



**STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BENEFITS ADMINISTRATION**

312 Rosa L. Parks Avenue
Suite 1900 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
Phone (615) 741-4517 or (866) 576-0029
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Stuart C. McWhorter
COMMISSIONER

Laurie Lee
EXECUTIVE DIRECTOR

NOTICE

The following documents contain confidential information and are subject to an exception to Tennessee Public Records Act. Tenn. Code Ann. § 10-7-504(n)(1)(A) defines and details the confidentiality of discount, rebate, pricing or other financial arrangements at the individual drug level as well as the individual provider level. The confidential information below is highlighted in yellow.



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COMMISSIONER

Laurie Lee
EXECUTIVE DIRECTOR

MEMORANDUM

TO: Krista Lee Carsner, Executive Director
Fiscal Review Committee Members

FROM: Laurie Lee, Benefits Administration

DATE: September 6, 2019

SUBJECT: Amendment Two to Pharmacy Benefit Manager (PBM) Contract

Benefits Administration (BA) submits for consideration by the Fiscal Review Committee Amendment Two to the contract for pharmacy benefits manager (PBM) services (Edison #43652). The current contractor for this program is CaremarkPCS Health, L.L.C.

Through this amendment, BA is requesting a one-year extension to the contract with no increase in the administrative fee rate and with a proposed maximum liability increase of \$2,557,000 for the one-year extension for a total maximum liability of \$19,679,000. The proposed end date would be June 30, 2021 (which includes plan member benefits ending December 31, 2020 and a six-month claims runoff period). In working with our current contractor, amendment two includes pricing changes estimated to achieve \$12,212,000 in claims savings for 2020.

BA issued a request for proposal (RFP) at the end of 2018. On May 23, 2019 the Insurance Committees authorized award of the PBM contract to the apparent winner of the procurement. However, a protest to this award was filed. This protest resulted in a stay of the process to enter into a contract, making it impossible to begin a new PBM contract by January 1, 2020. Since then, BA has determined to cancel the RFP and reissue the PBM

Pursuant to TCA 10-7-504(n)(1)(A), items highlighted in yellow are marked confidential

procurement. Without a contract in place, more than 281,000 members will not have a pharmacy benefit for calendar year 2020.

The following chart contains confidential information and is subject to an exception to Tennessee Public Records Act. Tenn. Code Ann. § 10-7-504(n)(1)(A) defines and details the confidentiality of discount, rebate, pricing or other financial arrangements at the individual drug level as well as the individual provider level. The confidential information below is highlighted in yellow.

The proposed 2020 pricing includes:

Service Description	Amount (per compensable increment)						
	1/1/15 – 12/31/15	1/1/16 – 12/31/16	1/1/17 – 6/30/17	7/1/17- 12/31/17	1/1/18 – 12/31/18	1/1/19 – 12/31/19	1/1/20- 12/31/20
FEES (Guaranteed Maximum PMPM)							
Administration Fee Per Member Per Month	\$0.90 Amount Per Member Per Month						
Clinical Fee Per Member Per Month							
DISPENSING FEES (Guaranteed Maximum Average Per Claim)							
Retail – Brand							
Retail – Generic							
90-Day Retail – Brand							
90-Day Retail – Generic							

Pursuant to TCA 10-7-504(n)(1)(A), items highlighted in yellow are marked confidential

SPECIALTY NETWORK DISCOUNTS (Guaranteed Minimum Average)							
All Brand Specialty Pharmacy Claims	[REDACTED]						
REBATES PER CLAIM (Guaranteed Minimum Average)							
All Retail Claim Basis (Brand & Generic)	[REDACTED]						
All 90-Day Retail Claim Basis (Brand & Generic)	[REDACTED]						
All Mail Claim Basis (Brand & Generic)	[REDACTED]						
All Brand Specialty Pharmacy Claims	[REDACTED]						

Through a competitive bid process, the current contractor, Caremark, was selected as the State’s Pharmacy Benefits Manager (PBM) with a contract effective date of December 15, 2014. This is a five-year service contract with a claims runoff period. Currently, the benefit services end December 31, 2019, with a contract end date of June 30, 2020.

BA also wanted to provide additional information including questions regarding legal action or illegal activity:

1. 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.

We do not believe there have been any disciplinary actions or similar legal matters taken against CaremarkPCS Health, L.L.C. in the last five years that would impact CaremarkPCS Health, L.L.C.’s contract with the State of Tennessee or its ability to

continue to provide its services as required by that contract. As a subsidiary of a publicly traded corporation, any material legal matters impacting CaremarkPCS Health, L.L.C. are disclosed in CVS Health Corporation's quarterly and annual 8K and 10K filings, which are available here: <https://investors.cvshealth.com/investors/sec-filings/default.aspx>. Relevant disclosures are located by searching the filings for the section titled "Legal Matters".

2. *Provide any information regarding the due diligence that the Department has taken to ensure that the vendor is not or has not been involved in any circumstances related to illegal activity, including but not limited to fraud.*

During the Request for Proposal (RFP) process we require all potential bidders to provide the following information:

- Provide a statement of whether the company or, to the company's knowledge, any of the company's employees, agents, independent contractors, or subcontractors, involved in the delivery of goods or performance of services on a contract, have been convicted of, pled guilty to, or pled *nolo contendere* to any felony. If so, include an explanation providing relevant details.
- Provide a statement of whether, in the last ten (10) years, the Company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, include an explanation providing relevant details.
- Provide a statement of whether there is any material, pending litigation against the Company that the Company should reasonably believe could adversely affect its ability to meet contract requirements or is likely to have a material adverse effect on the Company's financial condition.
- Provide a statement whether there is any pending or in progress Securities Exchange Commission investigations involving the Company.

On a semi-annual basis, BA requires all of our vendors to 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. Caremark has provided this attestation on time and throughout the life of this contract.

Enclosed in the Fiscal Review packet you will also find a supplemental report on any liquidated damages assessed by BA for the life of the contract (see pages 22-24). A total of \$112,500 has been assessed due to performance guarantees.

The original contract is included for review. BA submits the above referenced contract amendment for consideration and approval by the Fiscal Review Committee.

Supplemental Documentation Required for
Fiscal Review Committee

*Contact Name:	Seannalyn Brandmeir, Procurement and Contracting Manager	*Contact Phone:	615-532-4598			
*Presenter's name(s):	Laurie Lee, Executive Director; Keith Athow, Director of Pharmacy, HSA & FSA; Christa Martin, Director of Financial Management and Program Integrity; Seannalyn Brandmeir, Procurement and Contracting Manager					
Edison Contract Number: <i>(if applicable)</i>	43652	RFS Number: <i>(if applicable)</i>	31786-00121			
*Original or Proposed Contract Begin Date:	12/15/2014	*Current or Proposed End Date:	Current: 6/30/2020 Proposed: 6/30/2021			
Current Request Amendment Number: <i>(if applicable)</i>	Two					
Proposed Amendment Effective Date: <i>(if applicable)</i>	December 1, 2019					
*Department Submitting:	Finance and Administration					
*Division:	Benefits Administration					
*Date Submitted:	September 6, 2019					
*Submitted Within Sixty (60) days: <i>If not, explain:</i>	Yes					
*Contract Vendor Name:	CaremarkPCS Health, LLC					
*Current or Proposed Maximum Liability:	Current: \$17,122,000.00 Proposed: \$19,679,000.00					
*Estimated Total Spend for Commodities:						
*Current or Proposed Contract Allocation by Fiscal Year: (as Shown on Most Current Fully Executed Contract Summary Sheet)						
FY: 2015	FY: 2016	FY: 2017	FY: 2018	FY: 2019	FY: 2020	FY: 2021
\$2,215,750.00	\$4,431,500.00	\$4,431,500.00	\$4,129,500.00	\$1,913,750.00	\$1,278,500.00	\$1,278,500.00
*Current Total Expenditures by Fiscal Year of Contract: (attach backup documentation from Edison)						
FY: 2015	FY: 2016	FY: 2017	FY: 2018	FY: 2019		
\$1,713,801.14	\$3,208,753.36	\$2,885,900.79	\$2,990,715.36	\$3,209,466.69		
IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:				n/a		
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:				n/a		
IF Contract Expenditures exceeded				n/a		

