues with the CoverRx program should they arise.

Due to existing capabilities to support approximately 1.2 million TennCare enrollees, we believe that the CoverRx program will benefit from being added to the larger TennCare patient base population. The PBM will be able to leverage the size of the contract when administering the program with drug manufacturers, and the state will get the benefit of the vendor attending to the CoverRx program as part of a larger contract. The CoverRx program will get the benefit of cost savings and improved service through reduced administrative overhead, competitive pricing, and program analytics.

TennCare released an RFP for Pharmacy Benefits Management services in 2012 and Magellan, having had the highest combined technical, experience and cost scores was awarded the contract with a three year contract term, with two optional years available.

With this amendment, the Bureau would plan to keep the CoverRx program on the same procurement schedule as the TennCare Pharmacy Benefit Manager contract. When the TennCare PBM is again

Request Tracking #	31865-00346

competitively bid, the CoverRx program would be included in that procurement.

18. Justification

The current CoverRx contract for Pharmacy Benefits Management (PBM) ends December 31, 2014. HCFA is charged with providing a contract for administrative services for the State's pharmacy assistance program for the Cover Tennessee population. CoverRx provides limited pharmacy assistance through retail or mail order to eligible participants enrolled in the State's Department of Mental Health and Substance Abuse Services Safety Net program and for other eligible adults ages 19–64, needing access to prescription drugs for acute care and ongoing disease management. This Contract is responsible for all aspects of member enrollment, including the management of the enrollment process, and the production and distribution of enrollment documents, including enrollment letters, welcome kits, and benefit identification cards. The Contractor shall support the development and production of standard operational and ad hoc reports for the enrollment management process. Magellan Medicaid Administration, Inc. is the competitively procured contractor for provision of the State of Tennessee TennCare Pharmacy Benefits Manager. These services include a Point-of-Sale (POS) pharmacy claims processing system with prospective drug utilization review (DUR), retrospective drug utilization review (Retro-DUR), and reporting and adjudication capabilities. Due to Magellan's existing capabilities to support approximately 1.2 million TennCare enrollees, it has been determined to be in the best interest and most cost effective to the State to add the approximately 47,000 CoverRx members to those TennCare members already being served by this Contractor. With this amendment, the Bureau would plan to keep the CoverRx program on the same procurement schedule as the TennCare Pharmacy Benefit Manager contract. When the TennCare PBM is again competitively bid, the CoverRx program would be included in that procurement. HCFA respectfully requests approval of this amendment request.

Agency Head Signature and Date – *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*

Larry B. Martin/CD

6/27/2014

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00346	34942		01

Contractor Legal Entity Name	Edison Vendor ID
Magellan Medicaid Administration, Inc.	0000041004

Amendment Purpose & Effect(s)
Update Scope and Payment Terms to include CoverRx

Amendment Changes Contract End Date: ☐ YES x NO **End Date:** May 31, 2016

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$2,311,002.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2013	$787,491.75	$787,491.75			$1,574,983.50
2014	$9,761,570.57	$9,761,570.58			$19,523,141.15
2015	$11,273,491.68	$9,901,955.67			$21,175,447.35
2016	$10,162,457.00	$9,222,991.00			$19,385,448.00
TOTAL:	**$31,985,011.00**	**$29,674,009.00**			**$61,659,020.00**

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

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.

Speed Chart (optional)	Account Code (optional)

CPO USE

CENTRAL PROCUREMENT OFFICE

AMENDMENT #1
OF CONTRACT #34942
BETWEEN THE STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
AND
MAGELLAN MEDICAID ADMINISTRATION, 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 (HCFA), hereinafter referred to as the "State" or "TennCare," or "HCFA" and Magellan Medicaid Administration, 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. The first paragraph of the Contract is deleted and replaced with the following:

   This Contract, by and between the State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Bureau of TennCare, hereinafter referred to as the "State" or "TennCare" or "HCFA," and Magellan Medicaid Administration, Inc., hereinafter referred to as the "Contractor", is for the provision of online Point-of-Sale (POS) pharmacy claims processing system with prospective drug utilization review (DUR), retrospective drug utilization review (Retro-DUR), reporting and adjudication capabilities and for the CoverRx Program, as further defined in the "SCOPE OF SERVICES."

2. Contract Section A.7.1.m.ii. is deleted in its entirety and replaced with the following:

   A.7.1.m. ii. The Contractor shall provide sufficient, staff, facilities, and technology to maintain service levels within the Prior Authorization Unit such that all calls are answered within an Average Speed of Answer of 30 seconds, and the total number of abandoned calls shall not exceed 3%, measured and reported as a monthly average of the answer times for all calls within the month.

3. The following is added as new A.11.2.l:

   A.11.2.l. Member Satisfaction Reports- If requested by HCFA, the Contractor shall conduct periodic surveys of member satisfaction with its services.

   i. The surveys include content on perceived problems in the quality, availability, and accessibility of care.

   ii As a result of the surveys, the Contractor:

      (a) identifies and investigates sources of dissatisfaction;
      (b) outlines action steps to follow up on the findings, and
      (c) informs providers of assessment results.

   iii. The Contractor reevaluates the effects of the above activities.

   iv. 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 data on race, ethnicity, sex, primary language, and disability status, for applicants and members and from applicants' and members' parents or legal guardians if applicants or members are minors or legally incapacitated individuals. In collecting this data the Contractor shall use the Office of Management and Budget (OMB) standards, at a minimum, for race and ethnicity measures. Data collection standards for Race, Ethnicity, Sex, Primary Language, and Disability

Status are available from the Office of Minority Health and on its website located at: http://www.minorityhealth.hhs.gov/templates/content.aspx?ID=9227&lvl=2&lvlID=208.

4. Contract Section A.14 is deleted in its entirety and replaced with the following:

A.14. Non-Discrimination Compliance Requirements

The Contractor shall comply with all applicable State and Federal civil rights laws, regulations, rules, and policies and Section D.7 of this contract.

A.14.1. In order to demonstrate compliance with the applicable federal and state civil rights laws, which 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, and the Age Discrimination Act of 1975, the Contractor shall designate a staff person to be responsible for non-discrimination compliance. The Contractor's Non-discrimination Compliance Coordinator shall be responsible for compliance with the requirements set forth in this section. The Contractor does not have to require that civil rights compliance be the sole function of the designated staff member. However, the Contractor shall identify the designated compliance staff member to HCFA by name. The Contractor shall report to HCFA in writing, to the attention of the Director of Non-Discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the commencement of any period of time that the Contractor does not have a designated staff person for non-discrimination compliance. 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 the change.

a. The Contractor's Non-discrimination Compliance Coordinator shall develop a Contractor non-discrimination compliance training plan within thirty (30) days of Contract execution, to be approved by HCFA. This person shall be responsible for the provision of instruction regarding the plan to all staff within sixty (60) days of Contract amendment execution, and for the provision of instruction regarding the plan to providers and direct service subcontractors within ninety (90) days of Contract amendment execution. The Contractor shall be able to show documented proof of such instruction.

b. The Contractor's non-discrimination compliance plan shall include written policies and procedures that demonstrate non-discrimination in the provision of services to members. The policies shall include topics, such as, the provision of language services for members with Limited English Proficiency and those requiring communication assistance in alternative formats and providing assistance to individuals with disabilities. The nondiscrimination policies and procedures shall be prior approved in writing by HCFA.

c. 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.

d. The Contractor shall request that all staff provide their race or ethnic origin and sex. The Contractor is required to request this information from all Contractor staff and subcontractor staff providing services of this contract. However, staff response is voluntary. The Contractor is prohibited from utilizing information

CENTRAL PROCUREMENT OFFICE

obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts.

e. The Contractor shall submit an annual Summary Listing of Servicing Providers. The listing shall include, at a minimum, provider name, address, race or ethnic origin, language spoken other than English and shall be sorted by provider type. The Contractor shall use the following race or ethnic origin categories: American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin as indicated by HCFA. Provider response is voluntary. The Contractor is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the Contractor's provider network or in determination of compensation amounts.

A.14.2. Investigations. All discrimination complaints against the, Contractor, Contractor's employees, Contractor's providers, Contractor's provider's employees and Contractor's subcontractors shall be resolved according to the provisions of this Section A.14.2.

a. 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 nondiscrimination compliance officer 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 assist HCFA during the investigation and resolution of such complaints. HCFA 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 HCFA, the Contractor's nondiscrimination compliance officer 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 Section A.14.2(c) below. 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.

b. 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 HCFA covered services be reported to the Contractor, the Contractor's nondiscrimination compliance officer shall inform HCFA of such complaints within two (2) business days from the date Contractor learns of such complaints. If HCFA requests that the Contractor's nondiscrimination compliance officer assist HCFA 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 HCFA. 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. HCFA shall review the Contractor's initial investigations and determine the

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appropriate resolutions for the complaints as set forth in Section A.14.2(c) below. HCFA reserves the right to investigate and resolve all complaints concerning alleged acts of discrimination committed by the Contractor's providers, and subcontractors.

c. Corrective Action 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 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.

i. As part of the nondiscrimination complaint resolution process, the Contractor's non-discrimination compliance officer shall work with HCFA to develop an approved web-based non-discrimination training to be used as part of a corrective action plan. During the implementation process of this Agreement, HCFA shall approve the form and content for the web-based non-discrimination training. Prior to use, the web-based non-discrimination training must be approved by HCFA. Time periods for the implementation of the web-based non-discrimination training shall be designated by HCFA.

ii. The Contractor's non-discrimination compliance officer shall be responsible for the oversight of the web-based non-discrimination training and shall also provide instructions regarding the web-based non-discrimination training. In order to satisfy the terms of the correction action plan, the Contractor shall be able to show documented proof that all appropriate Contractor staff, providers or sub-contractors have received the web-based non-discrimination training.

d. The Contractor shall use and have available to members or complainants CoverRx's Discrimination complaint form and TennCare's Discrimination complaint form located on at the links below:
http://www.covertn.gov/web/coverrx_fair_treatment.html;
http://www.tn.gov/tenncare/forms/complaintform.pdf.
The discrimination complaint form shall be provided to members and complainants upon request, on the Contractor's website, and in the member handbook. 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 HCFA. In addition, the Contractor shall inform its employees, providers, and subcontractors how to assist members with obtaining discrimination complaint forms and assistance from the Contractor with submitting the forms to HCFA and the Contractor.

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A.14.3. On an annual basis the Contractor shall submit copies of the Contractor's non-discrimination policies that demonstrate non-discrimination in the provision of services to members. The policies shall also demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring communication assistance in alternative formats (auxiliary aids or services). This shall include a report that lists all interpreter/translator services used by the Contractor in providing services to members with Limited English Proficiency or that need communication assistance in an alternative formats. The listing shall identify the provider by full name, address, phone number, languages spoken, and hours services are available.

a. The Contractor shall have and provide its written procedures for the provision of language assistance and communication assistance in alternative formats to all staff, providers and subcontractors related to the provision of and/or access to HCFA covered services administered by the Contractor.

b. The Contractor shall have and provide a Toll Free Number and a TTY number to all staff, providers and subcontractors related to the provision of and/or access to HCFA covered services administered by the Contractor to be used for the assistance of members who require language assistance or communication assistance in an alternative format.

A.14.4. The Contractor shall submit the following non-discrimination compliance deliverables to HCFA as follows:

a. Annually, HCFA 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 HCFA 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 Nondiscrimination Compliance Plan shall be the same as the signature date of the Contractor's Assurance of Nondiscrimination. These deliverables shall be in a format specified by HCFA.

b. Quarterly the Contractor shall submit a Non-discrimination Compliance Report in a format specified by HCFA which shall include the following:

i. A summary listing totaling the number of the Contractor's supervisory personnel related to the provision of and/or access to HCFA covered services administered by the Contractor 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 or other race/ethnicity as indicated by HCFA and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin or other race/ethnic origin females as indicated by HCFA. Contractor staff response is voluntary.

ii. A listing of all complaints filed by employees, members, providers and subcontractors in which discrimination is alleged related to the provision of and/or access to HCFA covered services administered 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, if appropriate, the Contractor's initial investigation and date of resolution. As set forth in section A.14.2. Investigations, the Contractor is only responsible for the initial investigation of complaints concerning alleged acts of discrimination committed by providers and shall cooperate in the investigation and resolution of all other complaints.

iii. A listing of all member requests for language and communication assistance. The report shall list the member, the member's identification number, the date of the request, the date the service was provided and the name of the service provider.

5. Contract Sections A.15.5 and A.15.6 are deleted in their entirety and replaced with the following:

A.15.5. All written material shall inform members as how to obtain member materials in alternative formats for members with special needs and how to access oral interpretation services and that both alternative formats and interpretation services are available at no expense to the member. This information shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages.

A.15.6. All written material shall include notice of the right to file a complaint as set forth in 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, and the Age Discrimination Act of 1975. This notice shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages.

6. The following is added as new heading and Contract sections A.16 – A.39:

CoverRx Program

A.16. The Contractor shall provide administrative services for the State's pharmacy assistance program hereinafter referred to as "CoverRx." CoverRx provides limited pharmacy assistance through retail or mail order to eligible participants enrolled in the State's Department of Mental Health and Substance Abuse Services Safety Net program and for other eligible adults ages 19–64, hereinafter referred to as "participants", needing access to prescription drugs for acute care and ongoing disease management. The program is not a prescription drug benefit, an insurance program, nor an entitlement program. The Contractor shall be responsible for all aspects of member enrollment, including the management of the enrollment process, and the production and distribution of enrollment documents, including enrollment letters, welcome kits, and benefit identification cards. The Contractor shall support the development and production of standard operational and ad hoc reports for the enrollment management process.

A.17. The Contractor shall implement an end-to-end claim adjudication system capable of adjudicating claims at point-of-sale (POS) and process all electronic and paper retail and mail order pharmacy claims incurred during the term of the contract in accordance with the CoverRx formulary and program design.

A.18. Cost-Sharing - Participants will pay a Co-Pay at point of sale according to the sliding scale established by the state and provided to the contractor.

A.18.1. Limits - Participants are subject to a five (5) prescription limit per month Insulin and diabetic supplies are excluded from the prescription limit

A.18.2. Savings for enrollees in CoverRx could range from 0 to 35%. This savings information disclosure, provided in accordance to Tennessee Code Annotated 56-57-104(b), is an estimate and should not be relied upon as any form of guarantee and is not applicable across all medications. Savings, if any, vary member by member.

A.19. The Contractor shall manage membership for the Tennessee CoverRx program including eligibility determination, enrollment processing, and the distribution of enrollment

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materials. The Contractor shall develop an ongoing eligibility and enrollment system and each eligible individual is subject the State eligibility criteria.

A.19.1. The system shall have the capability to:

a. Assess whether or not an individual applicant meets the State's eligibility criteria, and

b. Enroll each eligible individual subject to the State's criteria.

A.19.2. The Contractor shall make a determination of eligibility within five (5) business days of receipt of a completed application for no less than ninety-five percent (95%) of new participants. Failure to meet this performance standard may result in liquidated damages set forth in Attachment C. A completed application is defined as one in which the applicant has provided the required data fields and supporting documentation.

A.19.3. The Contractor shall issue participant enrollment cards, descriptive booklets, and provider directories within seven (7) business days of determining eligibility. These Participant Communication Materials shall be distributed to no less than ninety-five percent (95%) of new participants within the required timeframe. Failure to meet this performance standard may result in liquidated damages set forth in Attachment C.

A.19.4 The Contractor shall track and report on intake of applications and turnaround time.

A.19.5. Thirty (30) days prior to each participant's anniversary date the Contractor shall annually verify participant eligibility for no less than ninety-five percent (95%) of participants. Failure to meet this performance standard may result in liquidated damages set forth in Attachment C.

A.19.6 Changes to the CoverRx plan are rare, however, the Contractor's POS plan management shall include up to one plan change per month.

A.20. The Contractor shall use the existing HCFA pharmacy network and HCFA drug pricing formula, consisting of all nationwide-supported major chains, regional chains as well as independent pharmacies, and manage a weekly pharmacy provider reimbursement process for claims adjudicated, as well as provide rebate management services for the one identified manufacturer, including rebate contracting, invoicing, payment posting, and dispute resolution.

A.20.1. The Contractor shall provide discount pricing on brand and generic drugs not on the CoverRx formulary that enables the lower of discount or Usual and Customary (U&C) pricing.

A.20.2. The Contractor shall ensure that within 90 days of implementation of the CoverRx Program, 95% of all CoverRx participants will have access to one (1) retail pharmacist within thirty (30) miles of participants' residence, as measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis. Failure to meet this performance standard may result in liquidated damages set forth in Attachment C.

A.21. The Contractor's Pharmacy Help Desk services shall include pharmacy provider and member call services, mirroring the service level agreements (SLAs) of the TennCare

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Medicaid program. These phone lines shall be operated in accordance with details Contract Section A.8.

A.22. The Contractor shall provide the planned implementation of the following systems and services for the CoverRx Program:

A.22.1. HCFA CoverRx eligibility management, member enrollment, and production and mailing of enrollment material, including member identification cards;

A.22.2. Data interface to perform a weekly match of Tennessee CoverRx enrollees to TennCare enrollees already established in the Contractor's FirstRx™ POS system and generate disenrollment file reports for Magellan operations staff to disenroll members in HCFA CoverRx who also have TennCare enrollment;

A.22.3. FirstRx™ POS claim adjudication configuration and management, including hardware. POS claims adjudication services on a 24-hours-a-day, 7-days-a-week, 365-days-a-year basis, with the exception of agreed upon POS system maintenance window;

A.22.4. FirstFinance™ checkwrite configuration and management, including hardware; weekly checkwrite services, including pharmacy provider payment and remittance advice (RA) distribution;

A.22.5. eRebate™ system to support rebate contracting and administration;

A.22.6. Data interfaces to support claim adjudication;

A.22.7. Cognos BI tool, standard operational reporting, and ad hoc analytical services.

A.22.8. Account management services and support, and

A.22.9. Systems' access for HCFA CoverRx staff via the FirstCI™ system.

A.23. The Contractor agrees that there are no conflicts preventing the TennCare Medicaid and HCFA CoverRx programs from sharing resources, including hardware, personnel, and data.

A.24. The Contractor shall assist the State with member inquiries that may include accessing claims history and follow-up with pharmacy or member as applicable. The enrollment validation process will be limited to the proper completion of the enrollment form and the contents of the enrollment form, which the Contractor shall treat at face value, however a member cannot participate in both TennCare and CoverRx.

A.25. The Contractor shall provide efficient and timely processing and approval of participant's claims and submission of those claims to CoverRx. CoverRx retains all discretion for determining whether claims are paid, denied in part or denied in whole. In the event that CoverRx receives inquiries concerning eligibility for the program or concerning claims that have been denied in part or in whole, the Contractor's local CoverRx support team shall provide any information requested by CoverRx so that CoverRx can make an appropriate response to the inquiring party.

A.26. The Contractor shall amend the TennCare pharmacy provider contracts as necessary to support the CoverRx Program. The network shall support retail, specialty and long-term care pharmacies. All pharmacies shall have received initial credentialing and the Contractor provide a monthly review of national, state and other agency exclusion lists to maintain a compliant network.

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A.27. The Contractor shall ensure that the HCFA CoverRx checkwrite financial process remains separate from the TennCare Medicaid program, including a separate bank account, however, the two programs will share the same workflow and funding frequency (weekly).

A.28. The HCFA CoverRx formulary will be provided to the Contractor during implementation and will be used to manage the CoverRx benefit plan configured in the FirstRx™ POS system. The Contractor shall maintain the State's established Formulary for the retail and mail order CoverRx program. Changes in the Formulary shall be submitted by the State to the Contractor no less than thirty (30) business days prior to change implementation date, unless the Contractor and State mutually agree to a shorter notification time.

A.29 The Contractor shall designate an individual with overall responsibility for administration of the CoverRx program. This person shall be at the Contractor's executive level and shall designate an individual (Program Coordinator) 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 CoverRx program. The Contractor shall maintain sufficient levels of staff including supervisory and support staff with appropriate training, work experience, and expertise for administration of the CoverRx program.

A.29.1 The Contractor shall meet with representatives of the State periodically, and participate in the CoverRx Annual Formulary Review.

A.29.2 The Contractor shall have in attendance, when requested by the State, the Program Coordinator and representatives from its organizational units required to respond to topics indicated by the State's agenda.

A.29.3 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 pharmacy assistance services.

A.29.4 The Contractor shall provide advice, assistance and information to the State regarding applicable existing and proposed Federal and State laws and regulations affecting pharmacy provider entities.

A.30. The Contractor shall provide to members several mail order options and be flexible on how mail order may be configured for the CoverRx program and shall maintain mail order facilities capable of processing participant subscriptions volume to include the following:

A.30.1. Provide a toll-free telephone number to the pharmacy mail-order program;

A.30.2. Provide an option on the toll-free telephone number for participants to consult with a registered pharmacist;

A.30.3. After verifying the client's eligibility, the Contractor will mail, or deliver, if the Contractor prefers, medications directly to the participant's designated address, or allow participant pickup at the Contractor's retail pharmacy, if the participant requests that arrangement. All completed, fillable prescriptions must be dispensed with a maximum turnaround time of less than forty-eight (48) hours. Failure to meet this timeframe may result in liquidated damages set forth in Attachment C.

A.31. Postage for all identification cards, letters, and other enrollment material will be handled as a pass-through expense from CoverRx to HCFA. In order to remain consistent with the base TennCare component of this contract, the Contractor shall provide pricing following the same structure, and all postage shall be billed to HCFA as a pass-through cost, with a detailed schedule of all postage for the month. No administrative overhead or other fee shall be added to this expense, and this billing applies to postage only; the

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production cost for ID cards, letters and enrollment material, and printing expense for enrollment materials is included in the fixed monthly fee as stated in contract section C.3.b.

A.32. The Contractor shall accept Tennessee CoverRx member enrollment by phone, mail, and Web. At the State's sole discretion, HCFA may choose to reduce the scope of the CoverRx Program enrollment services at anytime (i.e., discontinue Web enrollments).

A.33. The Contractor shall setup and configure the current eRebate™ system to handle drug rebate administration for the CoverRx Program with the existing TennCare drug manufacturers. The Contractor shall manage and assume all of the same responsibilities for the CoverRx Program that are currently being performed for TennCare, including contracting with drug manufacturers submitting such contracts to CoverRx for review, rebate invoicing, payment posting, and dispute resolution processes.

A.34. The Contractor shall maintain a full service staff to respond to inquiries, correspondence, complaints, and problems, and to assist with participant and provider education. The Contractor shall augment existing TennCare Call Center staff to handle Tennessee CoverRx call volume. Staff shall service both TennCare Medicaid and Tennessee CoverRx calls. The Contractor will adjust current TennCare Medicaid front-end phone messaging to support CoverRx services in the greeting as well, and will provide for caller identification and call routing in that front-end messaging for CoverRx callers. Staff will be added to cover increased CoverRx volume. The Contractor shall track calls and maintain data so as to be able to provide the following management reports containing, at a minimum, the following information:

A.34.1. number of calls received
A.34.2. number of calls abandoned
A.34.3. number of calls answered
A.34.4. average speed to answer a call
A.34.5. average caller queue time
A.34.6. average call duration

A.35. The Contractor shall submit Management Reports in a mutually agreeable electronic format (MSWord, MSExcel, etc.), of the type, at the frequency, and containing the detail described in Contract Attachment D. Reporting shall continue for the twelve (12) month period following termination of the contract.

A.36. The Contractor will implement the systems required to process all CoverRx claims and all other services described herein. The Contractor will work with HCFA to ensure that the program satisfies the functional and informational requirements of Tennessee's CoverRx pharmacy assistance program. The system must be thoroughly tested and accepted by the State prior to implementation.

A.37. Allow on-line access for State to verify enrollment services for existing and prospective participants of the CoverRx program

A.38. Unless specifically stated that services shall not apply to the CoverRx Program, the Contractor shall perform all applicable on-going services in this Contract for the CoverRx Program. The Contractor shall not be required to perform for CoverRx the following existing services that are currently being performed for the TennCare Medicaid Program:

A.38.1. Non-paid claim data conversion;
A.38.2. Grievances and appeals management and processing;
A.38.3. Prior authorization services;

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A.38.4. Enrollment match against Department of Mental Health and Substance Abuse Services Safety Net, and
A.38.5. RetroDUR and ePrescribiing
A.38.6. Grier Letter notifications

A.39. The Contractor shall provide the following specific deliverables relative to the HCFA CoverRx Program prior to implementation of services , January 1, 2015:

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Activities	Deliverable	Timing
Implementation Management ▪ Implement Magellan PBM systems and services identified in this Contract	▪ Biweekly Status Meetings and Status Updates ▪ Monthly Executive Status Updates ▪ Tennessee CoverRx Implementation Plan ▪ Tennessee CoverRx Communication Plan ▪ Tennessee CoverRx Risk Management Plan ▪ Tennessee CoverRx Readiness Review	September 1, 2014 – December 31, 2014
FirstRx™ / Claim Adjudication ▪ Setup / Configure FirstRx™ POS claim adjudication system	▪ FirstRx™ POS Business Requirements document for Tennessee CoverRx ▪ FirstRx™ POS quality assurance test plan ▪ FirstRx™ POS test results ▪ Provider and Switch Vendor test results ▪ FirstRx™ POS claim adjudication readiness review Tennessee CoverRx staff	September 1, 2014 – December 31, 2014
FirstFinance™ / CheckWrite ▪ Setup / Configure FirstFinance™ checkwrite system ▪ Setup process and procedures to handle Tennessee CoverRx checkwrite schedule. Setup checkwrite / financial management reporting	▪ FirstFinance™ Checkwrite business requirements document for CoverRx ▪ Documented checkwrite process, and schedule ▪ Setup electronic payment (EFT), positive pay, and reconciliation files through a secured banking data transmission Web service. ▪ Setup applicable checkwrite / financial management reporting; payment register, outstanding check report, escheatment letter, age reports, returned mail report, prompt pay file	September 1, 2014 – December 31, 2014
eRebate™ ▪ Setup / Configure	▪ Setup cash posting, invoicing, and balancing	September 1, 2014 – December 31, 2014

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Activities	Deliverable	Timing
rebate processing system to handle a single program and drug manufacturer.	workflows for the drug manufacturer Bayer.	
Data Interfaces ▪ Setup / Configure Internal Enrollment Interfaces ▪ Set up data match process for enrollment in TennCare against CoverRx enrollment ▪ Setup / Configure CheckWrite Extract to Tennessee CoverRx ▪ Setup / Configure Internal Data Interface to Pharmacy Data Warehouse ▪ Leverage TennCare reference files for Practitioner Panel, NCPDP, HCIDEA, FDB, and Medispan Files	▪ Master Data Interface List	September 1, 2014 – December 31, 2014
Cognos / Business Intelligence ▪ Setup / Configure Cognos Business Intelligence Portal for Tennessee CoverRx	▪ Standard Reporting Package	September 1, 2014 – December 31, 2014
Call Center Operations ▪ Setup / Configure Telecommunications For Tennessee CoverRx Program ▪ Setup / Configure FirstTrax™ system for call management, tracking, and reporting	▪ Call Center Operations business requirements document ▪ Call Center Volume Analysis ▪ Call Center Staffing Plan ▪ Call Center IVR, Call Flow, and Messaging ▪ Call Center reporting	September 1, 2014 – December 31, 2014

Activities	Deliverable	Timing
Member/Provider Operations ▪ Setup/Configure member enrollment system ▪ Setup Mailbox for Processing Paper Claims ▪ Setup Provider Operations Support Staff ▪ Setup/Configure Member ID Card production process. ▪ Setup/Configure Member letter notification process	▪ Member Communications Plan ▪ Member Communications – production ready materials ▪ Operational Staffing Plan ▪ Provider Communications Plan ▪ Provider Communications – production ready letters	September 1, 2014 – December 31, 2014
CoverRx Operational	▪ Implementation Deliverables complete and actual performance of pharmacy delivery services begin	January 1, 2015

7. Contract Section C.1 is deleted in its entirety and replaced with the following:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Sixty-One Million Six Hundred Fifty-Nine Thousand Twenty Dollars ($61,659,020.00). The payment rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

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

8. The following is added as new contract sections C.3.b(7), C.3.b(8), and C.3.b(9):

(7) The following Monthly Administration rates apply for the CoverRx Program for the period of January 1, 2015 – May 31, 2016:

Service Description	Amount

	(per compensable increment)
Monthly CoverRx Administrative Fee (January 1, 2015 – May 31, 2015)	$133,770.00 Per month
Monthly CoverRx Administrative Fee (June 1, 2015 – May 31, 2016)	$136,846.00 Per Month

(8) Should the contract be amended for extension of services for the period of June 1, 2016 through May 31, 2017, the following Monthly Administration rates for the CoverRx Program shall apply:

Service Description	**Amount** (per compensable increment)
Monthly CoverRx Administrative Fee (June 1, 2016 – May 31, 2017)	$139,993.00 Per month

(9) Should the contract be amended for extension of services for the period of June 1, 2017 through May 31, 2018, the following Monthly Administration rates for the CoverRx Program shall apply:

Service Description	**Amount** (per compensable increment)
Monthly CoverRx Administrative Fee (June 1, 2017 – May 31, 2018)	$143,213.00 Per month

9. Contract Attachment A is amended by adding the following Definition:

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 and any other documents designated by the State. At a minimum, all Vital Documents shall be available in the Spanish language.

10. Contract Attachment C, Performance, Deliverables, and Damages, is deleted in its entirety and replaced with the new, revised Attachment C attached hereto.

11. Contract Attachment D, CoverRx Management Reporting Requirements, attached hereto is added as a new attachment.

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 September 1, 2014. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

MAGELLAN MEDICAID ADMINISTRATION, INC.:

Greg Kaupp	9/5/2014
SIGNATURE	**DATE**

Greg Kaupp, SVP and General Manager

PRINTED NAME AND TITLE OF SIGNATORY (above)

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

Larry B. Martin/cx	9/5/2014
Larry B. Martin, Commissioner	**DATE**

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ATTACHMENT C

PERFORMANCE, DELIVERABLES AND DAMAGES

The table below summarizes Performance Measures and Deliverables described in other sections of this Contract based on applicable scope of work in this contract or any associated amendments. Included in the table are delivery schedules and non-performance damages. TennCare shall monitor the Contractor's performance meeting the required standards. If TennCare determines that the Contractor has failed to meet any of the requirements of this Contract, TennCare may, at its option, send a Notice of Deficiency to the Contractor as provided in Section E.2 of this Contract, identifying the Contract requirement(s) not being met by the Contractor. Receipt of a Notice of Deficiency shall be deemed to be a request for a Corrective Action Plan (CAP) from the Contractor. Within five (5) business days of receipt of the Notice of Deficiency, the Contractor shall submit a written CAP to TennCare for approval. Failure to submit a CAP or comply with its requirements, as approved by TennCare, may in the State's discretion, result in liquidated damages of one hundred dollars ($100) per day (unless otherwise specified herein) for each calendar day the CAP is late or compliance with the CAP is not complete. In situations where the Contractor wishes to dispute any liquidated damages (LDs) assessed by the State, the Contractor must submit a written notice of dispute, including the reasons for disputing the LD, within thirty (30) days of receipt of the letter from the State containing the total amount of damages assessed against the Contractor. Failure to submit a timely notice of dispute as provided herein terminates any and all rights the Contractor may have, at law or in equity, to dispute the assessed LD, refuse to pay it, or object to the reduction of a administrative services payment by TennCare in payment of the LD. Such failure to timely dispute the LD shall further act as a bar to the Contractor bringing any action relating to the LD in any forum or court having proper jurisdiction of this matter.

In addition to any other liquidated damage provided in this Contract, TennCare also reserves the right to assess a general liquidated damage of five hundred dollars ($500) per violation of any requirement of this Contract when the Notice of Deficiency is sent to the Contractor.

If damages are assessed, TennCare shall reduce the Contractor's payment for administrative services in the following month's invoice by the amount of damages. In the event that damages due exceed TennCare fees payable to Contractor in a given payment cycle, TennCare shall invoice Contractor for the amount exceeding the fees payable to Contractor, that shall be paid by Contractor within thirty (30) calendar days of the invoice date.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.2 Plan Implementation	Contractor shall complete all implementation actions prior to "go-live" date and according to the implementation timeline provided by the Contractor to TennCare. The Contractor shall receive TennCare's sign-off that each action has been completed successfully. Implementation action steps include the following minimum items: • Benefit plan designs loaded, operable and tested; • Perform comprehensive systems testing (including	Due prior to the claims processing commencement date of June 1, 2013, 1:00 a.m. Central Standard Time (CST)	Contractor may, in the State's discretion, be required pay to TennCare amount of ten thousand dollars ($10,000.00) per day for each day full implementation of the project is delayed by fault of the Contractor. This guarantee is dependent upon Contractor receiving necessary information

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PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
	interface testing with all third parties) and quality assurance audits, with results reported to the TennCare prior to the "Go-Live"; • Eligibility feed formats loaded and tested end to end; • Operable and tested toll-free numbers; • Signed agreements for Retail Pharmacy and Long-term Care Pharmacy networks; • Account management, Help Desk and Prior Authorization staff hired and trained; • Established billing/banking requirements; • Complete notifications to pharmacies and prescribers regarding contractor change; • Each component shall be met by an agreed upon deadline in an implementation timeline provided by Contractor to TennCare. Implementation action requirements may include other items necessary to meet the claims processing commencement date of June 1, 2013, 1:00 a.m. CST ; and • Claims history and existing prior authorizations and overrides shall be migrated to Contractors POS system		and approvals from TennCare in a timely manner.
A.2.2 Project Initiation and Requirements Definition Phase	The Contractor must be in sync with the TCMIS eligibility data.	All outbound 834 files from TennCare must be loaded to the Contractors data base within twenty-four (24) hours of receipt from TennCare. This requirement includes any 834 transactions that must be handled manually by the Contractor.	Penalty may, in the State's discretion, be ten-thousand dollars ($10,000) per day, or any part thereof, beyond the first twenty-four (24) hours, that any flies are not properly loaded into the Contractor's database.
A.3.2 Claim Payment and Remittance Services	The Contractor shall distribute and mail TennCare outputs as required by this Contract including, but not limited to: provider checks and remittance advices, returned claims, notices, provider bulletins, provider manuals and special mailings.	The Contractor shall mail checks and remittance advices to pharmacy providers each week on Fridays, with the exception of holiday weeks. With notice, holiday production shall not delay the process by more	Penalty may, in the State's discretion, be one-thousand dollars ($1,000) per business day, per file, for any files that are not delivered to the State on time.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
		than two (2) business days. TennCare shall be notified no later than two (2) business days of any systems or operational issues that may impact disbursements by the prescribed timelines. For checks to be issued on Friday, the Contractor shall deliver the two (2) files identified in Contract Sections A.3.2.a.(i) and A.3.2.a.(ii) to the State, in an electronic media suitable to the State, by 10:00 a.m. CST, on Thursday of each week.	
A.3.2. Claim Payment and Remittance Services	The Contractor shall distribute and mail TennCare outputs as required by this Contract including, but not limited to: provider checks and remittance advices, returned claims, notices, provider bulletins, provider manuals and special mailings.	The Contractor shall pay within fifteen (15) calendar days of receipt one-hundred percent (100%) of all clean claims submitted by network and non-network pharmacy providers through POS and batch electronic claims submission.	Penalty may, in the State's discretion, be one-thousand dollars ($1,000) per calendar day payment to pharmacy providers for clean claims exceeds fifteen (15) calendar days from the date of claim submission.
A.3.2 Encounter Data Files	All adjudicated claims (encounters) shall be transferred to TennCare on a schedule designated by TennCare.	File transfer due weekly and due forty-eight (48) hours after end of reporting week.	If the Contractor fails to produce the report, the calculation of the damages may, in the State's discretion, begin on the first day following the due date of the report and continue until receipt of the report by TennCare. Penalty may, in the State's discretion, be $5,000 per week.
A.3.3.d POS Claims	The Contractor shall process ninety-nine point five percent (99.5%) of	Ninety–nine point five percent (99.5%) of claims process	If ninety-nine point five percent (99.5%) of

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	POS pharmacy claims within ten (10) seconds on a daily basis. This is the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor and shall include all procedures required to complete claim adjudication.	shall process to completion within ten (10) seconds on a daily basis.	claims are not processed within the ten (10) second time frame then the daily penalty may, in the State's discretion, be $1,000 per day of non-compliant processing.
A.3.3. POS Downtime	System will operate without unscheduled or unapproved downtime. For purposes hereof "downtime" shall be any interruption involving more than 10% of production for a period greater than 15 minutes.	No unscheduled or unapproved downtime.	$2,500 per occurrence of unscheduled or unapproved downtime if deemed by TennCare to be the result of Contract's failure to comply with the requirements of the Contract.
A.3.3. POS Downtime Notification	Contractor shall report to TennCare immediately (within one (1) hour) upon knowledge of downtime. TennCare is to identify staff to be contacted after normal business hours in the event of an interruption of service.	Report is due within one (1) hour, upon knowledge of downtime.	Immediate report is due within one (1) hour upon knowledge of the downtime. $7,500 one time damage may, in the State's discretion, be assessed for not reporting immediately.
A.3.3.d Batch Electronic Media (EMC) Claims Processing	The Contractor shall receive claims in electronic format, via batch transmission, CD or DVD for immediate processing. The Contractor shall assign identification control numbers to all batch claims within three (3) business days of receipt. The Contractor shall maintain electronic backup of batch claims for the duration of the contract. If TennCare requests copies of batch electronic claims, these shall be provided within three (3) business days of request. As requested, the Contractor shall provide the batch files as they were originally received. These files shall be delivered to the TennCare site by Virtual Private Network connection. Electronic batch claims shall be	Assignment of identification control numbers to all batch claims within three (3) business days of receipt and provide TennCare with copies of batch electronic claims within three (3) business days of request.	Calculation of the damages may, in the State's discretion, begin on the first day following the due date and continue until receipt of the report by TennCare. Penalty may, in the State's discretion, be $1,000 per day.

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	submitted through a method that shall allow batch and POS claims to be adjudicated through the same processing logic. New providers requesting to submit batch claims shall provide at least a thirty (30) day notice and shall conform to the standard Change Control and testing process.		
A.3.3 POS Downtime Occurrence Reports	The Contractor shall provide TennCare with updates at regular intervals during a sustained downtime. TennCare shall be presented with recovery options as appropriate. Upon full recovery, the Contractor shall provide TennCare with a System Down Analysis describing root cause issues and actions to mitigate future downtime occurrences.	Report is due within five (5) business days after full system recovery.	Daily penalty may, in the State's discretion, be $1,000 per day. Calculation of the damages will begin on the sixth business day following full system recovery.
A.3.3.g Aged Checks Not Cashed	The Contractor shall provide TennCare Fiscal Services Unit a monthly report detailing all checks remitted to providers on behalf of the State that remain outstanding (have not been cashed) greater than ninety (90) days.	Contractor shall provide TennCare with a monthly report of remitted checks as stipulated. Reports are due monthly, due on the 15th day of the month following the reporting period.	Penalty may, in the State's discretion, be $500 per week that report is overdue.
A.3.3 Aged Account Payable Notices	The Contractor shall ensure that collection letters are sent to pharmacies that maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) workdays of becoming ninety (90) days old.	Contractor shall provide TennCare with a monthly report of notices sent. Reports are due monthly, ten (10) business days after end of month of reporting period.	If Contractor fails to send notice, the penalty may, in the State's discretion, be $100 per provider notice per month.
A.3.4 Claim Validation	The Contractor system shall approve for payment only those claims for members eligible to receive pharmacy services at the time the service was rendered. The Contractor shall immediately notify TennCare of any and all claims that have been erroneously processed, and initiate appropriate action to correct the errors.	Reimbursement or damages resulting from this section may be applied to as offsets to future administrative fees.	The Contractor shall reimburse TennCare for the cost of all claims paid as a result of contractor error. Penalty for claims inappropriately denied may, in the State's discretion, be $100 per occurrence. .