Supplemental Documentation Required for
Fiscal Review Committee

Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:			
*Contract Funding Source/Amount:			
State:		Federal:	
<i>Interdepartmental:</i>	\$19,679,000.00	<i>Other:</i>	
If “ <i>other</i> ” please define:			
If “ <i>interdepartmental</i> ” please define:		Employee paid premiums as well as legislative appropriations for health premiums.	
Dates of All Previous Amendments or Revisions: <i>(if applicable)</i>		Brief Description of Actions in Previous Amendments or Revisions: <i>(if applicable)</i>	
One		Change in pricing based on market check provision of the contract	
Method of Original Award: <i>(if applicable)</i>		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?		\$20,000,000 to \$25,000,000. Pharmacy benefits have been provided to plan members for multiple years so the State has historical spend data available. Our team also stays abreast of changes in this area, attends industry conferences and meetings to learn about changes and benchmarking in the Pharmacy industry. We also utilized our consultants for assistance in drafting the RFP, market trends, and pricing.	
*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.		In 2014, we identified 54 potential bidders.	

CaremarkPCS Health, L.L.C.

Edison Contract # 43652
Vendor Number 133265
Reports Pulled: 7/16/2019

Fiscal Year	Expenditures
FY 2015	1,713,801.14
FY 2016	3,208,753.36
FY 2017	2,885,900.79
FY 2018	2,990,715.36
FY 2019	3,209,466.69
Total Expenditures	14,008,637.34

31786	136,629.99	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001301	00006018	51496655	4/7/2016	2016
31786	136,695.78	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001252	00005831	51416237	1/8/2016	2016
31786	137,413.10	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001301	00005879	51444318	2/9/2016	2016
31786	137,458.88	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001301	00006192	51577416	7/11/2016	2016
31786	137,578.99	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001301	00006163	51552630	6/8/2016	2016
31786	137,953.92	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001301	00006121	3172825	5/20/2016	2016
31786	138,868.81	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001252	00005752	51361143	11/6/2015	2016
31786	139,755.20	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001252	00005650	51307853	9/11/2015	2016
31786	140,779.55	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001252	00005576	51280072	8/10/2015	2016

Total FY 2016

3,208,753.36

Unit	Sum Merchandise Amt	Edison Contract ID	Vendor ID	Vendor Name	Type	PO ID	Voucher #	Invoice	Date	Fiscal Year
31786	218.93	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006381	51660079	10/11/2016	2017
31786	283.92	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006933	51896574	7/7/2017	2017
31786	288.08	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006343	51630925	9/13/2016	2017
31786	291.20	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006439	51687057	11/7/2016	2017
31786	292.24	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006274	51604664	8/9/2016	2017
31786	293.28	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006512	51738571	1/9/2017	2017
31786	294.32	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006574	51766014	2/7/2017	2017
31786	294.32	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006872	51870270	6/7/2017	2017
31786	295.36	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006468	51712921	12/7/2016	2017
31786	298.48	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006654	51792324	3/8/2017	2017
31786	301.44	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006803	51844419	5/4/2017	2017
31786	305.76	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006722	51819310	4/6/2017	2017
31786	1,841.77	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006380	51660078	10/11/2016	2017
31786	1,891.42	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006721	51819309	4/6/2017	2017
31786	3,294.51	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006653	51792323	3/9/2017	2017
31786	3,638.05	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006870	51870269	6/8/2017	2017
31786	5,485.30	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006932	51896573	7/10/2017	2017
31786	6,209.83	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006931	51896572	7/10/2017	2017
31786	6,568.44	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006275	51604663	8/9/2016	2017
31786	6,664.32	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006342	51630924	9/13/2016	2017
31786	6,712.20	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006573	51766013	2/8/2017	2017
31786	6,749.58	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006438	51687056	11/8/2016	2017
31786	6,892.08	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006511	51738569	1/10/2017	2017
31786	6,973.20	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006467	51712920	12/9/2016	2017
31786	7,359.98	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006802	51844417	5/5/2017	2017
31786	7,731.61	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006720	51819308	4/7/2017	2017
31786	9,022.22	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006346	51630928	9/14/2016	2017
31786	9,500.74	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006656	51792326	3/9/2017	2017
31786	10,823.16	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006510	51738567	1/10/2017	2017
31786	12,127.17	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006273	51604662	8/9/2016	2017
31786	12,518.44	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006871	51870342	6/8/2017	2017
31786	12,545.37	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006725	51819313	4/7/2017	2017
31786	12,567.33	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006341	51630923	9/13/2016	2017
31786	12,569.51	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006572	51766012	2/8/2017	2017
31786	12,660.77	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006379	51660077	10/12/2016	2017
31786	12,792.00	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006466	51712919	12/8/2016	2017
31786	12,814.93	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006437	51687055	11/8/2016	2017
31786	13,158.25	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006655	51792325	3/9/2017	2017
31786	13,439.17	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006657	51792327	3/9/2017	2017
31786	17,391.01	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006806	51844422	5/5/2017	2017
31786	20,453.19	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006384	51660082	10/12/2016	2017

31786	23,486.32	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006435	51687060	11/8/2016	2017
31786	23,522.72	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006471	51712924	12/9/2016	2017
31786	23,599.68	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006515	51738577	1/10/2017	2017
31786	23,944.96	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006577	51766017	2/8/2017	2017
31786	24,186.24	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006936	51896577	7/10/2017	2017
31786	24,346.32	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006875	51870273	6/8/2017	2017
31786	32,084.89	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006724	51819312	4/7/2017	2017
31786	46,608.63	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006723	51819311	4/7/2017	2017
31786	91,829.92	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006805	51844421	5/5/2017	2017
31786	102,889.27	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006383	51660081	10/12/2016	2017
31786	106,809.93	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006436	51687059	11/8/2016	2017
31786	107,314.85	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006345	51630927	9/14/2016	2017
31786	107,369.51	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006935	51896576	7/10/2017	2017
31786	107,385.65	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006514	51738575	1/10/2017	2017
31786	107,916.64	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006470	51712923	12/9/2016	2017
31786	108,038.80	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006874	51870272	6/8/2017	2017
31786	108,089.31	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006576	51766016	2/8/2017	2017
31786	108,420.17	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006276	51604666	8/9/2016	2017
31786	113,753.24	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006804	51844420	5/5/2017	2017
31786	115,102.89	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006382	51660080	10/12/2016	2017
31786	128,488.15	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006934	51896575	7/10/2017	2017
31786	134,353.32	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006440	51687058	11/8/2016	2017
31786	135,961.17	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006344	51630926	9/14/2016	2017
31786	136,922.53	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006575	51766015	2/8/2017	2017
31786	138,032.96	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006469	51712922	12/9/2016	2017
31786	138,374.26	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006513	51738573	1/10/2017	2017
31786	139,092.64	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001440	00006873	51870271	6/8/2017	2017
31786	152,122.94	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001380	00006277	51604665	8/9/2016	2017

Total FY 2017 2,885,900.79

Unit	Sum Merchandise Amt	Edison Contract ID	Vendor ID	Vendor Name	Type	PO ID	Voucher #	Invoice	Date	Fiscal Year
31786	121.56	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007352	52110061	3/6/2018	2018
31786	130.35	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007471	52168480	5/4/2018	2018
31786	278.72	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00006996	51922626	8/4/2017	2018
31786	292.24	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007617	52223876	7/5/2018	2018
31786	294.32	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007042	51948430	9/7/2017	2018
31786	296.40	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007542	52196497	6/6/2018	2018
31786	298.48	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007424	52140018	4/5/2018	2018
31786	3,352.46	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007144	52001059	11/7/2017	2018
31786	3,717.72	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007423	52140017	4/6/2018	2018
31786	4,628.31	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007470	52168479	5/8/2018	2018
31786	4,643.69	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007046	51948429	9/11/2017	2018
31786	5,842.72	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007616	52223875	7/6/2018	2018
31786	5,877.36	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00006997	51922625	8/7/2017	2018
31786	5,932.16	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007541	52196496	6/7/2018	2018
31786	6,233.76	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007351	52110060	3/7/2018	2018
31786	6,279.52	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007288	52082724	2/8/2018	2018
31786	6,393.92	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007251	52058094	1/12/2018	2018
31786	6,449.04	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007091	51974772	10/6/2017	2018
31786	6,481.28	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007215	52027393	12/11/2017	2018
31786	6,620.54	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007145	52001060	11/7/2017	2018
31786	8,785.65	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007041	51948428	9/11/2017	2018
31786	8,844.98	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007469	52168478	5/8/2018	2018

31786	9,057.99	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007350	52110059	3/7/2018	2018
31786	9,811.53	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007090	51974771	10/6/2017	2018
31786	11,030.77	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007214	52027392	12/11/2017	2018
31786	11,233.38	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007615	52223874	7/6/2018	2018
31786	12,182.56	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007540	52196495	6/7/2018	2018
31786	12,227.28	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007422	52140016	4/6/2018	2018
31786	12,276.21	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007287	52082723	2/8/2018	2018
31786	12,402.00	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007250	52058093	1/12/2018	2018
31786	12,575.65	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00006998	51922624	8/7/2017	2018
31786	13,422.22	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007218	52027397	12/11/2017	2018
31786	19,477.49	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007045	51948433	9/11/2017	2018
31786	19,740.79	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007474	52168483	5/8/2018	2018
31786	21,815.30	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00006999	51922629	8/7/2017	2018
31786	22,612.18	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007254	52058098	1/12/2018	2018
31786	22,829.89	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007427	52140021	4/6/2018	2018
31786	23,136.47	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007620	52223879	7/6/2018	2018
31786	23,538.40	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007355	52110064	3/7/2018	2018
31786	24,025.04	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007094	51974776	10/6/2017	2018
31786	24,691.92	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007291	52082728	2/8/2018	2018
31786	24,710.40	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007545	52196500	6/8/2018	2018
31786	28,905.87	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007147	52001063	11/7/2017	2018
31786	65,272.53	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007473	52168482	5/8/2018	2018
31786	70,079.56	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007544	52196499	6/8/2018	2018
31786	71,381.80	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007472	52168481	5/8/2018	2018
31786	86,907.52	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007253	52058097	1/12/2018	2018
31786	95,146.83	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007426	52140020	4/6/2018	2018
31786	97,715.70	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007044	51948432	9/11/2017	2018
31786	102,045.82	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007619	52223878	7/6/2018	2018
31786	102,919.39	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007354	52110063	3/7/2018	2018
31786	103,541.58	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007217	52027396	12/11/2017	2018
31786	107,341.33	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00006995	51922628	8/7/2017	2018
31786	107,739.12	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007093	51974775	10/6/2017	2018
31786	108,748.63	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007290	52082727	2/8/2018	2018
31786	110,181.43	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007543	52196498	6/8/2018	2018
31786	111,764.43	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007146	52001062	11/7/2017	2018
31786	116,091.97	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007043	51948431	9/11/2017	2018
31786	123,802.90	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007353	52110062	3/7/2018	2018
31786	130,288.99	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007092	51974774	10/6/2017	2018
31786	132,054.12	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007216	52027395	12/11/2017	2018
31786	134,448.16	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007618	52223877	7/6/2018	2018
31786	135,086.64	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007425	52140019	4/6/2018	2018
31786	137,303.21	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00007252	52058096	1/12/2018	2018
31786	137,662.73	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001485	00006994	51922627	8/7/2017	2018
31786	139,692.45	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001525	00007289	52082726	2/8/2018	2018

Total FY 2018 2,990,715.36

Unit	Sum Merchandise Amt	Edison Contract ID	Vendor ID	Vendor Name	Type	PO ID	Voucher #	Invoice	Date	Fiscal Year
31786	284.96	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001587	00007995	52416101	2/7/2019	2019
31786	288.08	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001554	00007779	52307247	10/9/2018	2019
31786	290.16	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001554	00007723	52276416	9/7/2018	2019
31786	291.20	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001554	00007682	52251281	8/7/2018	2019
31786	293.28	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001554	00007836	52330261	11/7/2018	2019
31786	294.32	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001554	00007928	52388184	1/7/2019	2019

31786	132,273.90	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001554	00007837	52330262	11/8/2018	2019
31786	133,459.99	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001587	00008123	52469707	4/4/2019	2019
31786	134,750.78	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001554	00007929	52388185	1/9/2019	2019
31786	135,033.72	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001554	00007724	52276417	9/10/2018	2019
31786	135,826.90	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001554	00007780	52307248	10/10/2018	2019
31786	137,138.78	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001587	00008068	52442849	3/6/2019	2019
31786	138,327.37	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001587	00008258	52522791	6/7/2019	2019
31786	139,084.40	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001554	00007888	52361243	12/10/2018	2019
31786	139,189.33	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001554	00007683	52251282	8/8/2018	2019
31786	140,723.44	0000000000000000000043652	0000133265	Caremark PCS Health LLC	DFA	0000001587	00007996	52416102	2/8/2019	2019

Total FY 2019 3,209,466.69

CaremarkPCS Health, L.L.C.

Edison Contract # 43652
Vendor Number 133265
Reports Pulled: 7/16/2019

TN_PU_CN026 - Payments not on a contract

Payments Not On Contract	0							
Unit	Sum Merchandise Am	Edison Contract ID	Vendor ID	Vendor Name	PO_ID	D.VOUCHER_ID	Year	

CaremarkPCS Health, L.L.C.

Edison Contract #	43652
Vendor Number	133265
Reports Pulled:	7/16/2019

Total Contract Amount	17,122,000.00
Payments	14,008,637.34 (from Summary Spreadsheet)
Remaining Balance	3,113,362.66
Remaining Amt Edison	1,042,362.66
Difference	2,071,000.00
Reconciliation (PO 1634):	
Total Blanket PO Amount	2,071,000.00
Expended on Blanket PO	-
Total Remaining on Blanket PO	2,071,000.00
Difference explained if zero	-

CaremarkPCS Health, L.L.C.