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	In the event that claims are inappropriately denied the Contractor may be assessed damages denied the Contractor may be assessed damages.		
A.3.6 Emergency Supply Override	The Contractor shall assure that the TennCare-POS systems allows pharmacists to execute an emergency override that shall process an emergency seventy-two (72) hour supply for drugs that are eligible per TennCare requirements.	TennCare POS system to permit emergency seventy-two (72) hour override.	Penalty for not allowing emergency override claims to process correctly may, in the State's discretion, be $500 per occurrence. .
A.3.8 Reversals and Adjustments	The system shall provide an efficient means of reversing or adjusting claims both before and after the claim has been transmitted to the TCMIS. If reversed or adjusted, this information shall continue processing in TCMIS. TennCare shall make no payments to the Contractor for reversed, voided or adjusted claims.	Contractor shall process all reversals requested by TennCare Fiscal Services Unit within thirty (30) days and provide confirmation to TennCare Fiscal Services Unit upon occurrence.	A damage of $100 may, in the State's discretion, be assessed per transaction that has not been reversed or adjusted within thirty (30) days of written request of TennCare Fiscal Services Unit.
A.3.9. Manual Claims	The Contractor shall process manual claims within twenty one (21) calendar days of receipt from TennCare appeals unit; notify appeals unit of incomplete information for manual claim process within ten (10) calendar days of receipt from TennCare appeals unit.	The Contractor shall provide report of manual claims processed, prior authorizations submitted, prior authorizations received, claims paid or denied, date received and date completed on a weekly basis.	Failure to meet these service levels may, in the State's discretion, result in liquidated damages of $100 per occurrence.
A.4.2. PDL Design, Development, and Implementation	The Contractor shall implement changes in the POS system for PDL, Step Therapy, Prior Authorization requirements and all supporting systems within forty-five (45) days of approval from TennCare. Such changes to the POS system shall require provider notification thirty (30) days prior to the implementation. TennCare shall identify the targeted provider for each notification.	Implement changes and issue notification in specified time frames	Calculation of the damages may, in the State's discretion, begin on the first day following the due date and continue until required changes with proper notice are implemented. Penalty may, in the State's discretion, be $1,000 per day.

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A.4.4 TennCare Pharmacy Advisory Committee Support	The Contractor shall attend, support and facilitate meetings of the TennCare Pharmacy Advisory Committee (PAC) as necessary to maintain the TennCare PDL.	Approved meeting materials shall be distributed ten (10) business days prior to PAC meetings. Draft minutes shall be submitted to TennCare with two (2) weeks of PAC meeting.	Calculation of the damages may, in the State's discretion, begin on the first day following the due date for meeting material or minutes and may continue until delivered. Penalty may, in the State's discretion, be $1,000 per day.
A.4.5 Drug Rebate Dispute Data	The Contractor shall provide to the agency or business of the State's choosing, any and all appropriate, accurate, and balanced pharmacy level claims data needed to resolve or avoid any Medicaid or supplemental drug rebate disputes.	This data shall be provided to TennCare within fifteen (15) business days of a request by TennCare	Calculation of the damages may, in the State's discretion, begin on the first day following the due date and continue until receipt of the report by TennCare. Penalty may, in the State's discretion, be $1,000 per business day.
A.4.5 Delinquent Rebate Payment Notices	The Contractor shall ensure that written notification is sent to Drug Manufacturers concerning forty-five (45) day past-due undisputed account balances within fifty (50) days after the original invoice date. The Contractor shall also ensure that written notification is sent to Drug Manufacturers concerning seventy-five (75) day past-due undisputed account balances within eighty (80) days after the original invoice date. The Contractor shall also ensure that written notification is sent to Drug Manufacturers concerning ninety (90) day past-due undisputed account balances within ninety-five (95) days after the original invoice date. These notices shall remind the labeler that interest shall be assessed on all past due accounts as stipulated by their contract with the State.	Contractor shall provide TennCare with copies of all reports sent pursuant to this section. Reports due monthly, ten (10) business days after end of month of reporting period.	If Contractor fails to send notice, the penalty may, in the State's discretion, be $100 per Manufacturer per day independent of other dunning periods.

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A.4.5 Rebate Invoicing	The Contractor shall generate and issue quarterly Rebate invoices. Provide the designated TennCare staff data files that contain the specific information and in the specified format as required by TennCare	The quarterly Supplemental Medicaid Drug Rebate invoices shall be generated for all pharmaceutical manufacturers and TennCare approval by thirty (30) days after receipt of the quarterly CMS file. The quarterly Federal Medicaid Drug Rebate invoices shall be generated for all pharmaceutical manufacturers and TennCare approval by sixty (60) days after receipt of the quarterly CMS file.	Penalty may, in the State's discretion, be $1,000 per invoice per day invoice overdue.
A.4.5 Rebate Dispute Resolution	The Contractor shall be responsible for dispute resolution pertaining to supplemental rebates. The Contractor shall perform unit resolution based on unit resolution performed on CMS Rebates. The Contractor shall perform all other dispute resolution activities with pharmaceutical manufacturers pertaining to supplemental rebate calculations and collections.	Within ninety (90) days of dispute the contractor shall present the State with an analysis of why the monies were disputed and remedies.	Penalty may, in the State's discretion, be $1,000 per day past ninety (90) day timeframe of analysis and proposed remedy.
A.4.5 Delinquent Rebate Payment Interest Accrual	The Contractor shall ensure that all Drug Manufacturers are charged interest as stipulated in each Manufacturer's respective Supplemental Drug Rebate Contract. Interest shall be calculated on only the Manufacturer's undisputed account balance unless written notification is provided by TennCare to do otherwise.	Quarterly rebate reports submitted to TennCare will contain delinquent payments and interest accrued.	Failure by Contractor to start accruing interest on the date stipulated in the individual supplemental rebate agreements may, in the State's discretion, result in a penalty of $1,000 for every non-compliant invoice issued.
A.4.5.2 Supplemental Rebate Incentive	On an annual basis the percentage of effectiveness of the supplemental rebate program shall be measured against the Contractors response to the RFP. The Contractor shall be allowed a two percent (2%) deviation from its response.	For example, if the Contractor bids six percent (6%) for supplemental rebate percentage in the RFP, the allowable range shall be four to eight percent (4% - 8%).	100% of the difference between the supplement rebate amount that would have been paid to the state if the Contractor had performed at the lowest end of the allowed supplemental rebate percentage range vs. the actual supplemental rebate

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			amount paid to the state.
A.5.6. System Maintenance and Modification Deadlines/Damages	The Contractor shall correct system maintenance problems within five (5) business days or by a State-approved correction date.	System maintenance problems shall be corrected within five (5) business days or by State-approved correction date.	Five hundred dollars ($500.00) liquidated damages per work day or any part thereof shall be assessed for a maintenance problem not corrected within five (5) business days or by correction date approved by the State. These payments will be in addition to payment for any actual damages due to incorrect payment processing, including but not limited to damages based on loss of productivity of TennCare staff because of staff time required to respond to inquiries from auditors, users, members, advocates, legislators and in meetings with Contractor staff to rectify problems.
A.5.8 Disaster Preparedness and Recovery-Business Interruption	The Contractor shall submit the Contractor's Business Continuity/Disaster Recovery plan for their Central Processing Site to TennCare. If requested, test results of the plan shall be made available to TennCare	Plan due upon commencement of claims processing and annually on the anniversary date of the initial claims processing	Penalty may, in the State's discretion, be $1000 per week that report is overdue.

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A.5.8 Disaster Preparedness and Recovery-Business Interruption	The Contractor shall comply with their Contractor's Business Continuity/Disaster Recovery plan.	TennCare shall determine the final need to move to the disaster recovery plan based on the Contractor's recommendation.	Penalty may, in the State's discretion, be $10,000 per day Contractor is non-compliant with their Business Continuity/Disaster Recovery Plan
A.5.9 Program Integrity	The Contractor shall have TennCare-approved policies and procedures in place for ensuring protections against actual or potential fraud and abuse.	The Contractor shall have a detailed Program Integrity Plan. The Contractor shall complete all tasks as described in the Program Integrity Plan on a quarterly and annual basis.	$2,500 per occurrence of non compliance with the Program Integrity Plan.
A.5.10 Proprietary and Confidential Information	All information provided to TennCare, including but not limited to, provider, reimbursement and enrollee information shall be deemed confidential.	The Contractor shall immediately notify TennCare of any and all occurrences where TennCare's confidential information may have been breached and initiate appropriate action to prevent subsequent breaches.	$2,500 per occurrence of breach.
A.5.12 Member Identification Cards	The Contractor shall provide each TennCare enrollee with a NCPDP compliant pharmacy benefit identification (ID) card. The Contractor shall also provide enrollee with replacements cards.	Replacement and new cards shall be produced and mailed by the Contractor on the 15th day of each month.	Delays in producing ID cards may, in the State's discretion, result in $1,000 per day damages.
A.5.13 Mail Procedures	The Contractor shall open all returned mail from any mailings to enrollees or providers within thirty (30) days of receipt to determine if the enrollee has moved, if the Contractor has the wrong address, and/or if the enrollee is communicating other information to the Contractor or to TennCare. The Contractor shall track returned mail and shall report monthly to TennCare the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose	Monthly report, due ten (10) business days after end of month of reporting period, beginning the first full month after the report format has been agreed to by the parties.	Calculation of the damages may, in the State's discretion, begin on the first day following the report due date and continue until receipt of the report by TennCare. Penalty may, in the State's discretion, be $2,500 per week.

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	mail was undeliverable due to an incorrect address provided by TennCare.		
A.5.16 E-Prescribe	The Contractor shall participate in TennCare's E-Prescribe initiatives.	Provide accurate data files in the format agreed to as necessary to support E-Prescribe.	Damages for delays or errors may, in the State's discretion, be assessed at $1,000 per day begin on the first day following the file due date.
A.6 Drug Utilization Review Program	The Contractor shall provide on a quarterly basis • Provider and patient trending • Meetings and facilitation • Reports and website	Approved meeting materials shall be distributed ten (10) business days prior to DUR meetings. Draft minutes shall be submitted to TennCare with four (4) weeks of DUR meeting.	Calculation of the damages may, in the State's discretion, begin on the first day following the due date for meeting material or minutes and continue until delivered. Penalty, in the State's discretion, may be $1,000 per day.
A.6 Drug Utilization Review Program	The Contractor shall produce eight hundred (800) member profiles per month, or a minimum of two thousand four hundred (2,400) member profiles per quarter, and distribute to clinical reviewers for review and determination of appropriate interventions to be taken.	Monthly member profile reviews shall be completed and results/interventions distributed to prescribers within sixty (60) days of the end of the month.	Calculation of the damages, may in the State's discretion, be $100 assessed for each member profile less than the required 2,400 profiles, within 90 days of the end of each quarter.
A.6 Drug Utilization Review Program	The Contractor shall produce 2,400 provider profiles per quarter and determine appropriate interventions to address any potential problems identified during profile review. These interventions shall include at a minimum mailings sent to prescribers or pharmacy providers.	Quarterly provider profile reviews shall be completed and results/interventions distributed to prescribers within ninety (90) days of the end of the quarter.	Calculation of the damages, may in the State's discretion, be $100 assessed for each letter or other approved, documented intervention less than the required 2,400, within 90 days of the end of each quarter.

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A.7.1 Prior Authorization Processing time	The Contractor shall complete all requests for prior approval within twenty four (24) hours given sufficient information to make a determination.	Contractor must document the receipt and determination time for every request for PA. This must be provided to TennCare on a quarterly basis (Section A.11). Explanation must be given for falling outside the twenty four (24) hour timeframe.	The cost of services not provided plus $500 per day, per occurrence, for each day that it is determined the Contractor failed to acknowledge or act timely upon a request for prior authorization in accordance with TennCare rules and regulations
A.7.1.a Prior Authorization Unit	The Contractor shall (1) provide an approved service timely, i.e., in accordance with timelines specified in this Contract, or (2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	The cost of services not provided plus $500 per day, per occurrence for each day (1) that approved care is not provided timely; or (2) notice of delay is not provided and/or the Contractor fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service
A.7.1.m.ii Call Center Service Levels	The Contractor shall maintain service levels within the Prior Authorization Unit such that all calls are answered within an Average Speed of Answer of 30 seconds, and the total number of abandoned calls shall not exceed 3%, measured and reported as a monthly average of the answer times for all calls within the month..	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	Failure to meet these service levels may, in the State's discretion, result in liquidated damages of $500 per day for which service levels are not met.
A.7.3 Prior Authorization Reconsideration	The Contractor shall respond to all reconsideration requests within one (1) business day.	The Contractor shall provide monthly reports indicating the timeframe and outcome of every prior authorization reconsideration.	$200 per occurrence of failure to respond to reconsideration within one (1) business day

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A.7.3 Prior Authorization Reconsideration	The Contractor shall supply TennCare with all pertinent information pertaining to reconsideration requests within two (2) business days.	The Contractor shall provide monthly reports indicating the timeframe and outcome of every prior authorization reconsideration.	$200 per occurrence of failure to supply all pertinent information within two (2) business days
A.7.4 Enrollee Appeals	The Contractor shall provide a service or make payments for a service within five (5) calendar days of a directive from TennCare (pursuant to an appeal) to do so, or upon approval of the service or payment by the Contractor during the appeal process, or within a longer period of time which has been approved by TennCare upon the Contractor's demonstration of good cause	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	$500 per day beginning on the next calendar day after default by the Contractor in addition to the cost of services not provided
A.7.4 Enrollee Appeals	The Contractor shall provide proof of compliance to TennCare within five (5) calendar days of a directive from TennCare or within a longer period of time which has been approved by TennCare upon the Contractor's demonstration of good cause	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	$500 per day beginning on the next calendar day after default by the Contractor
A.7.4 Enrollee Appeals	The Contractor shall provide continuation or restoration of services where enrollee was receiving a service as required by TennCare rules or regulations, applicable state or federal law, and all court orders and consent decrees governing the appeal procedures as they become effective	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	An amount sufficient to at least offset any savings the Contractor achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense $500 per day for each calendar day the Contractor fails to provide continuation or restoration of services as required by TennCare or approved by the Contractor

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A.7.4 Enrollee Appeals	The Contractor shall forward an expedited appeal to TennCare in twenty-four (24) hours or a standard appeal in five (5) days	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	$500 per calendar day
A.7.4 Enrollee Appeals	The Contractor shall provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing the appeals procedures as they become effective	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	$500 per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TennCare
A.7.4 Enrollee Appeals	The Contractor shall process appeals as set forth in the Revised Grier Consent Decree to avoid "Systemic problems or violations of the law"	A failure in 20% or more of appealed cases over a 60-day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures, as they become effective	First occurrence: $500 per instance of such "systemic problems or violations of the law", even if damages regarding one or more particular instances have been assessed (in the case of "systemic problems or violations of the law" relating to notice content requirements, $500 per notice even if a corrected notice was issued upon request by TennCare) Damages per instance shall increase in $500 increments for each subsequent "systemic problem or violation of the law" relating to a particular requirement is identified; $1000 per instance for the 2nd time a "systemic problem or violation of the law" relating to the same requirement is identified; etc.)

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A.7.6.d Administer Prior Authorization Program for the TennCare PDL	The Contractor shall provide prior authorization services for prescriptions written for non-preferred drugs or otherwise requiring PA. Prior authorization services shall consist of prescription review by a licensed pharmacist or pharmacy technician to ensure that all predetermined clinically appropriate criteria have been met before the prescription may be dispensed and subsequently reimbursed.	The Contractor shall provide readily retrievable documentation for every prior authorization request made, which shall include all information offered by the prescriber, pharmacy, or enrollee, and shall include explanations on what criteria was used to make the final determination, and what final determination was made, and by whom.	$500 per instance of inappropriate denial; $100 per instance of appropriate approval plus the reimbursement for cost of medication and dispensing fee
A.9.5 Pharmacy Network and Enrollee Notices	The Contractor shall ensure that network pharmacies comply with all provisions of enrollee notices.	The Contractor's shall utilize feedback from TennCare, other state agencies, and enrollees, in addition to the audit process to perform additional training to pharmacies regarding notice obligations.	$100 per instance of failure of the Contractor to ensure pharmacies are compliant with notice requirements
A.9.6. Verification of Benefits (VOB) Notices	The Contractor shall send a letter to five hundred (500) randomly selected recipients each month requesting their reply to confirm whether they received the prescriptions processed in the preceding month and identified in the letter, as described in Contract Sections A.9.6.a-e.	VOB responses shall be followed up on by the Contractor's audit unit and the Contractor shall provide TennCare with a quarterly report on the findings from the responses.	Failure to generate Verification of Benefit (VOB) notices as described in the Contract, may, in the State's discretion, result in liquidated damages in the amount of $100 per day during the first month violations are identified. LDs may, in the State's discretion, be increased to $200 per day for the second consecutive month violations are identified.
A.9.9 Provider Service Agreements	Contractor to maintain provider agreements in accordance with Section A.9.9 of this Contract	The Contractor shall execute provider agreements with participating pharmacies that maintain all federal, state and local licenses, certifications, and permits, without restriction, required to provide pharmaceutical services to TennCare enrollees and shall comply	$5,000 per provider agreement found to be non-compliant with the requirements outlined in this Contract

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		fully with all applicable laws and regulations. The Contractor shall also ensure that the pharmacy provider is not currently nor has ever been sanctioned by HHS-OIG and is prevented from participating in a federally-funded program such as TennCare.	
A.10 Key Staff Position	The Contractor shall employ competent staff in all key positions listed in Section A.10.	Replacement staff shall be in place within sixty (60) days of vacancies, unless TennCare grants an exception to the requirement	Calculation of the damages may, in the State's discretion, begin on the sixty-first day following the vacancy of the position and may continue until monthly until the position is filed. The penalty may, in the State's discretion, be $2,500 per month in addition to the salary of the position being withheld from the monthly payment.
A.10 Key Staff Licensure	The Contractor shall provide to TennCare documentation verifying the state licensure of key staff.	The Contractor shall provide TennCare copies of current Tennessee licenses for key staff	Calculation of the damages may, in the State's discretion, continue until receipt of the licensure verification by TennCare. Penalty may, in the State's discretion, be $2,500 per week per employee.
A.11.1 Management Reports	The Contractor shall provide TennCare with industry standard utilization and financial management reporting. The Contractor's management reports shall provide a summary of drug costs sorted by therapeutic category, by top ranked drugs, and by benefit categories. Reports shall include, but not be limited to: □ Financial summary with change	Monthly and quarterly reports are due ten (10) business days after the end of the reporting period.	Damages may, in the State's discretion, be assessed weekly. Calculation of the damages will begin on the first day following the report due date and may continue until receipt of the report by TennCare. Penalty may, in the State's discretion, be $2,500

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	trend ☐ Utilization statistics ☐ Claim processing volume and statistics ☐ Pharmacy Drug Spend by category and drug Quarterly Net Cost trend reports ☐ PDL Compliance reports by provider and specialty ☐ Prior Authorization ☐ Call Center metrics ☐ Reconsideration volume, disposition and aging ☐ Prescriber profiles ☐ Rebate reports ☐ Pharmacy Lock-in reports showing current status of all enrollees subject to Lock-in, Escalated PA status, and Convicted PA status ☐ Specialty Drug Reports ☐ Compounded Prescription Reports ☐ All other reports referenced in the Contract		per week, per report.
A.11.2 On Request Reports (ORRs)	The Contractor shall be able to provide, at no extra cost to TennCare ORRs that shall assist in managing the pharmacy benefit for TennCare members. ORRs shall be provided in a format described by TennCare and in an agreed upon timetable.	ORRs shall be provided within the agreed upon timetable	Failure by the Contractor to produce ORRs in a reasonable timeframe requested by TennCare may, in the State's discretion, result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages may, in the State's discretion, increase to two hundred dollars ($200) per day for the second consecutive month violations are identified.

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PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.11.2 Emergency Supply Aggregate Reports	The Contractor shall provide TennCare with monthly emergency supply claims reports listing the enrollee information, drug information, quantity and days supply, pharmacy and prescriber information, along with the reason the original claim was rejected (Non-PDL, Clinical Criteria required, etc.). Contractor shall also provide semi-annual aggregate reports that list the top 100 pharmacies entering emergency supplies.. The emergency supply reports shall be delivered to TennCare in electronic format by a web-based report library, as agreed to by TennCare.	Reports shall be delivered on a weekly and monthly basis no longer than five (5) business days after the ending of the week/month.	Failure by the Contractor to provide emergency supply Aggregate Report may, in the State's discretion, result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages may, in the State's discretion, increase to two hundred dollars ($200) per day for the second consecutive month violations are identified.
A.11.2 Prior Authorization Unit Reports	The Contractor shall provide all Prior Authorization Unit Reports described in the Management Reports provided in Section A.11.2	Provide Prior Authorization Unit Reports as required in Section A.11.2	Failure by the Contractor to provide the Prior Authorization Call Center reports listed in a complete and timely manner may, in the State's discretion, result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages may, in the State's discretion, increase to two hundred dollars ($200) per day for the second consecutive month violations are identified.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.11.3 PDL Compliance Report	The Contractor shall monitor compliance by prescribers and pharmacists with the TennCare PDL and report that information to TennCare monthly, quarterly, and semiannually, and provide suggestions for improving PDL compliance.	Report shall be delivered within forty-five (45) days following the period, but not earlier than thirty (30) days following the period.	Penalty may, in the State's discretion, be $2500 per week that report is overdue.
A.11.4. Program Integrity Reports	The Contractor shall be required to provide the following program integrity reports on a daily basis: - Ingredient Cost/Prescription Report, identifying claims with total cost exceeding $2000 at retail, excluding specialty drugs. - Override report, reflecting daily claims paid with override, prior authorization, or other unique adjudication rules as defined by TennCare - Pharmacy Time of Claims Submission Report, reflecting controlled substance claims submitted between 10:00 pm and 6:00 am The Contractor shall be required to provide the following program integrity reports on a monthly basis: - Enrollees Using Multiple Prescribers Report - Enrollee Use of Controlled SubstancesLock-In Report - Pharmacy DAW Code Submission Report - Pharmacy Claim Reversals Report - Generic efficiency report, reflecting pharmacies processing ≥250 non-specialty drug claims per quarter and having <60% generic utilization - Pharmacy Submission of Package Size versus Day Supply Report, identifying	Reports shall be delivered on a daily or monthly basis (as described in previous column). Daily reports shall be produced, reviewed and delivered daily Monday through Friday by 3:00pm CT. Monthly reports shall be produced and reviewed monthly by ten (10) business days after end of month.	Failure by the Contractor to provide the required Program Integrity Reports on a daily or monthly basis may, in the State's discretion, result in liquidated damages of one hundred dollars ($100) per day the reports are late during the first month violations are identified. Liquidated damaged may, in the State's discretion, increase to two hundred ($200) per day for the second consecutive month violations are identified.

CENTRAL PROCUREMENT OFFICE

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
	claims with an invalid correlation between quantity and day supply		
A.12.1 Notices	The Contractor shall be required to send individualized notices to enrollees on a daily basis except for Sunday, worded at a six (6th) grade reading level.	Notices shall be approved by TennCare and include prior authorization denial notices, prescription limit notices, lock-in notices, or other notice as directed by TennCare.	Failure by the Contractor to produce notices in such a manner shall result in liquidated damages of five hundred dollars ($500) per occurrence
A.12.1 Notices	The Contractor shall comply with the notice requirements of this Contract, TennCare rules and regulations, and all court orders and consent decrees governing the appeal procedures as they become effective	The Contractor shall make available to various TennCare departments; readily retrievable documentation via an online document system for notices sent to TennCare enrollees and/or providers and shall produce same documentation for internal and external audits when requested.	$500 per occurrence in addition to $500 per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by the Agreement or required by TennCare

CENTRAL PROCUREMENT OFFICE

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.12.1 Notices	The Contractor shall submit a timely corrected notice of adverse action to TennCare for review and approval prior to issuance to the member	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided.	$1000 per occurrence if the notice remains defective plus a per calendar day assessment in increasing increments of $500 ($500 for the first day, $1000 for the second day, $1500 for the third day, etc.) for each day the notice is late or remains defective
A.12.2 Notices to Children in State Custody	Each week, the Contractor receives a file of TennCare recipients currently in State Custody from the Department of Children's Services (DCS). The Contractor shall be required to produce copies of any recipient denial notices generated over the previous week, and forward the notices (either hard copy or via secure electronic file transmission) to DCS.	Copies of denial notices generated for children in State custody shall be provided on a weekly basis to DCS (either hard copy or via secure electronic file transmission).	Failure by the Contractor to produce notices in such a manner shall result in liquidated damages of one hundred dollars ($100)per notice.
A.12.4 Returned Mail	The Contractor shall open all returned mail from any mailings to enrollees or providers to determine if the enrollee has moved, if the Contractor has the wrong address and/or if the enrollee is communicating other information to the Contractor or to TennCare.	Track returned mail and report monthly, in a yet to be determined mutually agreed upon format, to TennCare the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor.	$500 per missing report
A.18.2 CoverRx Eligibility Determination	For no less than ninety-five percent (95%) of new participants, a determination of eligibility will be made within five (5) working days of receipt of a completed application.	Determination of eligibility is defined as assessing whether or not an individual applicant meets the State's eligibility criteria for participation in CoverRx. A completed application is defined as one in which the applicant has provided the required data fields and supporting documentation	One thousand ($1,000) dollars per month for every month out of compliance.

CENTRAL PROCUREMENT OFFICE

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.18.3 CoverRx Participant Communication Materials	Participant enrollment cards, descriptive booklets, and provider directories will be distributed to no less than ninety-five percent (95%) of new participants within one (1) week of enrollment. Performance will be based on an annual average.	Participant Communication Materials are any written materials developed and/or distributed by the Contractor which can be used by the participant to access, understand, clarify or make decisions concerning CoverRx.	Two thousand $2,000 per year in which the standard is not met.
A.18.5 Annual Verification of CoverRx Participant Eligibility	Annual verification of participant eligibility, for no less than ninety-five percent (95%) of participants, shall occur within thirty (30) days of each participant's anniversary date.	Verification of participant eligibility is defined as assessing whether or not an individual applicant continues to meet the State's eligibility criteria for participation in CoverRx based on updated participant information that has been submitted by the participant to the Contractor.	One thousand ($1,000) dollars per month for every month out of compliance.
A.19.2 CoverRx Network Access	Within 90 days of CoverRx program implementation, 95% of all CoverRx participants will have access to at least one (1) retail pharmacist within thirty (30) miles of participants' residence.	The Contractor's provider and facility network will assure the access standard is met as measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis.	Five hundred dollars ($500) for each week beyond the first 90 days of program implementation that the defined access standard is not met.
A.29.3 CoverRx Mail Order Turn-Around	All completed and fillable mail order prescriptions must be dispensed and shipped with a maximum turnaround time no greater than forty-eight (48) hours.	Mail order turnaround is measured from the time a prescription or refill request is received by the mail order pharmacy to the time it leaves the mail order pharmacy and mailed to the participant. Completed and fillable prescriptions are those that require no intervention before they can be properly and/or accurately filled. (e.g. follow-up with participants or providers, for any reason)	One thousand dollars ($1,000) per month for each month the Contractor is five (5) full percentage points below one hundred percent (100%) compliance.
E.7 and E.8. HIPAA and HITECH Compliance	Contractor shall ensure that all TennCare data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such as through encryption or destruction, such that it is rendered unusable, unreadable and	Protected health Information is secure as defined by HIPAA and HITECH.	$500 per enrollee per occurrence, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those TennCare enrollees whose PHI was placed

CENTRAL PROCUREMENT OFFICE

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
	indecipherable to unauthorized individuals.		at risk by Contractor's failure to comply with the terms of this Agreement, the Contractor shall be liable for all costs associated with the provision of such monitoring and/or safeguard services
E.7 and E.8 HIPAA and HITECH Compliance	Contractor shall execute the appropriate agreements to effectuate transfer and exchange of TennCare enrollee PHI or TennCare 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	Appropriate agreements are in place to effectuate transfer and exchange of TennCare enrollee PHI or TennCare confidential information.	$500 per enrollee per occurrence
E.7 and E.8. HIPAA and HITECH Compliance	Contractor shall seek express written approval from TennCare prior to the use or disclosure of TennCare enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States	Contractor shall seek express written approval from TennCare prior to the use or disclosure of TennCare enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States	$1,000 per enrollee per occurrence
E.7 and E.8. HIPAA and HITECH Compliance	Contractor shall timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional	Contractor shall timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional	$500 per enrollee per occurrence, not to exceed $10,000,000
E.22 Breach, Partial Default	In the event of a Breach, the State may declare a Partial Default. In that case, the State shall provide the Contractor written notice of: (1) the date that Contractor shall terminate providing the service associated with the Breach; and (2) the date the State shall 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	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 that would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service,	$500 per enrollee per occurrence, not to exceed $10,000,000

CENTRAL PROCUREMENT OFFICE

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
	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 that 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) business days any requested material from Contractor. The State shall make the final and binding determination of said amount.	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) business days any requested material from Contractor. The State shall make the final and binding determination of said amount.	
E.30.1. Prevention/Detection of Provider Fraud and Abuse	The Contractor shall provide monthly reports to TennCare that describe pharmacy provider dispensing patterns that statistically identify the pharmacy as an outlier that may be representative of potential fraudulent, abusive or wasteful dispensing patterns.	This report shall be independent of routine audit activities, and shall include but not be limited to: referrals made to the Contractor by network pharmacies, prescribers, TennCare's Office of Program Integrity, the Tennessee Bureau of Investigation, the Tennessee Medicaid Fraud Control Unit, and the State of Tennessee's Office of Inspector General. Contractor shall meet with TennCare's Office of Provider Integrity to review all fraud activities quarterly.	Failure by the Contractor to provide the monthly reports in a complete and timely manner may, in the State's discretion, result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day for the second consecutive month violations are identified.

CENTRAL PROCUREMENT OFFICE

Attachment D

CoverRx Management Reporting Requirements

The Contractor shall submit Management Reports by which the State can assess the pharmacy assistance program's general activity and usage, as well as treatment and success tendencies.

Reports shall be submitted electronically, and shall be of the type and at the frequency indicated below. Management Reports shall include:

1) **Predictive Modeling Reports -** Contractor will provide a twelve (12) month forecast on a monthly basis of CoverRx cost and utilization based on historical trends. This includes, at a minimum:
   - PMPM cost and utilization
   - Drug usage trends
   - Projected savings with suggested formulary changes
   - Network adequacy

5) **Total Claims per quarter**
   - Number of funded claims (claims up to 5 script limit PMPM and on formulary plus insulin products and diabetic supplies); and
   - Number of unfunded claims (claims over 5 script limit PMPM and non formulary claims).

6) **Drug Cost Reconciliation Report -** Average drug discounts and average dispensing fees paid by the State in the aggregate annually, including:
   - Retail Brand drug discount
   - Retail Generic drug discount
   - Retail Brand dispensing fee
   - Retail Generic dispensing fee
   - Retail MAC dispensing fee

7) **Quarterly Brand Diabetic Report** - Contractor will provide a quarterly forecast of CoverRx cost and utilization based on historical trends. This includes, at a minimum:
   - Drug Brand Name
   - Most Common Indication
   - Total Rx Count
   - Total Ingredient Cost
   - Total Plan Cost
   - Total Member Contribution

8) **Quarterly Cost & Trends Detail Drugs by Plan Cost** - should be submitted electronically. Contractor will provide a quarterly forecast of CoverRx cost and trends detail. This includes, at a minimum:
   - Key statistics PMPM, Generic fill rate, plan cost
   - Top 10 Indications
   - Top 10 drugs by ingredient cost
   - Utilizers by Indication

9) **Quarterly Top 25 by Ingredient Cost** - Contractor will provide a quarterly forecast of CoverRx top 25 drugs by ingredient cost. This includes, at a minimum:
   - Drug Brand Name
   - Indication
   - Ingredient Cost Rank
   - Ingredient Cost
   - Rx Count Rank
   - Rx Count
   - Plan Cost Rank
   - Plan Cost
   - Ingredient Cost/Rx
   - Plan Cost/Rx
   - Mail Rx %
   - Qty

CENTRAL PROCUREMENT OFFICE

10) **Quarterly and Annual Operational Performance Report** - Contractor will provide program operation trend information. This includes at a minimum:
    - Home Delivery service outcome
    - Client reported Requests
    - Retail service outcome
    - Web access outcome
    - Patient Satisfaction measurements

11) **Monthly Enrollment Report** - Contractor will provide a monthly update of CoverRx total membership count.

12) **Monthly Application Statistics Report** - Contractor will provide a monthly update of CoverRx application information. This includes at a minimum:
    - New Enrollment Applications
    - Re-Enrollment Applications
    - Total Applications
    - Denials: (not eligible)
    - Rejects: (incomplete info, returned)
    - Calls Received by Call Center
    - Call Center ASA (in seconds)

CONTRACT

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

Begin Date	End Date	Agency Tracking #	Edison Record ID
December 20, 2012	May 31, 2016	31865-00346	34942

Contractor Legal Entity Name	Edison Vendor ID
Magellan Medicaid Administration, Inc.	00000041004

Service Caption (one line only)

TennCare Pharmacy Benefits Manager (PBM)

Subrecipient or Vendor	CFDA #
☐ Subrecipient ☒ Vendor	93.778 Dept of Health & Human Services/Title XIX

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2013	$787,491.75	$787,491.75			$1,574,983.50
2014	$9,761,570.57	$9,761,570.58			$19,523,141.15
2015	$9,901,955.68	$9,901,955.67			$19,803,911.35
2016	$9,222,991.00	$9,222,991.00			$18,445,982.00
TOTAL:	**$29,674,009.00**	**$29,674,009.00**			**$59,348,018.00**

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

Ownership/Control

☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Female

☐ Person w/Disability ☐ Small Business ☐ Government ☒ NOT Minority/Disadvantaged

☐ Other:

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

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

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

Speed Chart (optional)	Account Code (optional)
TN00000066	70803000

OCR USE – FA

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CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
MAGELLAN MEDICAID ADMINISTRATION, INC.

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Bureau of TennCare, hereinafter referred to as the "State" or "TennCare" and Magellan Medicaid Administration, Inc., hereinafter referred to as the "Contractor", is for the provision of online Point-of-Sale (POS) pharmacy claims processing system with prospective drug utilization review (DUR), retrospective drug utilization review (Retro-DUR), reporting and adjudication capabilities as further defined in the "SCOPE OF SERVICES."

The Contractor is a for-profit corporation.
Contractor Federal Employer Identification, Social Security, or Edison Registration ID # 00000041004
Contractor Place of Incorporation or Organization: Virginia

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. Applicable terms related to this contract are located in Attachment A.

A.2. Plan Implementation

A.2.1 Implementation of this TennCare pharmacy benefits manager (PBM) Contract shall be conducted as series of defined phases described below. The benefit shall become fully effective and operable on June 1, 2013. The Contractor shall be required to complete all the tasks, obligations and responsibilities listed under each phase by the dates identified in the project plan. The project plan shall be in Microsoft Project and include a detailed timeline description of all work to be performed both by the Contractor and TennCare. The plan shall also include a description of the participants on the transition team and their roles and schedules of meetings between the transition team and TennCare. This plan shall require approval by TennCare.

A.2.2. Project Initiation and Requirements Definition Phase

TennCare shall conduct a project kick-off meeting. All key Contractor project staff shall attend. TennCare project staff shall provide access and orientation to the TennCare Pharmacy Program and system documentation. TennCare technical staff shall provide an overview of the Tennessee TennCare Management Information System (TCMIS) emphasizing pharmacy claims processing and adjudication, reference files, and payment processes. During this phase the Contractor shall develop the following documentation:

a. Functional and Informational Requirements (FIR) Document. This document shall include detailed requirements for both internal and external interfaces and all TennCare Point-of-Sale (POS) functionalities required by the RFP and/or contained in the Contractor's proposal and/or this Contract. Eligibility interfaces with TennCare are critical and the Contractor must be in sync with the TCMIS eligibility data. All outbound 834 files from TennCare must be loaded to the Contractors data base within 24 hours of receipt from TennCare. This requirement includes any 834 transactions that must be handled manually by the Contractor. Failure to meet this performance standard may result in liquidated damages set forth in Attachment C.

b. Data Dictionary. For each data field this shall indicate content, size, values, structure, edit criteria and purpose.

c. Data Mapping. This shall consist of a cross-reference map of required TCMIS data and TennCare POS data elements and data structures. A separate data structure map shall be

required for each transaction and interface. A data conversion plan, that includes both automated and manual activities, shall be provided for each data structure map. TennCare shall make any necessary data formats available to the Contractor.

d. Additionally, the Contractor shall recommend design modifications to the Tennessee TCMIS. Performing any maintenance and design enhancements to TCMIS shall be the decision and responsibility of TennCare.

A.2.3. System Analysis/General Design Phase

After approval of the documentation by TennCare required in the Project Initiation and Requirements Definition Phase, the Contractor shall develop the General System Design Document. The General System Design Document shall include the following information:

a. An Operational Impact Analysis that details the procedures and infrastructure required to enable TCMIS, the Contractor's system, and the "switch" systems used by pharmacy providers to work effectively together.

b. A Detailed Conversion Plan that specifies plans for conversion of fifteen (15) months of TCMIS and the previous PBM contractor/processor's claims history, provider, recipient, preferred drug list, prior authorization, lock-in and reference data.

c. A Software Release Plan that sets forth the project's implementation into production. This document shall explain procedures for coordinating system changes that shall have an operational or information impact on TennCare POS operations. It shall detail how TennCare POS and/or TCMIS software releases are tested and coordinated. The plan shall include both initial implementation of the TennCare POS system and coordination of software releases between TCMIS and TennCare POS.

A.2.4. Technical Design Phase

During this phase, detailed specifications shall be developed for conversion and for the interface(s) between the TCMIS and the Contractor's system. The Contractor shall develop detailed plans that address back-up and recovery, information security and system testing. The Contractor shall develop the System Interface Design Overview Document (this document shall be completed after the Contractor has conducted a review of all previous design documents). In addition to the System Interface Design Overview, the Contractor shall provide the following system plan documents:

a. Unit Test Plan that includes test data, testing process, and expected results;

b. Back-up and Recovery Plan that includes processes for daily backup and recovery of system information;

c. Final Disaster Recovery Plan;

d. Information Security Plan that includes how the Contractor shall maintain confidentiality of TennCare data. This document shall include a comprehensive Risk Analysis; and

e. System, Integration, and Load and Test Plan.