Edison Contract # 43652
Vendor Number 133265
Reports Pulled: 7/16/2019

Maximum Liability \$ 17,122,000.00
Expenditures to Date \$ 14,008,637.34

Remaining Amount on Contract \$ 3,113,362.66

Projected Total Amount needed for June 2019 -
Dec 2020 \$ 5,670,017.60

Amount Needed to be added to contract \$ 2,556,654.94

Request rounded up to thousands \$ 2,557,000.00

Allocated as follows:

FY 2020 \$ 1,278,500.00
FY 2021 \$ 1,278,500.00

LD Assessment Report

Vendor	LD Number	Year Assessed	Quarter	Amount Assessed	Guarantee	Assessment
Caremark-2015	35	2015	1Q	\$10,000.00	Open Inquiry Closure: The Contractor shall close 95% of all open call issues within five (5) business days.	Ten thousand dollars (\$10,000) each quarter the standard is not met.
Caremark-2015	13	2015	2Q	\$20,000.00	Claims Payment Turnaround: As required in Contract Section A.6.h, 100% of direct reimbursement "clean" claims (both electronically through POS means or through member submitted paper claims) will be paid within the lesser of 30 days or the contracted turnaround time with the pharmacy.	Non-Investigated Claims (clean): Twenty thousand dollars (\$20,000) for each quarter the percentage falls below the required minimum standard of ninety-five percent (95%) within ten (10) days. Quarterly Guarantee. All Claims: \$ Twenty-thousand dollars (\$20,000) for each quarter the percentage falls below the required minimum standard of one hundred percent (100%) within thirty (30) days.
Caremark-2015	21	2015	3Q	\$5,000.00	PA Evaluation: As required in Contract Section A.11.h.4, the Contractor's call center staff shall evaluate ninety-nine percent (99%) of PA requests within twenty-four (24) hours.	Five thousand dollars (\$5,000) for each quarter that the standard is not met.
Caremark-2015	35	2015	3Q	\$10,000.00	Open Inquiry Closure: The Contractor shall close 95% of all open call issues within five (5) business days.	Ten thousand dollars (\$10,000) each quarter the standard is not met.
Caremark-2015	40	2015	4Q	\$10,000.00	Distribution of Ongoing Member ID Cards/Welcome Packets: Ninety-five percent (95%) of welcome packets shall be produced and mailed within ten (10) days of receipt of complete and accurate eligibility information, as required in Contract Section A.23.n.2.	Ten thousand dollars (\$10,000) per year in which the standard is not met.

LD Assessment Report

Caremark-2015	46	2015	4Q	\$7,500.00	Privacy and Security of Protected Health Information: In accordance with Contract Section E.7., the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act).	Two thousand five hundred dollars (\$2,500) for the first violation, five thousand dollars (\$5,000) for the second violation and ten thousand dollars (\$10,000) for the third and any additional violations with a maximum cap at one hundred thousand dollars (\$100,000) annually. The assessment will be imposed on a per incident basis meaning regardless of how many members are impacted and the assessment will be levied on the graduated basis detailed above. ***In the event Contractor is responsible for Federal Penalties related to a Privacy or HIPAA violation, the State may, at their discretion waive any Liquidated Damages due the State in association with the same violation.***
Caremark-2016	35	2016	4Q	\$10,000.00	Open Inquiry Closure: The Contractor shall close 95% of all open call issues within five (5) business days.	Ten thousand dollars (\$10,000) for each quarter the standard is not met.
Caremark-2017	35	2017	3Q	\$10,000.00	Open Inquiry Closure: The Contractor shall close 95% of all open call issues within five (5) business days.	Ten thousand dollars (\$10,000) for each quarter the standard is not met.
Caremark-2017	33	2017	4Q	\$10,000.00	Average Speed To Answer: The Contractor shall maintain an ASA of 30 seconds and callers may not be placed on hold after the call is answered, as required in Contract Section A.24.h.	Ten thousand dollars (\$10,000) for each quarter the standard is not met.
Caremark-2018	33	2018	1Q	\$10,000.00	Average Speed To Answer: The Contractor shall maintain an ASA of 30 seconds and callers may not be placed on hold after the call is answered, as required in Contract Section A.24.h.	Ten thousand dollars (\$10,000) for each quarter the standard is not met.

LD Assessment Report

Caremark-2018	35	2018	3Q	\$10,000.00	Open Inquiry Closure: The Contractor shall close 95% of all open call issues within five (5) business days.	Ten thousand dollars (\$10,000) for each quarter the standard is not met.
TOTAL ASSESSMENTS:				\$112,500.00		

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

CHIEF PROCUREMENT OFFICER

DATE

Agency request tracking #	31786-00121	
1. Procuring Agency	Benefits Administration	
2. Contractor	Caremark PCS Health, LLC	
3. Edison contract ID #	43652	
4. Proposed amendment #	Two	
5. Contract's Original Effective Date	12/15/2014	
6. Current end date	6/30/2020	
7. Proposed end date	6/30/2021	
8. Current Maximum Liability or Estimated Liability	\$17,722,000.00	
9. Proposed Maximum Liability or Estimated Liability	\$19,679,000.00	
10. Strategic Technology Solutions Pre-Approval Endorsement Request – information technology service (N/A to THDA)	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
11. eHealth Pre-Approval Endorsement Request – health-related professional, pharmaceutical, laboratory, or imaging	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
12. Human Resources Pre-Approval Endorsement Request – state employee training service	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
13. Explain why the proposed amendment is needed One-year extension of the contract		
14. If the amendment involves a change in Scope, describe efforts to identify reasonable, competitive, procurement alternatives to amending the contract. n/a		

Agency request tracking #	31786-00121
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)	



CONTRACT AMENDMENT COVER SHEET

Agency Tracking # 31786-00121	Edison ID	Contract # 43652	Amendment # 2		
Contractor Legal Entity Name CaremarkPCS Health, L.L.C.			Edison Vendor ID 133265		
Amendment Purpose & Effect(s) One-year extension of the contract					
Amendment Changes Contract End Date: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			End Date: 6/30/2021		
TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A):			\$2,557,000.00		
Funding —					
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2015			\$2,215,750		\$2,215,750
2016			\$4,431,500		\$4,431,500
2017			\$4,431,500		\$4,431,500
2018			\$4,129,500		\$4,129,500
2019			\$1,913,750		\$1,913,750
2020			\$1,278,500		\$1,278,500
2021			\$1,278,500		\$1,278,500
TOTAL:					\$19,679,000.00
American Recovery and Reinvestment Act (ARRA) Funding: <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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.			<i>CPO USE</i>		
Speed Chart (optional)		Account Code (optional)			

**AMENDMENT TWO OF
CONTRACT 43652**

This Amendment is made and entered by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and Local Government Insurance Committee, hereinafter referred to as the "State" and CaremarkPCS Health, LLC, 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:

B. CONTRACT TERM:

This Contract shall be effective for the period commencing on December 15, 2014 and ending on June 30, 2021.

The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period. The Contractor understands that they shall provide staff for an implementation period to last from the time of contract award until benefits go-live on January 1, 2015, and that the Contractor shall not collect any form of payment or administrative fees during this time. Conversely, for a period of six (6) months after the contract terminates, the Contractor shall continue to process and pay any claims that may arrive in any form as long as said claims are for a date of service within the term of this contract, and with the understanding that the Liquidated Damages stated in Attachment B shall not apply during this six (6) month period.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Nineteen Million, Six Hundred Seventy Nine Thousand Dollars (\$19,679,000.00). The payment rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the 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.3. Payment Methodology. The Contractor shall be compensated, beginning no earlier than January 1, 2015, 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:

Service Description	Amount (per compensable increment)						
	1/1/15 – 12/31/15	1/1/16 – 12/31/16	1/1/17 – 6/30/17	7/1/17- 12/31/17	1/1/18 – 12/31/18	1/1/19 – 12/31/19	1/1/20- 12/31/20
FEES (Guaranteed Maximum PMPM)							
Administration Fee Per Member Per Month	\$0.90 Amount Per Member Per Month	\$0.90 Amount Per Member Per Month	\$0.90 Amount Per Member Per Month	\$0.90 Amount Per Member Per Month	\$0.90 Amount Per Member Per Month	\$0.90 Amount Per Member Per Month	\$0.90 Amount Per Member Per Month
Clinical Fee Per Member Per Month							
DISPENSING FEES (Guaranteed Maximum Average Per Claim)							
Retail – Brand							
Retail – Generic							
90-Day Retail – Brand							
90-Day Retail – Generic							
Mail – Brand							
Mail – Generic							
All Brand Specialty Pharmacy Claims							
RETAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)							

Brand	[REDACTED]						
Generic	[REDACTED]						
90-DAY RETAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)							
Brand	[REDACTED]						
Generic	[REDACTED]						
MAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)							
Brand	[REDACTED]						
Generic	[REDACTED]						
SPECIALTY NETWORK DISCOUNTS (Guaranteed Minimum Average)							
All Brand Specialty Pharmacy Claims	[REDACTED]						
REBATES PER CLAIM (Guaranteed Minimum Average)							
All Retail Claim Basis (Brand & Generic)	[REDACTED]						

All 90-Day Retail Claim Basis (Brand & Generic)	[REDACTED]						
All Mail Claim Basis (Brand & Generic)	[REDACTED]						
All Brand Specialty Pharmacy Claims	[REDACTED]						

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

Amendment Effective Date. The revisions set forth herein shall be effective December 1, 2019. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

CAREMARKPCS HEALTH, L.L.C.:

SIGNATURE

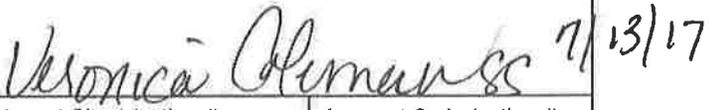
DATE

PRINTED NAME AND TITLE OF SIGNATORY (above)

**STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE:**

STUART C. MCWHORTER, CHAIRMAN

DATE

 CONTRACT AMENDMENT COVER SHEET					
Agency Tracking # 31786-00121		Edison ID 43652		Contract # 43652	Amendment # 1
Contractor Legal Entity Name CaremarkPCS Health, L.L.C.					Edison Vendor ID 133265
Amendment Purpose & Effect(s) change in pricing based on market check provision of the contract					
Amendment Changes Contract End Date: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				End Date: 6/30/2020	
TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A):					-\$604,000.00
Funding —					
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2015			\$2,215,750		\$2,215,750
2016			\$4,431,500		\$4,431,500
2017			\$4,431,500		\$4,431,500
2018			\$4,129,500		\$4,129,500
2019			\$1,913,750		\$1,913,750
TOTAL:					\$17,122,000.00
American Recovery and Reinvestment Act (ARRA) Funding: <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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.				CPO USE	
					
Speed Chart (optional)		Account Code (optional)			

**AMENDMENT ONE
OF CONTRACT 43652**

This Amendment is made and entered by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and Local Government Insurance Committee, hereinafter referred to as the ‘State’ and CaremarkPCS Health, LLC, 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:

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Seventeen Million, One Hundred Twenty-Two Thousand Dollars (\$17,122,000.00). The payment rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor’s obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the 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.3. Payment Methodology. The Contractor shall be compensated, beginning no earlier than January 1, 2015, 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:

Service Description	Amount (per compensable increment)					
	1/1/15 – 12/31/15	1/1/16 – 12/31/16	1/1/17 – 6/30/17	7/1/17- 12/31/17	1/1/18 – 12/31/18	1/1/19 – 12/31/19
FEES (Guaranteed Maximum PMPM)						
Administration Fee Per Member Per Month	\$0.90 Amount Per Member Per Month	\$0.90 Amount Per Member Per Month	\$0.90 Amount Per Member Per Month	\$0.90 Amount Per Member Per Month	\$0.90 Amount Per Member Per Month	\$0.90 Amount Per Member Per Month
Clinical Fee Per Member Per Month	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Service Description	Amount (per compensable increment)					
	1/1/15 – 12/31/15	1/1/16 – 12/31/16	1/1/17 – 6/30/17	7/1/17- 12/31/17	1/1/18 – 12/31/18	1/1/19 – 12/31/19
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
DISPENSING FEES (Guaranteed Maximum Average Per Claim)						
Retail – Brand	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Retail – Generic	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
90-Day Retail – Brand	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
90-Day Retail – Generic	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Mail – Brand	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Mail – Generic	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
All Brand Specialty Pharmacy Claims	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
RETAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)						
Brand	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Generic	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
90-DAY RETAIL NETWORK DISCOUNTS (Guaranteed						

Service Description	Amount (per compensable increment)					
	1/1/15 – 12/31/15	1/1/16 – 12/31/16	1/1/17 – 6/30/17	7/1/17- 12/31/17	1/1/18 – 12/31/18	1/1/19 – 12/31/19
Minimum Average)						
Brand	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Generic	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
MAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)						
Brand	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Generic	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
SPECIALTY NETWORK DISCOUNTS (Guaranteed Minimum Average)						
All Brand Specialty Pharmacy Claims	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
REBATES PER CLAIM (Guaranteed Minimum Average)						
All Retail Claim Basis (Brand & Generic)	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
All 90-Day Retail Claim Basis (Brand & Generic)	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
All Mail Claim Basis (Brand & Generic)	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
All Brand Specialty Pharmacy Claims	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Pursuant to TCA 10-7-504(n)(1)(A), items highlighted in yellow are marked confidential

D. 21 Iran Divestment Act. The requirements of Tenn. Code Ann. § 12-12-101 et.seq., addressing contracting with persons as defined at T.C.A. §12-12-103(5) that engage in investment activities in Iran, shall be a material provision of this Contract. The Contractor certifies, under penalty of perjury, that to the best of its knowledge and belief that it is not on the list created pursuant to Tenn. Code Ann. § 12-12-106.

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 August 1, 2017. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

CAREMARKPCS HEALTH, L.L.C.:

Diane Galo

June 22, 2017

SIGNATURE

DATE

Diane Galo, Vice President - Group Head

PRINTED NAME AND TITLE OF SIGNATORY (above)



STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE:

Larry B. Martin

7/13/17

LARRY B. MARTIN, CHAIRMAN

DATE



CONTRACT

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

Begin Date 12/15/2014	End Date 6/30/2020	Agency Tracking # 31786-00121	Edison Record ID 43652
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Contractor Legal Entity Name CaremarkPCS Health, L.L.C.	Edison Vendor ID 133265
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Service Caption (one line only)
Pharmacy Benefits Manager for the State, Local Education, and Local Government Insurance Plans

Subrecipient or Vendor <input type="checkbox"/> Subrecipient <input checked="" type="checkbox"/> Vendor	CFDA #
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Funding — FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2015			2,215,750.00		1,772,600.00
2016			4,431,500.00		3,545,200.00
2017			4,431,500.00		3,545,200.00
2018			4,431,500.00		3,545,200.00
2019			2,215,750.00		1,772,600.00
TOTAL:			\$17,726,000.00		\$17,726,000.00

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

Ownership/Control

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

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



Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.		OCR USE - FA
<i>Felenceo M. Hill</i>		
Speed Chart (optional) Multiple Speedchart Codes Apply	Account Code (optional) 78908000 <i>m</i>	



**CONTRACT
BETWEEN THE STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
AND LOCAL GOVERNMENT INSURANCE COMMITTEE
AND
CAREMARKPCS Health, LLC**

This Contract, by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and the Local Government Insurance Committee, hereinafter referred to as the "State" and CaremarkPCS Health, LLC, hereinafter referred to as the "Contractor," is for the provision of a pharmacy benefits manager for the Public Sector Plans, as further defined in the "SCOPE OF SERVICES."