A.2.5. Development Phase

This phase includes activities that shall lead to the implementation of the TennCare-POS System. The Contractor shall develop interface and conversion programs, develop system documentation, and develop Unit Test Plans. Where manual data entry screens are required, the Contractor shall develop these screens. Testing shall be performed on all phases and programs shall be documented. System testing shall require reports to substantiate and document the testing. These reports shall include number of tests run, number of requirements tested, number of tests passed, number of tests failed, and number of tests retested after initial failure. The Contractor must maintain an issues log which details any testing failures and includes the resolution for those issues. During final User Acceptance Testing (UAT) with TennCare, only TennCare can approve the Contractor's issue resolutions. The Contractor shall perform testing activities that shall include the following:

a. TennCare POS system test to validate the appropriate adjudication of a claim which shall include a description of the test procedure, expected results, and actual results;

b. Integration testing shall test external system impacts including provider POS systems, downstream TCMIS applications, and all interfaces. It shall include a description of the test procedure, expected results, and actual results; and

c. Load and Stress testing shall include volume and efficiency to ensure that the system is able to process the volume of TennCare pharmacy claims. It shall include a description of the test procedure, expected results, and actual results.

A.2.6. Implementation/Operations Phase

During this phase the Contractor and TennCare shall assess the operational readiness of all required system components including TCMIS, the TennCare-POS, and required communications links with the pharmacy "switch" providers. This shall result in the establishment of the operational production environment in which all TennCare pharmacy claims shall be accurately and reliably processed, adjudicated and paid. TennCare shall have final approval for the elements of the operational production environment.

a. The Contractor shall develop and prepare the operations documentation of all procedures of the Contractor's performance. This shall include, but may not be limited to: automated operations, data entry operations, Help Desk operations, prior authorization operations/interfaces, check and remittance fulfillment and member notifications.

b. With the approval of TennCare, the Contractor shall develop production and report distribution schedules.

c. The Contractor shall update the operations training plan for TennCare approval. The Contractor shall schedule and conduct training and develop the training materials for TennCare staff, pharmacy providers, and other identified stakeholders.

d. The Contractor and TennCare shall prepare a final conversion plan and perform final conversion activities that include procedures for testing the conversion data. The conversion plan shall include loading fifteen (15) months of claims history from the current POS system. The plan shall also include migrating current prior authorizations, overrides and grandfather provisions with their end dates into the Contractor's POS system, running other conversion programs, performing manual functions, performing quality control, reporting on outcomes, and converting files in preparation for system operation.

A.2.7. Readiness Review

The State may conduct an on-site review to assess the readiness of the Contractor to effectively administer and provide the services as defined in this Contract. The Contractor shall complete all implementation actions prior to "go-live" date and according to the implementation timeline provided by the Contractor to TennCare. The Contractor shall receive TennCare's sign-off that each action has been completed successfully. Implementation action steps include the following minimum items:

a. Benefit plan designs loaded, operable and tested;
b. Perform comprehensive systems testing (including interface testing with all third parties) and quality assurance audits, with results reported to the TennCare prior to the "Go-Live";
c. Eligibility feed formats loaded and tested end to end;
d. Operable and tested toll-free numbers;
e. Signed agreements for Retail Pharmacy and Long-term Care Pharmacy networks;
f. Account management, Help Desk and Prior Authorization staff hired and trained;
g. Established billing/banking requirements;
h. Complete notifications to pharmacies and prescribers regarding contractor change;
i. Each component shall be met by an agreed upon deadline in an implementation timeline provided by Contractor to TennCare. Implementation action requirements may include other items necessary to meet the claims processing commencement date of June 1, 2013, 1:00 a.m. CST, and
j. Claims history and existing prior authorizations and overrides shall be migrated Contractors POS system.

A.3. TennCare Point-of-Sale System

A.3.1. The Contractor shall provide an online pharmacy POS system that can be modified to meet the needs of TennCare. The Contractor shall provide system design and modification, development, implementation and operation for the TennCare-POS system. The Contractor's POS system shall allow it to interface with the existing pharmacy "switch" networks that connect the pharmacy providers with the Contractor's system.

The Contractor shall be responsible for operating the provided system that automates the entire pharmacy claims processing system for the complete pharmacy benefit for all TennCare enrollees. All payments for pharmacy claims shall be made through the Contractor's system and electronically invoiced to TennCare weekly as a pass through cost.

The source of the claims shall be enrolled network pharmacy providers such as retail pharmacies, firms supplying Tennessee's nursing homes, some hospitals, specialty pharmacies, and health department pharmacies. The majority of claims shall be submitted through point-of-sale telecommunications devices. However, the Contractor shall also process claims on batch electronic media for long term care pharmacy providers, the Tennessee Department of Health's TennCare pharmacy claims and non-traditional pharmacy providers.

Prospective Drug Utilization Review (Pro-DUR) functions provided by the Contractor through the TennCare-POS system shall alert pharmacists when several defined conditions are present. These conditions shall include recognizing that a prescribed drug could cause an adverse reaction when taken in combination with other drugs prescribed for the same recipient. It shall also include situations when a drug may be contraindicated due to the presumed physical condition of the patient based on their drug history. The Contractor shall recommend to TennCare new Pro-DUR edits that improve quality and reduce pharmacy program costs. DUR edits shall be customizable to allow for any adjustments recommended by TennCare's DUR Board.

A.3.2. Claim Adjudication Services - General Requirements

This section defines claim adjudication requirements for all TennCare pharmacy claims regardless of source and including electronic batch and POS claims. The timing of the adjudication shall differentiate POS claims from claims submitted in batch. However, all claims shall be adjudicated through a common set of processing modules. All claims adjudicated as payable shall be for eligible members to enrolled or appropriate providers for approved services and in accordance with the payment rules and other policies of TennCare. All adjudicated claims shall be captured to an encounter file and transferred weekly to the TennCare TCMIS by the Contractor. The National Council for Prescription Drug Programs (NCPDP) Post Adjudication Standard 3.0 format shall be used for the encounter file. The encounter file shall include all relevant data elements used to process each claim. At the direction of TennCare, the Contractor shall make changes to data elements included on the encounter file with no additional cost to TennCare.

The Contractor shall distribute and mail TennCare outputs (hard copy and electronic) as directed by TennCare, including but not limited to provider checks and remittance advices (PAs), returned claims, notices, provider bulletins, provider manuals and special mailings. Every Friday, with the exception of weeks during which the State is officially closed due to a holiday or for any other reason (holiday weeks), the Contractor shall mail checks and Remittance Advices for claims submitted through its POS online pharmacy claims processing system for that work week. In the case of holiday weeks, the Contractor shall notify pharmacy providers if a schedule change is to occur at least two (2) weeks in advance and issue checks and remittance advices within two (2) business days of the routine date. Failure to meet the performance standards set forth in this Contract Section may result in liquidated damages as set forth in Attachment C. The Contractor shall use first class rate for all TennCare mailings, unless otherwise directed by TennCare. Postage costs incurred by the Contractor shall be treated as pass-through costs. Such costs shall be billed on a monthly basis to the TennCare Bureau in addition to regular invoices and shall include substantiating documentation. Each batch shall have its own reconciliation and money remits. No overhead, administrative or other fee shall be added to such pass-through costs. Printing and supply costs for check and remittance mailings are to be included in the base rate of this Contract. The Contractor shall be responsible for system messages and notice of claims being adjudicated payable, denied or rejected. Claims denied or rejected shall return situation specific messages to assist pharmacies with resubmissions.

a. Cash flow – For checks to be issued on Friday, the Contractor shall deliver the following two (2) files to the State, or it's designees, in an electronic media suitable to the State, by 10:00 a.m. Central Standard Time, on Tuesday of each week:

i. All transactions, (i.e., claims, financial adjustment, etc.) identified by MCO, that comprise the payments to be issued for Friday of that week. In cases of holidays the Contractor shall notify pharmacy providers if a schedule change is to occur at least two (2) weeks in advance and issue checks and remittance advices within two (2) business days of the routine date.

ii. All payments, (check register) identified by MCO, to be made on Friday of that week. TennCare shall be notified no later than one (1) business day of any systems or operational issues that may impact disbursements by the prescribed time lines. The file described in Section A.3.2.a. shall contain all transactions that make up the payments in the file described.

b. TennCare reserves the right to review the files prior to issuing payment and to hold or adjust any payment that is not satisfactory to the State. The Contractor is required to offer automatic deposit to its providers. If the Contractor submits a claims payment request and the State overpays the claim, the State reserves the right to withhold the overpaid monies. The Contractor shall be responsible for providing RAs to providers unless the provider elects not to receive hardcopy RAs. Remittance Advices shall be included in payments by the Contractor to providers. The Contractor shall be required to be compliant with the American National Standards Institute Care Claims Payment and Remittances Advice Format known as the "ANSI 835". The ANSI 835 is a HIPAA compliant format. The Contractor shall be responsible for ensuring that any payments funded by TennCare are accurate and in compliance with the terms of this Contract, agreements between the State or Contractor and providers, and state and federal laws and regulations.

c. The Contractor shall have in place a POS claims processing system capable of accepting and processing claims submitted electronically. To the extent that the Contractor compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the Contractor shall electronically process the provider's claims for covered benefits provided to members consistent with applicable TennCare policies and procedures and the terms of this Contract. The Contractor shall mail checks and RAs to pharmacy providers weekly on Fridays for all claims submitted through the POS online pharmacy claims processing system and for all batch claims. In the case of holiday weeks, the Contractor shall notify pharmacy providers if a schedule change is to occur at least two (2) weeks in advance and issue checks and RAs within two (2) days of the routine date.

d. The Contractor shall: (1) process ninety-nine and a half percent (99.5%) of POS claims on a daily basis within ten (10) seconds of receipt by the Contractor's processor (as set forth in Contract Section A.3.2.e.), and, (2) if appropriate, pay within fifteen (15) days of receipt one hundred percent (100%) of all clean claims submitted by network and non-network pharmacy providers through POS and batch electronic claims submission. The term "pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by that provider to the Contractor. The Contractor shall pay the clean claim or advise the provider that a submitted claim is: (1) a "denied claim" (specifying all reasons for denial); or, (2) an "incomplete claim" that cannot be denied or allowed due to insufficient information and/or documentation (specifying in detail all information and/or documentation that is needed from the provider in order to allow or deny the claim). An incomplete claim may be resubmitted with the information necessary to complete the claim. This resubmission shall constitute a new claim only for the purpose of establishing a timeframe for claims processing. The Contractor shall develop, maintain and distribute to pharmacy providers a pharmacy procedure and billing manual. Manuals shall be posted on the Contractor's dedicated TennCare website and distributed to pharmacies with acknowledgement of network participation. The manuals shall provide instructions to providers regarding the process by which the provider receives payment, in order to diminish the potential for incorrect billing and the need for adjustments or recoupments. The content of the manuals shall be

approved by TennCare before distribution. Failure to meet the performance standards set forth in this Contract Section may result in liquidated damages as set forth in Attachment C.

e. The Contractor shall be responsible for processing all TennCare pharmacy claims through a POS system using the specified, current NCPDP format. Pharmacy claims shall be priced and adjudicated in an online, real time POS system that results in a claim pay status of pay, deny or reject. The system must allow a pharmacy to initiate a reversal (void) of a submitted claim. The telecommunications system supporting the POS function shall be available for claims submissions by pharmacies twenty-four (24) hours-a-day, seven (7) days-a-week (except for regularly scheduled and separately approved downtimes). The Contractor shall not charge pharmacies a POS transaction fee. TennCare providers are responsible for purchasing POS hardware, software and all telecommunications linkages. The POS function shall be required of all pharmacy providers. The Tennessee Department of Health may submit batch claims as described herein.

f. TennCare covers medically necessary OTC drugs for children (under twenty-one (21) years old) and a selective list (e.g., prenatal vitamins for women up to age 50) for adults. OTC drugs shall only be covered to the extent that they are prescribed by a health care provider legally qualified to write prescriptions. The Contractor shall have appropriate processes in place to assure that OTC drugs are only reimbursed as described above, or in another manner as described by TennCare.

A.3.3. Claims Receipt and Management

a. The Contractor shall receive batch electronic and point of sale (POS) claims. The Contractor shall apply a unique identification number to each claim and any supporting documentation regardless of submission format. The identification number shall be used to recognize the claim for research or audit purposes. Control totals shall be utilized to ensure that all claims have been processed to completion. Appropriate safeguards shall be in place to protect the confidentiality of TennCare and enrollee information.

b. At the point of sale, the Contractor shall identify and deny claims that contain invalid provider numbers. This shall include cases where the number is missing, the check digit fails, or the provider number does not identify an entity to receive a Remittance Advice. Claims that contain these errors shall be returned to the originating provider. Pharmacy Providers shall submit claims and be identified by their individual and specific NPI (National Provider Identification) numbers. Prescribers shall be identified on all pharmacy claims by their specific NPI. .

c. The Contractor shall identify and deny claims (unless specifically instructed differently by TennCare) that contain National Drug Code (NDC) numbers for which drug rebates under the Omnibus Budget Reconciliation Act (OBRA) of 1990 and subsequent amendments of OBRA in 1993, are not available, including non-covered drug codes, DESI, LTE and IRS drug codes and any terminated or obsolete drug codes. Such claims shall reject with situation specific messaging and error codes.

d. Unless a claim resolution is being managed by TennCare staff in accordance with TennCare guidelines or held by the Contractor under TennCare written directive, the Contractor shall be held to the following timeline requirements:

i. POS Claims - The Contractor shall process ninety-nine and a half percent (99.5%) of POS claims on a daily basis within ten (10) seconds. This is the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor and shall include all procedures required to complete claim adjudication. The Contractor shall notify TennCare within one hour (1) of sub-standard system performance. Failure to meet this performance standard may result in liquidated damages set forth in Attachment C.

ii. Batch Electronic Media Claims (EMC) - The Contractor shall receive claims in electronic format, via batch transmission, CD or DVD. All batch claims should be scheduled for immediate processing. The Contractor shall assign identification control numbers to all batch claims within three (3) business days of receipt. The

Contractor shall maintain electronic backup of batch claims for the duration of this Contract. At the end of the Contract, the Contractor shall follow the guidelines set forth in the Business Associate's Agreement with TennCare. If TennCare requests copies of batch electronic claims, these shall be provided within three business days of request. Electronic batch claims shall be submitted through a method that shall allow batch and POS claims to be adjudicated through the same processing logic.

e. The Contractor's system shall operate without unscheduled or unapproved downtime. The Contractor shall report to TennCare immediately (within one (1) hour) upon knowledge of unscheduled or unapproved downtime. A system down or "downtime" shall be defined as an interruption involving more than ten percent (10%) of production for a period greater than fifteen (15) minutes. The Contractor shall also provide TennCare updates at regular intervals during a sustained downtime. TennCare shall be presented with recovery options as appropriate. Upon full system recovery, the Contractor shall provide TennCare with a System Downtime Analysis describing root cause issues and actions to mitigate future downtime occurrences within five (5) business days after full system. Failure to meet this performance standard may result in liquidated damages set forth in Attachment C.

f. The Contractor shall ensure that collection letters are sent to contracting pharmacies that maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) business days of becoming ninety (90) days old. The Contractor shall provide TennCare with a monthly report of notices sent, due within ten (10) business days after end of month of reporting period. Failure to send the notices as scheduled may result in liquidated damages set forth in Attachment C. Postage costs incurred by the Contractor shall be treated as pass-through costs. In addition to regular invoices, these costs shall be billed on a monthly basis to the State and shall include any necessary substantiating documentation. Printing and supply costs for collection mailings shall be included in the base rate of this Contract.

g. The Contractor shall provide TennCare Fiscal Services Unit a report detailing all checks remitted to contracted pharmacies on behalf of the State that remain outstanding (that have not been cashed) more than ninety (90) days. Reports are due monthly on the fifteenth (15th) day of the month following the reporting period. Failure to report to TennCare as scheduled may result in liquidated damages set forth in Attachment C.

h. Help Desk for System Support - The Contractor shall maintain toll-free telephone access to support system operations. This Help Desk shall be available twenty-four (24) hours a day, seven (7) days a week to respond to questions and problems from providers regarding system operations and claims inquiries. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations. In no event should the Contractor use off shore sites for any area of performance of this contract.

A.3.4. Data Validation Edits and Audits

The system shall screen all claims and apply all TennCare-approved and required data validation procedures and edits. Consistency controls shall be in place to ensure that dates, types, and number of services are reasonable and comply with TennCare policy and/or rules. These control measures may be changed by TennCare at no cost.

The Contractor shall immediately notify TennCare of any and all claims that have been erroneously processed, and initiate appropriate action to correct the errors (e.g., adjustments, recoveries, etc.). Incorrect claims include, but are not limited to: claims paid for ineligible members; claims paid to a terminated provider; claims paid for duplicate services; claims paid for a non-covered service; and claims paid at an incorrect rate or claims that denied or rejected inappropriately. The Contractor shall follow-up such notification to TennCare by letter for any system errors that resulted in provider overpayment or other incorrect payment. The Contractor shall reimburse TennCare for the cost of all claims paid as a result of Contractor error. In the event that claims are inappropriately denied the Contractor may be assessed damages as specified in Attachment C. Reimbursement or damages resulting from this Section may be applied as offsets to future administrative fees.

Using an industry-accepted standard, the Contractor shall define the categories of data elements such as brand/generic classification, therapeutic categories, and OTC classification. The Contractor's system shall permit TennCare to override these values using its own policies/procedures.

The Contractor's system, for reasonable requests, shall be capable of adding, changing, or removing claim adjudication processing rules at no cost to TennCare to accommodate TennCare required changes to the pharmacy program. At installation, the system shall be able to perform the following validation edits and audits, which TennCare shall have the ability to and shall have the right to override at its discretion.

TennCare reserves the right to override any system edit whenever it deems appropriate and necessary.

a. Prior authorization - The system shall determine whether a prescribed drug requires prior authorization, and if so, whether approval was granted prior to dispensing the prescribed drug and reimbursement to the provider.

b. Valid Dates of Service - The system shall ensure that dates of services are valid dates, are no older than ninety (90) days from the date of the prescription (unless approved by TennCare) and are dates that have already occurred (not dates in the future).

c. Duplicate Claims - The system shall automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate.

d. Prescription Validity - The system shall ensure that the time period for a prescription has not expired and that the number of valid refills has not been exceeded.

e. Covered Drugs – Unless otherwise directed by TennCare, the system shall verify that a drug code (NDC) is valid and the drug is eligible for payment under the TennCare pharmacy program and eligible for Medicaid drug rebates and any supplemental rebates.

f. 340B Claims -- The system shall capture, edit and adjudicate pharmacy claims as necessary to support TennCare's 340B claim rules, as well as support a customized pharmacy network of 340B providers. System shall ensure that claims transmitted by pharmacies that are flagged as 340B claims, are rejected if not received from pharmacies that are contracted as 340B providers.

f. Compounded Drugs - The system shall capture, edit, and adjudicate pharmacy claims as necessary to support TennCare compounded drug prescription coding policy and/or rules. All system edits that are in place for non-compounded prescriptions shall be in place and active for compounded prescriptions (e.g. prior authorization).

g. Provider Validation - The system shall approve payment only for claims received from providers who are eligible to provide pharmacy services, and for TennCare and non-TennCare providers who are authorized (as required by TennCare) to prescribe pharmaceuticals. The system shall be populated with current, updated pharmacy and prescriber provider location and contact information.

   The system shall be capable of customizing prescriber networks upon TennCare's request, and accepting prescriber provider files from TennCare in a mutually agreed upon format. The system shall have the capability to determine whether the prescriber is a network provider, and reject claims based on the provider's network status, if requested by TennCare. The system shall also have the capability to report on claims (both paid and rejected) based on provider status, whether in-network or out-of-network.

h. Recipient Validation – A valid claim is a claim for service for those members eligible to receive pharmacy services at the time the services were rendered. The system shall approve only these valid claims. TennCare shall transmit eligibility/enrollment information to the Contractor by the standard HIPAA compliant 834 transaction as defined by the TennCare Companion Guide. TennCare shall be responsible for assuring that the eligibility file provided is accurate and complete. The Contractor shall use this information to immediately (within one (1) business day) identify individuals whose enrollment status has changed, update the eligibility information in the Contractor's data system, and take appropriate action as outlined below. The NCPDP Post Adjudication Standard 3.0 format shall be used for encounter reporting sent to TennCare. If the Contractor has been billed for any claims for a recipient who was deceased at the time the service was allegedly provided or who is no longer eligible for TennCare, then the Contractor

shall be required to recoup monies paid to any provider and to repay any monies collected by the Contractor for the claims that were paid post date of death or post eligibility for enrollment. On a monthly basis, the Contractor shall report the amount recouped by the Contractor and the amount to be repaid to TennCare. In addition, the Contractor shall reimburse TennCare monthly for monies owed to TennCare as a result of billing for recipients not eligible to receive services. Failure to report monthly and/or reimburse TennCare monthly may result in liquidated damages set forth in Attachment C.

i. Quantity of Service - The system shall validate claims to ensure that the quantity of services is consistent with TennCare policy and/or rules (i.e., verify that drug specific minimum and maximum quantity limitations, as well as days supply and number of prescriptions per month limitations, if imposed, are followed as described by TennCare).

j. Rejected Claims - The system shall determine whether a claim is acceptable for adjudication and reject claims that are not.

k. Third Party Liability/Coordination of Benefits - The Contractor shall obtain current information regarding recipients' other health insurance coverage, and perform daily updates to a third party liability (TPL) file. The TPL file shall then be used to enable the point of service (POS) system to validate claims to determine whether there is a liable third party. In situations where other insurance coverage is detected for the date of service, an edit would be generated at the POS prompting the pharmacy to process the claim through other existing third party coverage prior to processing the claim through the TennCare pharmacy benefit. The following information shall be included in the POS messaging, when available: Phone number for the primary third party insurer, Bank Identification Number (BIN), Processor Control Number (PCN), Group Number, and Cardholder ID. The POS system shall be able to process claims where there may be more than one (1) liable third party. In the event that the amount paid by the third party insurer(s) exceeds TennCare's maximum allowable, then the claim shall return a paid amount of zero ($0.00) through TennCare. In addition, the system shall allow pharmacies to override the TPL edit at the POS level with the use of standard POS Other Coverage Code (OCC) overrides. The Contractor shall provide pharmacy assistance with TPL edits/coordination of benefits (including use of OCC overrides) through the Technical Pharmacy Help Desk (described in Section A.8 of this Contract).

Pharmacy providers shall be educated by the Contractor regarding proper billing practices and carrier codes associated with NCPDP version D.0. The Contractor and the Contractor's POS system shall strictly adhere to state and federal laws and regulations and TennCare policy and/or rules regarding coordination of benefits and third party liability. TennCare shall be the payer of last resort.

The Contractor shall be required to provide TennCare with monthly TPL reports that, at a minimum, include the following information: number of claims hitting the TPL POS edit, total amount submitted for claims hitting the TPL POS edit, number of claims hitting the TPL POS edit that went on to be paid (either in part of in full) by TennCare, final amount paid on claims hitting the TPL POS edit, and number of claims processed with each type of OCC override. In addition, the Contractor shall provide TennCare with a monthly report of the top pharmacies utilizing the OCC override codes to assist in identifying providers who may be abusing these codes. In exchange for providing the TPL services described in this Section of the Contract, the Contractor shall receive payment in the amount of twelve and one-half percent (12.5%) of actual POS cost avoidance savings. Actual POS cost avoidance savings shall be determined on a monthly basis by claim level reporting. Savings shall be calculated only from claims where the TPL edit was the sole reason for claim denial.

l. Lock-in - The system shall have the capability to impose a "lock-in", as defined in Attachment A, such as pharmacy and prescriber benefit restrictions that apply to a given recipient. This includes, but is not limited to, lock-in conditions. Information inputted into the system for purposes of lock-in programs must be readily retrievable from the system for reporting purposes.

m. Managed Care Organizations - The system shall reject claims that are required to be processed and paid by a member's MCO for any and all medical benefits (when that MCO is responsible for those claims).

n. Early Refills - The systems shall be able to recognize when an enrollee attempts to refill a prescription (either the original prescription or a new prescription for the same drug) and require

that eighty-five percent (85%) or any other percentage threshold as directed by TennCare, or the original days supply has passed since the original filling. Overrides at the pharmacy level shall be permitted by the Contractor's Help Desk for drug categories as directed by TennCare, but monthly reports shall identify the enrollee and the pharmacy provider where such overrides occurred.

o. Tiered Co-pay Edit - A tiered co-pay structure shall be coded into the POS system. Initially, only two (2) tiers may be established. At a later date, a more complex structure may be required by TennCare without any additional cost to TennCare.

p. Gross Amount Due (GAD) Edit – Reimbursement logic shall compare the sum the ingredient cost and dispensing fee to the submitted GAD amount and pay the less amount.

q. Maximum Dollar Amount Edit – All pharmacy claims over a specified dollar amount per claim shall reject at the POS and the pharmacy provider shall be required to call the Contractor Call Center regarding rejected claims. This includes a two hundred fifty dollar ($250) limit on compounded claims (including intravenous compounds), a one thousand five hundred dollar ($1,500) limit on non-compounded, non-exception claims, and a forty thousand dollar ($40,000) limit on exception claims (blood factors and other identified products). The Contractor's system shall be capable of adding, changing, or removing maximum dollar edit rules at no cost to TennCare when requested by TennCare.

r. Prescriber Number Edit - The POS claims processing system shall be configured to require that all claims shall be submitted with the prescriber's NPI number. The validity of NPI numbers shall be determined by the most current data available from the National Technical Information Service.

s. Unit of Measure Edit - The Unit of Measure (UOM) edit shall perform two (2) main functions:

   i. Check incoming claim units (i.e., gram, milliliter, etc) versus the units listed in Reporting System for that particular NDC; and

   ii. Verify that the unit amounts transmitted is consistent with the unit amounts in Reporting System. The submitted quantity shall be a multiple of the unit size shown in Reporting System (i.e., claim shall be rejected if unit amount transmitted has been rounded). For example, the units transmitted is fourteen (14), but the unit amount is thirteen point seven (13.7) in the Reporting System.

t. Prescriber Last Name Edit -The claims processing system shall be set to ensure that the submitting prescriber's last name correctly matches the last name associated with the NPI number.

Throughout the term of this Contract, the Contractor shall be responsible for making recommendations to TennCare regarding the need for the edits, associated criteria and call center protocol development. The Contractor and TennCare staff shall agree upon criteria to produce a retrospective report containing findings and recommendations for prevention of such practices.

A.3.5. Prospective Drug Utilization Review (Pro-DUR)

The Contractor shall furnish a fully automated Prospective Drug Utilization Review (Pro-DUR) system that meets all applicable state and federal requirements including those identified in the OBRA 1990 and OBRA 1993. The Pro-DUR function shall meet minimum federal Drug Utilization Review (DUR) regulations as well as the additional specifications in this section and be flexible enough to accommodate any future edit changes required by TennCare. The Contractor shall prepare all CMS-required annual DUR reports.

The Contractor's system shall provide Pro-DUR services that apply TennCare-approved edits to all claims. The edits shall determine problems with a prescription and shall validate medical appropriateness of the prescribed drug by comparing the circumstances surrounding the request with established pharmacy-related therapeutic criteria.

The Contractor's POS system shall be capable of applying results of Pro-DUR processing in the claim adjudication process. Claims that reject as a result of Pro-DUR processing shall include situation specific messaging and error codes that enable the pharmacy provider to take appropriate actions. The Contractor may use an existing DUR package but shall be prepared to make any modifications required by TennCare. The Contractor shall work with TennCare in setting the disposition of Pro-DUR edits that may vary by type of submission (e.g., POS versus batch). The Contractor's system shall include the following minimum prospective drug utilization review (Pro-DUR) features at installation:

a. Potential Drug Problems Identification - The Contractor's system shall accept and use only TennCare-approved criteria and shall perform automated Pro-DUR functions that include, but are not limited to:

   i. Automatically identify and report problems that involve potential drug over-utilization;

   ii. Automatically identify and report problems that involve therapeutic duplication of drugs when the submitted claim is associated with other drugs or historical claims identified for a given enrollee;

   iii. Automatically identify and report problems that involve drug use contraindicated by age, gender and presumed diagnosis codes on historical claims for a given enrollee, or if requested by TennCare, based on actual diagnosis information provided by TennCare in a format mutually agreed upon by Contractor and TennCare;

   iv. Automatically identify and report problems that involve drug use contraindicated by other drugs on current or historical claims for a given enrollee (drug-to-drug interactions);

   v. Automatically indicate and report the level of severity of drug/drug interactions;

   vi. Automatically identify and report potentially incorrect drug dosages or limit the quantity per prescription to ensure the most cost-effective strength is dispensed.

   vii. Automatically identify and report potentially incorrect drug treatments;

   viii. Automatically indicate and report potential drug abuse and/or misuse based on a given members prior use of the same or related drugs; and

   ix. Automatically identify early refill conditions and provide, at the drug code level, the ability to deny these claims;

b. POS Provider Cancel or Override Response to Pro-DUR Messages – Prior to the final submission of POS pharmacy claims, the Contractor's system shall automatically generate Pro-DUR messages in a manner that shall enable a pharmacy provider to cancel submission of the claim or to submit it if it is a message that can be overridden.

c. POS Provider Comment on Pro-DUR Messages - The Contractor's system shall allow providers to enter responses utilizing NCPDP Professional Pharmacy Services (PPS) intervention codes in response to Pro-DUR messages. The system shall capture and store all NCPDP standard DUR conflict, intervention, and outcome messages for reporting to TennCare. The Contractor shall make changes to the PPS intervention configuration as directed by TennCare at no cost to the State.

d. Flexible Parameters for Generation of Pro-DUR Messages - The Contractor's system shall have the ability to transmit new or revised Pro-DUR messages and to define the Pro-DUR criteria that activate these messages. The system shall maintain a TennCare-controlled set of parameters to the situations involving generation of online Pro-DUR messages. The system shall provide and permit the use of all general system parameters regarding data access, support, and maintenance. Variables subject to TennCare definition and control include, but are not limited to: NDC code (including multiple NDC codes subject to potential drug/drug interaction); date of service; drug strength; drug quantity; daily supply; and Generic Product ID (GPI), Generic Drug Code (GCN) or Generic Sequence Number (GSN).

e. Pro-DUR Enrollee Profile Records - The Contractor's system shall provide and maintain enrollee profiles for Pro-DUR processing of submitted claims. Recipient profiles shall be based on inferred and actual diagnoses from pharmacy claims and other data available.

f. Disease/Drug Therapy Issues Screening - The Pro-DUR system shall have the capability to screen for drug therapy concerns by specific drugs relative to high-risk disease, to include but not limited to: cardiovascular disease; cerebrovascular disease; central nervous system disease; renal disease; endocrine disease; gastrointestinal disease; psychiatric disease; and respiratory disease.

g. Patient Counseling Support - The Contractor's system shall present Pro-DUR results to pharmacy providers in a format that supports their ability to advise and counsel members appropriately. The system shall be able to print out these instructions for the member.

A.3.6. Prescription Limits

a. The Contractor shall restrict the maximum number of claims per month that certain, specified recipients can receive under the TennCare benefit package. A "soft" limit restricts dispensing to the specified limit with the exception of drugs included on one of two lists (Auto Exemption and Prescriber Attestation) developed by TennCare. As of the beginning date of this Contract, the prescription limit applies to most adults, is calculated on a monthly basis and is set at five (5) prescriptions per month of which no more than two (2) may be brands.

b. Prescription Limit Overrides - The Contractor shall support two (2) mechanisms for allowing enrollees to get prescriptions beyond the limit. The first, known as the Auto-Exemption List, shall be developed by TennCare with the assistance of the Contractor and shall include products that shall never count against the prescription limit. The second, known as the Prescriber Attestation List, shall normally count against the prescription limit unless the prescriber calls the Contractor's Prior Authorization Call Center and obtains the necessary approval. The Contractor shall be responsible for developing the process to support both long and short term override capabilities.

The Contractor shall support any changes to the prescription limit process including, but not limited to: changes in the five (5) prescription/two (2) brand limit; changes in the Auto-Exemption or Prescriber Attestation lists; and changes to definitions of what constitutes a brand versus a generic at no additional cost to TennCare.

c. The Emergency Supply Override -The Contractor shall assure that the TennCare-POS systems allows pharmacists to execute an emergency override that shall process an emergency seventy-two (72) hour supply of drugs in normally covered therapeutic categories that are non-preferred or would otherwise require prior authorization. The Contractor's TennCare-POS system shall post a message for the dispensing pharmacist to contact the prescriber and suggest alternative therapies listed on the TennCare PDL. Drugs eligible for the emergency override shall be in a therapeutic class normally covered by TennCare. The Contractor's system shall allow for differentiation of drug categories that can be overridden by the pharmacist in the POS system and drug categories that the pharmacy shall call the technical call center for an override. The Contractor shall instruct pharmacy providers how to perform the emergency override in the National Council of Prescription Drug Programs (NCPDP) environment of the TennCare-POS pharmacy claims processing system. Failure of Contractor's POS systems to execute an emergency override for eligible drugs shall result in Liquidated Damages as set forth in Attachment C

d. Emergency Supply Copays – The enrollee shall not be charged a copay for the emergency supply. The emergency supply shall count against the monthly prescription limit. However, if later in the same month the provider obtains a Prior Authorization (PA) or changes to a drug not requiring a PA, the remainder of the prescription and /or the substitute prescription shall not count against the monthly prescription limit.

f. Number of emergency supply - Only one (1) seventy-two (72) hour supply shall be provided per patient, per prescription. Prescription refers to the entire course of therapy ordered by single prescription (i.e., first fill and subsequent refills included with the order for the first fill). In addition, only one (1) seventy-two (72) hour supply shall be provided per patient, per GSN, GPI, or industry equivalent, per month.

A.3.7 Pharmacy Claim Processing and Payments

The system shall process claims in accordance with existing TennCare policy and rules and Tennessee regulations for dispensing fees.

a. All payments for pharmacy claims shall be made through the Contractor's system and electronically invoiced to TennCare weekly. A pharmacy claim is a request for payment for a specific drug, typically at the NDC code level. An adjudicated pharmacy claim is one that has been processed to either a Payable or Denied status. An adjudicated claim also includes a claim that has been previously rejected and resubmitted by the provider and is later deemed either Payable or Denied.

b. Claims pricing is driven by the pricing methodologies described by TennCare rules and policies. Currently Average Wholesale Price minus thirteen percent (13%) is the payment for brand name and non-MAC'd medications. The system shall compare the calculated allowed (i.e., quantity multiplied by price plus the dispensing fee) to the billing charge and authorize payment based on the current TennCare pricing methodology. Most generic drugs and multi-source products shall be assigned Maximum Allowable Cost (MAC) prices by the Contractor, federal government or TennCare. The Contractor's system shall allow for such MAC price changes, as well as any other price adjustments submitted by the TennCare Pharmacy Director or his/her appropriate staff to be effective within two (2) business days. The Contractor's system shall allow the use of NCPDP standard Dispense as Written (DAW) codes, which shall be defined by TennCare.

   TennCare's claim pricing for generics and multi-source brands is based on the MAC pricing provided by the Contractor, or set by the Federal Government or TennCare. The Contractor shall be responsible to ensure that MAC pricing suggested to TennCare reflects current market conditions and price fluctuations. The Contractor shall provide documentation to TennCare upon request for any MAC price suggested to TennCare.

c. Specialty Drug Pricing— The Contractor shall be responsible to maintain a customized list of prices for all specialty drugs, as defined by TennCare. TennCare's claim pricing for specialty drugs is based on pricing provided by the Contractor. Contractor shall be responsible to ensure that specialty drug pricing suggested to TennCare reflects current market conditions and price fluctuations. The Contractor shall provide documentation to TennCare upon request for any specialty drug price suggested to TennCare, and shall make suggestions based on experience from other managed care and commercial clients, as to the products that should be considered for the specialty drug list.

d. Manual Pricing- The Contractor shall provide the services of licensed Pharmacists for calculating the reimbursement pricing using guidelines provided by TennCare, for certain prior authorized drugs (i.e., compounded prescriptions). The price established for the specific prescription shall be used to adjudicate claims for the patient, and not the price set in the system.

e. The system shall recognize all applicable copays or coinsurance and deduct that amount from the payment made to the pharmacy provider. The Contractor shall be required to report copay, coinsurance and deductible information to TennCare as required by TennCare and the TennCare manager of the TCMIS.

f. For the purposes of this Contract, an adjudicated claim shall not include a point-of-sale transaction that was canceled by the sender or a claim that was rejected before it could be fully adjudicated.

g. The Contractor shall be responsible for the preparation of any applicable tax information for service provider payments and the federal government (i.e., Form 1099).

h. The Contractor shall be able to support any/all changes to discount rates and standard pharmaceutical pricing methodologies (i.e., AWP, AMP, WAC, FUL) and incorporate them into pharmacy claim pricing policies at the sole discretion of TennCare with no additional cost.

A.3.8. Reversals and Adjustments

The system shall provide an efficient means of reversing or adjusting claims before and after the claim has been transmitted to the TCMIS. If reversed or adjusted, this additional claim information shall be transferred to TCMIS for further processing. TennCare shall not pay the Contractor for reversed, voided or adjusted claims. The Contractor shall process all reversals requested by TennCare's fiscal unit within thirty (30) days and provide confirmation to TennCare's fiscal unit upon occurrence. Failure to reverse or adjust claims within thirty (30) days may result in liquidated damages as set forth in Attachment C.

A.3.9. Manual Claims

a. TennCare's appeals unit may submit to the Contractor's manual claims unit, paper claims for those members who were eligible to receive pharmacy services at the time services were rendered. Manual claims may contain multiple products and/or services. Each manual claim shall include sufficient information to allow the Contractor to identify the member and the covered product and/or service, which information shall include, but not be limited: (1) the complete member name, including middle initial (if applicable); (2) the amount paid; (3) the name of the pharmacy that dispensed the prescription; (3) prescription fill date; (4) name of product; (5) amount of prescription dispensed; and (6) the number of days prescription was written for. In the event that the claim information does not include the data elements necessary for the Contractor to adjudicate a transaction using the TennCare POS system, the Contractor shall directly contact the applicable pharmacy, member and/or doctor in order to obtain sufficient documentation containing the missing information. Once the Contractor has received the necessary data elements, the Contractor shall enter the applicable data elements for each transaction into the TennCare POS system for adjudication. If the contractor does not receive the necessary data elements then they shall notify TennCare appeals unit within ten (10) calendar days from original receipt from TennCare appeals unit.

b. If the transaction is adjudicated by the TennCare POS system and such adjudication results in a "paid" status, the Contractor shall submit payment directly to the applicable member for the applicable Transaction using the address information contained in the TennCare POS system.

c. If the transaction is adjudicated by the TennCare POS system and such adjudication results in a "rejected" status, the Contractor shall inform the TennCare appeals unit. Contractor will then submit for prior authorization for these rejected claims and inform TennCare appeals unit of prior authorization approval or denial.

d. The Contractor shall resubmit those manual claims that have received prior authorization approval and shall submit payment directly to the applicable member for the applicable Transaction using the address information contained in the TennCare POS system.

e. The Contractor shall mail notice to member for all manual claims that could not be reimbursed.

f. The Contractor shall complete the process set forth in sections a thru e above within twenty one (21) calendar days.

g. Failure to meet the performance standards noted in this section may result in liquidated damages set forth in Attachment C.

A.4. TennCare Preferred Drug List (PDL)

The Contractor shall manage the PDL program in an ongoing manner, which assures that new drugs and clinical information are addressed appropriately. PDL changes will be reviewed by the TennCare Pharmacy Advisory Committee and coordinated with the Contractor's supplemental rebate offers. The Contractor shall assure that the PDL decision-making process is evidence-based, assures enrollee access to clinically superior drugs, and takes into account the relative cost of therapeutically equivalent drugs. The Contractor shall identify for TennCare therapeutic alternatives and opportunities for savings, including opportunities to promote competition to drive rebate bidding. The Contractor shall also make recommendations concerning therapeutic categories that should be avoided with regard to inclusion on the TennCare PDL.