The Contractor is A LIMITED LIABILITY COMPANY.
Contractor Place of Incorporation or Organization: Delaware
Contractor Edison Registration ID # 133265

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.

The Contractor shall provide pharmacy benefit management services, which shall include custom clinical programs as required, specialty care management, formulary management, network management, member services, and a state-of-the-art online Point-of-Sale (POS) pharmacy claims processing system. This POS system shall include a state-wide retail pharmacy network, prospective/concurrent drug utilization review (DUR), retrospective drug utilization review (Retro-DUR), reporting capabilities, adjudication capabilities, and full pharmacy benefit member services for retail, mail order and specialty pharmacy benefits for members of the Public Sector Plans.

A.2. Pharmacy Benefit and Policies

- a. The State will determine all pharmacy benefits and related policies. If the Contractor has a question on policy determinations, benefits, or operating guidelines required for proper performance of the Contractor's responsibilities, then the Contractor shall request a determination in writing from the State. The State will respond in writing with a determination and the Contractor shall then act in accordance with such policy determinations and/or operating guidelines.
- b. The State will have the sole responsibility for and authority to clarify and/or revise the Plan Documents (located on the State's website at (<http://www.tn.gov/finance/ins/publications.shtml>)), which governs the structure of the pharmacy benefits available to members. It is understood between the parties that the program cannot and does not cover all benefit situations. In a case where the benefits are not referenced or are not clear, the Contractor shall clarify the State's intent with the State. The State shall have the exclusive and final authority to interpret the Plan Documents.
- c. Unless otherwise directed by the State in writing, the Contractor shall not attempt to interpret statutes, regulations, plan documents, or policy materials. Rather, the Contractor shall refer, in writing, all questions regarding a policy interpretation to the contact designated by the State within one (1) business day of discovery of the issue in question.



- d. The Contractor shall possess and maintain full Pharmacy Benefit Management accreditation status with URAC, formerly the Utilization Review Accreditation Commission, during the entire term of this contract.

A.3. Plan Implementation

- a. The pharmacy benefit for the Public Sector Plans will take effect and be fully operational on the "go-live" date specified in Contract Section A.31. (Project Deliverables/Milestones).
- b. The Contractor shall implement the systems required to process all Public Sector Plan pharmacy claims and all other services described herein. The Contractor shall work with the State to ensure that the program satisfies the functional and informational requirements as outlined by this Scope of Services, by the State and in the Plan Document.
- c. The Contractor shall provide a dedicated full-time implementation team. All of the Contractor's implementation team members shall have participated, as team members, in the implementation of pharmacy benefit services for at least one other large employer (i.e. employers with pharmacy plans covering at least 100,000 lives). The Contractor's implementation team shall include a full-time licensed Pharmacist designated to this contract, and a full-time Account Manager designated to this contract, who will be the main contact with the State for all of the day-to-day matters relating to the implementation and ongoing operations of the contract. Also, the Contractor shall assign an Information Systems Project Coordinator (i) to coordinate activities among the Contractor and the State's existing vendors and all the internal and external participating and affected entities.
- d. All key Contractor project staff shall attend a project kick-off meeting at the State of Tennessee offices in Nashville, TN within the first thirty (30) days after the contract start date or after notification of the awarding of the contract to the vendor, as requested by the State. State project staff shall provide access and orientation to the Public Sector Plans and system documentation, as requested by the Contractor.
- e. The Contractor shall provide a project implementation plan to the State no later than thirty (30) days after the Contract start date. The plan shall be electronically maintained, daily, in Microsoft Excel or Microsoft Project. The plan shall detail all aspects of implementation, which includes all tasks with deliverable dates necessary to satisfactorily install the program no later than the go-live date specified in Contract Section A.31. (Project Deliverables/Milestones) and a description of the members on the transition team and their roles. The plan shall include a detailed timeline description of all work to be performed both by the Contractor and the State. This plan shall require written approval by the State. At a minimum, the implementation plan shall provide specific details on the following:
 - (1) Identification and timing of significant responsibilities and tasks;
 - (2) Names and titles of key implementation staff;
 - (3) Identification and timing of the State's responsibilities;
 - (4) Data requirements (indicate type and format of data required);
 - (5) Data conversion plan including procedures for testing the conversion data;
 - (6) Identification and timing for the testing, acceptance and certification of receipt of State's eligibility through Edison;
 - (7) Identification and timing for testing and certification of claims payment and reconciliation process;
 - (8) Drug formulary development consistent with the State pharmacy benefit;
 - (9) Plan member communications;
 - (10) Schedule of in-person meeting and conference calls;
 - (11) Transition requirements with the incumbent PBM; and



(12) Staff assigned to attend and present (if required) at open enrollment/ educational sessions.

- f. The Contractor shall schedule an implementation meeting on-site at the State of Tennessee offices in Nashville, TN no later than sixty (60) days prior to the pharmacy benefit go-live date.
- g. The Contractor shall provide for a comprehensive operational readiness review (pre implementation audit) by the State, and/or its designee, at least sixty (60) days prior to the pharmacy benefit go-live date. The Contractor shall pay for the comprehensive readiness review to ensure the plan design, eligibility and financial contract terms have been set up correctly. Such review by the State, and/or its designee, may include, but not be limited to, an on-site review of the Contractor's operational readiness for all services required in this contract (e.g. claims processing and payment, customer services, Contractor staff education, website development, etc.). The review may also include desk reviews of documentation that includes but is not limited to:
 - (1) Policy and Procedures Manual;
 - (2) Information systems; and
 - (3) Any and all deliverables required under this Contract.
- h. At its discretion, the State may conduct an additional, pre-implementation review of the Contractor's progress towards fulfilling the IT and telecommunication technology requirements of this Contract.
- i. The Contractor shall participate in all readiness review activities conducted by State staff and/or the State's designee to ensure the Contractor's operational readiness for all services required in this contract. The State will provide the Contractor with a summary of findings that may include areas requiring corrective action prior to the pharmacy benefit go-live date. The Contractor shall ensure that the State has the opportunity to thoroughly test the system prior to the go-live date and that any findings identified by the State are resolved prior to the go-live date.
- j. At the State's request and expense, the Contractor shall host one or more officials of the State (or agents of the State) onsite at its Call Center no later than one month (12/1/2014) prior to the go-live date of January 1, 2015 for the purpose of ensuring that all customer service representatives have been adequately trained on all aspects of the State's unique benefit plans (i.e. to ensure that accurate benefits and information are provided to our plan members). A tour of the facility and a review of the plan of benefits and go-live date will be reviewed as well. These officials will help to coordinate activities with Benefits Administration staff and the Call Center.
- k. The Contractor shall conduct status meetings concerning project development, project implementation and Contractor performance at least bi-weekly during implementation and daily for the first month following the go-live date, unless otherwise approved by the State. Thereafter, all ongoing operational meetings shall be conducted on a State specified schedule, but shall occur no less than once a month. Such meetings shall be either by phone or on-site at the offices of the State, as determined by the State and shall include the Account Manager, Pharmacist and appropriate systems staff. Any costs incurred by the Contractor as a result of a meeting with the State shall be the responsibility of the Contractor.
- l. No later than forty-five (45) days post-implementation, the Contractor shall provide the State with an Implementation Performance Assessment, which will be completed and provided back to the Contractor. This assessment will be used to document the State's satisfaction with the implementation process.

A.4. Staffing



- a. The Contractor shall provide an ongoing designated, full-time Account Team that can provide daily operational support as well as strategic planning and analysis. All members of the Account Team shall have previous experience administering pharmacy benefits for large employers.
- b. The Account Team shall be available for consultation with the State 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.
- c. The Contractor shall designate a full time licensed Chief Pharmacist as a member of the ongoing account team. This individual shall have over 5 years experience working at the executive level for a PBM and shall have the responsibility for providing the State with clinical pharmacological advice in the review and development of a specific formulary for the State Plans, pharmacy benefit design and utilization review activities to include Prior Authorization (PA), Step Therapy and other innovative approaches to managing the prescription drug benefits for the Public Sector Plans. In addition, the Contractor shall, at the State's request, have said Pharmacist available to participate with the State's Wellness Contractor and/or Case Managers at the State's TPAs in regular (or as needed) calls to discuss complex member cases, member issues, poly pharmacy issues, and other similar issues. These discussions will typically take place via teleconference on an as-needed basis as determined by the Case Managers and/or the Medical Director at the State's Wellness Contractor.
- d. The Contractor shall designate a full time Account Manager as a member of the ongoing account team. The Account Manager shall be a member of the implementation team in order to ensure a seamless transition from implementation to ongoing operations.
- e. The Account Manager shall have the responsibility and authority to manage the entire range of services discussed in this Contract and shall respond immediately to changes in benefit plan design, changes in claims processing procedures, or general administrative problems identified by the State. Further, this Account Manager shall be someone who is readily available via telephone and email throughout the work day to answer calls and emails by the Director of Pharmacy Services at the State and also by other state staff to research member issues that make their way to the State. Contractor expressly agrees that all plan member calls regarding pharmacy benefits, including but not limited to copayments, deductibles, out of pocket maximums, network pharmacies, drug coverage, and coordination of benefits shall be directed to the Contractor's customer service center. The Contractor further agrees that the State Benefits Administration Service Center representatives only serve to answer questions about eligibility and that Contractor's customer service center representatives should only refer eligibility-related issues back to Benefits Administration.
- f. At a minimum, the Account Manager shall meet in person with the State once a month and more often if required by the State. At its discretion, the State may allow the Contractor to participate in such meetings by teleconference.
- g. The Contractor shall survey the State annually during the contract period to determine the State's satisfaction with the ongoing account team.
- h. The Contractor shall train all Contractor staff and sub-contracted staff regarding all applicable aspects of the Public Sector Plan Pharmacy Program. The State may approve or disapprove the Contractor's Subcontractors or its staff providing core services assigned to this Contract prior to the proposed staff assignment. All new Subcontractors, who will be providing core services not already identified in the Contractor's RFP response, must be approved by the State in writing prior to the performance of any work required under this contract. For the purpose of this Contract, core services are defined as those that touch or affect the member, specifically member customer services, member call center, mail and specialty pharmacy services (if used by the member), claims processing and adjudication, appeals processing at all levels. Also included are such services that affect the plan administrator such as the contractor's account



team that interacts with the state on a daily basis through telephone calls, emails, and face to face meetings, clinical advisors or pharmacists on the account team, and the contractor's P&T (pharmacy & therapeutics) committee which develops the contractor's standard national drug formulary.

- i. The State may direct the Contractor to replace staff members or subcontractors providing core services, as it deems necessary and appropriate. The decision of the State on these matters shall not be subject to appeal.
- j. Key personnel commitments (i.e. Implementation or Ongoing Account Manager and Chief Pharmacist) made in the Contractor's proposal shall not be changed unless the Contractor receives prior written approval from the State. The Contractor shall notify the State at least fifteen (15) business days in advance, or as soon as the information is available, of proposed changes and shall submit justification (including proposed substitutions) in sufficient detail regarding education and experience equal to previous staff to the State to evaluate the impact upon the Contract. The decision of the State on these matters shall not be subject to appeal.
- k. If any key positions (e.g. the State's designated account Strategic Account Executive, Account Manager, Clinical Pharmacist) become vacant, then the Contractor shall provide a replacement with commensurate experience and required professional credentials within sixty (60) days of the vacancy unless the State grants an exception to this requirement in writing.
- l. For matters designated as urgent by the State, the Contractor shall provide a response to the State within four (4) hours. Staff members, from the respective business unit, with final decision making authority shall provide responses.
- m. The Contractor shall participate in review meetings with the State on a monthly basis for the first six (6) months of the contract, and quarterly thereafter. In these meetings, the Contractor's account team and the State will review the operations and financial performance of the Public Sector Plan pharmacy benefit. These meetings will take place at the State of Tennessee offices in Nashville, TN. However, at its discretion, the State may allow the Contractor to participate in such meetings by teleconference.
- n. For its work under this Contract, the Contractor shall employ no employees or contract with subcontractors that are on the U.S. Department of Health and Human Services' Office of Inspector General (OIG) exclusions list unless the Contractor receives prior, written approval from the State.

A.5. Point-of-Sale Claims Adjudication (for Retail, Mail Order, and Specialty Pharmacy)

- a. The Contractor shall provide an integrated, electronic retail, mail order and specialty pharmacy Point-of-Sale (POS) claims processing system that can meet the needs of the State and the Public Sector Plans, as outlined by this Scope of Services.
- b. The Contractor shall provide system design, modification, development, implementation and operation for the Public Sector Plan POS system, which uses the specified, current National Council for Prescription Drug Programs, Inc. (NCPDP) format. The Contractor's POS system shall allow it to interface with the existing pharmacy "switch" networks that connect pharmacy providers with the Contractor's system.
- c. The POS system shall automate the entire pharmacy claims processing system and shall price and adjudicate claims online and in real time. The POS system shall adjudicate and process all retail, specialty and mail order electronic point of sale and paper claims incurred during the term of the contract in strict accordance with the State Pharmacy Benefits as contained in the State Plan Document, which is located on the State's website.
(<http://www.tn.gov/finance/ins/publications.shtml>)