The Contractor shall advise and update TennCare on all drugs in development, and all potential changes in the pharmacy marketplace potentially affecting TennCare's drug spend. The Contractor shall present to TennCare on a quarterly basis new market entries expected within the next sixty (60) to one hundred eighty (180) days, and new brand-to-generic market changes, along with recommendations on how to best manage these new entries and changes. The Contractor shall also design and implement a process that ensures that TennCare's choice of how the new product or change should be managed will become effective immediately as the change occurs.

A.4.1. Preferred Drug List (PDL)

a. The Contractor shall design, develop, implement, administer and maintain a PDL program for TennCare. On the date the Contractor assumes full responsibility for the pharmacy benefits program, the Contractor shall assume responsibility for administering and maintaining the existing PDL, including the existing prior authorization criteria. Most preferred drugs may be prescribed and dispensed with no prior authorization. Non-preferred drugs may be prescribed, but require prior authorization from the Contractor prior to being dispensed by the pharmacist and reimbursed. As the PDL is re-evaluated and/or expanded, the Contractor shall develop proposed prior authorization criteria for non-preferred drugs and certain preferred drugs and present those criteria to the TennCare Pharmacy Advisory Committee for review and input and to TennCare for final approval. The Contractor shall prepare and maintain a document suitable for printing or posting to the TennCare website providing the PDL listing and all applicable drug prior authorization (PA) criteria including step-therapy algorithms. Prior authorization criteria and procedures shall be fully disclosed to TennCare.

   The Contractor shall design, develop, implement, administer and maintain a listing of quantity limits for certain preferred and non-preferred drugs. This list shall be based on therapeutic best practices or opportunities to reduce the cost of the most appropriate dosage form. This list is distinct from the maximum tolerated to dose. Drugs and quantities on the quantity limits listing shall be included in the PDL documents and coded into the TennCare POS system.

b. The TennCare PDL shall be designed to maximize the prescribing and dispensing of safe and clinically effective drugs within each therapeutic class that are the most cost-effective. Conversely, the TennCare PDL shall ensure that more costly drugs, which do not have any significant clinical or therapeutic advantage over others in their class, are used only when medically necessary.

c. The Contractor's PDL design shall include a stringent clinical review of clinical guidelines and medical literature to identify which agents and classes of drugs shall be subject to the PDL program. Within the classes of drugs determined to be subject to the PDL, the Contractor shall determine which drugs within each class are safe, clinically effective, and provide equivalent clinical outcomes. Recommendations for inclusion on the PDL shall be based on a thorough review of clinical effectiveness, safety, and health outcomes, followed by an analysis of the relative costs of the drugs in each class under consideration.

d. Drugs within a reviewed class that are excluded from the PDL shall be considered non-preferred and require prior authorization by the Contractor's Prior authorization Unit in order to be dispensed to a TennCare member.

e. The Contractor shall establish policies and procedures describing the manner in which pharmaceutical manufacturer industry personnel contact appropriate Contractor staff. This should include specifying which Contractor staff may be contacted and the content of discussions when contact or visits take place. Further, the policies shall restrict contacts and visits to discussions related to the TennCare PDL and to appropriate pharmaceutical manufacturer personnel. The Contractor's policies shall guide the content of discussion and forum for such discussions with pharmaceutical manufacturers as they relate to the TennCare PDL. The Contractor's policies shall be approved by TennCare. Nothing in this Contract shall constrain the Contractor from engaging in contact with manufacturer personnel on behalf of other Contractor clients.

f. The Contractor shall design, develop, test and implement an electronic interface with the Contractor's POS pharmacy claims processing system to assure timely transmission and uploading (posting) of prior authorization data from the Prior Authorization Call Center to the TennCare-POS pharmacy system.

g. The Contractor shall monitor compliance with the TennCare PDL, report that information to TennCare monthly, and provide suggestions for improving PDL compliance.

h. Final decisions for inclusion or exclusion from the TennCare PDL shall be at the sole discretion of TennCare.

A.4.2. PDL Design, Development, and Implementation

a. The Contractor shall use pharmacoeconomic modeling and evidence-based data in the maintenance of the TennCare PDL that ensures clinically safe and effective pharmaceutical care and yields the highest overall level of cost effectiveness. The Contractor shall develop and submit to TennCare a schedule for review of the TennCare PDL (including addition of drug classes as appropriate) that meets the State's pharmacy program goals and timelines. The Contractor shall develop and present to the TennCare Pharmacy Advisory Committee the clinical and pharmacoeconomic review criteria the Contractor used to make recommendations regarding preferred and non-preferred drugs and the specific written guidelines/criteria to be used in the administration of the prior authorization of non-preferred drugs.

b. The Contractor's PDL development and criteria shall be coordinated with the Contractor's Prior Authorization Unit to ensure scaleable processes and minimize enrollee or prescriber impact.

c. The Contractor shall design, develop and implement an ongoing, broad-based educational effort to ensure that prescribers and pharmacists are fully aware of the TennCare PDL and prior authorization requirements. Prior to the program implementation, the Contractor shall submit educational plans to TennCare for review and approval.

d. The Contractor shall ensure that the TennCare-POS pharmacy claims processing system fully integrates the TennCare PDL and prior authorization programs.

e. For the term of this Contract, the Contractor shall comply with all applicable federal and state statutes, regulations, rules and policy requirements and all applicable administrative rules, statutes, policies and guidelines.

f. The Contractor shall ensure that the TennCare PDL program and TennCare-POS system include provisions for:

   i. The dispensing of an emergency supply, as described and determined by TennCare policy, of the prescribed drug and a dispensing fee to be paid to the pharmacy for such supply;

   ii. Prior authorization decisions to be made within twenty-four (24) hours and timely notification of the prescribing physician;

   iii. Prescriber and pharmacy provider education, training and information regarding the TennCare PDL prior to implementation of any changes, and ongoing communications to include computer and website access to information; and

   iv. The Contractor shall ensure that all prescribers and pharmacy providers have timely and complete information about all drugs on the TennCare PDL. The Contractor shall make such information available through written materials, internet sites, and electronic personal data assistants (PDA).

g. The Contractor shall support the management and coordination of all activities related to the maintenance of the TennCare PDL. Activities shall include but not be limited to the following:

   i. The Contractor shall present to the TennCare Pharmacy Advisory Committee clinical reviews of new brand-name drugs and new generic drugs for clinical safety and efficacy, and make recommendations regarding possible inclusion in the TennCare PDL.

   ii. The Contractor shall annually review drugs within chosen therapeutic classes in order to affirm or change the recommendations to TennCare regarding supplemental rebate strategies.

   iii. The Contractor shall develop changes to review drug criteria for the TennCare PDL based on new clinical and pharmacoeconomic information. The Contractor shall conduct

class reviews of all existing therapeutic categories over a time-frame to be co-developed with TennCare.

iv. The Contractor shall analyze cost information relative to drug alternatives as they affect the TennCare PDL. The Contractor shall produce PDL compliance reports as described in A.11.

The Contractor shall manage the PDL timeline from preparing for the TennCare Pharmacy Advisory Committee meeting through follow up implementation. This timeline shall be co-developed with TennCare.

The Contractor shall implement changes to PDL, Step Therapy or prior authorization requirements within forty-five (45) days of approval from TennCare. Changes shall include modifications to the POS system and all supporting systems and documents. Such changes to the program shall require provider notification at least thirty (30) days prior to the implementation. TennCare shall approve all documents and identify the targeted providers for each notification.

A.4.3. Step Therapy

The PDL program shall also identify and promote the use of the most cost-effective drug therapy for a specific indication, regardless of drug class. On the date the Contractor assumes full responsibility for the pharmacy benefits program, the Contractor shall assume responsibility for administering and maintaining the existing Step Therapy program. As the PDL is revised, the Contractor shall recommend changes or additions to the existing Step Therapy program. These recommendations should be based on therapeutic best practices and drive utilization to the most cost effective agents or classes. Drugs and criteria included in the Step Therapy program shall be included on the PDL documents and coded into the TennCare POS system.

The POS system shall be coded to edit on all drugs in the target classes that are being submitted for dispensing. Before the new drug may gain approval through a PA, there shall be evidence in the claims history of prior use of a drug in a more cost-effective class. This also includes a capability requirement to establish prior authorization criteria that cannot be handled with system edits but shall require calls to the Contractor's call center. The Contractor shall be responsible for making recommendations to TennCare regarding the need for such criteria and for subsequent criteria and call center protocol development. TennCare shall have the final decision on the method and timing of implementation.

The Contractor shall assure that the Call Center staff shall be available to evaluate prior authorization requests per the standards required in Section A.7 of this Contract. An agreed upon set of edits and PA criteria shall be implemented on the date the Contractor assumes full responsibility for the pharmacy benefits program. Additional edits of this type may be implemented at TennCare's direction at any point in the term of this Contract without additional cost to TennCare.

A.4.4. TennCare Pharmacy Advisory Committee

The Contractor shall attend, support and facilitate meetings of the TennCare Pharmacy Advisory Committee (PAC) as necessary to maintain the TennCare PDL. Such support shall include the responsibility to develop drug class reviews, prior authorization criteria, quantity limits and step therapy recommendations. The Contractor shall coordinate with TennCare to determine quarterly dates for the PAC meetings. The Contractor shall also be responsible for arrangements for meeting facilities, distribution of meeting materials and preparation of meeting minutes. No less than ten (10) business days prior to the scheduled PAC meeting, the Contractor shall have the meeting materials approved by TennCare and distributed to committee members. Meeting minutes are to be taken by Contractor and the draft copy shall be available for review by the appropriate TennCare staff no more than two (2) weeks after the scheduled PAC meeting. After approval, the draft minutes shall be disseminated to PAC members for approval at the next regularly scheduled PAC meeting. After approval of the minutes they shall be posted on the TennCare and Contractor's dedicated websites. The TennCare Pharmacy Advisory Committee make up and duties may be found at Tennessee Code Annotated (TCA) § 71-5-2401, *et seq.* Failure to attend, support, and facilitate meetings of the PAC in accordance with the requirements of this Contract may result in liquidated damages as set forth in Attachment C.

The Contractor's clinical staff shall present to the TennCare Pharmacy Advisory Committee drug class reviews for new or existing drugs and new indications that might affect their inclusion in the TennCare PDL.

a. The primary function of the drug class review is to assist TennCare and the TennCare Pharmacy Advisory Committee members in determining if the drugs within the therapeutic class of interest can be considered therapeutic alternatives.

b. PDL reviews are therapeutic comparisons - PDL drug class reviews should assess a drug or class's place in therapy, including comparisons to other drugs outside the drug class in question.

c. The PDL reviews may also make recommendations for other program initiatives such as development of DUR criteria, prospective edits, step therapy edits and prior authorization.

e. The Contractor shall monitor compliance by prescribers and pharmacists with the TennCare PDL, report that information to TennCare monthly, quarterly, and semiannually, and provide suggestions for improving PDL compliance.

f. Meeting facility costs, as well as meals, lodging and mileage reimbursement for PAC members will be paid by the State. Costs for production of materials will be paid by the Contractor. Postage will be a pass through cost.

A.4.5. Rebate Administration

The Contractor shall process, invoice and collect federal (OBRA, CMS) and supplemental rebates through the Contractor's rebate administration systems, and shall assume all responsibility for uncollected receivables at the time of the contract date. The Contractor's system shall be capable of payment tracking and reconciliation and dispute resolution for disputes related to federal and supplemental rebate unit issues and utilization. The Contractor shall import historical quarterly rebate data into their rebate management system, provided by TennCare's current rebate vendor. The Contractor shall assume all administrative and management tasks associated with rebates for historical quarters as well as future quarters occurring during the contract period. The Contractor shall generate and issue quarterly invoices for federal and supplemental rebates. The Contractor shall provide the designated TennCare staff data files that contain the specific information and in the specified format as required by TennCare. The quarterly rebate invoices shall be generated for all pharmaceutical manufactures and TennCare approval by thirty (30) days after the receipt of the quarterly CMS file for supplemental rebates and by sixty (days) for federal rebates. Failure to generate quarterly supplemental and federal rebate invoices may result in liquidated damages as set for thin Attachment C.

The Contractor shall accept medical claims data from TennCare, in a format mutually agreed upon by both parties, and shall submit paid claims for physician-administered drugs for federal and supplemental (if applicable) rebates. Contractor shall assume all of the same responsibilities for the submission and collection of federal and supplemental rebates for physician-administered drugs as outlined in the preceding paragraph.

The Contractor shall ensure that claims received and paid from pharmacies contracted as 340B providers, are not submitted for federal rebates if such claims are flagged as 340B claims.

The Contractor shall ensure that written notifications are sent to Drug Manufacturers concerning past-due rebate payments for undisputed account balances. Past-due balances shall be identified when they are at forty-five (45), seventy-five (75) and ninety (90) days of delinquency. Notifications shall be issued within five (5) days of delinquent date for supplemental rebates. TennCare shall be copied on all past-due notifications. The Contractor shall ensure that all drug manufacturers are charged interest as stipulated in each supplemental drug rebate contract and shall send notices to remind the drug manufacturers that interest shall be assessed on all past due accounts as stipulated by their contract with the State. Failure to charge interest as stipulated in each manufacturer's respective supplemental drug rebate contract and send the notices as scheduled may result in liquidated damages as set forth in Attachment C. The Contractor shall

provide TennCare with monthly reports, due ten (10) business days after the end of the month for the reporting period, detailing past-due notifications sent to drug manufacturers. Failure to provide reports of past-due notifications sent to drug manufacturers may result in liquidated damages as set forth in Attachment C.

Dispute resolution pertaining to units billed for supplemental rebates shall be done by the Contractor based on unit resolution performed on CMS Rebates. The Contractor shall perform all dispute resolution activities with pharmaceutical manufacturers pertaining to supplemental rebate calculations and collections. The Contractor shall present for TennCare approval remedies for all disputes within ninety (90) days of dispute. TennCare shall have final approval of all settlements negotiated. Failure to provide TennCare with an analysis of all disputes and remedies within ninety (90) days of dispute may result in liquidated damages as set forth in Attachment C.

One hundred percent (100%) of all monies collected on behalf of the State,shall be remitted to the State. The Contractor agrees that all rebates collected on behalf of the State shall be collected for the sole benefit of the State's share of costs, and that no other monies other than rebates shall be collected based on the State's program

The Contractor shall provide to the agency or business of the State's choosing, any and all appropriate, accurate, and balanced pharmacy level claims data needed to resolve or avoid any Medicaid or supplemental drug rebate disputes. This pharmacy level claims data shall be provided within fifteen (15) business days of the request by TennCare. Failure to provide pharmacy level claims data as scheduled may result in liquidated damages as set forth in Attachment C.

A.4.5.1 Supplemental Rebates

a. The Contractor shall negotiate supplemental rebates through an open competition process within specific drug classes, thereby encouraging maximum participation among manufacturers. The Contractor shall negotiate supplemental rebates with pharmaceutical manufacturers as part of the TennCare PDL program. The resulting contract, negotiated by the Contractor and approved by TennCare, regarding supplemental rebates shall be between the pharmaceutical manufacturer and the State. The Supplemental Rebate Contract shall be written using the template that is approved by CMS. Such agreements shall be in a format agreed to by TennCare and approved by CMS. TennCare shall review and approve agreements before execution. The Contractor shall establish and operate a process for accurate reporting and monitoring of negotiated supplemental rebate payments and perform all supplemental rebate dispute resolutions to maximize collections for the State.

b. The Contractor shall include diabetic supplies such as syringes, lancets, strips, glucose control solutions and glucose testing monitors in the TennCare-POS pharmacy claims processing system and PDL. For this category, the Contractor shall provide TennCare a class review, preferred product recommendation and supplemental rebate offer similar to that provided for pharmaceutical agents.

c. The Contractor, if required by the State, shall provide annual opportunities for manufacturers to amend supplemental rebate agreements. However, nothing in this Contract shall prevent a manufacturer from offering supplemental or enhanced rebates or amendments to existing supplemental rebates at any time. The Contractor shall report to TennCare, on a time schedule and in a format specified by TennCare, the results of those negotiations and their clinical and fiscal impact on the PDL. TennCare shall have final approval on all supplemental rebate agreements and amendments.

d. The Contractor shall, concurrent with the development of the PDL, conduct meetings with TennCare to develop and analyze the different potential supplemental rebate strategies with the designated pharmaceutical manufacturers.

e. The Contractor shall provide TennCare with access to all supplemental rebate contracts and related documentation. This shall include quarterly analysis by therapeutic category including the net cost per drug entity in the category including the demonstration of how that net cost was achieved. This report shall include all Therapeutic Categories, regardless of whether Supplemental rebates are paid or not.

f. The Contractor shall ensure that supplemental rebates are in addition to federal rebates as required by Section 1927 of the Social Security Act and complies with CMS guidelines, regulations and policies.

g. The Contractor shall maintain the State's supplemental rebate contracts confidentially and separate from its other clients. The Contractor shall propose a plan for securing and maintaining the supplemental rebate contracts and related confidential information in a format agreed to by TennCare. TennCare shall approve confidentiality agreements.

h. The Contractor shall perform supplemental rebate calculations including National Drug Code (NDC) information and invoice the manufacturers within thirty (30) days after receipt of the quarterly CMS file. The invoices shall be approved by TennCare and contain information sufficient to minimize disputes and comply with supplemental rebate contracts.

k. One hundred percent (100%) of the supplemental rebates collected pursuant to implementation of the TennCare PDL, on behalf of the State, shall be remitted to the State. The Contractor agrees that all rebates collected on behalf of the State shall be collected for the sole benefit of the State's share of costs.

l. In a format agreed to by TennCare, the Contractor shall provide to TennCare monthly and on request reports (ORRs) on the performance of the TennCare PDL and supplemental rebates.

m. The Contractor shall consider a variety of potential rebate strategies and shall compare and contrast for the State the clinical and economic ramifications of each strategy for the State.

n. For the term of this Contract, The Contractor may, on behalf of the State and with the prior approval of the State, assemble or join a multi-state pharmaceutical purchasing coalition or cooperative in order to maximize the State's purchasing power.

o. Inclusion into the State's PDL shall be based on lowest net cost to the State in a product category over a two (2) year projection, and not highest supplemental rebate achievable.

p. In cases where a product has demonstrated a clear clinical superiority, as defined by the TennCare Pharmacy Advisory Committee majority vote and State agreement, that product shall receive PDL status regardless of supplemental rebates.

q. In cases where a product has demonstrated a clear clinical inferiority, as defined by the TennCare Pharmacy Advisory Committee majority vote and State agreement, that product shall receive non-PDL status regardless of supplemental rebates.

r. During PDL transition a minimum of three (3) months and maximum of six (6) months shall be required to transition users of maintenance medications to different PDL agents. During their negotiations with pharmaceutical manufacturers. the Contractor shall make all attempts to include contract language which requires the manufacturer to continue to pay supplemental rebates during transitions from the placement of their product, to another manufacturer's product on the PDL.

s. Changes in drug category PDL status shall be made no more than once in any two (2) year period of time.

t. Failure to achieve program effectiveness may result in liquidated damages as set forth in Attachment C.

A.4.5.2 <u>Supplemental Rebate Incentive</u>

a. The Contractor shall be responsible for maintaining the effectiveness of their supplemental rebate program as described in the RFP response and reflected in Section C.3.

b. The formula for calculation of supplemental rebate program effectiveness shall be the sum of all supplemental rebates collected for claims paid on an annual basis divided by total pharmacy reimbursement, projected to be Seven Hundred Eighty Million Dollars ($780 million) annually, less dispensing fees, for the same time period.

c. Any category in which the State decides to forgo Sections A.4.5. the category shall, by mutual consent of the State and Contractor, be removed from the supplemental rebate calculation for both supplemental rebates collected and category cost.

d. On an annual basis the percentage of effectiveness of the supplemental rebate program shall be measured against the Contractors response to the RFP as stipulated in Contract Section C.3. The Contractor shall be allowed a two percent (2%) deviation from its response. For example, if the Contractor bid six percent (6%) for supplemental rebate percentage, the allowable range shall be four to eight percent (4 - 8%). Rebates shall be calculated on the basis of any rebates obtained outside of the OBRA rebates. Failure to achieve supplemental rebate within this range will result in liquidated damages as set forth in Attachment C. Annually, if the Contractor exceeds the upper figure of the allowed supplemental rebate percentage range they shall receive an annual incentive based on the following table:

Exceed by less than one percent (1%)	One hundred thousand dollars ($100,000)
Exceed by more than or equal to one percent (1%), but less than two percent (2%)	Two hundred thousand dollars ($200,000)
Exceed by more than or equal to two percent (2%), but less than three percent (3%)	Three hundred thousand dollars ($300,000)
Exceed by more than or equal to three percent (3%)	Six Hundred thousand dollars ($600,000)

e. Collection of the supplemental rebates for claims billed by May 31, 2013 shall be the obligation of the Contractor of record as of May 31, 2013.

f. The calculation will occur one hundred eighty (180) days after initial billing of a full year is complete. Rebates for that year collected after the calculation date will be accounted for in the next year. At the calculation date, if outstanding invoices for rebates would account for a substantial change in the rebates collected, then upon mutual agreement the State and the Contractor can set a new calculation date not to exceed ninety (90) days from the initial calculation date.

g. Changes in reimbursement methodology that result in a two percent (2%) or greater change in reimbursement amount shall result in a corresponding recalculation of the guaranteed rebate percentage to be mutually agreed upon by the Contractor and the State. This shall only apply to changes in methodology such as calculation on a standard other than AWP, or change in the AWP discount from thirteen percent (13%), or other industry changes affecting federal rebates which correspondingly may affect supplemental rebates, that may arise during the Contract period that neither party were able to anticipate in advance. Changes in prices for individual products shall not be included for purposes of adjusting the guaranteed rebate percentage.

A.5. **TennCare -Technical Requirements**

A.5.1. TCMIS Interface- Operation of the TennCare-POS requires ongoing interfaces with TCMIS. The Contractor shall coordinate with TennCare to design and maintain an effective interface between TCMIS and the Contractor's system for pharmacy claims processing, Pro-DUR and financial systems.

a In order to ensure the security and confidentiality of all transmitted files, the Contractor shall have a system that establishes a dedicated communication line connecting TCMIS to the Contractor's processing site. The cost of this communication line is to be borne solely by the Contractor. This dedicated communication line shall meet specifications of the TennCare Bureau, OIR and the State of Tennessee.

i. All circuits, circuit terminations and supported network options are to be coordinated through the TennCare Director of Information Services, TennCare, 310 Great Circle Road, Nashville, Tennessee 37243.

ii. Contractor shall contact the TennCare Director of Information Services before placing all line orders.

iii. Contractor shall be responsible for providing compatible mode table definitions and NCP configurations for all non-standard system generations.

iv. Contractor shall be responsible for supplying both host and remote modems for all non-State initiated circuits.

v. Dial-up access into production regions shall be prohibited.

b. After the pre-implementation conversion process, transaction data that changes baseline TCMIS files shall be transferred to the Contractor's system on a daily basis unless TennCare approves a less frequent schedule. The system design shall be finalized during the (DDI) phase and shall result in the daily update of the TennCare-POS system with the most current information from TCMIS. This may include, but not be limited to: recipient eligibility, prior authorization information, provider, and reference information.

c. The format of the data exchange shall be determined during DDI and shall resolve any incompatible data format issues that may exist between the Contractor's system and TCMIS. TCMIS may be modified to expand certain fields. Although no significant changes to TCMIS file structures are anticipated, the TCMIS may be enhanced to improve data compatibility between the POS environment and TCMIS. The Contractor shall make changes as needed, at no cost to TennCare.

d. Daily batch files shall be transmitted from TCMIS to the Contractor and from the Contractor to TCMIS. The transmission from TCMIS may contain, but not be limited to: recipient and provider eligibility records, claim history, prior authorization information and drug formulary information (Procedure Formulary File or PFF). The recipient identification number is a nine (9) byte record and is the key indicator for the eligibility record. This number is constant for a given recipient. The transmission of data from the Contractor to the TCMIS shall contain records of processed, adjudicated and paid claims.

e. The Contractor shall be required to notify TennCare, in a manner agreed to by TennCare each time a file is received from TennCare in order to verify transmission and receipt of the files.

A.5.2 <u>POS Network Interfaces</u>

a. At initial system implementation, data transmissions between the TennCare-POS and the pharmacy providers shall be in National Council on Prescription Drug Programs' (NCPDP) most current version. As updates to the NCPDP format become available, the TennCare-POS Contractor shall maintain compatibility both with Providers using the updated version and those using the superseded versions. Compatibility maintenance for each superseded version shall continue until the updated version becomes generally available and TennCare has approved discontinuation of such maintenance.

b. The Contractor shall support pharmacy providers in their interaction with the TennCare-POS and coordinate with network vendors to ensure smooth operation of the TennCare-POS with the commercial pharmacy POS environment. At the date of the release of the RFP, there are approximately sixteen hundred (1,600) pharmacy providers in Tennessee in the TennCare Participating Pharmacy Provider network, along with an additional over thirty thousand (30,000) chain and specialty providers outside of Tennessee. The Contractor shall establish testing procedures and certify provider practice management systems (i.e., "switches") as compatible and ready to interface with the TennCare-POS. The Contractor shall not be required to supply hardware or software to pharmacy providers.

c. The Contractor may not use its position as the TennCare pharmacy claims processing agent to create barriers to providers, or pharmacy practice management vendors who wish to participate in the TennCare-POS. The Contractor shall not charge connection or access fee to pharmacies or switching companies.

d. Federal regulations require TennCare to maintain appropriate controls over POS eligibility Contractors who perform both switching services and billing services. Switch and billing agent functions, if provided by the same company, shall be maintained as separate and distinct operations. If the Contractor acting as the TennCare-POS Contractor also provides services as the providers' agent, an organizational "firewall" shall be in place to separate these functions.

A.5.3 Batch Claim Submission Format and HIPAA Compliance

a. Pharmacy providers will use NCPDP format for submission of pharmacy transactions. The X12 837 Standard Claim format may be used at some point to allow institutional and professional claims to be submitted in batch electronic claim format so long as the batches are compliant with standards and formats published by TennCare, including the X12 837 and NCPDP formats promulgated by the Secretary of Human Services as specified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

b. The Contractor shall coordinate with TennCare to ensure that the electronic formats used for the TennCare-POS conform to present and future regulations as they exist during the term of this Contract.

A.5.4. TennCare-POS Interface Software- The Contractor shall provide software to allow TennCare to test the Contractor's system through the TennCare network. During the DDI Phase, TennCare shall test submission and receipt of NCPDP point-of-sale transactions. After implementation, and during the term of this Contract, TennCare shall test and audit performance of the system. An ongoing project plan shall be required to coordinate a software release schedule and detail how TennCare and/or TCMIS efforts are to be coordinated.

A.5.5. TennCare-POS System Availability Requirements- The Contractor shall ensure that the average system response time is no greater than ten (10) seconds for a minimum of ninety-nine and a half percent (99.5 %) of all transactions, seven (7) days per week twenty-four (24) hours per day. Cumulative system downtime shall not exceed two (2) hours during any continuous five (5) day period.

The TennCare-POS system shall be available twenty-four (24) hours per day, seven (7) days per week, for provider inquiry or billing purposes. Such availability shall include all normal forms of entry. The Contractor may have scheduled maintenance downtime that is pre-approved by the State.

A.5.6. System Maintenance and Modification Deadlines and Damages. System maintenance problems shall be corrected within five (5) business days or by a State-approved correction date. Failure to resolve system eminence issues in this timeframe shall result in liquidated damages as noted in Attachment C

A.5.7. System Security. The Contractor shall apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and the results shall be included in the Information Security Plan provided during the DDI phase. The risk analysis shall also be made available to appropriate Federal agencies. As determined by the State to be appropriate, the following specific security measures may be included in the system design documentation, operating procedures and State agency security program:

a. Computer hardware controls that ensure acceptance of data from authorized networks only;

b. Placement of software controls, at the Contractor's central facility, that establish separate files for lists of authorized user access and identification codes;

c. Manual procedures that provide secure access to the system with minimal risk;

d. Multilevel passwords, identification codes or other security procedures that shall be used by State or Contractor personnel;

e. All TennCare-POS software changes subject to TennCare approval prior to implementation; and

f. System operation functions segregated from systems development duties.

A.5.8. Disaster Preparedness and Recovery at the Automated Claims Processing Site. The Contractor shall submit the Contractor's Business Continuity/Disaster Recovery plan for their Central Processing Site to TennCare. If requested, test results of the plan shall be made available to TennCare. The plan shall be able to meet the requirements of any applicable state and federal regulations, TennCare and the State of Tennessee Office of Information Resources (OIR). Failure to submit the Business Continuity/Disaster

Recovery plan to TennCare upon commencement of claims processing and annually on the date of the initial claims processing may result in liquidated damages as set forth in Attachment C. Contractor's failure to comply with its Business Continuity/Disaster Recovery plan may result in liquidated damages as set forth in Attachment C.

a. After award of this Contract, but during the development of the Information Security Plan, a Contractor representative shall work in conjunction with a team member from both OIR and TennCare's TCMIS in order to ensure that the plan is compatible with TCMIS and TennCare policy and procedures and/or rules.

b. The Contractor shall include sufficient information to show that they meet the following requirements:

   i. Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation shall be in the form of a formal Disaster Recovery Plan. The Contractor shall apply recognized industry standards governing Disaster Preparedness and Recovery including the ability to continue processing in the event that the central site is rendered inoperable.

   ii. Employees at the site shall be familiar with the emergency procedures.

   iii. Smoking shall be prohibited at the site.

   iv. Heat and smoke detectors shall be installed at the site both in the ceiling and under raised floors (if applicable). These devices shall alert the local fire department as well as internal personnel.

   v. Portable fire extinguishers shall be located in strategic and accessible areas of the site. They shall be vividly marked and periodically tested.

   vi. The site shall be protected by an automatic fire suppressing system.

   vii. The site shall be backed up by an uninterruptible power source system.

c. The Contractor shall describe their secondary processing site and how quickly TennCare-POS operations can be transferred to that site. TennCare shall have direct, "read only" access allowing the designated staff to review the accuracy of TennCare data on the Contractor's system.

A.5.9. Program Integrity Requirements. The Contractor shall have TennCare-approved policies and procedures in place for ensuring protections against actual or potential fraud and abuse. The Contractor shall have a detailed Program Integrity Plan. The Program Integrity Plan shall define how the Contractor shall adequately identify and report suspected fraud and abuse by recipients, providers, by subcontractors and by the Contractor. The Program Integrity Plan shall be submitted yearly on the contract anniversary. The Contractor shall meet with TennCare and discuss the monitoring tools and controls necessary to protect against theft, embezzlement, fraudulent practices or other types of fraud and program abuse, and describe the type and frequency of training that shall be provided to detect fraud. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the State of Tennessee and/or federal laws and regulations. The Contractor's Program Integrity Plan shall address the following requirements:

a. Written Policies and Procedures. The Contractor shall develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards for the prevention, detection and reporting of incidents of potential fraud and abuse by members, providers, subcontractors and the Contractor.

b. Compliance Officer. The Contractor shall designate a Compliance Officer and a Compliance Committee, accountable to senior management, to coordinate with TennCare and other state agencies on any fraud or abuse case. The Contractor may identify different contacts for member fraud and abuse, provider fraud and abuse, subcontractor fraud and abuse, and Contractor fraud and abuse.

c. Training and Education. The Contractor shall establish effective program integrity training and education for the Compliance Officer and all Contractor staff

d. Effective Lines of Communication between Contractor Staff. The Contractor shall establish effective lines of communication between the Compliance Officer and other Contractor staff.

e. Well-Publicized Disciplinary Guidelines. The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines.

f. The Contractor shall review and summarize network pharmacy audit findings on a quarterly basis.

g. Internal Monitoring and Audit. The Contractor shall establish and implement procedures for internal monitoring and auditing. These activities and their reporting mechanism shall be defined in the Program Integrity Plan.

h. Process for Reporting Potential or Actual Fraud and Abuse. The Contractor shall provide information and a procedure for members, providers and subcontractors to report incidents of potential or actual fraud and abuse to the Contractor and to TennCare.

i. Development of Corrective Action Initiatives. The Contractor's program integrity plan shall include provisions for corrective action initiatives.

j. Time Frame for Reporting Fraud and Abuse to TennCare. The Contractor shall report incidents of potential or actual fraud and abuse to the TBI and TennCare within forty-eight (48) hours of initiation of any investigative action by the Contractor or within forty-eight (48) hours of Contractor notification that another entity is conducting such an investigation of the Contractor, network providers, or the members. All reports shall be sent to the TBI and TennCare in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities.

k. Cooperation with State and Federal Investigations. The Contractor shall cooperate with all fraud and abuse investigation efforts by TennCare and other state and federal offices.

l. Failure to comply with the Program Integrity Requirements as defined herein may result in liquidated damages as provided in Attachment C.

A.5.10. Proprietary and Confidential Information

a. All proprietary information, including but not limited to, provider reimbursement information provided to TennCare, shall be deemed confidential and not subject to disclosure under the Tennessee Public Records Act. 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 federal law, State law and ethical standards and 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 federal law, State law and ethical standards. Confidential information includes any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is supplied by TennCare to the Contractor or acquired by the Contractor on behalf of TennCare under this Contract.

b. Confidentiality of Records and Duty to Protect. Strict standards of confidentiality of records shall be maintained in accordance with federal and state laws and regulations and TennCare policies, procedures and rules. The Contractor shall exercise the same or greater level of care to preserve the confidentiality of the State's information as the Contractor exercises to protect its own confidential information so long as such standard of care does not violate the applicable provisions of the first paragraph of this section. Confidential Information (i) shall be held by the Contractor in strictest confidence at all times; (ii) shall not be disclosed or divulged by the Contractor to any person or entity, except those employees and agents of the Contractor who require access to such information, and only after those employees and agents have been instructed that the information is subject to the confidentiality obligations set forth herein; and (iii) shall not be used by the Contractor for any purpose not set forth herein or otherwise authorized in writing by TennCare. Contractor shall diligently exercise the highest degree of care to preserve the privacy, security and integrity of, and prevent unauthorized access to, the Confidential Information. Contractor ensures that it has established written policies and procedures relating to confidentiality, including the confidentiality of protected health information and eligibility information. Contractor ensures that it has implemented administrative, technical and physical safeguards and mechanisms that protect against the

unauthorized or inadvertent disclosure of confidential information to any person or entity outside its organization not in accordance with this Agreement.

c. The Contractor shall maintain the confidentiality of TennCare member information. Any information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, relating to individuals enrolled in the TennCare program ("TennCare enrollees"), or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained through the Contractor's performance under this Agreement, shall also be treated as confidential information to the extent that confidential status is afforded such information under State and federal laws or regulations. The Contractor shall ensure that access to this information shall be limited to the Contractor. The Contractor shall take measures to prudently safeguard and protect unauthorized use and/or disclosure of TennCare member information in its possession. The Contractor shall establish internal policies to ensure compliance with federal and state laws and regulations regarding confidentiality including, but not limited to, 42 Code of Federal Regulations (CFR) § 431, Subpart F, 42 United States Code Annotated (USC) §§ 1320d, *et seq.*, all applicable Tennessee statutes and TennCare rules and regulations. In no event may the Contractor provide, grant, allow, or otherwise give, access to TennCare member information to anyone without the express written permission of TennCare. In the event that information is used and/or disclosed in any manner, the Contractor shall assume all liabilities under both State and federal law.

d. The Contractor shall immediately notify TennCare of any and all occurrences were TennCare's Confidential information may have been breached and initiate appropriate action to prevent subsequent breaches. Failure to notify TennCare as required herein may result in liquidated damages as provided in Attachment C.

A.5.11. Third Party Administrator Requirement

a. The Contractor shall qualify as an Administrator (also described as "Third Party Administrator") in compliance with TCA § 56-6-401, *et seq.* and shall be licensed to operate as an adjuster or settler of claims in connection with pharmacy benefits coverage in the State of Tennessee and shall be capable of providing or arranging for health care services provided to covered persons for whom it received payment and is engaged in said business and is shall do so upon and subject to the terms and conditions hereof.

b. If during the term of this Contract, TennCare directs the Contractor, through a contract amendment. to operate as a risk-bearing entity for pharmacy services, the Contractor shall establish and maintain all financial reserves required by the Tennessee Department of Commerce and Insurance of HMOs, Third Party Administrator, or Prepaid Limited Health Services Organization licensed by the State of Tennessee, including, but not limited to, the reserves required by TCA § 56-32-112 as amended or Tennessee Code Annotated § 56-51-136 as amended. The Contractor shall demonstrate evidence of its compliance (or process of compliance) with this provision to the Tennessee Department of Commerce and Insurance, TennCare Division, in the financial reports filed with that Department by the Contractor.

A.5.12. TennCare Member Identification Cards

a. The Contractor shall provide each TennCare member with permanent pharmacy benefit identification (ID) card. This shall occur at least three (3) weeks prior to the commencement of the Contractor processing claims. The card shall comply with all state laws and NCPDP guidelines, as amended, regarding the information required on the card, as well as any other information required by TennCare, and must be approved by TennCare. In no event shall the Contractor print or otherwise include the individual TennCare enrollee's Social Security Number on any identification card required for the individual to access products or services provided under this Agreement. The Contractor shall provide pharmacy benefit identification cards for new TennCare members added to the TennCare eligibility file on an ongoing basis. The Contractor shall establish a process that allows enrollees to request replacement cards. Replacement and new cards shall be produced and mailed by the Contractor on the 15th day of each month. Failure to meet this requirement may result in liquidated damages set forth in Attachment C.

b. The Contractor shall establish and maintain a process to produce ID cards for new enrollees and issue replacement ID cards upon request from a TennCare enrollee. The Contractor shall be reimbursed for actual postage costs. Such costs shall be billed on a monthly basis to TennCare in addition to regular invoices and shall include substantiating documentation. The cost related to the production of the identification cards shall be included in the Contractor's base rate in this Contract.

c. Other mailings pursuant to this Contract shall be mailed first class unless otherwise directed by the State. The actual postage cost shall be a pass-through item and shall be billed on a monthly basis to the TennCare Bureau in addition to regular invoices and shall include substantiating documentation. Printing and supply costs are to be included in the base rate of this Contract. The Contractor shall not invoice TennCare for Contractor business operations.

A.5.13 Returned Mail

The Contractor shall open all returned mail from any mailings to enrollees or providers within thirty (30) days of receipt to determine if the enrollee has moved, if the Contractor has the wrong address, and/or if the enrollee is communicating other information to the Contractor or to TennCare. The Contractor shall track returned mail and shall report monthly to TennCare the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose mail was undeliverable due to an incorrect address provided by TennCare. This monthly report is due ten (10) business days after end of month of reporting period, beginning the first full month after the report format has been agreed to by all parties. Nothing in this section shall prevent the Contractor from sub-contracting responsibilities returned mail to a vendor approved by TennCare. Failure to report monthly to the Bureau or to open and appropriately manage returned mail may result in liquidated damages as described in Attachment C.

A.5.14 Website

The Contractor shall have available an up-to-date web-site dedicated to TennCare that shall aid providers and enrollees in all aspects of the pharmacy program. The web-site shall be available for TennCare approval at least one (1) month prior to the commencement of claims processing and be available on the internet two (2) weeks prior to the commencement of claims processing. The web-site shall contain a home page with general pharmacy information with links to dedicated areas for prescribers, pharmacists and enrollees. Each of these sections shall contain information that shall answer, in an interactive format, the majority of questions that each group would ask. This shall include, but it not limited to:

a. Home Page, which includes:

   i. General information related to pharmacy benefit, and recent changes occurring within the TennCare Pharmacy Program, including pertinent fact sheets;

   ii. Access to the Auto-exemption and Provider Attestation lists; and

   iii. An interactive Preferred Drug List (PDL) with links to Clinical Criteria, Step Therapy criteria, and Quantity Limits

b. Prescriber Page, which includes:

   i. An interactive preferred drug list (PDL) of the TennCare pharmacy program, complete with hot-links from drugs to the prior authorization (PA) criteria established for those drugs and also linked to drug specific PA facsimile forms and drug specific web-based PA application;

   ii. A search function which allows providers to enter a drug name and be routed to the drug in the interactive PDL;

   iii. Procedures for obtaining Prior Authorizations (PA's). Call Center hours of operation and contact numbers; and

   iv. Printable education material specific to prescribers.

c. Pharmacist Page, which includes:

i. An interactive inquiry system using pharmacy providers' identifying number (i.e. NCPDP, NPI, etc) to verify the status of pending payments, RAs, and other supported function(s) as deemed necessary by TennCare;

ii. An on-line listing of the Contractors MAC drug list; and

iii. Printable on-line pharmacy handbook and Provider Education Material specific to Pharmacist.

d. Enrollee Page, which includes:

i. A description of services provided including limitations, exclusions and out-of-network use;

ii. Information regarding what to do if the enrollee is unable to fill a prescription because PA is required, but has not been obtained, including information on the enrollee-initiated PA process;

iii. Printable education material specific to enrollees; and

iv. On-line search, by address or zip code, to locate the network pharmacies nearest to the enrollee.

A.5.15. The Contractor's system shall be a secure, HIPAA-compliant and data-encrypted electronic system. The system shall have the ability to be easily customized and have interactive communication capabilities to meet the needs of TennCare and its providers. The Contractor shall provide support and maintenance of the website and guarantee any data exchange between the Contractor and TennCare or its providers and enrollees shall be secure and compliant with current HIPAA guidelines concerning data encryption and/or password protection. TennCare shall transmit eligibility/enrollment information to the Contractor by the standard HIPAA 834 transaction defined by the TennCare Companion Guide. The Contractor shall use this information to immediately (no more than two (2) business days) identify those enrollees who have no limits, have no pharmacy benefit, or are subject to limits, and make necessary systems changes to process claims accordingly. The NCPDP 3.0 formats shall be used for encounter reporting sent to TennCare.

A.5.16. The Contractor shall participate in TennCare's E-Prescribe initiatives and provide needed, accurate data files to TennCare initially and on an ongoing basis, in the format and timeframes agreed to by TennCare, as required to support E-Prescribe. This may include, but is not limited to: electronic formulary files (denoting preferred and non-preferred drugs), electronic files denoting drugs requiring prior authorization (including specific PA criteria for each drug), electronic files denoting drugs with quantity limits (including specific information regarding the nature of such limits), weekly encounter files to update the E-prescribe platform, and links into the Contractors web-site for PA specific facsimile forms and criteria. The Contractor shall also coordinate the E-Prescribe initiatives within the pharmacy network it is managing for TennCare. Failure to provide accurate data files to TennCare in the format agreed to as necessary to support E-Prescribe may result in liquidated damages as set forth in Attachment C.

A.6. Drug Utilization Review and Provider Education

A.6.1. Retrospective Drug Utilization Review (Retro-DUR)

The Contractor shall provide TennCare with a Retrospective Drug Utilization Review (Retro-DUR) program. On a quarterly basis, the Retro-DUR system shall trend providers' prescribing habits and identify those who practice outside of their peers' norm. The Contractor's Retro-DUR system shall provide TennCare with provider practice analyses that include identification of prescribers who routinely prescribe non-preferred drugs. The Contractor's Retro-DUR system shall also identify patients who may be abusing resources through poly-pharmacy utilization patterns or visiting multiple providers. The Contractor shall produce reports that detail patient and prescriber trends and that identify potential quality of care problems and/or potential fraud and abuse. The Contractor's Retro-DUR system's intervention processes shall include, at a minimum, letter-based information to providers and a system for tracking provider response to the interventions. The Contractor shall prepare, for TennCare approval, provider letters containing information related to the operation of the TennCare pharmacy program

The Contractor shall have a qualified dedicated DUR Clinical Pharmacist prepare presentations and attend each quarterly meeting of the TennCare DUR Board to present Prospective DUR (Pro-DUR) and Retro-DUR data, findings, and as utilization data. The DUR Clinical Pharmacist shall be dedicated solely to the gathering of data, analysis of results, developing recommendations and presentation of such to TennCare and the TennCare DUR Board. The DUR Clinical Pharmacist shall schedule and conduct a Pre-DUR meeting with appropriate TennCare staff no less than four (4) weeks prior to the scheduled meeting. This pharmacist shall be outside the scope of the staffing section as noted in Section A.10. No less than ten (10) business days prior to the scheduled DUR meeting date, the DUR Clinical Pharmacist shall present to TennCare the proposed agenda and meeting materials for approval and later posting on the TennCare and Contractor's websites in compliance with Open Meetings Act (Sunshine Law) as defined in TCA § 8-44-101 *et.seq.* No greater than two (2) weeks after the DUR meeting, the DUR Clinical Pharmacist shall schedule a Post-DUR meeting with appropriate TennCare staff. No greater than four (4) weeks after the DUR meeting the meeting minutes shall be available for review.

The Contractor shall also implement a complete Retro-DUR program to be coordinated and maintained by the full-time DUR Clinical Pharmacist dedicated to TennCare and supported by provider educators who are Tennessee-licensed pharmacists and additional clinical reviewers who are also Tennessee-licensed pharmacists. In addition, the Contractor's dedicated DUR Clinical Pharmacist shall be responsible for the operation of the DUR Board including the recruitment of DUR Board members, with consultation from TennCare.

Failure to provide meet these requirements may result in liquidated damages as set forth in Attachment C.

A.6.1.1. Description of the Operation of the Retro-DUR Program -The Contractor shall provide to TennCare all necessary components of a Retro-DUR program and shall operationalize those as specified in 42 CFR 456.716:

a. Establishment of a Drug Utilization Review (DUR) Board as follows:

i. The Contractor's DUR Clinical Pharmacist shall recruit and maintain a DUR Board composed of five (5) physicians, five (5) pharmacists, one (1) nurse practitioner alternating with one (1) physician assistant as suggested by the Contractor and approved by TennCare. The Board composition shall comply with 42 CFR § 456.716(b). Board participants shall be required to submit a TennCare approved conflict of interest statement on an annual basis. Term lengths shall be staggered, as necessary, to assure only partial turnover of members in any given year.

ii. Selection of DUR Board members shall be based on medical and pharmacy expertise and willingness to serve in this capacity and provide the services specified by TennCare in writing. Members shall be required to be available for quarterly meetings and to review drug information and drug utilization materials as necessary to improve patient quality of care, to prevent fraud and abuse, and to control the costs of drug utilization;

iii. The Contractor shall determine quarterly dates for the DUR Board meetings, schedule the meeting location and determine the agenda for those meetings. Minutes for those meetings shall be taken by Contractor and the draft copy shall be available for review by the appropriate TennCare staff no later than four (4) weeks after the scheduled DUR meeting. After approval, the draft minutes shall be disseminated to DUR Board members for approval at the next regularly scheduled DUR Board meeting. After approval of the minutes they shall be posted on the TennCare and Contractor's websites. The DUR Clinical Pharmacist shall prepare the following reports/information, at minimum, for presentation or for reference at DUR Board meetings:

(1) TennCare utilizing-members data;
(2) TennCare utilization by age demographics;
(3) TennCare utilization by top ten (10) therapeutic classes determined both by number of claims and by payment amount;
(4) TennCare top ten (10) drugs as ranked by claim count and by total payment;

(5) Pro-DUR data including totals of Pro-DUR messages sent and savings associated with the top ten (10) drugs associated with each Pro-DUR edit;
(6) Retro-DUR intervention analysis and cost savings information as associated with both member profile review and interventions and provider profile review and interventions;
(7) Reports and presentations should convey rolling twelve (12) month trends:
(8) Distribution of Clinical Alerts as prepared monthly by the Contractor's Clinical Management staff;
(9) Pharmacy lock-in summary level reports, and
(10) Additional reports, as requested by TennCare or the DUR Board.

iv. The process of selecting DUR Board members shall incorporate suggestions concerning pharmacy providers from the Tennessee Pharmacists Association (TPA) and physicians with the Tennessee Medical Association (TMA) and/or other provider associations as designated by TennCare;

v. The DUR Clinical Pharmacist shall consult with TennCare to obtain approval for the DUR Board appointments;

vi. The primary role of the DUR Board shall be to provide program oversight and advice concerning provider education initiatives and current or proposed DUR POS edits outlined in 42 CFR § 456.716. The DUR Board shall not be involved with PDL coverage decisions but shall be notified of current PDL changes; and

vii. The Contractor shall send all DUR Board members a letter explaining that the responsibility for the Retro-DUR program is being transitioned to the Contractor. New members shall receive a Letter of Appointment that specifies the lengths of the appointment term.

b. Recruit, maintain, and reimburse a panel of clinical pharmacists sufficient to review member profiles as noted in section A.6.1.1.e. below. The clinical pharmacists shall recommend appropriate interventions related to each profile reviewed.

c. Develop, maintain and update a set of evidence-based clinical criteria that shall meet all CMS requirements and that shall be used to detect potential problems such as polypharmacy and related over-utilization, underutilization, drug-to-drug interactions, therapeutic duplications, incorrect drug dosage and duration of treatment, possible fraud and abuse issues, and other instances of inappropriate drug therapy as may also be related to a member's age or disease state.

d. With input from TennCare and the DUR Board, the Contractor shall determine the focus of and generate data through the clinical criteria noted in Section A.6.1.1.c. above for each of four (4) quarterly provider profile runs and each of twelve (12) monthly member profile runs. Quarterly provider profile reviews shall be completed and results/interventions distributed to prescribers within ninety (90) days of the end of the quarter. Monthly member profile reviews shall be completed and results/interventions distributed to prescribers within sixty (60) days of the end of the month.

e. After approval by TennCare of the focus of, and methodology to be used in, the member profile reviews, the Contractor shall produce eight hundred (800) member profiles per month, or a minimum of two thousand four hundred (2,400) member profiles per calendar quarter, and distribute to clinical reviewers for review and determination of appropriate interventions to be taken. Any summaries, correspondence or other documents produced as a result of the review process shall be approved by TennCare prior to their distribution.

f. After approval by TennCare of the focus of, and the methodology to be used in, the provider profile reviews, the Contractor shall produce two thousand, four hundred (2,400) provider profiles per calendar quarter and determine appropriate interventions to address any potential problems identified during profile review. Unlike member profiling, provider profiles need not reviewed by

clinical reviewers, as they simply detail members for whom a prescriber or pharmacy provider has prescribed or dispensed a medication under review for the calendar quarter.

g. Implement interventions designed to address problems identified during profile review. These interventions shall include at a minimum mailings sent to prescribers or pharmacy providers, but phone calls or visits may also be conducted if appropriate and/or upon the direction of TennCare. Mailings shall consist of an intervention letter to the prescriber or pharmacy provider detailing the reason for the letter, the purpose of the intervention and providing educational information. Member profile(s) illustrating the potential problem and suggesting corrective action may also be included, along with a provider response form seeking input for the value of the intervention. The postage associated with these mailings shall be reimbursed by TennCare as a pass-through cost. Interventions regarding possible fraud and abuse shall be reported to TennCare on the report referenced in E.30.

h. Maintain a system capable of tracking all interventions, both letters and direct communication, and determining cost savings related to the specific interventions. This system shall also record input received from providers regarding the value of the intervention.

i. The Contractor shall establish and maintain a toll free telephone number and voice mail box to receive provider responses to Retro-DUR notices. The DUR Clinical pharmacist shall be responsible for management of call backs from the inquires received through this telephone number and voice mail box.

j. Report quarterly or as requested by the DUR Board to the DUR Board on monthly member reviews and quarterly provider reviews to include interventions taken, responses, and outcomes.

k. Produce an Annual Drug Utilization Review Report for the TennCare program using the annual CMS requirements as stated in 42 CFR § 456.712.

l. The Board may request additional reports as needed to conduct business as provided herein.

m. Failure to provide meet these requirements may result in liquidated damages as set forth in Attachment C.

A.6.2. Retro DUR Reporting System

a. The Contractor shall provide a reporting system that tracks the outcomes of the Retro DUR initiatives. TennCare's Retro DUR initiatives are mainly focused on improving care quality. The Contractor's system shall be able to track the impact of DUR initiatives by comparing specified data elements pre and post intervention. The data elements tracked will vary according to the focus of study and/or type of intervention employed and may include, but shall not be limited to:

i. Drug change within a sixty (60) or ninety (90) day period of the intervention;
ii. Total number of drugs pre- and post- intervention;
iii. Change in dose/dosing frequency of medication within a sixty (60) or ninety (90) day period of intervention;
iv. Daily dose of drug in question pre- and post- intervention;
v. Assessment of various interactions (as relevant to the activity) pre- and post- intervention which may include drug-drug interactions (e.g., number of drugs identified and severity index), pregnancy interactions, disease state interactions, therapeutic duplications, allergy interactions, and age-related medication problems;
vi. Compliance with national guidelines (e.g.., percentage of patients with CHF on beta-blocker, diuretic, etc.) depending on the disease state targeted by the RetroDUR initiative;
vii. Generic medication utilization;
viii. Emergency supply frequency;
ix. Prescription limit override frequency;
x. PDL compliance;
xi. Patient compliance;

xii. Hospitalizations and/or doctor visits pre and post intervention, and
xiii. Prescription and/or medical costs pre and post intervention.

A.6.3. Provider Education

a. The Contractor shall develop and implement ongoing educational programs for the TennCare provider community designed to improve provider awareness of TennCare pharmacy program policies and procedures and to assure PDL compliance by prescribers. These educational initiatives shall include, but not be limited to: provider letters, PDL distribution, POS messaging, training sessions, website postings of the PDL and other educational materials for prescribers. Prior to the go-live date the Contractor shall conduct educational meetings for providers in East Tennessee, Middle Tennessee, and West Tennessee. In each calendar year during the term of this Contract, the Contractor shall exhibit at Tennessee Pharmacist Association (TPA) and Tennessee Medical Association (TMA) meetings with an informational booth, and at The University of Tennessee's Spring Pharmacy Update meetings in all locations. a. The Contractor shall develop notification and education strategies for TennCare providers. Educational topics for prescribers shall include, at a minimum: PDL program intent; the process that was used to develop the TennCare PDL and prior authorization criteria; how to access and use the PDL; how to access drug-specific prior authorization criteria; processes for obtaining prior authorization; prescription limits (including the associated auto-exemption list and the prescriber attestation process); other POS edits that may result in a prior authorization requirement; and the prescriber reconsideration process for denied prior authorizations. Educational topics for pharmacy providers shall include, at a minimum all those mentioned in the preceding paragraph as well as the requirements under the February 5, 2008 Order Amending Revised Consent Decree (Modified) issued in *Grier v. Goetz*, 424 F.Supp.2d1052 (M. D.TN 2008) and information concerning provision of the seventy-two (72) hour emergency supply in applicable situations.

b. The Contractor shall provide an information plan detailing education to TennCare providers regarding the TennCare PDL and associated prior authorization programs. The Contractor shall provide education and notification processes and methods designed to increase TennCare PDL compliance rates and minimize transition disruptions.

c. Upon TennCare approval, the Contractor shall develop and produce program material to be provided to TennCare for distribution and supplied directly by the Provider Educator to provider groups.

d. The Contractor shall implement the agreed upon communication strategies through direct involvement with prescribers and pharmacy providers and a combination of site visits, telephone support, internet-based application, and direct mail.

e. The Contractor shall develop a process or system to capture the activities of the field-based provider educators. On a calendar quarterly basis, the Contractor shall summarize, review and offer recommendations to TennCare regarding provider education.

A.7. Prior Authorization (PA) Unit

A.7.1. The Contractor shall operate a Prior Authorization (PA) Review Unit. A prior authorization shall be required for all non-preferred drugs or utilization of preferred drugs outside of established guidelines. These established guidelines can include, but are not limited to: Step Therapy; Clinical Criteria; Pro-Dur edits such as Drug-Gender and Drug-Drug interactions; quantity limits; etc.

a. Prior authorization services shall consist of prescription review by a licensed pharmacist or pharmacy technician to ensure that all predetermined clinically appropriate criteria have been met before the prescription may be dispensed and subsequently reimbursed. A clinical pharmacist shall be on duty (not on call) twenty-four (24) hours a day, seven (7) days a week. This Unit shall have the capacity to render clinical determinations, issue notices to requestors and make reconsiderations on a twenty-four (24) hours-a-day, and seven (7) days-a-week basis for approximately one million, two hundred thousand (1,200,000) covered lives.

b. The Prior Authorization Unit shall accept requests for prior authorization by telephone, facsimile, mail and through a web-based application. All prior authorization determinations shall be based on criteria approved by TennCare. The Contractor shall be responsible for the entire prior

authorization transaction, including initial determinations, handling complaints and reconsiderations, making final determinations associated with the TennCare PDL and other approved guidelines or processes and issuing notices in accordance with TennCare approved protocols. TennCare shall also approve the Contractor's process flow and notification format prior to implementation or changes. Operational criteria and updates shall be disclosed to TennCare on a regular basis for review and approval.

c. The Contractor shall provide TennCare with toll-free (in-state and out-of-state) telephone and facsimile numbers, appropriate mailing address for prior authorization requests, and web-site address sixty (60) days prior to the date the Contractor assumes full responsibility for the pharmacy benefits program. This toll-free number shall be transferable to TennCare upon termination of this Contract. The Contractor shall also distribute this/these number(s) to providers at all training and provider education sessions. It is anticipated that a significant number of the prior authorization requests for the TennCare PDL and other associated prior authorizations shall be received through the telephone system.

d. The Prior Authorization Unit shall effectively manage all contacts in an efficient manner. The Prior Authorization Unit shall provide an automated call distribution system with a greeting message when necessary and educational messages approved by TennCare while callers are on hold. The Prior Authorization unit shall install and maintain its telephone line in a way that allows calls to be monitored remotely by TennCare in real-time or retrieved if TennCare can provide the date, time, caller's number, or enrollee identification for the purposes of evaluating Contractor performance. The Prior Authorization Unit's telephone greeting shall include a message that informs callers that such monitoring is occurring.

e. Call monitoring by a third party, for accuracy and quality of information, shall be available at the Contractor's Prior Authorization Unit location and from the TennCare main office.

f. The Prior Authorization Unit shall ensure that there is a backup telephone and fax system in place that shall operate in the event of an interruption in operations of 10 (ten) minutes or longer, or other problems so that access to the Prior Authorization Unit by telephone and fax is not disrupted. The Contractor shall notify TennCare of any system or business interruption that is ten (10) minutes or longer in duration. In no event should the back-up telephone and fax systems be in an off shore site.

g. The Prior Authorization Unit shall provide sufficient telecommunications capacity to meet TennCare's needs with acceptable call completion and abandonment rates as specified in the performance standards below. This capacity shall be scalable (both increases and decreases) to demand in the future.

h. The Contractor shall ensure that qualified personnel responding to prior authorization requests are fully trained and knowledgeable about TennCare standards and protocols, have the capacity to handle all telephone calls, facsimiles and web requests at all times and have the upgrade ability to handle any additional call, facsimile or web request volume. The Contractor shall be responsible for adequate staffing and equipment at all times, especially during high peak times. Any additional staff or equipment needs shall be the responsibility of the Contractor. The Prior Authorization Unit shall provide licensed pharmacists during all hours of unit operation to respond to pharmacy related questions that require clinical interventions, reconsiderations and consultation, and provide physician support for responses to prior authorization request reconsiderations.

i. The Contractor shall design and implement a contact management and reporting system with capabilities to include an electronic recording of all calls and to provide a complete record of communication and documents from providers and other interested parties. The Contractor shall provide complete online access by TennCare to all computer files and databases that support the system for applicable pharmacy programs and develop, maintain, and ensure compliance with TennCare confidentiality procedures/policies, including HIPAA requirements, within the Prior Authorization Unit.

j. The Contractor shall be responsible for a Quality Assurance program that shall be in place to sample calls and follow up calls to confirm the quality of responses, and caller satisfaction. The Contractor shall be responsible for providing quarterly reports on the outcomes of the Quality

Assurance program, and any training required to assure adherence to PA criteria and consistent application of such criteria across all PA Unit staff.

k. The Contractor's staff shall assist TennCare with the development of clinical prior authorization review criteria. The Contractor shall develop drug-specific prior authorization forms for prescribers to use when sending a request via facsimile or via the web. The prior authorization forms shall be available to prescribers via web download or fax-on-demand. TennCare shall review and approve the PA request forms prior to distribution by the Contractor.

l. The Contractor shall develop a process by which every request for prior authorization is handled with the same procedure. This may be done by developing an algorithm/hierarchy for every PA that can be requested or other process developed by the Contractor and approved by TennCare.

m. The Contractor shall be responsible for meeting the following performance standards and is required to provide reports as required under Contract Section A.11.2 demonstrating that it has performed as follows:

i. The Prior Authorization Unit shall be available twenty-four (24) hours-a-day, seven (7) days-a-week, to respond to prior authorization requests, except for downtime that has been prior approved in writing by TennCare.

ii. The Contractor shall provide sufficient staff, facilities, and technology such that eight-five percent (85%) of all call line inquiry attempts are answered within thirty (30) seconds during a twenty-four (24) hour period. Answer percentage rate shall be defined as the number of calls answered through the Automatic Call Distributor (ACD) line divided by (the total number of ACD incoming calls added to the number of abandoned calls). The total number of abandoned calls shall not exceed three percent (3%) during a twenty-four (24) hour period.

iii. Calls shall be answered within thirty (30) seconds. If an automated voice response system is used as an initial response to inquiries, an option shall exist that allows the caller to speak directly with an operator. The Contractor shall provide sufficient staff such that average wait time to speak to a live representative shall not be in excess of thirty (30) seconds during a twenty-four (24) hour period.

iv. All call line inquiries that require a call back, including general inquiries, shall be returned within one (1) business day of receipt one hundred percent (100%) of the time.

n. The Prior Authorization Unit shall also process prior authorization requests from prescribers via facsimile transmission, web-based transmission and U.S. Mail. All forms of requests shall also be responded to within twenty-four (24) hours of receipt one hundred percent (100%) of the time.

o. The Contractor shall be responsible for providing a Help Desk to answer calls from TennCare members. The Contractor shall triage those calls regarding eligibility, lock-ins, and general questions about the TennCare benefit either by warm transfer or by call back request form. The Contractor shall be responsible for meeting the following performance standards and is required to provide reports as required under Contract Section A.11.2 demonstrating that it has performed as follows:

i. The Help Desk shall be available twenty-four (24) hours-a-day, seven (7) days-a-week, to respond to member questions, except for downtime that has been prior approved in writing by TennCare.

ii. The Contractor shall provide sufficient staff, facilities, and technology such that eight-five percent (85%) of all call line inquiry attempts are answered within thirty (30) seconds during a twenty-four (24) hour period. Answer percentage rate shall be defined as the number of calls answered through the Automatic Call Distributor (ACD) line divided by (the total number of ACD incoming calls added to the number of abandoned calls). The total number of abandoned calls shall not exceed three percent (3%) during a twenty-four (24) hour period.

iii. Calls shall be answered within thirty (30) seconds. If an automated voice response system is used as an initial response to inquiries, an option shall exist that allows the caller to

speak directly with an operator. The Contractor shall provide sufficient staff such that average wait time to speak to a live representative shall not be in excess of thirty (30) seconds during a twenty-four (24) hour period.

iv. All call line inquiries that require a call back, including general inquiries, shall be returned within one (1) business day of receipt one hundred percent (100%) of the time.

v. All call line inquiries that require a call back from TennCare, shall be forwarded to TennCare via call back request form within one (1) business day of receipt one hundred percent (100%) of the time.

p. Activities of the Prior Authorization Unit shall be summarized and reported to TennCare as described in section A.11 of this Contract. Failure to meet any of these standards may result in liquidated damages set forth in Attachment C.

A.7.2. Prior Authorization Process

Upon receipt of a request, the pharmacy technician at the Prior Authorization Unit shall query patient and/or drug information. If the request is consistent with the prior authorization and/or medical necessity criteria approved by TennCare, the technician shall document the request in the Contractor pharmacy case management system and enter an override in TennCare-POS system for the appropriate period of time.

If the request is not consistent with the prior authorization criteria or protocols and the prescriber wishes to have the request escalated, the request shall be referred to a clinical pharmacist on the Prior Authorization Unit. If upon review, the clinical pharmacist finds sufficient justification for an override, the request shall be documented and an override entered in the TennCare-POS system. If sufficient justification is not evident this shall be documented and the request shall be denied. The Contractor shall generate a notice to the requestor for all prior authorization request denials as specified in Section A.12 of this Contract. If the request requires further escalation or the prescriber requests reconsideration of a denied PA request, the request shall be forwarded to the Contractor's physician for reconsideration and final review. A physician shall review all reconsideration requests for denials and shall be available by telephone at all times for clinical support.

A.7.3. Prior Authorization Peer-to-Peer Reconsideration

The Contractor shall have a peer-to-peer reconsideration process, administered by a board certified physician, available to providers who wish to challenge adverse prior authorization decisions. This process shall ensure that appropriate decisions are made and communicated to the prescriber within one (1) business day of the initial request by a prescriber. The Contractor shall supply TennCare with all pertinent information pertaining to reconsideration requests within two (2) business days. The Contractor shall develop policies and procedures regarding the peer-to-peer reconsideration processes. These shall be reviewed and approved by TennCare prior to implementation. The Contractor shall notify providers of the reconsideration process with respect to re-review of adverse prior authorization decisions. The Contractor shall provide TennCare with monthly reports indicating the number of peer-to-peer reconsideration requests, analysis and disposition. Failure to administer the peer-to-peer reconsideration process in accordance with the requirements of this Contract may result in liquidated damages as set forth in Attachment C.

A.7.4. Enrollee Appeals Members shall have the right to file appeals regarding adverse actions taken by the Contractor. For purposes of this requirement, appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the Contractor to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness, or availability of such benefits. The Contractor shall provide a service or make payments for a service within five (5) calendar days of a directive from TennCare (pursuant to an appeal) to do so, or upon approval of the service or payment by the Contractor during the appeal process, or within a longer period of time which has been approved by TennCare upon the Contractor's demonstration of good cause. The Contractor shall provide written confirmation in the form of a letter, fax or e-mail to the requestor and additional TennCare associates if requested that the service has been provided or payment has been made.

a. The Contractor shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The Contractor shall notify TennCare of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.
b. The Contractor shall have sufficient support staff (clerical and professional) available to process reimbursement and billing appeals in accordance with TennCare requirements. Members with retroactive eligibility frequently submit bills for reimbursement which will be sent to the Contractor and must be handled in accordance with the required appeal timelines as specified by TennCare and/or applicable TennCare rules and regulations.
c. The Contractor shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action shall be taken by the Contractor regarding the handling and disposition of an appeal.
d. Upon request, the Contractor shall provide members a TennCare approved appeal form. However, members shall not be required to use a TennCare approved appeal form in order to file an appeal.
e. The Contractor shall require providers to display notices of members' right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The Contractor shall ensure that providers have correct and adequate supply of public notices and shall ensure that these notices are on display at all times.
f. The Contractor shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures as they become effective. When the Contractor approves a requested service on appeal, the Contractor will assure that the member is notified in writing of such approval.
g. The Contractor shall timely and fully respond to reconsideration requests from the TennCare Solutions Unit (TSU) within the timeframes as specified by TennCare and/or applicable TennCare rules and regulations. Contractor staff shall be consistently responsive, helpful and courteous when responding to the inquiries received from TSU.
h. The Contractor is responsible for eliciting pertinent medical history information from the treating provider(s), as needed, for purposes of making medical necessity determinations. The Contractor shall provide TennCare with individualized medical record information from the treating provider(s). The Contractor shall take whatever action necessary to fulfill this responsibility within the required appeal timelines as specified by TennCare and/or applicable TennCare rules and regulations.
i. In addition to providing a reconsideration determination, upon notification of an appeal from TSU, the Contractor shall produce and deliver to the TSU all pertinent information regarding that particular prior authorization within the required timeframes.
j. The Contractor shall furnish specific telephone numbers for TSU staff to make contact with the Contractor after normal business hours, and on weekends and holidays in order to assure eligibility and coverage issues can be timely addressed and corrected pursuant to an appeal by a TennCare enrollee. The Contractor's supervisory personnel shall be required to respond immediately to inquiries from TSU personnel. TSU may require the Contractor's staff to enter a TennCare enrollee's eligibility information and allow processing of pharmacy claims in "after-hours" situations.
k. The Contractor shall forward an expedited appeal to TennCare within twenty-four (24) hours or a standard appeal within five (5) days. The Contractor shall provide written confirmation in the form of letter, fax or e-mail to the requestor and additional TennCare associates if requested, that the service has been provided.
l. The Contractor shall process appeals as set forth in the Revised Grier Consent Decree to avoid "Systemic Problems or violations of the law." A failure in 20% or more of appealed cases over a sixty (60) day period regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures may result in Liquidated Damages as specified in Attachment C.
m. Failure to comply with any of the directives contained in Contract Section A.7.4. may result in Liquidated Damages as specified in Attachment C.

A.7.5. Member-Initiated Prior Authorization Request

The Contractor shall establish a Member-initiated prior authorization process that allows TennCare enrollees to request a prior authorization when twenty four (24) hours have elapsed since the claim's denial at the

POS without a prior authorization request being made by the prescriber. The Contractor shall implement and manage the Member-Initiated Prior Authorization Process as follows:

a. The Contractor shall develop a Member Unit for incoming Member telephone calls regarding prior authorizations. The Unit shall be fully operational and ready to receive telephone calls on the date the Contractor assumes full responsibility for the pharmacy benefits program

b. Upon receipt of a Member telephone call, the Contractor call service representative (hereinafter referred to as "CSR") shall authenticate the caller as a TennCare member or his/her authorized representative and confirm that twenty four (24) hours have elapsed since the provider submitted the claim and received the denial.

c. If the requisite twenty four (24) hours have elapsed, the CSR shall obtain the Member's cardholder ID number, confirm the name of the drug the Member is requesting for approval, and the name and contact information of the prescriber. The CSR shall also note if the Member has previously received this drug.

d. The CSR shall review the information in the reporting system to verify whether the prior authorization process has been initiated by the prescriber. If the prescriber has initiated the process, the CSR shall inform the Member of the status of the prior authorization request and ask the Member to contact the prescriber for any follow-up inquiries.

e. If the prior authorization process has not been initiated by the prescriber, the CSR shall log a prior authorization request into the Reporting System based on the information provided by the Member. The Requester Type shall be logged as "Patient". This shall generate a facsimile to be sent to the prescriber requesting further information to determine if the Member meets the necessary criteria for the prior authorization to be granted. The prescriber has three (3) business days from the initial Member telephone call to respond to the request for further information.

f. The Contractor shall develop an operational process to identify requests that are still pending after the three (3) business day period has passed, which process shall be approved in writing by TennCare prior to its implementation.

g. At the end of the above process, one (1) of the four (4) following outcomes shall result:

   i. The prescriber does not reply to the Contractor within the three (3) business day period. If so, the Contractor shall automatically identify requests that have not received a response, and shall generate a letter that shall inform the Member of the outcome. The Contractor shall generate and mail one (1) of the following TennCare approved letters to the Member: (1) if the Member has not taken the requested drug recently, the Prior Authorization Denied Notice shall be sent to that Member; (2) if the Member has taken the requested drug recently, the Prior Authorization Denied – Continuation of Benefits Notice shall be sent to that Member.

   ii. The prescriber changes the drug initially requested to a drug on the PDL. If so, the Contractor shall log the outcome of the request into the Reporting System. The Contractor shall contact the Member to explain this outcome and shall generate and mail the appropriate TennCare approved Prescription Change Notice to the Member.

   iii. The prescriber provides sufficient information to grant a prior authorization. If so, the Contractor shall log the outcome of the request into the Reporting System. The Contractor shall contact the Member to explain the outcome and shall generate and mail the TennCare approved PA Granted Notice to the Member.

   iv. The prescriber contacts the Contractor, but the prior authorization request is denied for lack of clinical support. If so, the Contractor shall generate and mail one (1) of the following TennCare approved letters to the Member: (1) if the Member has not taken the requested drug recently, the Prior Authorization Denied Notice shall be sent to that Member; (2) if the Member has taken the requested drug recently, the Prior Authorization

Denied – Continuation of Benefits shall be sent to that Member. This shall inform the Member of his/her Continuation of Benefits rights through the appeals process.

h. The contractor shall provide sufficient staff, facilities, and technology such that calls to the Member-Initiated Prior Authorization Unit achieve daily average speed to answer performance of eighty-five percent (85%) in thirty (30) seconds and daily call abandonment rates less than three percent (3%).

A.7.6. Administer Prior Authorization Program for the TennCare PDL

a. Prescriptions for non-preferred drugs shall require prior authorization (PA). A PA shall also be required for prescriptions that violate any of a variety of pro-DUR edits and/or are subject to clinical criteria or step therapy.

b. The Contractor shall develop clinical prior authorization review criteria. CMS-approved reference books as well as current medical literature may be used to develop the criteria. The Contractor shall make all TennCare-approved prior authorization review criteria easily understood and widely available to TennCare providers through various media. The Contractor shall also present all prior authorization review criteria to the TennCare Pharmacy Advisory Committee prior to implementation.

c. The Contractor shall develop a plan for administering the prior authorization program. The plan shall achieve the objective of compliance with the PDL without unduly disrupting access to care or increasing provider costs, and demonstrate the means by which this shall be accomplished.

d. The Contractor shall provide prior authorization services for prescriptions written for non-preferred drugs or otherwise requiring PA. Prior authorization services shall consist of prescription review by a licensed pharmacist or pharmacy technician to ensure that all predetermined clinically appropriate criteria have been met before the prescription may be dispensed and subsequently reimbursed. The Contractor shall provide readily retrievable documentation for every prior authorization request made, which shall include all information offered by the prescriber, pharmacy, or enrollee, and shall include explanations on what criteria was used to make the final determination, what final determination was made, and by whom.

e. Prior authorization services for newly marketed prescription drugs that are in a new category or a category that has not been reviewed by PAC, shall consist of prescription review by a licensed pharmacist to ensure that the drug will be used appropriately according to its FDA indication and recommended dose.

f. The Contractor shall have an automated approval process for prior authorization based on the member's specific drug history with an emphasis on reduction of transactions and manual interventions.

g. The Contractor shall ensure that all prior authorizations conducted by telephone meet the service and quality standards required by TennCare in this Contract.

h. Failure to meet any of these standards may result in liquidated damages set forth in Attachment C.

A.8. Pharmacy Help Desk

A.8.1 The Contractor shall operate a technical Pharmacy Help Desk with the capability to promptly respond to systems and claims submission inquiries from pharmacies providing services to TennCare recipients. The hours of operation shall be twenty four (24) hours per day and seven (7) days per week. Pharmacy inquiries arising from eligibility, benefit and DUR edits shall be resolved by this unit. The Help Desk shall also function as a recipient customer service unit after hours and on weekends and holidays. In no event should the Help Desk be in an off shore location.

A.8.2. The Contractor shall provide a toll-free telephone number with capacity such that daily call blockage rates do not exceed point twenty-five percent (0.25%). This toll free number shall be transferable to TennCare upon contract termination. The Contractor shall provide TennCare with the Help Desk's toll free number

sixty (60) days prior to the date the Contractor assumes full responsibility for the pharmacy benefits program. All telecommunication transaction cost are included in this Contract.

A.8.3. The Contractor shall install, operate, monitor and support an automated call distribution system that has capability to provide messaging regarding time to live agent pick up, tele-FAQs and fax-on-demand. The contractor's system shall record all calls in a digital format. The contractor shall allow TennCare staff to monitor calls in real-time and hear specific calls made to the Help Desk if TennCare provides the date, time or callers number.

A.8.4. The Contractor shall install, operate, monitor and support a contact management system that has capability to provide the management and on request reporting needs of TennCare.

A.8.5. The Contractor shall provide sufficient staff, facilities, and technology such that the Technical Help Desk achieves daily average speed to answer performance of eighty-five percent (85%) in thirty (30) seconds and daily call abandonment rates less than three percent (3%).

A.8.6. All Help Desk inquiries that require a call back shall be returned within one (1) business day of receipt one hundred percent (100%) of the time.

A.8.7. The Help Desk shall have efficient escalation process with a pharmacist onsite at all times, in order to be able to respond to escalated inquiries within one (1) hour or emergency inquiries immediately.

A.9 Pharmacy Network

The Contractor shall establish and maintain a statewide pharmacy provider network of retail, specialty and Long Term Care Pharmacies, adequate to provide Pharmaceutical services and Pharmacy location sites available and accessible in accordance with the provider network requirements as set forth by TennCare. Other than those addressed in this Contract, the Contractor shall not collect any additional fees, rebates, premiums or revenue from processing TennCare claims.

Pharmacies providing pharmaceutical services solely through the internet or mail order shall not be included in the network. Retail pharmacies who offer mail prescriptions as part of their business may be included in the network, subject to quantity limits of the TennCare benefit.

A Specialty pharmacy network shall be established within the first fiscal year of this Contract. The specialty pharmacy network shall be the preferred provider of certain drugs identified by TennCare. The network specialty pharmacy shall agree to more favorable reimbursement rates (i.e., deeper discounts) on the designated products and possess unique clinical monitoring and distribution capabilities. Specialty pharmacy services may be provided through the mail.

A.9.1 Access to Services. The Contractor shall maintain a network of pharmacy providers with a sufficient number of pharmacy providers who accept TennCare enrollees within each geographical location in the state so travel times do not exceed the allotted standard for a particular location. The Contractor shall consider the following:

a. The anticipated need to have a prescription filled outside the service area;
b. The expected utilization of services, taking into consideration the pharmaceutical needs of specific TennCare populations represented in the PBM;
c. The numbers and types (in terms of training, experience, and specialization) of pharmacy providers required to furnish the contracted TennCare services; and
d. The geographic location of pharmacy providers and TennCare enrollees, considering distance, travel time, the means of transportation ordinarily used by TennCare enrollees, and whether the location provides physical access for TennCare enrollees with disabilities.

The Contractor shall ensure that network pharmacy providers offer hours of operation to TennCare enrollees that are no less than the hours of operation offered to commercial enrollees.

A.9.2. Network Access. The Contractor shall maintain under contract a network of pharmacy providers to provide the covered services such that in urban areas, at least ninety percent (90%) of TennCare enrollees on average, live within two (2) miles of a retail pharmacy participating in the Contractor's network; in suburban areas, at least ninety percent (90%) of TennCare enrollees on average, live within five (5) miles of a retail pharmacy participating in the Contractor's network; and in rural areas, at least

seventy percent (70%) of TennCare enrollees, on average, live within fifteen (15) miles of a retail pharmacy participating in the Contractor's network. Exceptions shall be justified and documented to the State on the basis of community standards. When requested by TennCare, the Contractor shall make arrangements to provide pharmacy services to enrollees residing in locations where a suitable network provider is not available.

A.9.3. The Contractor shall submit a monthly Provider Enrollment File that includes information on all providers of TennCare pharmacy services. The Contractor shall submit this report in the format agreed to by TennCare. The Contractor shall submit this report by the 5th day of each month, or as otherwise requested by TennCare. Each monthly Provider Enrollment File shall include information on all providers of TennCare pharmacy services and shall provide a complete replacement for any previous Provider Enrollment File submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.

A.9.4. The Contractor shall be required to produce a provider directory that shall be made available on the Contractors website and in print by request. All provider directories shall be approved by TennCare prior to the Contractor's distribution. The Contractor shall provide a data file that shall include current pharmacy provider name, NPI, address(es), telephone numbers fax numbers, and hours of operation in the format prescribed by TennCare. In addition, the provider information used to populate the provider directory shall be submitted as a TXT file or such format as otherwise approved by TennCare and be produced using the same extract process as the actual provider directory. On a quarterly basis, the Contractor shall also be responsible for updating the pharmacy provider information in the provider directory.

The Contractor shall require all network providers to have online access to the Contractor's website, and shall require current email addresses from each network provider.

A.9.5. Pharmacy Notices. The Contractor shall assure that contracted pharmacies comply with TennCare notice requirements which include, but are not limited to prominent display of TennCare pharmacy poster and distribution of member notices from pharmacist to enrollee upon non-dispensing of a prescription for which PA is required. All notices must comply with requirements as provided in the *Grier* Revised Consent Decree. The Contractor shall specify in provider contracts that failure to comply with notice requirements may result in a financial penalty of fifty dollars ($50) per occurrence and/or contract termination. The Contractor shall utilize feedback from TennCare, other state agencies, and enrollees, in addition to the audit process to perform additional training to pharmacies regarding notice obligations. Failure by the Contractor to comply may result in liquidated damages as described in Attachment C.

A.9.6. Pharmacy Audit. The Contractor shall establish and maintain a Program Integrity process. The process shall detect and prevent errors, fraud or abusive pharmacy utilization by enrollees, pharmacies or prescribers. The Contractor shall also review children's prescriptions at POS to screen for possible fraudulent attempts by adult recipients to obtain prescriptions for themselves. Pharmacies with aberrant claims or trends shall be contacted by the Contractor's staff to gain an acceptable explanation for the finding or to submit a corrected claim. The Contractor shall develop a trend or log of aberrations that shall be shared with TennCare. Each quarter the Contractor shall summarize findings from the reports and meet with TennCare to address program revisions. Revisions to the desk audit reports and review process shall be provided at no cost to TennCare. Program Integrity activities shall be summarized and reported to TennCare as described in section A.11.4 of this Contract.

a. TennCare shall request that the Contractor initiate a field audit when desk audits consistently identify aberrations that cannot be explained by other means or upon requests from legal authorities or regulatory agencies. The objective of the field audit shall include financial recovery, and elimination of the aberrant practice. The Contractor shall have the qualified staff available to conduct field audits or have an agreement with a vendor acceptable to TennCare within ninety (90) days of on the date the Contractor assumes full responsibility for the pharmacy benefits program start date. The Contractor shall conduct ten (10) field audits per quarter.

b. Verification of Benefits (VOB) Letters

i. Each month, five hundred (500) randomly selected recipients shall be sent a letter requesting their reply to confirm whether they received the prescriptions processed in the

preceding month and identified in the letter. Failure to send a letter to the five hundred (500) randomly selected recipients may result in liquidated damages as set forth in Attachment C.

ii. The process of identifying the claims for inclusion is as follows:
   (1) Only paid claims adjudicated during the previous month shall be included
   (2) Medications shall be in one of the classes identified on the "inclusion list" to be finalized by the parties; and
   (3) Up to five (5) claims shall be included for each recipient. Once a recipient has been mailed a VOB letter, they shall be exempted from the VOB lettering process for the following six (6) months.

iii. TennCare may request to include claims from up to five (5) specific pharmacies during each month's run.

c. Each mailing shall include a double-sided document including the letter on the front page, with the claim detail and signature line on the back, as well as a postage paid envelope for the recipient to use for the return mailing. The letters must be preapproved by TennCare.

d. TennCare shall be responsible for postage related to the mailing of these letters, as well as the return postage.

e. VOB responses shall be followed up on by the Contractor's audit unit and the Contractor will provide TennCare with a quarterly report on the findings from the responses.

f. Failure by the Contractor to comply with these requirements in A.9.6. may result in liquidated damages as described in Attachment C.

A.9.7. Non-Network Providers- , The Contractor may not deny any licensed pharmacy or licensed pharmacist the right to participate as a participating provider in any policy, contract or plan on the same terms and conditions as are offered to any other providers of pharmacy services under the policy, contract or plan. The Contractor shall provide an emergency override process, at no additional cost to TennCare, whereby a non-network pharmacy may be approved to process a claim for a TennCare recipient in an emergency, and when the use of a network pharmacy is not an option. This non-network emergency override process will be subject to TennCare approval. In addition, the Contractor will ensure that information regarding in-network providers is readily available on the website and through the Pharmacy Help Desk.

A.9.8. The Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds.

A.9.9. Provider Service Agreements- The Contractor shall assure the provision of all covered Pharmacy services specified in this Contract. The Contractor shall enter into standard provider agreements pursuant to a template supplied by TennCare with providers who shall provide pharmacy services to the enrollees in exchange for payment from the State for services rendered. The Contractor should make every effort to enter into pharmacy provider agreements with those entities whose practices exhibit a substantive balance between TennCare and commercial customers. Provider agreements shall be between the pharmacy provider and Contractor, not between the pharmacy provider and TennCare.

a. The Contractor shall submit one copy of all template pharmacy provider agreements and copies of the face and signature pages in an electronic format agreed to by TennCare of all executed agreements to TennCare. This information should be refreshed annually or upon TennCare's request.

b. The Contractor shall execute such template provider agreements with participating pharmacies that maintain all federal, state and local licenses, certifications, and permits, without restriction, required to provide pharmaceutical services to TennCare enrollees and shall comply fully with all applicable laws and regulations. Further, all template pharmacy provider agreements and revisions shall be approved in advance by the TennCare pharmacy program and the Tennessee Department of Commerce and Insurance.

c. In addition to the TennCare approved template being required for all pharmacy provider agreements executed by the Contractor, any agreements entered into between the Contractor and subcontracting entities or organizations for the provision of TennCare pharmacy services shall also be in the form of the template provided by TennCare, and shall otherwise comply with this Section A.9.

d. The Contractor shall ensure provider compliance with federal Law, when implemented, requiring that written prescriptions only be filled if they are presented on an approved tamper proof form. Failure of Provider to follow this law shall be grounds for dismissal from the network.

e. The Contractor shall ensure that the pharmacy provider is not currently nor has ever been sanctioned by HHS-OIG and is prevented from participating in a federally-funded program such as TennCare.

f. The Contractor shall include provisions for resolution of disputes either by arbitration or another process mutually agreed to by the parties. Specify the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the Contractor as provided at T.C.A.§ 56-32-126(b).

g. Failure by the Contractor to comply with these requirements in A.9.9. may result in liquidated damages as described in Attachment C.

A.9.10 Network Deficiency

Upon Notification from TennCare of a network deficiency, which shall be based on the Terms and Conditions for Access of the TennCare Waivers, the Contractor shall immediately provide written notice to enrollees living in the affected area of a provider shortage in the Contractor's network. The notice content shall be reviewed and approved by TennCare prior to distribution.

A.9.11. Provider Sole Service Agreements

The Contractor shall assure the provision of all covered Pharmacy services specified in this Contract. When necessary to fulfill the terms of this agreement, the Contractor shall enter into short term agreements with non-network pharmacy providers who shall provide pharmacy services to the enrollees for a specified period in exchange for payment from the Contractor for services rendered. The Contractor shall make every effort to enter into pharmacy provider agreements with those entities under the same rules and regulations as outlined in the pharmacy Provider Service agreement for In-Network pharmacy providers.

A.9.12. Return of TennCare-Specific Data

At termination of this Contract, whether or not before the Contract termination date, the Contractor shall deliver to TennCare in a TennCare-approved format, a list of the current provider network including, but not limited to demographic and credentialing information.

A.9.13. The Contractor shall have in place written policies and procedures for the selection and/or retention of pharmacy providers and policies and procedures shall not discriminate against particular pharmacy provider that service high risk populations or specialize in conditions that require costly treatment.

A.9.14. Should the Contractor decline to include individual or groups of pharmacy providers in its network, it shall give the affected pharmacy providers written notice of its decision.

A.10. Staffing

The Contractor shall have total responsibility for hiring and management of any and all Contractor staff as determined necessary to perform the services in accordance with the terms of this Contract and shall provide a proposed staffing plan for review and approval by TennCare. The Plan shall include at a minimum, key staff identified below and corresponding job descriptions. The Contractor's failure to provide and maintain key staff may result in liquidated damages as set forth in Attachment C.

A.10.1. Staff Requirements

a. The Contractor shall provide to TennCare documentation verifying that all staff employed by the Contractor or employed as a sub-contractor are licensed to practice in his or her area of specialty. This documentation shall be supplied at the execution of this Contract and annually thereafter, due on September 15 of each year of the Contract. Failure to provide documentation verifying that all staff employed by the Contractor, or employed as a sub-contractor are licensed may result in liquidated damages as set forth in Attachment C.

b. The Contractor shall provide TennCare with copies of resumes and job descriptions for all persons employed under this Contract. TennCare reserves the right, at its sole discretion, to request dismissal of Contractor staff and sub-contracted staff, for services under this Contract only, from this project based on performance deficiencies and/or lack of knowledge, skills or demonstrated expertise necessary to perform contracted activities.

c. The Contractor shall reallocate staffing resources based on current TennCare program needs and current TennCare structure, subject to approval by TennCare. Such reallocations may be requested of the Contractor by TennCare management.

d. The Contractor shall ensure that all Contractor staff and sub-contracted staff are trained and knowledgeable regarding all applicable aspects of the TennCare Pharmacy Programs.

e. The Contractor shall employ competent staff in all key positions listed below. If any key position becomes vacant, the Contractor shall employ an adequate replacement within sixty (60) days of the vacancy unless TennCare grants an exception to this requirement. Failure to fill vacancies within 60 days may result in liquidated damages as set forth in Attachment C.

A.10.2. A training plan shall be submitted and approved by TennCare within ten (10) business days of the execution of this Contract. Contractor shall be responsible for providing training to any newly hired Contractor staff and sub-contracted staff prior to those individuals performing any reviews. Training for newly hired Contracted staff and sub-contracted staff shall be approved by the Chief Pharmacy Officer at least seventy-two (72) hours in advance.

A.10.3. The Contractor shall provide staff that is current and knowledgeable in their respective areas of expertise. This staff shall provide quality consultation and technical assistance services regarding all matters pertaining to pharmacy benefits.

A. 10.4. The Contractor shall, at a minimum, have at least fifty percent (50%) of its staff in the core disciplines available during the hours of 8:00 a.m. to 4:30 p.m. Central Standard Time, Monday through Friday, as required to fulfill the scope of services specified in this Contract. If the Contractor is not adequately staffed, TennCare may assess liquidated damages of two thousand, five hundred dollars ($2,500) for each occurrence as set forth in Attachment C.

A. 10.5. Staff Dedicated to TennCare

Pharmacy Contract Project Director and Staff

The Contractor shall designate and maintain, subject to TennCare approval, a Project Director for this Contract who has day-to-day authority to manage the total project. The Project Director shall be readily available to TennCare staff during regular working hours by working onsite at least seventy-five percent (75%) of the time within the TennCare Bureau. The Project Director shall be one hundred percent (100%) dedicated to the TennCare Pharmacy Program. The Contractor's staff addressed herein shall be available to attend meetings as requested by TennCare. TennCare shall provide office space for the Contractor's onsite Pharmacy Project Director and staff. The Contractor shall maintain sufficient levels of staff including supervisory and support staff with appropriate training, work experience, and expertise to perform all contract requirements on an ongoing basis including but not limited to the following personnel, all of whom shall be dedicated one hundred percent (100%) to TennCare.

a. Clinical PDL Pharmacists- Two (2) clinical pharmacists, licensed by the State of Tennessee Board of Pharmacy to be located on site, and shall be responsible for, but not be limited to all aspects of the TennCare Preferred Drug List (PDL) and processes described in Section A.4.

b. Clinical Administrative Pharmacists- Two (2) clinical pharmacists, licensed by the State of Tennessee Board of Pharmacy to be located on site, and shall be responsible for, but not be limited to the support of the Prior Authorization process, First Level Appeals process, Pharmacy Lock-In process and assist with the Pharmacy Audit process.

c. Provider Educators- Two (2) provider educator pharmacists located in Tennessee. These positions shall be field based, one in East Tennessee, and one based in West Tennessee, and these associates shall spend 80% of their time in the academic detailing of prescriber and pharmacy providers. Such academic detailing shall include, but not be limited to PDL compliance initiatives, DUR and Provider Practice Activity follow up, and to educate and assist providers in working with TennCare utilization management programs (i.e. Prior Authorization requests, Attestations, Emergency Supply, and others).

d. Data Research Analyst- One (1) data research analyst located on site shall be responsible to generate daily, weekly, monthly, quarterly and yearly reports required by the contract, in addition to all ad hoc requests made by TennCare, in formats requested by TennCare. The Data Research Analyst shall be expert in data that is warehoused by Contractor on behalf of TennCare and shall be available to assist TennCare associates with Contractor's decision support systems, both pharmacy associates and other departmental associates if requested by TennCare.

d. Program Coordinator- One (1) program coordinator located on site shall be responsible for, but not limited to communications with PAC and DUR Board members, and to assist in the facilitation of Board meetings, along with the coordination of enrollee and provider mailings and other communications.

e. System Liaison- One (1) system liaison located on site shall be responsible for, but not limited to the planning and timely coding of edits to the Contractor's system when requested by TennCare, the quality control of such edits to ensure proper functioning within the system, and to ensure that newly entered system changes and edits do not affect existing edits within Contractor's system causing unanticipated adverse system events affecting TennCare's claims, enrollees and providers. The System Liaison shall be responsible for all testing of new programs or modules to be used by Contractor to manage TennCare's business. The System Liaison shall also be responsible for the maintenance and management of Contractor's website, including the updating of new PDL changes, changes to clinical criteria, MAC price updates and Specialty price updates.

f. Contract Manager- One (1) contract manager located on site shall be responsible for, but not limited to being the primary owner and contact for all TennCare "On Request Reports" via TennCare's Team Track system, along with all requests from other areas within TennCare as a result of comptroller audits, CMS audits, internal audits or Program Integrity audits. The contract manager shall also be responsible for all deliverables from Contractor to TennCare as required by this contract.

The Contractor's Project Director shall present a summary of projects and their status along with accomplishments for each position to TennCare on a quarterly basis. Based on the results of this quarterly meeting, Contractor may be required by TennCare to hire additional staff in order to satisfy the requirements of this contract. Failure to meet contract requirements due to insufficient staffing levels on the part of Contractor may result in liquidated damages as set forth in Attachment C.

A.11. TennCare Reporting Requirements

The Contractor shall submit accurate and complete reports to TennCare as described through this Contract. Reports shall meet the content, format and method of delivery requirements of TennCare. TennCare requires that all management reports be provided in accordance with the time frames set forth in the Performance and Deliverables section in Attachment C. Failure to provide reports as described herein may result in liquidated damages as set forth in Attachment C. All reports, analyses, and/or publications developed under this Contract shall be the property of TennCare. TennCare reserves the right to change reporting requirements and request ORRs reports. All reporting shall be delivered through a web-based report library that can be imported to Microsoft Excel, or formatted as tab- or comma-delimited text files if requested by TennCare.

A.11.1 Management Reports

The Contractor shall provide TennCare with industry standard utilization and financial management reporting. The Contractor's management reports shall provide a summary of drug costs by therapeutic category, by top ranked drugs, and by benefit categories. Reports shall include, but not be limited to:

a. Financial summary with change trend;
b. Utilization statistics'
c. Claim processing volume, processing time and other statistics to be reviewed by Contractor daily (abnormalities to be reported to TennCare immediately);
d. Pharmacy Drug Spend by category and also by drug; to be reported monthly;
e. Quarterly Net Cost trend reports, including Federal Rebate and Supplemental Rebate data by drug, with details included on multiple worksheets to drill down to all drugs and categories;
f. PDL Compliance reports by provider and specialty;
g. Prior Authorization including number of requests, number of approvals, number of denials, number of cancellations, and number of interventions;
h. Call Center metrics to be reviewed by Contractor daily (abnormalities to be reported to TennCare);
i. Grievance, appeal volume, disposition and aging to be reviewed by Contractor daily and reviewed with appropriate TennCare personnel quarterly (abnormalities to be reported to TennCare immediately). ;
j. Prescriber profiles, including up-to-date demographics including current address and contact information for all Tennessee prescribers;
k. Rebate reports to be reviewed by Contractor weekly and then presented to TennCare at quarterly clinical meetings (abnormalities to be reported to TennCare immediately). ;
l. Pharmacy Lock-in reports showing current status of all enrollees subject to Lock-in, Escalated PA status, and Convicted PA Status;
m. All other reports referenced in this Contract.
n. Specialty Drug reports
o. Compounded Prescription reports

A.11.2. In addition to standard management reports, the Contractor shall provide the following additional capabilities and custom reports in a format agreed to by TennCare. Failure to provide the below referenced reports as required may result in liquidated damages as set forth in Attachment C:

a. Clinical Initiative Reports - As clinical programs are implemented, the Contractor's staff shall coordinate with TennCare to define additional reports to gauge the effectiveness of various clinical initiatives, including movement of market share within given therapeutic categories of the TennCare PDL. The criteria and format for clinical initiative reporting shall be mutually agreed upon by TennCare and the Contractor. The Contractor's utilization management reporting package shall be customizable to meet TennCare program analysis needs.

b. On Request Reports (ORRs) - The Contractor shall be able to provide, at no extra cost to TennCare ORRs that shall assist in managing the pharmacy benefit for TennCare members. ORRs shall be provided in a format agreed to by TennCare and on a reasonable timetable.

c. Decision Support Tools - The Contractor shall also furnish TennCare staff with access to the Contractor's Data Warehouse allowing TennCare to retrieve raw paid, rejected and reversed claims data, along with a user interface that shall allow user defined queries to address managerial concerns that would normally be requested in an ORR. The capability shall not diminish the Contractors responsibility for responding to requests for ORRs. Contractor shall be responsible to offer assistance to TennCare associates using Contractor's Data Warehouse as needed, including both pharmacy staff and other departmental staff's users.

d. TennCare Staff Online Access - The Contractor shall provide the TennCare staff and their designees individual access to the Contractor's POS claims system, prior authorization system,

decision support system and other information systems as necessary via an online, real time connection at no additional cost.

e. Emergency Supply Aggregate Reports - The Contractor shall provide TennCare with monthly emergency supply claims reports listing the enrollee information, drug information, quantity and days supply, pharmacy and prescriber information, along with the reason the original claim was rejected (Non-PDL, Clinical Criteria required, etc.). The Contractor shall also provide semi-annual aggregate reports that list the top 100 pharmacies entering emergency supplies. The emergency supply reports shall be delivered to TennCare in electronic format via web-based report library, as described by TennCare.

f. Monthly Batch Claim Operations Reports – If requested by TennCare, the Contractor shall provide reports of data entry volumes and types of transactions with daily, weekly and monthly summaries.

g. Help Desk and Prior Authorization Call Center Activity Reports - The Contractor shall produce reports on usage of the Help Desk and Prior Authorization Call Center services, including numbers of inquiries, types of inquiries, and timeliness of responses. Help Desk Activity Reports shall be reported to TennCare as a split skill daily interval report. Prior Authorization Call Center Activity Reports shall be reviewed by the Contractor daily and report to TennCare immediately when abnormal results occur. If there are no urgent issues from the Prior Authorization Call Center Activity Report, these reports are to be reported to TennCare during quarterly clinical meetings and monthly Call Center conference calls.

h. Help Desk Reporting – The Help Desk Call Center reporting shall be provided on a daily basis, and at a minimum, shall include the following:

   i. Total hours of daily call center access provided, and any downtime experienced;

   ii. Call abandonment rate, and average abandon time by day;

   iii. Average answer speed in seconds by day;

   iv. Average ACD time of calls handled by day;

   v. Average wait time per caller;

   vi. Number of calls answered daily, and

   vii. Number of calls transferred to TennCare.

i. Prior Authorization Call Center Reporting - Prior Authorization Call Center reporting shall be provided on a weekly and monthly basis, and, at a minimum, shall include the following:

   i. Total hours of daily call center access provided, and any downtime experienced;

   ii. Call abandonment rate, and average abandon time by day;

   iii. Average answer speed in seconds by day;

   iv. Comprehensive report listing the type and disposition of all requests handled during the month. Report should provide approval rates by drug and therapeutic class;

   v. Request volume by prescriber and pharmacy, with indication of the key types of requests being received, including drug names and categories;

   vi. Average ACD time of calls handled by day;

   vii. Total number of intervention requests received by day;

   viii. Total number of PA requests processed by day;

   ix. Total number of PA requests approved by day;

   x. Total number of PA requests denied by day;

   xi. Total number of intervention requests received by facsimile by day;

   xii. Total number of intervention requests received by U.S. Mail by day, and

xiii. Total number and types of complaints received from TennCare enrollees regarding any difficulties receiving pharmacy services under the TennCare Pharmacy Program by day.

j. Top 50 Narcotic Prescribers Report- Twice yearly the Contractor will report on the Top 50 prescribers of narcotic prescriptions including information needed to follow up with Managed Care Organizations (MCO) which includes, but is not limited to, number of claims. enrollees, enrollee demographic information such as MCO, and types/names of drugs prescribed.

k. Monthly benefit limit report summarizing the number of recipients and claims encountering prescription limits, number of recipients and claims filled from Auto-Exemption list and number of recipients and claims filled through the Attestation process, and semi-annual summaries of the top prescribers utilizing the Attestation process

A.11.3. The Contractor shall monitor compliance by prescribers and pharmacists with the TennCare PDL and report that information to TennCare monthly, quarterly, and semiannually, and provide suggestions for improving PDL compliance. The Contractor shall produce the monthly PDL compliance reports listed below. Failure to provide the reports as described below may result in the assessment of liquidated damages as set forth in Attachment C.

a. Monthly Cost Savings/Avoidance Report that includes: utilization shifts by drug and drug class; cost savings by pharmacy paid amount and by net cost resulting from changes in prescribing, by drug and drug class; compliance with TennCare PDL drug classes by prescribers; expenditure per claim comparison (monthly/quarterly/yearly);

b. Quarterly evaluation of the effectiveness of the TennCare PDL and Prior Authorization programs, including recommendations for changes to TennCare PDL drugs. the criteria for review and approval of drugs, and protocols and procedures;

c. Monthly Supplemental Rebate Negotiations Status Report underway and/or completed, the status of negotiation outcomes and the product-specific financial impact of the supplemental rebates on the TennCare PDL;

d. Report on Total Estimated and Projected Future Savings from the TennCare PDL and Prior Authorization programs (monthly for the initial twelve (12) months of this contract and quarterly thereafter) when requested by TennCare, and

e. Quarterly reports, to be presented to TennCare by Contractor's Provider Educator staff, demonstrating the nature and extent of educational interventions to outlier prescribers and pharmacists and the clinical and financial outcomes of those interventions.

A. 11.4. The Contractor shall produce the following Program Integrity reports. Daily reports shall be produced, reviewed and delivered daily Monday through Friday by 3:00pm CT. Monthly reports shall be produced and reviewed monthly by ten (10) business days after end of month. Failure to provide the reports as described below may result in the assessment of liquidated damages as set forth in Attachment C.

a. Ingredient Cost/Prescription Report - This daily report shall identify claims with a total cost that exceeds Two Thousand Dollars ($2,000.00) at retail. Claims in this report shall be flagged if the product is considered by TennCare to be a specialty drug. The claims must be reviewed by Contractor's clinical pharmacists on a daily basis for reasonableness, and reported to TennCare when/if abnormal results occur, Report to be used to identify incorrect claims submission, for identification medications for steerage to specialty vendors and for identification opportunities to suggest utilization management edits or benefit design changes.

b. Override Report - Daily claims paid with unique adjudication rule reporting, as defined bv TennCare, as requested by TennCare.

c. Enrollee Lock-in Report - The report shall screen for inappropriate, duplicate or conflicting pharmacotherapy; screen for potential fraud or drug diversion; and identify patients for referral to pain management or substance abuse services. The report shall identity enrollees for pharmacy lock-in initiative. TennCare shall define the report base on the number of prescribers, pharmacies, percentage controlled substance dose exceeding the Maximum Daily Dose, and other indications of potential abuse including buprenophrine utilization for opioid detoxification. The report shall be produced and reviewed monthly within ten (10) business days after end of month.

d. Pharmacy DAW Code Submission - The report shall identify the top 20 pharmacies and the top 20 prescribers associated with claims submitted as DAW-1. The report shall be produced and reviewed monthly by ten (10) business days after end of month.

e. Pharmacy Claim Reversals Report - The report shall identify pharmacies for which claim reversals may have manipulated payment by excessive reversals or failure to issue credits:

1. Reports pharmacies whose reversals total greater the three (3) percent or less than one percent (1%) of the total submitted prescription claims in a period. The report shall be produced and reviewed monthly by ten (10) business days after end of month.

f. A report that shall identify pharmacies which are not maximizing generic switch opportunities and cost savings; screen for potential site audit for facility inspection or record keeping; and identify optimization of generic dispensing opportunities. Generic efficiency shall mean the number of generic prescriptions dispensed divided by the number of generic prescriptions plus the number of multi-source brand prescriptions. The calculation shall be based on a minimum of two hundred and fifty (250) non-specialty drug claims per quarter and less than sixty percent (60%) generic utilization. The report shall be produced and reviewed monthly by ten (10) business days after end of month.

g. Pharmacy Submission of Package Size versus Days Supply - The report shall identify claim manipulation by pharmacies by screening for invalid correlation between the quantity and days supply submitted (i.e., eye drops, ear drops, miscellaneous topical preparations). Report shall identify inconsistencies between package size and days supply for the following: eye, ear, nasal preparations, or other miscellaneous topical preparations. The report shall be produced and reviewed monthly by ten (10) business days after end of month.

h. Pharmacy Time of Claims Submission - The report shall identify controlled substance prescription claims submitted between 10:00 p.m. and 6:00 a.m. and identify the number and type of prescriptions filled between this time period to evaluate for claim fraud, controlled substance abuse, and drug diversion.

A.11.5. The State, at its discretion, may choose to delegate oversight of portions of this contract to other agencies. The Contractor shall be required to produce reports for other state agencies in a manner consistent with the terms of the contract.

A.12. Communication

A.12.1 Notices

The Contractor shall be required to send individualized notices to enrollees, worded at a sixth (6th) grade reading level and using plain language, unless otherwise approved by TennCare. Template notices shall be approved by TennCare prior to sending to enrollees. Additionally, the Contractor shall submit timely corrected notices of adverse action to TennCare for review and approval prior to issuance to the member. Notices should be printed with an assurance of non-discrimination both in English and Spanish.

The Contractor shall provide individualized notices to enrollees for pharmacy lock in or when any adverse action is taken by the Contractor to deny, reduce, terminate, delay or suspend covered services as well as any other acts or omissions of the Contractor which impair the quality, timeliness, or availability of such benefits. Such notices shall include, but not be limited to:

a. Notification of prescription limits being met
b. Notification that a Prior Authorization request has been denied, which may or may not include a provision for continuation of benefits
c. Outcomes of a member initiated prior authorization request, which may include:
   i. Prescription change;
   ii. PA granted; or
   iii. PA denied.
d. Notification of drug not covered
e. Notification of blocked prescriber
f. Notification of pharmacy lock-in

g. Response to prescriber on outcome of prior authorization request. This may be completed by utilizing facsimile technology.

A.12.1.1. The Contractor shall clearly document and communicate the reasons for each denial of prior authorization request in a manner sufficient for the provider and member to understand the denial and decide about requesting reconsideration of or appealing the decision.

A.12.1.2. The Contractor shall comply with all member notice provisions in TennCare Rules, and all court orders and consent decrees governing the appeal procedures as they become effective.

A.12.1.3. Notices shall be mailed daily except Sunday each week. The previous day's claims and/or Prior Authorization requests shall be mailed the following day. Monday mailings shall include letters based on claims denied on Saturday and Sunday. The Contractor shall provide TennCare with a web-based system to search and view individual notices that have been sent. The Contractor shall have approval to subcontract the notice process as defined herein with the requisite approval from TennCare, but in no event shall off shore vendors be utilized. The direct postage cost for recipient prescription limit denial letters, prior authorization letters, non-covered drug letters, blocked prescriber letters, and lock in letters shall be a pass through item. Failure to provide notices may result in liquidated damages as described in Attachment C.

A.12.2. The State shall provide the Contractor with an eligibility record file containing indicators identifying recipients in the Department of Children's Services (DCS). Updates to this file will be provided on a weekly basis. The Contractor shall produce copies of any recipient denial notices generated over the previous week and forward the notices (via secure electronic file transmission) to DCS. Failure to provide denial notices to DCS on a weekly basis shall result in liquidated damages as described in Attachment C.

A.12.3. Prescription Limit Letters The Contractor shall generate, and mail letters to recipients regarding claims denied for the Script Limit edit. The extract shall be inclusive of claims that have received the initial denial for exceeding the limit of five (5) scripts per month and/or two (2) brand name scripts per month. Recipients shall receive a maximum of two (2) letters monthly, related to the maximum of five (5) scripts monthly and/or the maximum of two (2) brand scripts monthly. If two (2) letters are generated in an extract for the same mailing, they shall be mailed as two (2) separate pieces of mail. TennCare shall draft each of the two (2) possible recipient Script Limit denial letters for submission to the Contractor. Recipient letters shall be generated on TennCare letterhead. The return address on recipient letter mailing envelopes shall be identical to that on mailing envelopes for recipient ID cards:

TennCare Pharmacy Program
c/o The Contractor Corp

A.12.4. The Contractor shall open all returned mail from any mailings to enrollees or providers to determine if the enrollee has moved, if the Contractor has the wrong address and/or if the enrollee is communicating other information to the Contractor or to TennCare. The Contractor shall track returned mail and shall report monthly, in a yet to be determined mutually agreed upon format, to TennCare the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose mail was undeliverable due to an incorrect address provided by TennCare. Failure to report monthly to TennCare or to open and appropriately manage returned mail may result in liquidated damages as set forth in Attachment C. The Contractor shall have the right to subcontract this requirement after approval by TennCare.

A.13. Business Continuity and Contingency Plan – Disaster Recovery, System Back-up

A.13.1. Business Continuity and Contingency Plan - The Contractor shall deliver a preliminary Business Continuity and Contingency Plan (BCCP) during the Transition and Implementation activities, and shall update and test this plan as agreed upon with TennCare. The plan shall be in accordance with state standards as established by the Tennessee Emergency Management Agency (TEMA) for Continuity of Operations Plan documentation. The BCCP plan shall establish adequate backup processes for all PBM systems and operational functions and address the potential impacts of disaster occurrence. Contingency plans are composed of two (2) fundamental operations - System Back-up and Disaster

Recovery.

A.13.2. System Back-up and Disaster Recovery Contractor Requirements:

a. The Contractor shall establish and maintain daily back-ups that are adequate and secure for all computer software and operating programs, databases, files, and systems, operations, and user documentation (in electronic and non-electronic form) that are updated on a daily basis.

b. The Contractor shall establish and maintain a weekly back-up that is adequate and secure for all computer software and operating programs, databases, files, and systems, operations, and user documentation (in electronic and non electronic form).

c. The Contractor shall develop a plan for physical and system security that shall identify all potential security hazards at the physical site, including systems and networks, and shall identify the associated protection plans for the system assets and controls.

d. The Contractor shall follow all applicable technical standards for site and system security during the operation of the system, using best practices as developed by the National Institute of Standards and Technology (NIST).

e. The Contractor shall provide for off-site storage of back-up operating instructions, procedures, reference files, systems documentation, programs, procedures, and operational files. Procedures shall be specified for updating off-site materials.

f. The Contractor shall establish and maintain complete daily back-ups of all data and software and support the immediate restoration and recovery of lost or corrupted data or software.

g. Disaster planning documentation and procedures shall be approved by TennCare and put in place before system operations begin.

h. The Contractor shall provide for a back-up processing capability at a remote site(s) from the Contractor's primary site, such that normal payment processing, as well as other system and TennCare services deemed necessary by TennCare, can continue in the event of a disaster or major hardware problem at the primary site(s).

i. All proposed off-site procedures, locations, and protocols shall be approved by the Bureau in advance.

j. The Contractor shall clearly document all of the components and file systems that would be required for a full restore.

k. The Contractor shall document batch processes as to sender, receiver, location, process, date and databases updated and have a plan that details how each batch process would be supported and carried out to achieve a full restore.

l. In the event of a disaster, the Contractor shall specify the respective time frames deemed reasonably necessary for complete recovery.

m. The recovery period, in the event of a catastrophic disaster, shall not exceed thirty (30) calendar days.

n. The recovery period, in the event of a disaster caused by criminal acts or natural disasters, shall not exceed ten (10) calendar days.

o. The Contractor shall take all steps necessary to fully recover the data and/or system from the effects of a disaster and to reasonably minimize the recovery period.

p. The Contractor shall perform back-up demonstrations at no additional cost to TennCare. Failure

to successfully demonstrate the procedures may be considered grounds for termination of this Contract. TennCare reserves the right to waive part or all of the demonstrations. In the event the Contractor's test is deemed by the Bureau to be unsuccessful, the Contractor shall continue to perform the test until satisfactory, at no additional cost.

q. The Contractor shall develop a Business Continuity and Contingency Plan (BCCP) that identifies the core business processes involved in the system.

r. The BCCP Plan shall be available and present at the TennCare site.

s. The BCCP shall identify potential system failures for each core business process.

t. The BCCP shall contain a risk analysis for each core business process.

u. The BCCP shall contain an impact analysis for each core business process.

v. The BCCP shall contain a definition of minimum acceptable levels of outputs for each core business process

w. The BCCP shall contain documentation of contingency plans.

x. The BCCP shall contain definition of triggers for activating contingency plans.

y. The BCCP shall contain discussion of establishment of a business resumption team.

z. The BCCP shall address maintenance of updated disaster recovery plans and procedures.

aa. The BCCP shall address planning for replacement of personnel to include:

i. Replacement in the event of loss of personnel before or after signing this Contract;

ii. Replacement in the event of inability by personnel to meet performance standards;

iii. Allocation of additional resources in the event of the Contractor's inability to meet performance standards;

iv. Replacement/addition of personnel with specific qualifications;

v. Time frames necessary for replacement;

vi. Contractor's capability of providing replacements/additions with comparable experience; and

vii. Methods for ensuring timely productivity from replacements/additions.

bb. The system shall maintain appropriate checkpoint/restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications for voice and data circuits, and disaster recovery.

cc. The Contractor shall be required to prepare and maintain a Disaster Recovery Plan as part of the BCCP and provide TennCare with up-to-date copies at least once a year during the term of this Contract. The disaster recovery plan shall be submitted to TennCare for approval prior to the systems implementation and whenever changes are required.

dd. The Contractor shall ensure that each aspect of the Disaster Recovery Plan is detailed as to both Contractor and TennCare responsibilities and shall satisfy all requirements for federal certification. Normal PBM related day-to-day activities and services shall be resumed within five (5) working days of the inoperable condition at the primary site(s).

ee. The Contractor shall dedicate two (2) Subject Matter Experts (SMEs) to be onsite to participate in the disaster recovery drills.

ff. The Contractor shall coordinate with the State to demonstrate any near real-time failover capabilities in the primary data center or between primary and backup data centers in support of business continuity requirements. Failure to successfully demonstrate failover capabilities may be considered grounds for termination of this Contract. TennCare reserves the right to waive part or all of the demonstrations. In the event the Contractor's test is deemed by TennCare to be unsuccessful, the Contractor shall continue to perform the test until satisfactory, at no additional cost to the State.

gg. The Disaster Recovery Plan shall address Checkpoint/restart capabilities.

hh. The Disaster Recovery Plan shall address retention and storage of backup files and software.

ii. The Disaster Recovery Plan shall address Hardware backup for the main processor(s).

jj. The Disaster Recovery Plan shall address network backup for voice and data telecommunications circuits.

kk. The Disaster Recovery Plan shall address Contractor provided voice and data telecommunications equipment.

ll. The Disaster Recovery Plan shall address the Uninterruptible Power Source (UPS) at both the primary and alternate sites with the capacity to support the system and its components;

mm. The Disaster Recovery Plan shall address the continued processing of TennCare transactions (claims, eligibility, provider file, and other transaction types), assuming the loss of the Contractor's primary processing site. This shall include interim support for the TennCare online component of the TCMIS and how quickly recovery may be accomplished.

nn. The Disaster Recovery Plan shall address back-up procedures and support to accommodate the loss of online communication between the Contractor's processing site and TennCare.

oo. The Disaster Recovery Plan shall contain detailed file back-up plan and procedures, including the off-site storage of crucial transaction and master files. The plan and procedures shall include a detailed frequency schedule for backing up critical files and (if appropriate to the back-up media) their rotation to an off-site storage facility. The off-site storage facility shall provide security of the data stored there, including protections against unauthorized access or disclosure of the information, fire, sabotage, and environmental considerations.

pp. The Disaster Recovery Plan shall address the maintenance of current system documentation and source program libraries at an off-site location.

qq. The Contractor shall provide documentation defining back-up processing capacity and availability. Included shall be a prioritized listing of all of the Contractor's back-up processing that shall be performed at the back-up processing facility in the event of an inoperable condition at the primary site. Estimated back-up processing capacity utilization shall be included for each back-up processing item listed. Documentation shall include written agreements with the management of the back-up processing facility. Agreements shall identify duties and responsibilities of all parties involved as well as specify the level of back-up service to be provided to the Bureau.

rr. The Contractor shall demonstrate the disaster recovery capability for all critical system components at a remote site once during the first year of this Contract period and no less often than every two (2) calendar years, in accordance with the 45 CFR §95.621(f). The demonstration at the remote site shall be performed for all administrative, manual, input, processing, and output procedures functions, and include:

i. The processing of one (1) daily and one (1) weekly payment processing cycle, at a minimum;

ii. A test of all online transactions;

iii. A test of query and reporting capability; and

iv. Verification of the results against the corresponding procedures and production runs conducted at the primary site.

A.13.3. The Contractor shall provide the following Business Continuity and Contingency Plan Deliverables:

a. Submit BCCP and Disaster Recovery Plans to TennCare at least sixty (60) days prior to assumption of PBM operations.

b. Submit a Security Plan within thirty (30) calendar days of Contract Implementation, and update annually thereafter.

A.14. Non-Discrimination Compliance Requirements

The Contractor shall comply with all applicable State and Federal non-discrimination laws, regulations, rules, and policies.

A.14.1. In order to demonstrate compliance with Federal and State laws and regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209), the Contractor shall designate a staff person to be responsible for non-discrimination compliance in the TennCare Program. The Contractor shall document the designation of its non-discrimination compliance officer in writing to TennCare. The Contractor's non-discrimination compliance officer shall receive instruction regarding non-discrimination compliance in the TennCare Program from TennCare.

A.14.2. Investigations. When complaints concerning alleged acts of discrimination committed by providers are reported to the Contractor, the Contractor's non-discrimination compliance officer shall document and conduct the initial investigations, which includes, developing resolutions for the complaints. The initial investigation shall begin within five (5) business days of receiving a complaint. Once an initial investigation has been completed, the Contractor's non-discrimination compliance officer shall report his/her determinations to TennCare. At a minimum, the non-discrimination 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. TennCare shall review the Contractor's initial investigations and determine the appropriate resolutions for the complaints. Where a complaint is found to be valid, the Contactor shall implement a TennCare approved corrective action plan. TennCare reserves the right to investigate and resolve all complaints concerning alleged acts of discrimination committed by providers.

A.14.2.1. When complaints concerning alleged acts of discrimination committed by the Contractor and/or its subcontractors are reported to the Contractor, the Contractor shall send such complaints within two (2) business days of receipt to TennCare. TennCare shall investigate and resolve all alleged acts of discrimination committed by the Contractor and/or its subcontractors. The Contractor shall assist TennCare during the investigation and resolution of such complaints. Where a complaint is found to be valid. the Contactor shall implement a TennCare approved corrective action plan.

A.14.2.2. As part of the nondiscrimination complaint resolution process, the Contractor's non-discrimination compliance officer shall work with TennCare to develop an approved web-based non-discrimination training to be used as part of a corrective action plan. During the implementation process of this Agreement, TennCare shall approve the form and content for the web-based non-discrimination training. Prior to use, the web-based non-discrimination training must be approved by TennCare. Time periods for the implementation of the web-based non-discrimination training shall be designated by TennCare.

A.14.2.3. The Contractor's non-discrimination compliance officer shall be responsible for the oversight of the web-based non-discrimination training and shall also provide instructions regarding the web-based non-discrimination training. In order to satisfy the terms of the correction action

plan, the Contractor shall be able to show documented proof that all appropriate Contractor staff, providers or sub-contractors have received the web-based non-discrimination training.

A.14.3. The Contractor's non-discrimination policies and procedures shall demonstrate compliance in the provision of services for members with Limited English Proficiency and for members requiring communication assistance in alternative formats. The Contractor's non-discrimination policies and procedures shall be prior approved in writing by TennCare and shall include, but not be limited to the following topics:

A.14.3.1. Written policies and procedures for handling all nondiscrimination complaints received by the Contractor from members, providers, and sub-contractors. The policies and procedures shall implement the requirements set forth in section A.14.2. Investigations.

A.14.3.2. The Contractor shall use and have available to members TennCare's nondiscrimination complaint form located on TennCare's website.(currently found at http://www.tn.gov/tenncare/members.shtml.) This form shall be placed upon the Contractor's website and provided to a complainant upon request. This complaint form shall be available in English and Spanish. When requests for assistance are made by complainants, the Contractor shall assist complainants with the process of submitting a complaint.

A.14.3.3. Written policies and procedures for the provision of language assistance for individuals who do not speak or read English as a primary language or who need language assistance services in an alternative format.

A.14.3.4. The Contractor shall have and provide its written procedure for the provision of language assistance and communication assistance in alternative formats to all staff, providers and subcontractors related to the provision of and/or access to TennCare covered services administered by the Contractor.

A.14.3.4. The Contractor shall have and provide a Toll Free Number and a TTY number to all staff, providers and subcontractors related to the provision of and/or access to TennCare covered services administered by the Contractor to be used for the assistance of members who require language assistance or communication assistance in an alternative format.

A.14.4. The Contractor shall, at a minimum, emphasize non-discrimination in its personnel policies and procedures associated with hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees related to the provision of and/or access to TennCare covered services administered by the Contractor.

A.14.4.1. The Contractor shall ask all Contractor staff related to the provision of and/or access to TennCare covered services administered by the Contractor to provide their race or ethnic origin and sex. Contractor staff response is voluntary.

A.14.4.2. 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 or other employment benefits.

A.14.5. The Contractor shall submit the following non-discrimination compliance deliverables to TennCare as follows:

A.14.5.1. Annually, TennCare shall provide the Contractor with a Non-Discrimination Compliance Plan, which the Contractor shall submit to TennCare with any requested documentation, which includes, but is not limited to, the Assurance of Non-Discrimination. The signature date of the Contractor's Non-discrimination Compliance Plan shall must be the signature date of the Contractor's Assurance of Non-Discrimination. These deliverables shall be in a format specified by TennCare.

A.14.5.2. Quarterly the Contractor shall submit a Non-discrimination Compliance Report in a format specified by TennCare which shall include the following:

a. A summary listing totaling the number of the Contractor's supervisory personnel related to the provision of and/or access to TennCare covered services administered by the Contractor 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 or other race/ethnicity as indicated by TennCare and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin or other race/ethnic origin females as indicated by TennCare. Contractor staff response is voluntary.

b. A listing of all complaints filed by employees, members, providers and subcontractors in which discrimination is alleged related to the provision of and/or access to TennCare covered services administered 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, if appropriate, the Contractor's initial investigation and date of resolution. As set forth in section A.14.2. Investigations, the Contractor is only responsible for the initial investigation of complaints concerning alleged acts of discrimination committed by providers and shall cooperate in the investigation and resolution of all other complaints.

c. A listing of all member requests for language and communication assistance. The report shall list the member, the member's identification number, the date of the request, the date the service was provided and the name of the service provider.

A.15. Member Materials Shall Meet the Following Requirements

A.15.1. All member materials shall be worded at a sixth (6th) grade reading level, unless TennCare approves a higher grade reading level.

A.15.2. All written materials shall be clearly legible with a minimum font size of 12pt. with the exception of member I.D. cards, and unless otherwise approved in writing by TennCare.

A.15.3 All written materials shall be printed with the assurance of non-discrimination herein referred to as a "tagline", to be provided by TennCare.

A.15.4. All written member materials shall be made available in alternative formats for persons with special needs at no expense to the member. Alternative formats may include, but may not be limited to: Braille, large print, and audio and shall be based on the needs of the individual enrollee. The Contractor shall have processes in place to ensure that alternative format material will be made available to the member within forty five (45) days of a request.

A.15.5. All written material shall inform members as how to obtain member materials in alternative formats for members with special needs and how to access oral interpretation services and that both alternative formats and interpretation services are available at no expense to the member.

A.15.6. All written material shall include notice of the right to file a complaint as set forth in 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).

B. CONTRACT TERM:

B.1. This Contract shall be effective for the period beginning December 20, 2012, and ending on May 31, 2016. Actual delivery of services shall begin on June 1, 2013 after completion of transition, should one be necessary, and completion of readiness review. The Contractor hereby acknowledges and affirms that the State shall have no obligation for services rendered by the Contractor which were not performed within this specified contract period.

B.2. Term Extension. The State reserves the right to extend this Contract for an additional period or periods of time representing increments of no more than one year and a total contract term of no more than five (5) years, six (6) months, provided that such an extension of the contract term is 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 Fifty-Nine Million Three Hundred Forty-Eight Thousand Eighteen Dollars ($59,348,018.00). The payment rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

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

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

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

a. The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in section A.

b. The Contractor shall be compensated for said units, milestones, or increments of service based upon the following payment rates:

(1) For service performed from December 1, 2012, through May 31, 2013, the following rates shall apply:

Service Description	Amount (per compensable increment)
Implementation Cost (Paid in Three Equal Installments) 1/3 Due Four Months Prior to Delivery of Services 1/3 Due Two Months Prior to Delivery of Services 1/3 Due Upon Delivery of Services	$ 0.00

(2) For service performed from June 1, 2013, through May 31, 2014, the following rates shall apply:

Service Description	Amount (per compensable increment)
Monthly Administrative Fee	$858,033.50 Per month
Clinical PDL Pharmacist Based in Nashville	$16,000.00 Per month

Clinical PDL Pharmacist Based in Nashville	$16,000.00 Per month
Clinical Administrative Pharmacist Based in Nashville	$13,200.00 Per month
Clinical Administrative Pharmacist Based in Nashville	$13,200.00 Per month
Provider Educator Based in Field	$13,200.00 Per month
Provider Educator Based in Field	$13,200.00 Per month
Data Research Analyst Based in Nashville	$9,100.00 Per month
Program Coordinator Based in Nashville	$4,500.00 Per month
System Liaison Based in Nashville	$7,300.00 Per month
Contract Manager Based in Nashville	$11,250.00 Per month

(3) For service performed from June 1, 2014, through May 31, 2015, the following rates shall apply:

Service Description	**Amount** (per compensable increment)
Monthly Administrative Fee	$877,864.17 Per month
Clinical PDL Pharmacist Based in Nashville	$16,480.00 Per month
Clinical PDL Pharmacist Based in Nashville	$16,480.00 Per month
Clinical Administrative Pharmacist Based in Nashville	$13,596.00 Per month
Clinical Administrative Pharmacist Based in Nashville	$13,596.00 Per month
Provider Educator Based in Field	$13,596.00 Per month
Provider Educator Based in Field	$13,596.00 Per month
Data Research Analyst Based in Nashville	$9,373.00 Per month
Program Coordinator Based in Nashville	$4,635.00 Per month
System Liaison Based in Nashville	$7,519.00 Per month
Contract Manager Based in Nashville	$11,587.50 Per month

(4) For service performed from June 1, 2015, through May 31, 2016, the following rates shall apply:

Service Description	**Amount** (per compensable increment)
Monthly Administrative Fee	$898,289.74 Per month
Clinical PDL Pharmacist Based in Nashville	$16,974.40 Per month
Clinical PDL Pharmacist Based in Nashville	$16,974.40 Per month
Clinical Administrative Pharmacist Based in Nashville	$14,003.88 Per month
Clinical Administrative Pharmacist Based in Nashville	$14,003.88 Per month
Provider Educator Based in Field	$14,003.88 Per month
Provider Educator Based in Field	$14,003.88 Per month

Data Research Analyst Based in Nashville	$9,654.19 Per month
Program Coordinator Based in Nashville	$4,774.05 Per month
System Liaison Based in Nashville	$7,744.57 Per month
Contract Manager Based in Nashville	$11,935.13 Per month

(5) Should the Contract be amended for Extension of Services, for the services performed from June 1, 2016, through May 31, 2017, the following rates shall apply:

Service Description	Amount (per compensable increment)
Monthly Administrative Fee	$919,328.14 Per month
Clinical PDL Pharmacist Based in Nashville	$17,483.63 Per month
Clinical PDL Pharmacist Based in Nashville	$17,483.63 Per month
Clinical Administrative Pharmacist Based in Nashville	$14,424.00 Per month
Clinical Administrative Pharmacist Based in Nashville	$14,424.00 Per month
Provider Educator Based in Field	$14,424.00 Per month
Provider Educator Based in Field	$14,424.00 Per month
Data Research Analyst Based in Nashville	$9,943.82 Per month
Program Coordinator Based in Nashville	$4,917.27 Per month
System Liaison Based in Nashville	$7,976.91 Per month
Contract Manager Based in Nashville	$12,293.18 Per month

(6) Should the Contract be amended for an additional year for the services performed from June 1, 2017, through May 31, 2018, the following rates shall apply:

Service Description	Amount (per compensable increment)
Monthly Administrative Fee	$940,997.64 Per month
Clinical PDL Pharmacist Based in Nashville	$18,008.14 Per month
Clinical PDL Pharmacist Based in Nashville	$18,008.14 Per month
Clinical Administrative Pharmacist Based in Nashville	$14,856.72 Per month
Clinical Administrative Pharmacist Based in Nashville	$14,856.72 Per month
Provider Educator Based in Field	$14,856.72 Per month
Provider Educator Based in Field	$14,856.72 Per month
Data Research Analyst Based in Nashville	$10,242.13 Per month
Program Coordinator Based in Nashville	$5,064.79 Per month
System Liaison Based in Nashville	$8,216.22 Per month
Contract Manager Based in Nashville	$12,661.98 Per month

c. Rebate Incentive - Per Section A.4.5.2., Annual Rebates for each year of the contract shall be calculated on the basis of any rebates obtained outside of the OBRA rebates. Annually, if the Contractor exceeds the upper figure of the allowed supplemental rebate percentage range they shall receive an annual incentive based on the following table:

Exceed by less than one percent (1%)	One hundred thousand dollars ($100,000)
Exceed by more than or equal to one percent (1%), but less than two percent (2%)	Two hundred thousand dollars ($200,000)
Exceed by more than or equal to two percent (2%), but less than three percent (3%)	Three Hundred thousand dollars ($300,000)
Exceed by more than or equal to three percent (3%)	Six hundred thousand dollars ($600,000)

d. Rebate Incentive - Per Section A.4.5.2., Annual Rebates for each year of the contract shall be calculated on the basis of any rebates obtained outside of the OBRA rebates. The Table below lists the Contractor's Annual Allowed Supplemental Percentage for each year of the contract:

	June 1, 2013-May 31, 2014	June 1, 2014-May 31, 2015	June 1, 2015-May 31, 2016	June 1, 2016-May 31, 2017	June 1, 2017-May 31, 2018
Annual Allowed Supplemental Rebate Percentage	7.45%	7.13%	6.45%	5.80%	5.65%

e. In exchange for providing the TPL services described in Contract Section A.3.4.k., the Contractor shall receive payment in the amount of twelve and one-half percent (12.5%) of actual POS cost avoidance savings. Actual POS cost avoidance savings shall be determined on a monthly basis by claim level reporting. Savings shall be calculated only from claims where the TPL edit was the sole reason for claim denial.

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 after completion of all work, described in section A of this Contract, and present said invoices no more often than required, with all necessary supporting documentation, to:

Division of Health Care Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

a. Each invoice shall clearly and accurately detail all of the following required information (calculations must be extended and totaled correctly).

(1) Invoice Number (assigned by the Contractor);
(2) Invoice Date;
(3) Contract Number (assigned by the State);

(4) Customer Account Name: Department of Finance and Administration, Division of Health Care Finance and Administration, Bureau of TennCare
(5) Customer Account Number (assigned by the Contractor to the above-referenced State Agency);
(6) Contractor Name;
(7) Contractor Federal Employer Identification, Social Security, or Tennessee Edison Registration ID Number Referenced in Preamble of this Contract;
(8) Contractor Contact for Invoice Questions (name, phone, and/or fax);
(9) Contractor Remittance Address;
(10) Description of Delivered Service;

b. The Contractor understands and agrees that an invoice 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 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 payment, 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

sixty (60) days written notice before the effective termination date. The Contractor shall be entitled to receive 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 TCA 12-4-124, *et seq.*, addressing the use of illegal immigrants in the performance of any Contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment B, 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 Code Annotated*, Section 12-4-124, *et seq.* for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Contract.

e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.

D.9. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.10. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.11. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.12. Strict Performance. Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

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

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

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

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

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

D.17. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising there from, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.

D.18. Completeness. This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D.19. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.

D.20. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

E. SPECIAL TERMS AND CONDITIONS:

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.

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

The State:

Deputy Commissioner
Department of Finance and Administration
Division of Health Care Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville TN 37243
(615) 507-6443 (Phone)
(615) 253-5607 (FAX)

The Contractor:

Timothy P. Nolan, President
Magellan Medicaid Administration
11013 West Broad Street
Suite 500
Glen Allen, VA 23060
Telephone # (804) 548-0020
FAX # (804) 548-0015

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

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

E.4. Tennessee Consolidated Retirement System. The Contractor acknowledges and understands that, subject to statutory exceptions contained in *Tennessee Code Annotated*, Section 8-36-801, *et. seq.*, the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to *Tennessee Code Annotated*, Title 8, Chapter 35, Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor, 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.5. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

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

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

E.6. Social Security Administration (SSA) Required Provisions for Data Security. 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 of 2002 (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology guidelines. In addition, the Contractor shall have in place administrative, physical, and technical safeguards for data.

a. The Contractor shall not duplicate in a separate file or disseminate, without prior written permission from TennCare, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the TennCare program. Should the Contractor propose a redisclosure of said data, the Contractor must specify in writing to TennCare the data the Contractor proposes to redisclose, to whom, and the reasons that justify the redisclosure. TennCare will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.

b. The Contractor agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.

c. The Contractor shall provide a current list of the employees of such contractor with access to SSA data and provide such lists to TennCare.

d. The Contractor shall restrict access to the data obtained from TennCare 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 TennCare's prior written approval.

e. The Contractor shall ensure that its employees:

(1) properly safeguard PHI/PII furnished by TennCare 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 TennCare or TennCare 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.

f. 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 immediately contact TennCare **within 1 hour** to report the actual or suspected loss. The Contractor will use 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 TennCare 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, TennCare 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.

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

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

(1) Sections 1137,453, and 1106(b) of the Act (42 U.S.C. 1320b-7, 653, and 1306(b)) (income and eligibility verification data);
(2) 26 U.S.C. 6103(l)(7) and (8) (tax return. data);
(3) Section 202(x)(3)(B)(iv) of the Act (42 U.S.C. 401(x)(3)(B)(iv))(prisoner data);
(4) Section 205(r)(3) of the Act (42, U.S.C. 405(r)(3)) and Intelligence Reform and Terrorism Prevention Act of 2004, Pub. L. 108-458, 7213(a)(2) (death data);
(5) Sections 402,412, 421, and 435 of Pub. L. 104-193 (8 U.S.C. 1612, 1622, 1631, and 1645) (quarters of coverage data);
(6) Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-3 (citizenship data); and
(7) Routine use exception to the Privacy Act, 5 U.S.C. 552a(b)(3)(data necessary to administer other programs compatible with SSA programs).

This Section further carries out Section 1106(a) of the Act (42 U.S.C. 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy 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 ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. 3541 *et seq.)*, and related National Institute of Standards and Technology ("NIST") guidelines, which

provide the requirements that the Contractor must follow with regard to use, treatment, and safeguarding data.

i. Definitions

(1) "SSA-supplied data" – information, such as an individual's social security number, supplied by the Social Security Administration to TennCare to determine entitlement or eligibility for federally-funded programs (CMPPA between SSA and F&A; IEA between SSA and TennCare).

(2) "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 CFR 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.7. 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.

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.

The 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.

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.8. 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 TennCare 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 TennCare so long as TennCare 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 TennCare 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, TennCare 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 TennCare 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 TennCare'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 TennCare 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 TennCare immediately upon request by TennCare;

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 TennCare 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 an 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 CFR 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; 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 and employees and maintain signed acknowledgements by staff and employees of the Contractor's HIPAA/HITECH policies;

r. Be allowed to use and receive information from TennCare 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 performing work for the Contractor to have only minimum necessary access to PHI and personally identifiable data within their organization;

u. Continue to protect and secure PHI AND personally identifiable information relating to enrollees who are deceased;

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 CFR 164.524;

x. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR 164.526; and

y. Obtain a third (3rd) party certification of their HIPAA transaction compliance ninety (90) calendar days before the start date of operations.

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.9. TennCare and the Contractor are "information holders" as defined in TCA 47-18-2107. In the event of a breach of the security of Contractor's information system, as defined by TCA 47-18-2107, the Contractor shall indemnify and hold TennCare 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 TCA 47-18-2107(e)(2)and(3), shall only be permitted with TennCare's express written approval. The Contractor shall notify TennCare'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 TCA 47-18-2107.

E.10. Notification of Breach and Notification of Provisional Breach - The Contractor shall notify TennCare's Privacy Office immediately upon becoming aware of any incident, either confirmed or provisional, that represents or may represent 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.

E.11. Applicable Laws, Rules and Policies. Contractor agrees to comply with all applicable federal and State laws, rules, regulations and executive orders, including, but not limited to, Constitutional provisions regarding due process and equal protection of the laws.

E.12. The Contractor shall comply and submit to TennCare the disclosure of ownership and control information in accordance with the requirements specified in 42 C.F.R. Part 455, Subpart B, using the form approved by TennCare

E.13. 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.

E.14. 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 six (6) 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.

E.15. State Ownership of Work Products. The State shall have ownership, right, title, and interest, including ownership of copyright, in all work products, including computer source code, created, designed, developed, derived, documented, installed, or delivered under this Contract subject to the next subsection and full and final payment for each "Work Product." The State shall have royalty-free and unlimited rights and license to use, disclose, reproduce, publish, distribute, modify, maintain, or create derivative works from, for any purpose whatsoever, all said Work Products.

a. To the extent that the Contractor uses any of its pre-existing, proprietary or independently developed tools, materials or information ("Contractor Materials"), the Contractor shall retain all right, title and interest in and to such Contractor Materials, and the State shall acquire no right, title or interest in or to such Contractor Materials EXCEPT the Contractor grants to the State an unlimited, non-transferable license to use, copy and distribute internally, solely for the State's internal purposes, any Contractor Materials reasonably associated with any Work Product provided under the Contract.

b. The Contractor shall furnish such information and data as the State may request, including but not limited to computer code, that is applicable, essential, fundamental, or intrinsic to any Work Product and Contractor Materials reasonably associated with any Work Product, in accordance with this Contract and applicable state law.

c. Nothing in this Contract shall prohibit the Contractor's use for its own purposes of the general knowledge, skills, experience, ideas, concepts, know-how, and techniques obtained and used during the course of providing the services requested under this Contract.

d. Nothing in the Contract shall prohibit the Contractor from developing for itself, or for others, materials which are similar to and/or competitive with those that are produced under this Contract.

E.16. Incorporation of Additional Documents. Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below.

a. this Contract document with any attachments or exhibits (excluding the items listed at subsections b. through e., below);

b. any clarifications of or addenda to the Contractor's proposal seeking this Contract;

c. the State solicitation, as may be amended, requesting proposals in competition for this Contract;

d. any technical specifications provided to proposers during the procurement process to award this Contract;

e. the Contractor's proposal seeking this Contract.

E.17. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's proposal responding to RFP 31865-00346 (Attachment 6.2) and resulting in this Contract.

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 Diversity Business Enterprise in form and substance as required by said office.

E.18. 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.19. 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 sub recipients 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 31 United States Code Annotated (USC) § 1352.

E.20. 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.21. 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.22. Breach. A party shall be deemed to have breached the Contract if any of the following occurs:

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

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

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

(1) In event of a Breach by Contractor, the State shall have available the remedy of Actual Damages and any other remedy available at law or equity.

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

The State may continue to withhold the Liquidated Damages or a portion thereof until the Contractor cures the Breach, the State exercises its option to declare a Partial Default, or the

State terminates the Contract. The State is not obligated to assess Liquidated Damages berore availing itself of any other remedy. The State may choose to discontinue Liquidated Damages and avail itself of any other remedy available under this Contract or at law or equity; provided, however, Contractor shall receive a credit for said Liquidated Damages previously withheld except in the event of a Partial Default.

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

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

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

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

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

E.23. 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.24. 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 sub awards); 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 sub awards); 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.25. Offer of Gratuities. By signing this contract, the Contractor signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the federal General Accounting Office, federal Department of Health and Human Services, the Center for Medicare and Medicaid Services, or any other state or federal agency has or will benefit financially or materially from this Contract. This Contract may be terminated by TennCare as provided in Section D.4, if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, its agent, or employees.

E.26. Employees Excluded from Medicare, Medicaid or CHIP. The Contractor does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly employ, in the performance of this Contract, employees who have been excluded from participation in the Medicare, Medicaid, and/or CHIP programs pursuant to Sections 1128 of the Social Security Act.

E.27. Unencumbered Personnel. All persons assigned by the Contractor to perform services for the State under this Contract, whether they are employees, agents, subcontractors, or principals of the Contractor, shall not be subject to any employment contract or restrictive covenant provisions which would preclude those persons from performing the same or similar services for the State after the termination of this Contract, either as a State employee, an independent contractor, or an employee, agent, subcontractor or principal of another contractor with the State. If the Contractor provides the State with the services of any person subject to a restrictive covenant or contractual provision in violation of this provision, any such restrictive covenant or contractual provision will be void and unenforceable, and the Contractor will pay the State and any person involved all of its expenses, including attorneys fees, caused by attempts to enforce such provisions.

E.28. Records Discovery. In addition to the records audits referenced in D.9, the Contractor shall make available all records of whatever media (correspondence, memoranda, databases, worksheets, training material, etc.), in their original form, be it electronic or paper, including emails with metadata preserved. These records shall be produced to TennCare at no cost to the State, as required to satisfy evidence discovery demands of any of litigation, including state or federal class action, affecting TennCare. The State shall endeavor to keep the evidence discovery requests as limited as reasonably possible. The Contractor shall retain the right to object in court to any evidence discovery requests it may feel is too broad or otherwise unduly burdensome.

E.29. Notwithstanding any language or provisions in Section E to the contrary, upon termination of this Contract for any reason, the Contractor shall transfer to the State all rights, title and interest in any personal computer work stations, hardware, software, furnishings, copiers, printers, fax machines and office equipment purchased pursuant to this Contract. In the event that the Contractor determines that any such furnishings or equipment should be disposed of prior to the termination of this Contract, such disposition must be subject to the prior written approval of TennCare.

E.30. Tennessee Bureau of Investigation Medicaid Fraud and Abuse Unit (MFCU) Access to Contractor and Provider Records Office of TennCare Inspector General Access to Contractor, Provider, and Enrollee Records

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, MFCU and TennCare OIG shall be health oversight agencies as defined at 45 C.F.R. §§ 164.501 and 164.512(d) and 65 F.R. § 82462. When acting in their respective capacities as health oversight agencies, MFCU and TennCare OIG do not need authorization to obtain enrollee protected health information (PHI). Because MFCU and TennCare OIG will request the information mentioned above for health oversight activities, "minimum necessary" standards do not apply to disclosures to MFCU or TennCare OIG that are required by law. See 45 C.F.R. §§ 164.502(b)(2)(iv), 164.502(b)(2)(v), and 164.512(d).

a. The Contractor shall report all possible fraud and abuse to TennCare and the appropriate agency as follows:

(1) All possible enrollee fraud and abuse shall be reported immediately to OIG;
(2) All possible provider fraud and abuse shall be reported immediately to TennCare and MFCU;
(3) Possible fraud and abuse by the Contractor in the administration of the program shall be reported to TennCare.

b. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting possible fraud or abuse, the Contractor shall not take any of the following actions as they specifically relate to TennCare claims:

(1) Contact the subject of the investigation about any matters related to the investigation;
(2) Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
(3) Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

c. This Section applies even if the source of the reported activity is an audit or investigation done by another State or federal agency (e.g. Comptrollers office, licensing agency) as these investigations or audits often have Program Integrity implications. The Contractor shall promptly provide the results of its preliminary investigation to the agency to whom the incident was reported, or to another agency designated by the agency that received the report.

e. The Contractor shall cooperate with all appropriate state and federal agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the Contractor shall fully comply with the TCA §§ 71-5-2601 and 71-5-2603 in performance of its obligations under this Contract.

f. Enrollee Records-Consent. As a condition of participation in TennCare, enrollees shall give TennCare, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the Contractor, TennCare or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ.

g. TennCare, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, DOJ and their authorized agents, as well as any authorized state or federal agency or entity shall have the right to access through inspection, evaluation, review or request, whether announced or unannounced, or other means any TennCare records pertinent to this Contract including, but not limited to medical records, billing records, financial records including 1099 forms, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution.

(1) Such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the requesting agency.

(2) Upon request, the provider shall assist in such reviews, including the provision of complete copies of medical records at no cost to the requesting agency.

(3) The Contractor acknowledges that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to TennCare, OIG, TBI MFCU, DHHS OIG and DOJ and their authorized agents. Any authorized state or federal agency or entity, including, but not limited to TennCare, OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for medical audit, medical review, utilization review and administrative, civil or criminal investigations and prosecutions

E.30.1. Prevention/Detection of Provider Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

The Contractor shall provide monthly reports to TennCare that describe pharmacy provider dispensing patterns that statistically identify the pharmacy as an outlier that may be representative of potential fraudulent, abusive or wasteful dispensing patterns. Additionally, the Contractor shall provide specific recommendations to TennCare, via a plan of correction that will eliminate the potentially fraudulent, abusive or wasteful dispensing patterns of these specific pharmacy providers. The reports shall be due on the fifteenth (15th) day of the month for the previous month's pharmacy claims. The report shall be independent of routine audit activities, and shall include but not be limited to referrals made to the Contractor by network pharmacies, prescribers, TennCare's Office of program, the Tennessee Bureau of Investigation, the Tennessee Medicaid Fraud Control Unit, and the State of Tennessee's Office of Inspector General. The Contractor shall meet with TennCare's Office of Provider Integrity to review all fraud activities quarterly.

TennCare will monitor the delivery and content of these reports and notify the Contractor of any violations as well as any possible sanctions related to those violations. The Contractor shall have thirty (30) calendar days, following written notification, to correct all violations prior to assessment of liquidated damages by TennCare. The Contractor shall submit to TennCare, within five (5) business days, a corrective action plan for each violation. Such notices will be sent to the Contractor via certified U.S. Mail.

E.30.2. Fraud and Abuse Compliance Plan

The Contractor shall have a written Fraud and Abuse compliance plan. A paper and electronic copy of the plan shall be provided to TennCare and the State Office of the Inspector General. The Contractor's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the State Office of the Inspector General within ninety (90) days of the effective date of this Agreement. The State Office of the Inspector General shall provide notice of approval, denial, or modification to the Contractor within thirty (30) days of review. The Contractor shall make any requested updates or modifications available for review to TennCare and/or the State Office of the Inspector General as requested by TennCare and/or the State Office of the Inspector General within thirty (30) days of a request. The State shall not transfer their law enforcement functions to the Contractor. At a minimum the written plan shall:

i. Ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;

ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract:

iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:

Claims edits;
Post-processing review of claims:
Provider profiling and credentialing;
Prior authorization;
Utilization management;
Relevant subcontractor and provider agreement provisions;
Written provider and enrollee material regarding fraud and abuse referrals.

iv. Contain provisions for the confidential reporting of plan violations to the designated person as described in item E.30.4. below;

v. Contain provisions for the investigation and follow-up of any compliance plan reports;

vi. Ensure that the identities of individuals reporting violations of the plan are protected;

vii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;

viii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU (Medicaid Fraud Control Unit) and that enrollee fraud and abuse be reported to the State Office of the Inspector General;

ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

E.30.3. Claims Attestation. Per 42 CFR § 455.18 and 455.19, the following statement shall be included in any Agreement that an MCC Contractor has with its subcontractors and/or providers: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."

E.30.4. Return of Overpayments. In accordance with the Affordable Care Act and TennCare policy and procedures, the Contractor and its subcontractors and providers shall report overpayments and, when it is applicable, return overpayments within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may result in a penalty pursuant to state or federal law.

E.30.5. False Claims Act. The Contractor and its subcontractors and Providers shall comply with the provisions of 42 USC § 1396a(a)(68) *et seq.*, as applicable, regarding policies and education of employees as regards the terms of the False Claims Act and whistleblower protections.

E.30.6. The Contractor shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG).

E.30.7. The Contractor shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

E.30.8. The Contractor shall submit an annual report to the State Office of the Inspector General that includes summary results of fraud and abuse tests performed as required by E.30.2.iii. and detailed in the Contractor's Fraud and Abuse compliance plan. The report should cover results for the year ending June 30 and be submitted by September 30 each year. This information in this report shall be provided in accordance with and in a format as described in the Contractor's approved compliance plan.

E.31. Ownership & Control Disclosure Information. The Contractor and their subcontractors and Providers shall disclose, to TennCare, the Comptroller General of the United States or CMS, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in the time and manner set forth in accordance with federal and state requirements, including but not limited to 42 CFR § 455.101 *et seq.*; 42 CFR § 1001.1001 and 42 CFR § 455.436. These disclosures shall be made on the form provided by TennCare.

The Contractor and its subcontractors shall collect the disclosure of health care-related criminal conviction information as required by 42 CFR § 455.106 and establish policies and procedures to ensure that applicable criminal convictions are reported timely to the State. The Contractor shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128 B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The results of said screenings shall be provided to TennCare on a monthly basis. The word "contractors" in this section shall refer to all individuals listed on the disclosure form including providers and non-providers such as board members, owners, agents, managing employees, etc.

The Contractor and its subcontractors and providers agree to disclose business transaction information up request and as otherwise specified in federal and state regulations.
Contractors Program Integrity responsibilities are as follows:

Contractor will collect all necessary information required for screening and enrollment of all Billing Providers {Pharmacies}, as required by Federal law in 42 CFR §§ 455.410.and 455.450. Contractor will submit this information to the Provider Enrollment division of the Bureau of TennCare. TennCare shall issue the appropriate TennCare Provider ID number upon completion of the screening and enrollment process. In the event that the federal regulations require a site visit for a particular provider as part of the screening process, Contractor shall make the required site visit if requested to do so by the Bureau of TennCare.

E.32. Failure to Meet Contract Requirements - It is acknowledged by TennCare and the Contractor that in the event of failure to meet the requirements provided in this Contract and all documents incorporated herein, TennCare will be harmed. The actual damages that TennCare will sustain in the event of and by reason of such failure are uncertain, are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the Contractor shall be subject to damages and/or sanctions as described in Section A and Section E.22. of this Contract. It is further agreed that the Contractor shall pay TennCare liquidated damages as directed by TennCare and not to exceed the fixed amount as stated in Section A of this Contract and identified in Attachment C of the *pro forma* contract; provided however, that if it is finally determined that the Contractor would have been able to meet the Contract requirements listed in Section A of this Contract but for TennCare's failure to perform as provided in this Contract, the Contractor shall not be liable for damages resulting directly therefrom.

IN WITNESS WHEREOF,

MAGELLAN MEDICAID ADMINISTRATION, INC.:

12/17/2012

CONTRACTOR SIGNATURE **DATE**

Timothy P. Nolan, President

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

December 18, 2012

CONTRACTOR SIGNATURE **DATE**

René Lerer, Chairman and CEO, Magellan Health Services, Inc.

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

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

December 19, 2012

MARK A. EMKES, COMMISSIONER **DATE**

ATTACHMENT A

DEFINITIONS

Any terms used in this Contract that are not defined herein shall have the meaning set forth in the TennCare Rules. The following terms and acronyms used in this Contract shall have the meanings set forth below. In the event of a conflict between the definitions set forth herein and those contained in the TennCare Rules, the definitions set forth in this contract shall govern.

1. **340B Pharmacy** - A pharmacy participating in a special drug discount program authorized by Section 340B of the Public Health Service Act. Participation is limited to the following types on providers: Consolidated Health Centers, AIDS clinics and drug programs, Black Lung Clinics, Federally Qualified Health Center Look-a-likes, Disproportionate Share Hospitals, Hemophilia treatment centers, Native Hawaiian health centers, Urban Indian clinics/638 tribal centers, Title X family planning clinics, STD clinics, TB clinics.

2. **ACD** - Automatic Call Distributor (ACD) is a system or devise that distributes incoming calls to a specific group of representatives and designated terminals .

3. **AMP** - Average Manufacturer Price, a reference drug price calculated by CMS. It is based on data provided by pharmaceutical manufacturers. This value is used to calculate Medicaid Drug Rebates for state Medicaid programs.

4. **AWP** - Average Wholesale Price is a reference price for prescription drug products. Pharmacy reimbursement can be calculated based on AWP minus a percentage. The AWP amount is provided by commercial publishers of drug pricing data such as First Data Bank or Thomson Medical Economics.

6. **Business Interruption** - Any disruption in operations that is equal to or longer than ten minutes in duration.

7. **Clean Claim** - A claim received by the PBM for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the PBM.

8. **CHF** - Congestive Heart Failure is a condition in which the heart's function as a pump to deliver oxygen rich blood to the body is inadequate to meet the body's needs.

9. **CMS** - Centers for Medicare & Medicaid Services.

1. **CSR** - Customer Service Representative is a person working in a Contractor's call center operation.

2. **Complete Claim** – Any claim received by the PBM for adjudication where sufficient information has been provided to permit the claim to have been either denied or allowed

12. **DAW** – Dispense as Written - A prescription that cannot be filled with a generic because the prescriber has indicated Dispense as Written on the prescription.

13. **Disaster** - A negative event that significantly disrupts business operations for more than one hour.

14. **Disenrollment** - The discontinuance of a member's entitlement to receive covered services under the terms of this Contract, and deletion from the approved list of members furnished by TennCare to the Contractor.

15. **DDI Phase** - Design Development and Implementation

16. **DEA Number** - A Drug Enforcement Agency (DEA) Number is a series of numbers assigned to a health care provider allowing them to write prescriptions for controlled substances. The DEA number is often used asa prescriber identifier.

17. **Drug Efficacy Study Implementation (DESI) Drug** - A drug that has been designated as experimental or ineffective by the Food and Drug Administration (FDA).

18. **DSS** - A decision support system is a database and query tool.

19. **DUR** - Drug Utilization Review is program is to improve patient safety and care and to reduce overall drug costs. Medicaid DUR programs are required by the federal Omnibus Budget Reconciliation Act of 1990 to provide prospective claim edits, retrospective analysis and educational programs.

20. **Pro-DUR** - A point of sale claim edit to facilitate drug utilization review objectives.

21. **Retro-DUR** - A post payment claims analysis to facilitate drug utilization review objectives.

22. **EMC** - Electronic Media Claims.

23. **Enrollee** - Any person who has enrolled in the TennCare program in accordance with the TennCare Rules. (See Member or Recipient, also).

24. **FAQs** - Frequently Asked Questions.

25. **FIR** - Functional and Informational Requirements.

26. **FTE** - Full time equivalent position.

27. **FUL** - Most current Federal Upper Limit price as listed by CMS.

28. **GCN** - Generic Code Number.

29. **GSN** - Generic Sequence Number.

30. **HIPAA** - Health Insurance Portability and Accountability Act of 1996.

31. **Hot Site** - An alternative facility with the capability to readily assume responsibility for carrying out the activities carried out at the Contractor's main site.

32. **Incomplete Claim** – Any claim received by the PBM for adjudication that cannot either be denied or allowed due to insufficient information and/or documentation that is needed from the provider in order to allow or deny the claim.

33. **IVR or IVRU** - Interactive voice response unit is a telephone technology that allows a computer to detect voice and touch tones using a phone call and provide individualized system generated information for callers.

34. **IRS** - Drugs that are identical, related or similar to drugs identified as LTE (less than effective) by the FDA.

35. **Limited English Proficiency** - Refers to individuals have a limited ability to read, speak, write, or understand English.

36. **"Lock In"** - A restrictive logic that limits claims at point of sale to selected prescribers or pharmacies. Members under this restriction are said to be "locked-In".

37. **Long-Term Care** - The services of one of the following: a nursing facility (NF); An Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a Home and Community-Based Services (HCBS) waiver program.

38. **LTE** - Drugs that the Food and Drug Administration (FDA) considers to be Less Than Effective because there is a lack of substantial evidence of effectiveness for all labeled indications and for which there is no compelling justification for their medical need.

39. **MAC** - Maximum Allowable Cost.

40. **MCO** - A managed care organization participating in the TennCare program.

41. **Member** - Any person who has enrolled in the TennCare program in accordance with the TennCare Rules and Regulations. (See Enrollee or Recipient, also).

42. **NCPDP** - National Council of Prescription Drug Programs.

43. **NDC** - National Drug Code Number.

44. **NPI** - National Provider Identification Number.

45. **NTIS** - National Technical Information Service operated by the US Department of Commerce.

46. **OBRA** - Omnibus Budget Reconciliation Act

47. **OIR** - Office of Information Resources

48. **OTC** - Over-the-counter medications.

49. **PA** - Prior Authorization - A program requirement where certain therapies must gain approval before payment can be authorized.

50. **PDL** - Preferred Drug List.

51. **PHI** - Protected Health Information, as defined in HIPAA (45 C.F.R. §§ 160 and 164).

52. **POS** - Point-of-Sale.

53. **Provider** - An institution, facility, agency, person, corporation, partnership, or association approved by TennCare which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with an MCO.

54. **Quality Management/Quality Improvement (QM/QI)** - The ongoing process of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical knowledge, and the effort to assess and improve the performance of a program or organization. Quality Improvement includes quality assessment and implementation of corrective actions to address any deficiencies identified.

55. **RA** - Remittance Advice.

56. **Recipient** - Any person who has enrolled in the TennCare program in accordance with the TennCare Rules. (See Member or Enrollee, also).

57. **RFP** - Request for Proposal.

58. **State** - The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Department of Finance and Administration (F&A), the Division of Health Care Finance and Administration (HCFA), the TennCare Office of Inspector General (OIG), the Bureau of TennCare, the Medicaid Fraud Control Unit (MFCU), the Department of Mental Health (DMH), the Department of Children's Services (DCS), the Department of Health (DOH), the TennCare Oversight Division within the Department of Commerce and Insurance (C&I) and the Office of the Attorney General (AG).

59. **Step Therapy** - A program requirement to begin drug therapy with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary. The objectives are to control costs and minimize risks.

60. **Subcontract** - An agreement that complies with all applicable requirements of this Contract entered into between the Contractor and another organization or person to perform any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract, (e.g., marketing).

61. **Subcontractor** - Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract.

62. **System Interruption** - Any event that affects more than five percent (5%) of POS transactions and call center operations, or a data integrity issue that compromises the confidentiality of the system of data contained within the system.

63. **TCA** - Tennessee Code Annotated.

64. **TCMIS** - TennCare Management Information System.

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

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

67. **Total Parenteral Nutrition (TPN)** - A compounded nutritional prescription for patients unable to gain nourishment through their gastrointestinal tract.

68. **U & C** - Usual and customary price.

69. **UOM** - Unit of Measure.

70. **WAC** - Wholesale Acquisition Cost represents the manufacturer's published *catalog* or *list* price for a drug product to wholesalers. WAC does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions in price.

ATTACHMENT B

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	

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.

Timothy P. Nolan President, Magellan Medicaid Administration

PRINTED NAME AND TITLE OF SIGNATORY

December 17, 2012

DATE OF ATTESTATION

PERFORMANCE, DELIVERABLES AND DAMAGES

The table below summarizes Performance Measures and Deliverables described in other sections of this Contract. Included in the table are delivery schedules and non-performance damages. TennCare shall monitor the Contractor's performance meeting the required standards. If TennCare determines that the Contractor has failed to meet any of the requirements of this Contract, TennCare may, at its option, send a Notice of Deficiency to the Contractor as provided in Section E.2 of this Contract, identifying the Contract requirement(s) not being met by the Contractor. Receipt of a Notice of Deficiency shall be deemed to be a request for a Corrective Action Plan (CAP) from the Contractor. Within five (5) business days of receipt of the Notice of Deficiency, the Contractor shall submit a written CAP to TennCare for approval. Failure to submit a CAP or comply with its requirements, as approved by TennCare, may, in the State's discretion, result in liquidated damages of one hundred dollars ($100) per day (unless otherwise specified herein) for each calendar day the CAP is late or compliance with the CAP is not complete. In situations where the Contractor wishes to dispute any liquidated damages (LDs) assessed by the State, the Contractor must submit a written notice of dispute, including the reasons for disputing the LD, within thirty (30) days of receipt of the letter from the State containing the total amount of damages assessed against the Contractor. Failure to submit a timely notice of dispute as provided herein terminates any and all rights the Contractor may have, at law or in equity, to dispute the assessed LD, refuse to pay it, or object to the reduction of a administrative services payment by TennCare in payment of the LD. Such failure to timely dispute the LD shall further act as a bar to the Contractor bringing any action relating to the LD in any forum or court having proper jurisdiction of this matter.

In addition to any other liquidated damage provided in this Contract, TennCare also reserves the right to assess a general liquidated damage of five hundred dollars ($500) per violation of any requirement of this Contract when the Notice of Deficiency is sent to the Contractor.

If damages are assessed, TennCare shall reduce the Contractor's payment for administrative services in the following month's invoice by the amount of damages. In the event that damages due exceed TennCare fees payable to Contractor in a given payment cycle, TennCare shall invoice Contractor for the amount exceeding the fees payable to Contractor, that shall be paid by Contractor within thirty (30) calendar days of the invoice date.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.2 Plan Implementation	Contractor shall complete all implementation actions prior to "go-live" date and according to the implementation timeline provided by the Contractor to TennCare. The Contractor shall receive TennCare's sign-off that each action has been completed successfully. Implementation action steps include the following minimum items: • Benefit plan designs loaded, operable and tested; • Perform comprehensive systems testing (including interface testing with all third parties) and quality assurance audits, with results reported to the TennCare prior to the "Go-Live"; • Eligibility feed formats loaded and tested end to end; • Operable and tested toll-free	Due prior to the claims processing commencement date of June 1, 2013, 1:00 a.m. Central Standard Time (CST)	Contractor may, in the State's discretion, be required pay to TennCare amount of ten thousand dollars ($10,000.00) per day for each day full implementation of the project is delayed by fault of the Contractor. This guarantee is dependent upon Contractor receiving necessary information and approvals from TennCare in a timely manner.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
	numbers; • Signed agreements for Retail Pharmacy and Long-term Care Pharmacy networks; • Account management, Help Desk and Prior Authorization staff hired and trained; • Established billing/banking requirements; • Complete notifications to pharmacies and prescribers regarding contractor change; • Each component shall be met by an agreed upon deadline in an implementation timeline provided by Contractor to TennCare. Implementation action requirements may include other items necessary to meet the claims processing commencement date of June 1, 2013, 1:00 a.m. CST ; and • Claims history and existing prior authorizations and overrides shall be migrated to Contractors POS system		
A.2.2 Project Initiation and Requirements Definition Phase	The Contractor must be in sync with the TCMIS eligibility data.	All outbound 834 files from TennCare must be loaded to the Contractors data base within twenty-four (24) hours of receipt from TennCare. This requirement includes any 834 transactions that must be handled manually by the Contractor.	Penalty may, in the State's discretion, be ten-thousand dollars ($10,000) per day, or any part thereof, beyond the first twenty-four (24) hours, that any files are not properly loaded into the Contractor's database.
A.3.2 Claim Payment and Remittance Services	The Contractor shall distribute and mail TennCare outputs as required by this Contract including, but not limited to: provider checks and remittance advices, returned claims, notices, provider bulletins, provider manuals and special mailings.	The Contractor shall mail checks and remittance advices to pharmacy providers each week on Fridays, with the exception of holiday weeks. With notice, holiday production shall not delay the process by more than two (2) business days. TennCare shall be notified no later than two (2) business days of any systems or operational issues that may impact disbursements by the prescribed timelines. For checks to be issued on Friday, the Contractor shall deliver the two (2) files identified in Contract	Penalty may, in the State's discretion, be one-thousand dollars ($1,000) per business day, per file, for any files that are not delivered to the State on time.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
		Sections A.3.2.a.(i) and A.3.2.a.(ii) to the State, in an electronic media suitable to the State, by 10:00 a.m. CST, on Thursday of each week.	
A.3.2. Claim Payment and Remittance Services	The Contractor shall distribute and mail TennCare outputs as required by this Contract including, but not limited to: provider checks and remittance advices, returned claims, notices, provider bulletins, provider manuals and special mailings.	The Contractor shall pay within fifteen (15) calendar days of receipt one-hundred percent (100%) of all clean claims submitted by network and non-network pharmacy providers through POS and batch electronic claims submission.	Penalty may, in the State's discretion, be one-thousand dollars ($1,000) per calendar day payment to pharmacy providers for clean claims exceeds fifteen (15) calendar days from the date of claim submission.
A.3.2 Encounter Data Files	All adjudicated claims (encounters) shall be transferred to TennCare on a schedule designated by TennCare.	File transfer due weekly and due forty-eight (48) hours after end of reporting week.	If the Contractor fails to produce the report, the calculation of the damages may, in the State's discretion, begin on the first day following the due date of the report and continue until receipt of the report by TennCare. Penalty may, in the State's discretion, be $5,000 per week.
A.3.3.d POS Claims	The Contractor shall process ninety-nine point five percent (99.5%) of POS pharmacy claims within ten (10) seconds on a daily basis. This is the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor and shall include all procedures required to complete claim adjudication.	Ninety–nine point five percent (99.5%) of claims process shall process to completion within ten (10) seconds on a daily basis.	If ninety-nine point five percent (99.5%) of claims are not processed within the ten (10) second time frame then the daily penalty may, in the State's discretion, be $1,000 per day of non-compliant processing.
A.3.3. POS Downtime	System will operate without unscheduled or unapproved downtime. For purposes hereof "downtime" shall be any interruption involving more than 10% of production for a period greater than 15	No unscheduled or unapproved downtime.	$2,500 per occurrence of unscheduled or unapproved downtime if deemed by TennCare to be the result of

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
	minutes.		Contract's failure to comply with the requirements of the Contract.
A.3.3. POS Downtime Notification	Contractor shall report to TennCare immediately (within one (1) hour) upon knowledge of downtime. TennCare is to identify staff to be contacted after normal business hours in the event of an interruption of service.	Report is due within one (1) hour, upon knowledge of downtime.	Immediate report is due within one (1) hour upon knowledge of the downtime. $7,500 one time damage may, in the State's discretion, be assessed for not reporting immediately.
A.3.3.d Batch Electronic Media (EMC) Claims Processing	The Contractor shall receive claims in electronic format, via batch transmission, CD or DVD for immediate processing. The Contractor shall assign identification control numbers to all batch claims within three (3) business days of receipt. The Contractor shall maintain electronic backup of batch claims for the duration of the contract. If TennCare requests copies of batch electronic claims, these shall be provided within three (3) business days of request. As requested, the Contractor shall provide the batch files as they were originally received. These files shall be delivered to the TennCare site by Virtual Private Network connection. Electronic batch claims shall be submitted through a method that shall allow batch and POS claims to be adjudicated through the same processing logic. New providers requesting to submit batch claims shall provide at least a thirty (30) day notice and shall conform to the standard Change Control and testing process.	Assignment of identification control numbers to all batch claims within three (3) business days of receipt and provide TennCare with copies of batch electronic claims within three (3) business days of request.	Calculation of the damages may, in the State's discretion, begin on the first day following the due date and continue until receipt of the report by TennCare. Penalty may, in the State's discretion, be $1,000 per day.
A.3.3 POS Downtime Occurrence Reports	The Contractor shall provide TennCare with updates at regular intervals during a sustained downtime. TennCare shall be presented with recovery options as appropriate. Upon full recovery, the Contractor shall provide TennCare with a System Down Analysis describing root cause issues and actions to mitigate future downtime occurrences.	Report is due within five (5) business days after full system recovery.	Daily penalty may, in the State's discretion, be $1,000 per day. Calculation of the damages will begin on the sixth business day. following full system recovery.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.3.3.g Aged Checks Not Cashed	The Contractor shall provide TennCare Fiscal Services Unit a monthly report detailing all checks remitted to providers on behalf of the State that remain outstanding (have not been cashed) greater than ninety (90) days.	Contractor shall provide TennCare with a monthly report of remitted checks as stipulated. Reports are due monthly, due on the 15th day of the month following the reporting period.	Penalty may, in the State's discretion, be $500 per week that report is overdue.
A.3.3 Aged Account Payable Notices	The Contractor shall ensure that collection letters are sent to pharmacies that maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) workdays of becoming ninety (90) days old.	Contractor shall provide TennCare with a monthly report of notices sent. Reports are due monthly, ten (10) business days after end of month of reporting period.	If Contractor fails to send notice, the penalty may, in the State's discretion, be $100 per provider notice per month.
A.3.4 Claim Validation	The Contractor system shall approve for payment only those claims for members eligible to receive pharmacy services at the time the service was rendered. The Contractor shall immediately notify TennCare of any and all claims that have been erroneously processed, and initiate appropriate action to correct the errors. In the event that claims are inappropriately denied the Contractor may be assessed damages denied the Contractor may be assessed damages	Reimbursement or damages resulting from this section may be applied to as offsets to future administrative fees.	The Contractor shall reimburse TennCare for the cost of all claims paid as a result of contractor error. Penalty for claims inappropriately denied may, in the State's discretion, be $100 per occurrence. .
A.3.6 Emergency Supply Override	The Contractor shall assure that the TennCare-POS systems allows pharmacists to execute an emergency override that shall process an emergency seventy-two (72) hour supply for drugs that are eligible per TennCare requirements.	TennCare POS system to permit emergency seventy-two (72) hour override.	Penalty for not allowing emergency override claims to process correctly may, in the State's discretion, be $500 per occurrence. .
A.3.8 Reversals and Adjustments	The system shall provide an efficient means of reversing or adjusting claims both before and after the claim has been transmitted to the TCMIS. If reversed or adjusted, this information shall continue processing in TCMIS. TennCare shall make no payments to the Contractor for reversed, voided or adjusted claims.	Contractor shall process all reversals requested by TennCare Fiscal Services Unit within thirty (30) days and provide confirmation to TennCare Fiscal Services Unit upon occurrence.	A damage of $100 may, in the State's discretion, be assessed per transaction that has not been reversed or adjusted within thirty (30) days of written request of TennCare Fiscal Services Unit.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.3.9. Manual Claims	The Contractor shall process manual claims within twenty one (21) calendar days of receipt from TennCare appeals unit; notify appeals unit of incomplete information for manual claim process within ten (10) calendar days of receipt from TennCare appeals unit.	The Contractor shall provide report of manual claims processed, prior authorizations submitted, prior authorizations received, claims paid or denied, date received and date completed on a weekly basis.	Failure to meet these service levels may, in the State's discretion, result in liquidated damages of $100 per occurrence.
A.4.2. PDL Design, Development, and Implementation	The Contractor shall implement changes in the POS system for PDL, Step Therapy, Prior Authorization requirements and all supporting systems within forty-five (45) days of approval from TennCare. Such changes to the POS system shall require provider notification thirty (30) days prior to the implementation. TennCare shall identify the targeted provider for each notification.	Implement changes and issue notification in specified time frames	Calculation of the damages may, in the State's discretion, begin on the first day following the due date and continue until required changes with proper notice are implemented. Penalty may, in the State's discretion, be $1,000 per day.
A.4.4 TennCare Pharmacy Advisory Committee Support	The Contractor shall attend, support and facilitate meetings of the TennCare Pharmacy Advisory Committee (PAC) as necessary to maintain the TennCare PDL.	Approved meeting materials shall be distributed ten (10) business days prior to PAC meetings. Draft minutes shall be submitted to TennCare with two (2) weeks of PAC meeting.	Calculation of the damages may, in the State's discretion, begin on the first day following the due date for meeting material or minutes and may continue until delivered. Penalty may, in the State's discretion, be $1,000 per day.
A.4.5 Drug Rebate Dispute Data	The Contractor shall provide to the agency or business of the State's choosing, any and all appropriate, accurate, and balanced pharmacy level claims data needed to resolve or avoid any Medicaid or supplemental drug rebate disputes.	This data shall be provided to TennCare within fifteen (15) business days of a request by TennCare	Calculation of the damages may, in the State's discretion, begin on the first day following the due date and continue until receipt of the report by TennCare. Penalty may, in the State's discretion, be $1,000 per business day.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.4.5 Delinquent Rebate Payment Notices	The Contractor shall ensure that written notification is sent to Drug Manufacturers concerning forty-five (45) day past-due undisputed account balances within fifty (50) days after the original invoice date. The Contractor shall also ensure that written notification is sent to Drug Manufacturers concerning seventy-five (75) day past-due undisputed account balances within eighty (80) days after the original invoice date. The Contractor shall also ensure that written notification is sent to Drug Manufacturers concerning ninety (90) day past-due undisputed account balances within ninety-five (95) days after the original invoice date. These notices shall remind the labeler that interest shall be assessed on all past due accounts as stipulated by their contract with the State.	Contractor shall provide TennCare with copies of all reports sent pursuant to this section. Reports due monthly, ten (10) business days after end of month of reporting period.	If Contractor fails to send notice, the penalty may, in the State's discretion, be $100 per Manufacturer per day independent of other dunning periods.
A.4.5 Rebate Invoicing	The Contractor shall generate and issue quarterly Rebate invoices. Provide the designated TennCare staff data files that contain the specific information and in the specified format as required by TennCare	The quarterly Supplemental Medicaid Drug Rebate invoices shall be generated for all pharmaceutical manufacturers and TennCare approval by thirty (30) days after receipt of the quarterly CMS file. The quarterly Federal Medicaid Drug Rebate invoices shall be generated for all pharmaceutical manufacturers and TennCare approval by sixty (60) days after receipt of the quarterly CMS file.	Penalty may, in the State's discretion, be $1,000 per invoice per day invoice overdue.
A.4.5 Rebate Dispute Resolution	The Contractor shall be responsible for dispute resolution pertaining to supplemental rebates. The Contractor shall perform unit resolution based on unit resolution performed on CMS Rebates. The Contractor shall perform all other dispute resolution activities with pharmaceutical manufacturers pertaining to supplemental rebate calculations and collections.	Within ninety (90) days of dispute the contractor shall present the State with an analysis of why the monies were disputed and remedies.	Penalty may, in the State's discretion, be $1,000 per day past ninety (90) day timeframe of analysis and proposed remedy.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.4.5 Delinquent Rebate Payment Interest Accrual	The Contractor shall ensure that all Drug Manufacturers are charged interest as stipulated in each Manufacturer's respective Supplemental Drug Rebate Contract. Interest shall be calculated on only the Manufacturer's undisputed account balance unless written notification is provided by TennCare to do otherwise.	Quarterly rebate reports submitted to TennCare will contain delinquent payments and interest accrued.	Failure by Contractor to start accruing interest on the date stipulated in the individual supplemental rebate agreements may, in the State's discretion, result in a penalty of $1,000 for every non-compliant invoice issued.
A.4.5.2 Supplemental Rebate Incentive	On an annual basis the percentage of effectiveness of the supplemental rebate program shall be measured against the Contractors response to the RFP. The Contractor shall be allowed a two percent (2%) deviation from its response.	For example, if the Contractor bids six percent (6%) for supplemental rebate percentage in the RFP, the allowable range shall be four to eight percent (4% - 8%).	100% of the difference between the supplement rebate amount that would have been paid to the state if the Contractor had performed at the lowest end of the allowed supplemental rebate percentage range vs. the actual supplemental rebate amount paid to the state.
A.5.6. System Maintenance and Modification Deadlines/Damages	The Contractor shall correct system maintenance problems within five (5) business days or by a State-approved correction date.	System maintenance problems shall be corrected within five (5) business days or by State-approved correction date.	Five hundred dollars ($500.00) liquidated damages per work day or any part thereof shall be assessed for a maintenance problem not corrected within five (5) business days or by correction date approved by the State. These payments will be in addition to payment for any actual damages due to incorrect payment processing, including but not limited to damages based on loss of productivity of TennCare staff because of staff time required to respond to inquiries from auditors, users, members, advocates, legislators and in meetings with Contractor staff to rectify problems.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.5.8 Disaster Preparedness and Recovery-Business Interruption	The Contractor shall submit the Contractor's Business Continuity/Disaster Recovery plan for their Central Processing Site to TennCare. If requested, test results of the plan shall be made available to TennCare	Plan due upon commencement of claims processing and annually on the anniversary date of the initial claims processing	Penalty may, in the State's discretion, be $1000 per week that report is overdue.
A.5.8 Disaster Preparedness and Recovery-Business Interruption	The Contractor shall comply with their Contractor's Business Continuity/Disaster Recovery plan.	TennCare shall determine the final need to move to the disaster recovery plan based on the Contractor's recommendation.	Penalty may, in the State's discretion, be $10,000 per day Contractor is non-compliant with their Business Continuity/Disaster Recovery Plan
A.5.9 Program Integrity	The Contractor shall have TennCare-approved policies and procedures in place for ensuring protections against actual or potential fraud and abuse.	The Contractor shall have a detailed Program Integrity Plan. The Contractor shall complete all tasks as described in the Program Integrity Plan on a quarterly and annual basis.	$2,500 per occurrence of non compliance with the Program Integrity Plan.
A.5.10 Proprietary and Confidential Information	All information provided to TennCare, including but not limited to, provider, reimbursement and enrollee information shall be deemed confidential.	The Contractor shall immediately notify TennCare of any and all occurrences where TennCare's confidential information may have been breached and initiate appropriate action to prevent subsequent breaches.	$2,500 per occurrence of breach.
A.5.12 Member Identification Cards	The Contractor shall provide each TennCare enrollee with a NCPDP compliant pharmacy benefit identification (ID) card. The Contractor shall also provide enrollee with replacements cards.	Replacement and new cards shall be produced and mailed by the Contractor on the 15th day of each month.	Delays in producing ID cards may, in the State's discretion, result in $1,000 per day damages.
A.5.13 Mail Procedures	The Contractor shall open all returned mail from any mailings to enrollees or providers within thirty (30) days of receipt to determine if the enrollee has moved, if the Contractor has the wrong address, and/or if the enrollee is communicating other information to the Contractor or to TennCare. The Contractor shall track	Monthly report, due ten (10) business days after end of month of reporting period, beginning the first full month after the report format has been agreed to by the parties.	Calculation of the damages may, in the State's discretion, begin on the first day following the report due date and continue until receipt of the report by TennCare. Penalty may, in the

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
	returned mail and shall report monthly to TennCare the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose mail was undeliverable due to an incorrect address provided by TennCare.		State's discretion, be $2,500 per week.
A.5.16 E-Prescribe	The Contractor shall participate in TennCare's E-Prescribe initiatives.	Provide accurate data files in the format agreed to as necessary to support E-Prescribe.	Damages for delays or errors may, in the State's discretion, be assessed at $1,000 per day begin on the first day following the file due date.
A.6 Drug Utilization Review Program	The Contractor shall provide on a quarterly basis • Provider and patient trending • Meetings and facilitation • Reports and website	Approved meeting materials shall be distributed ten (10) business days prior to DUR meetings. Draft minutes shall be submitted to TennCare with four (4) weeks of DUR meeting.	Calculation of the damages may, in the State's discretion, begin on the first day following the due date for meeting material or minutes and continue until delivered. Penalty, in the State's discretion, may be $1,000 per day.
A.6 Drug Utilization Review Program	The Contractor shall produce eight hundred (800) member profiles per month, or a minimum of two thousand four hundred (2,400) member profiles per quarter, and distribute to clinical reviewers for review and determination of appropriate interventions to be taken.	Monthly member profile reviews shall be completed and results/interventions distributed to prescribers within sixty (60) days of the end of the month.	Calculation of the damages, may in the State's discretion, be $100 assessed for each member profile less than the required 2,400 profiles, within 90 days of the end of each quarter.
A.6 Drug Utilization Review Program	The Contractor shall produce 2,400 provider profiles per quarter and determine appropriate interventions to address any potential problems identified during profile review. These interventions shall include at a minimum mailings sent to prescribers or pharmacy providers.	Quarterly provider profile reviews shall be completed and results/interventions distributed to prescribers within ninety (90) days of the end of the quarter.	Calculation of the damages, may in the State's discretion, be $100 assessed for each letter or other approved, documented intervention less than the required 2,400, within 90 days of the end of each quarter.

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A.7.1 Prior Authorization Processing time	The Contractor shall complete all requests for prior approval within twenty four (24) hours given sufficient information to make a determination.	Contractor must document the receipt and determination time for every request for PA. This must be provided to TennCare on a quarterly basis (Section A.11). Explanation must be given for falling outside the twenty four (24) hour timeframe.	The cost of services not provided plus $500 per day, per occurrence, for each day that it is determined the Contractor failed to acknowledge or act timely upon a request for prior authorization in accordance with TennCare rules and regulations
A.7.1.a Prior Authorization Unit	The Contractor shall (1) provide an approved service timely, i.e., in accordance with timelines specified in this Contract, or (2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	The cost of services not provided plus $500 per day, per occurrence for each day (1) that approved care is not provided timely; or (2) notice of delay is not provided and/or the Contractor fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service
A.7.1.m.ii Call Center Service Levels	The Contractor shall maintain service levels within the Prior Authorization Unit such that 85% of call line inquiry attempts are answered within 30 seconds and the total number of abandoned calls shall not exceed 3%.	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	Failure to meet these service levels may, in the State's discretion, result in liquidated damages of $500 per day for which service levels are not met.
A.7.3 Prior Authorization Reconsideration	The Contractor shall respond to all reconsideration requests within one (1) business day.	The Contractor shall provide monthly reports indicating the timeframe and outcome of every prior authorization reconsideration.	$200 per occurrence of failure to respond to reconsideration within one (1) business day
A.7.3 Prior Authorization Reconsideration	The Contractor shall supply TennCare with all pertinent information pertaining to reconsideration requests within two (2) business days.	The Contractor shall provide monthly reports indicating the timeframe and outcome of every prior authorization reconsideration.	$200 per occurrence of failure to supply all pertinent information within two (2) business days

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A.7.4 Enrollee Appeals	The Contractor shall provide a service or make payments for a service within five (5) calendar days of a directive from TennCare (pursuant to an appeal) to do so, or upon approval of the service or payment by the Contractor during the appeal process, or within a longer period of time which has been approved by TennCare upon the Contractor's demonstration of good cause	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	$500 per day beginning on the next calendar day after default by the Contractor in addition to the cost of services not provided
A.7.4 Enrollee Appeals	The Contractor shall provide proof of compliance to TennCare within five (5) calendar days of a directive from TennCare or within a longer period of time which has been approved by TennCare upon the Contractor's demonstration of good cause	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	$500 per day beginning on the next calendar day after default by the Contractor
A.7.4 Enrollee Appeals	The Contractor shall provide continuation or restoration of services where enrollee was receiving a service as required by TennCare rules or regulations, applicable state or federal law, and all court orders and consent decrees governing the appeal procedures as they become effective	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	An amount sufficient to at least offset any savings the Contractor achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense $500 per day for each calendar day the Contractor fails to provide continuation or restoration of services as required by TennCare or approved by the Contractor
A.7.4 Enrollee Appeals	The Contractor shall forward an expedited appeal to TennCare in twenty-four (24) hours or a standard appeal in five (5) days	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	$500 per calendar day
A.7.4 Enrollee Appeals	The Contractor shall provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing the appeals procedures as they become effective	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided or payment has been made.	$500 per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
			provisions set forth by this Agreement or required by TennCare
A.7.4 Enrollee Appeals	The Contractor shall process appeals as set forth in the Revised Grier Consent Decree to avoid "Systemic problems or violations of the law"	A failure in 20% or more of appealed cases over a 60-day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures, as they become effective	First occurrence: $500 per instance of such "systemic problems or violations of the law", even if damages regarding one or more particular instances have been assessed (in the case of "systemic problems or violations of the law" relating to notice content requirements, $500 per notice even if a corrected notice was issued upon request by TennCare) Damages per instance shall increase in $500 increments for each subsequent "systemic problem or violation of the law" relating to a particular requirement is identified; $1000 per instance for the 2nd time a "systemic problem or violation of the law" relating to the same requirement is identified; etc.)
A.7.6.d Administer Prior Authorization Program for the TennCare PDL	The Contractor shall provide prior authorization services for prescriptions written for non-preferred drugs or otherwise requiring PA. Prior authorization services shall consist of prescription review by a licensed pharmacist or pharmacy technician to ensure that all predetermined clinically appropriate criteria have been met before the prescription may be dispensed and subsequently reimbursed.	The Contractor shall provide readily retrievable documentation for every prior authorization request made, which shall include all information offered by the prescriber, pharmacy, or enrollee, and shall include explanations on what criteria was used to make the final determination, and what final determination was made, and by whom.	$500 per instance of inappropriate denial; $100 per instance of appropriate approval plus the reimbursement for cost of medication and dispensing fee

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A.9.5 Pharmacy Network and Enrollee Notices	The Contractor shall ensure that network pharmacies comply with all provisions of enrollee notices.	The Contractor's shall utilize feedback from TennCare, other state agencies, and enrollees, in addition to the audit process to perform additional training to pharmacies regarding notice obligations.	$100 per instance of failure of the Contractor to ensure pharmacies are compliant with notice requirements
A.9.6. Verification of Benefits (VOB) Notices	The Contractor shall send a letter to five hundred (500) randomly selected recipients each month requesting their reply to confirm whether they received the prescriptions processed in the preceding month and identified in the letter, as described in Contract Sections A.9.6.a-e.	VOB responses shall be followed up on by the Contractor's audit unit and the Contractor shall provide TennCare with a quarterly report on the findings from the responses.	Failure to generate Verification of Benefit (VOB) notices as described in the Contract, may, in the State's discretion, result in liquidated damages in the amount of $100 per day during the first month violations are identified. LDs may, in the State's discretion, be increased to $200 per day for the second consecutive month violations are identified.
A.9.9 Provider Service Agreements	Contractor to maintain provider agreements in accordance with Section A.9.9 of this Contract	The Contractor shall execute provider agreements with participating pharmacies that maintain all federal, state and local licenses, certifications, and permits, without restriction, required to provide pharmaceutical services to TennCare enrollees and shall comply fully with all applicable laws and regulations. The Contractor shall also ensure that the pharmacy provider is not currently nor has ever been sanctioned by HHS-OIG and is prevented from participating in a federally-funded program such as TennCare.	$5,000 per provider agreement found to be non-compliant with the requirements outlined in this Contract

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A.10 Key Staff Position	The Contractor shall employ competent staff in all key positions listed in Section A.10.	Replacement staff shall be in place within sixty (60) days of vacancies, unless TennCare grants an exception to the requirement	Calculation of the damages may, in the State's discretion, begin on the sixty-first day following the vacancy of the position and may continue until monthly until the position is filed. The penalty may, in the State's discretion, be $2,500 per month in addition to the salary of the position being withheld from the monthly payment.
A.10 Key Staff Licensure	The Contractor shall provide to TennCare documentation verifying the state licensure of key staff.	The Contractor shall provide TennCare copies of current Tennessee licenses for key staff	Calculation of the damages may, in the State's discretion, continue until receipt of the licensure verification by TennCare. Penalty may, in the State's discretion, be $2,500 per week per employee.
A.11.1 Management Reports	The Contractor shall provide TennCare with industry standard utilization and financial management reporting. The Contractor's management reports shall provide a summary of drug costs sorted by therapeutic category, by top ranked drugs, and by benefit categories. Reports shall include, but not be limited to: ☐ Financial summary with change trend ☐ Utilization statistics ☐ Claim processing volume and statistics ☐ Pharmacy Drug Spend by category and drug Quarterly Net Cost trend reports ☐ PDL Compliance reports by provider and specialty ☐ Prior Authorization ☐ Call Center metrics ☐ Reconsideration volume, disposition and aging ☐ Prescriber profiles ☐ Rebate reports ☐ Pharmacy Lock-in reports showing current status of all enrollees subject to Lock-in, Escalated PA status, and Convicted PA status	Monthly and quarterly reports are due ten (10) business days after the end of the reporting period.	Damages may, in the State's discretion, be assessed weekly. Calculation of the damages will begin on the first day following the report due date and may continue until receipt of the report by TennCare. Penalty may, in the State's discretion, be $2,500 per week, per report.

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	ı.ı Specialty Drug Reports ı ı Compounded Prescription Reports ı ı All other reports referenced in the Contract		
A.11.2 On Request Reports (ORRs)	The Contractor shall be able to provide, at no extra cost to TennCare ORRs that shall assist in managing the pharmacy benefit for TennCare members. ORRs shall be provided in a format described by TennCare and in an agreed upon timetable.	ORRs shall be provided within the agreed upon timetable	Failure by the Contractor to produce ORRs in a reasonable timeframe requested by TennCare may, in the State's discretion, result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages may, in the State's discretion, increase to two hundred dollars ($200) per day for the second consecutive month violations are identified.
A.11.2 Emergency Supply Aggregate Reports	The Contractor shall provide TennCare with monthly emergency supply claims reports listing the enrollee information, drug information, quantity and days supply, pharmacy and prescriber information, along with the reason the original claim was rejected (Non-PDL, Clinical Criteria required, etc.). Contractor shall also provide semi-annual aggregate reports that list the top 100 pharmacies entering emergency supplies.. The emergency supply reports shall be delivered to TennCare in electronic format by a web-based report library, as agreed to by TennCare.	Reports shall be delivered on a weekly and monthly basis no longer than five (5) business days after the ending of the week/month.	Failure by the Contractor to provide emergency supply Aggregate Report may, in the State's discretion, result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages may, in the State's discretion, increase to two hundred dollars ($200) per day for the second consecutive month violations are identified.

PERFORMANCE MEASURE	STANDARD / REQUIREMENT	DELIVERABLE	DAMAGE
A.11.2 Prior Authorization Unit Reports	The Contractor shall provide all Prior Authorization Unit Reports described in the Management Reports provided in Section A.11.2	Provide Prior Authorization Unit Reports as required in Section A.11.2	Failure by the Contractor to provide the Prior Authorization Call Center reports listed in a complete and timely manner may, in the State's discretion, result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages may, in the State's discretion, increase to two hundred dollars ($200) per day for the second consecutive month violations are identified.
A.11.3 PDL Compliance Report	The Contractor shall monitor compliance by prescribers and pharmacists with the TennCare PDL and report that information to TennCare monthly, quarterly, and semiannually, and provide suggestions for improving PDL compliance.	Report shall be delivered within forty-five (45) days following the period, but not earlier than thirty (30) days following the period.	Penalty may, in the State's discretion, be $2500 per week that report is overdue.
A.11.4. Program Integrity Reports	The Contractor shall be required to provide the following program integrity reports on a daily basis: - Ingredient Cost/Prescription Report, identifying claims with total cost exceeding $2000 at retail, excluding specialty drugs. - Override report, reflecting daily claims paid with override, prior authorization, or other unique adjudication rules as defined by TennCare - Pharmacy Time of Claims Submission Report, reflecting controlled substance claims submitted between 10:00 pm and 6:00 am The Contractor shall be required to	Reports shall be delivered on a daily or monthly basis (as described in previous column). Daily reports shall be produced, reviewed and delivered daily Monday through Friday by 3:00pm CT. Monthly reports shall be produced and reviewed monthly by ten (10) business days after end of month.	Failure by the Contractor to provide the required Program Integrity Reports on a daily or monthly basis may, in the State's discretion, result in liquidated damages of one hundred dollars ($100) per day the reports are late during the first month violations are identified. Liquidated damaged may, in the State's discretion, increase to two hundred ($200) per day for the second consecutive

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	provide the following program integrity reports on a monthly basis: - Enrollees Using Multiple Prescribers Report - Enrollee Use of Controlled SubstancesLock-In Report - Pharmacy DAW Code Submission Report - Pharmacy Claim Reversals Report - Generic efficiency report, reflecting pharmacies processing ≥250 non-specialty drug claims per quarter and having <60% generic utilization - Pharmacy Submission of Package Size versus Day Supply Report, identifying claims with an invalid correlation between quantity and day supply		month violations are identified.
A.12.1 Notices	The Contractor shall be required to send individualized notices to enrollees on a daily basis except for Sunday, worded at a six (6th) grade reading level.	Notices shall be approved by TennCare and include prior authorization denial notices, prescription limit notices, lock-in notices, or other notice as directed by TennCare.	Failure by the Contractor to produce notices in such a manner shall result in liquidated damages of five hundred dollars ($500) per occurrence
A.12.1 Notices	The Contractor shall comply with the notice requirements of this Contract, TennCare rules and regulations, and all court orders and consent decrees governing the appeal procedures as they become effective	The Contractor shall make available to various TennCare departments; readily retrievable documentation via an online document system for notices sent to TennCare enrollees and/or providers and shall produce same documentation for internal and external audits when requested.	$500 per occurrence in addition to $500 per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by the Agreement or required by TennCare

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A.12.1 Notices	The Contractor shall submit a timely corrected notice of adverse action to TennCare for review and approval prior to issuance to the member	The Contractor shall provide written confirmation in the form of letter, fax or email to requestor and additional TennCare associates if requested, that service has been provided.	$1000 per occurrence if the notice remains defective plus a per calendar day assessment in increasing increments of $500 ($500 for the first day, $1000 for the second day, $1500 for the third day, etc.) for each day the notice is late or remains defective
A.12.2 Notices to Children in State Custody	Each week, the Contractor receives a file of TennCare recipients currently in State Custody from the Department of Children's Services (DCS). The Contractor shall be required to produce copies of any recipient denial notices generated over the previous week, and forward the notices (either hard copy or via secure electronic file transmission) to DCS.	Copies of denial notices generated for children in State custody shall be provided on a weekly basis to DCS (either hard copy or via secure electronic file transmission).	Failure by the Contractor to produce notices in such a manner shall result in liquidated damages of one hundred dollars ($100)per notice.
A.12.4 Returned Mail	The Contractor shall open all returned mail from any mailings to enrollees or providers to determine if the enrollee has moved, if the Contractor has the wrong address and/or if the enrollee is communicating other information to the Contractor or to TennCare.	Track returned mail and report monthly, in a yet to be determined mutually agreed upon format, to TennCare the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor.	$500 per missing report
E.7 and E.8. HIPAA and HITECH Compliance	Contractor shall ensure that all TennCare data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of TennCare enrollee PHI	Protected health Information is secure as defined by HIPAA and HITECH.	$500 per enrollee per occurrence, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those TennCare enrollees whose PHI was placed at risk by Contractor's failure to comply with the terms of this Agreement, the Contractor shall be liable for all costs associated with the provision of such monitoring and/or safeguard services

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E.7 and E.8 HIPPA and HITECH Compliance	Contractor shall execute the appropriate agreements to effectuate transfer and exchange of TennCare enrollee PHI or TennCare 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	Appropriate agreements are in place to effectuate transfer and exchange of TennCare enrollee PHI or TennCare confidential information.	$500 per enrollee per occurrence
E.7 and E.8. HIPPA and HITECH Compliance	Contractor shall seek express written approval from TennCare prior to the use or disclosure of TennCare enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States	Contractor shall seek express written approval from TennCare prior to the use or disclosure of TennCare enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States	$1,000 per enrollee per occurrence
E.7 and E.8. HIPPA and HITECH Compliance	Contractor shall timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional	Contractor shall timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional	$500 per enrollee per occurrence, not to exceed $10,000,000
E.22 Breach, Partial Default	In the event of a Breach, the State may declare a Partial Default. In that case, the State shall provide the Contractor written notice of: (1) the date that Contractor shall terminate providing the service associated with the Breach; and (2) the date the State shall 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 that 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) business days any	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 that 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) business days any requested material from Contractor. The State shall make the final and binding determination of said amount.	$500 per enrollee per occurrence, not to exceed $10,000,000

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	requested material from Contractor. The State shall make the final and binding determination of said amount.		
E.30.1. Prevention/Detection of Provider Fraud and Abuse	The Contractor shall provide monthly reports to TennCare that describe pharmacy provider dispensing patterns that statistically identify the pharmacy as an outlier that may be representative of potential fraudulent, abusive or wasteful dispensing patterns.	This report shall be independent of routine audit activities, and shall include but not be limited to: referrals made to the Contractor by network pharmacies, prescribers, TennCare's Office of Program Integrity, the Tennessee Bureau of Investigation, the Tennessee Medicaid Fraud Control Unit, and the State of Tennessee's Office of Inspector General. Contractor shall meet with TennCare's Office of Provider Integrity to review all fraud activities quarterly.	Failure by the Contractor to provide the monthly reports in a complete and timely manner may, in the State's discretion, result in the assessment of liquidated damages by TennCare of one hundred dollars ($100) per day during the first month violations are identified. Liquidated damages will increase to two hundred dollars ($200) per day for the second consecutive month violations are identified.