- d. The Contractor shall process ninety-nine and one half percent (99.5%) of POS claims on a daily basis within five (5) seconds. For this calculation the number of claims processed within five (5) seconds during each twenty-four (24) hour period shall be the numerator and the number of claims processed during each twenty-four (24) hour period shall be the denominator. To measure compliance with this standard, the Contractor shall measure for each claim 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. The Contractor's measure shall reflect the time required for all procedures required to complete claim adjudication.
- e. The Contractor shall notify the State's Project Manager, via e-mail and phone, immediately upon knowledge of unscheduled or unapproved downtime involving more than ten percent (10%) of production for a period greater than 15 minutes. The Contractor shall also provide the State updates at regular intervals during a sustained downtime. The State will be presented with recovery options as appropriate. Upon full system recovery, the Contractor shall provide the State with a System Downtime Analysis describing root cause issues and actions to mitigate future downtime occurrences.
- f. Enrolled network pharmacy providers such as retail pharmacies, specialty pharmacies, outpatient hospital retail pharmacies and mail order pharmacies will be responsible for submitting member claims through point-of-sale telecommunications devices. However, the Contractor shall also process paper claims within thirty (30) days of receipt when submitted by members or for members on behalf of a prescriber.
- g. The Contractor shall ensure that retail network claims submitted by network pharmacy providers will be paperless for the members. The Contractor's agreement with network pharmacy providers shall obligate the network pharmacy providers to submit claims directly to the Contractor.
- h. The contractor's system's must provide members a point-of-sale explanation of pharmacy benefits for Claims processed through its mail service and Specialty pharmacies, and concurrently provide online Claims records for prescriptions dispensed through all channels, which lists the individual member's pharmaceutical out-of-pocket expenses, the plan sponsor's costs, and any cost savings opportunities for the member, as well as providing members, on at least an annual basis, with a summary of their benefit cost savings opportunities from the prior year.
- i. Contractor shall work as needed and requested with the state's Third Party Administrators (TPAs) in their work related to subrogation claims. Contractor shall be ready and willing to share data or support the TPAs as needed in this work.
- j. The POS claims system shall fully integrate the PA and Step Therapy programs, as described in sections A.11.g and A.11.h, and have edits to verify eligibility, the current formulary, and claim completeness as claims are submitted.
- k. The Contractor shall confirm eligibility of each member on the basis of enrollment information provided by the State, which applies to the period during which the charges were incurred. On a quarterly basis, the Contractor shall accurately process a minimum of ninety-eight percent (98%) of claims either filed directly by members and/or their prescriber(s), in accordance with the Liquidated Damages section (Contract Attachment B) of this contract. The Contractor shall provide Public Sector Plan pharmacy services only to eligible members. The Contractor shall track member utilization across all participating pharmacy providers (i.e. retail, mail, and specialty) and shall report member utilization to the State at the State's request.
- l. The POS system shall generate a claim pay status of pay or deny. The system shall 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) and shall be accessible and operational no less than ninety-seven percent (97%) of this time. The Contractor shall not charge participating pharmacy providers any POS fees for services rendered under this contract. Network pharmacy providers are responsible for purchasing POS hardware, software and all telecommunications linkages. The Contractor shall require all participating network pharmacy providers to have the POS function.

- m. The Contractor shall apply a unique identification number to each claim and any supporting documentation. The Contractor shall use said identification number to recognize the claim for research or audit purposes. The Contractor shall ensure that all claims have been processed to completion (e.g. approved or denied). The Contractor shall ensure that safeguards are in place to protect the confidentiality of member information.
- n. At the point of sale, the Contractor shall identify and deny claims that contain invalid provider numbers. Pharmacy providers shall submit claims and be identified by their individual and specific National Provider Identification numbers (NPI). Prescribers shall be identified on all pharmacy claims by their specific NPI or Drug Enforcement Agency (DEA) numbers, or any other identifying number as required by the State or HIPAA.
- o. The Contractor shall identify and deny claims (unless specifically instructed differently by the State) that contain National Drug Code (NDC) numbers including non-covered drug codes, less-than effective (LTE) drug codes based on the Drug Efficacy Study Implementation (DESI), drug codes which are identical, related or similar (IRS) to DESI drugs and any terminated or obsolete drug codes. Such claims shall reject with situation specific messaging and error codes.
- p. The Contractor's POS adjudication system must have the ability to reject claims when the member's State plan coverage is secondary to another plan and notify members and the retail pharmacy why the claim rejected. Secondary coverage claims must be submitted to the Contractor for possible reimbursement.
- q. Upon conclusion of this contract, or in the event of its termination or cancellation for any reason, the Contractor shall be responsible for the processing of all claims incurred for eligible Public Sector Plan members rendered during the period of this contract with no additional administrative cost to the State and according to the pharmaceutical price quoted for the year in which the pharmacy expense was incurred. The Contractor shall also be responsible for the payment of rebates on all claims incurred prior to termination or cancellation. The claims run out period shall commence for a period of six (6) calendar months after the contract term date, unless otherwise directed by the State.
- r. The Contractor shall maintain a dedicated toll-free number to support system operations. This Help Desk shall be available twenty-four (24) hours a day, seven days a week to respond to questions and problems from pharmacy providers regarding system operations and claims inquiries. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations. The Contractor's Help Desk and Help Desk representatives/operators shall be located in the United States.
- s. The Contractor shall process all of the State's claims on the same platform during the term of this Contract and shall not transition the State from the claims adjudication platform that they are implemented onto during the term of this contract without prior written approval by the State.

A.6. Claims Payment and Reconciliation

- a. The Contractor shall adjudicate claims as payable only if said claims are (i) for eligible members (ii) for approved services (iii) dispensed by in-network pharmacy providers (or out-of-network providers, payable up to the MAC and minus any member cost sharing) and (iv) in accordance with the payment rules and other policies of the State. The State will only pay for



approved and correctly paid claims, not for rejected or reversed claims. Out of network claims shall be paid via direct member reimbursement for (i) eligible members (ii) for approved services (iii) and in accordance with the payment rules and other policies of the State.

- b. The Contractor shall pay the claim or advise the provider that a submitted claim is: (1) a "denied claim" (specifying all reasons for denial); or, (2) remains as a transaction that cannot be denied or allowed due to insufficient information and/or documentation (specifying all information and/or documentation that is needed from the provider in order to allow or deny the claim). An incomplete transaction may be resubmitted with the information necessary to complete the claim.
- c. The Contractor shall pass directly to the Public Sector Plan the contract terms the Contractor has negotiated with retail pharmacies (discounts and dispensing fees) and pharmaceutical manufacturers (rebates). Thus, the Contractor shall not receive any differential, or "spread", between the pharmacy or manufacturer contracted rate and the plan sponsor contracted rate. The Contractor shall provide a quarterly report to demonstrate the level of pass-through pricing.
- d. The Contractor shall be responsible for ensuring that any payments funded by or to the State are accurate and in compliance with the terms of this contract, including the Liquidated Damages section (Contract Attachment B) of this contract; agreements between the Contractor and providers; and state and federal laws and regulations.
- e. The Contractor shall ensure that every paid claim is attributed to one of the state's funding accounts. Currently there are six (6) accounts (55000 State Plan Actives, 56000 Local Education Plan Actives, 58000 Local Government Plan Actives, 51000 State Plan Retirees, 52000 Local Education Plan Retirees, and 53000 Local Government Plan Retirees). Any later adjustments of claims requested or initiated by either the State or by the Contractor shall be debited or credited to one of the state's funds and not to the funds that are paid to the Contractor in the way of administrative fees. Any adjustments or later claims processed that results in the state being owed money or the state owing money for a claim processed should be debited or credited against one of the state's funds and NOT against any administrative fees payments. Claims payment accuracy shall be ninety-eight percent (98%) or higher.
- f. The Contractor shall notify the State within thirty (30) days of a retroactive termination of all claims paid on behalf of the affected plan member during the period covering the retroactivity. The State will require the Contractor to assist the State in the recovery of claims.
- g. The Contractor shall reimburse pharmacies for claims from their own funds and accounts. For the payment of all claims under this contract, the Contractor shall issue payments in the form of checks and/or Automated Clearing House (ACH) electronic funds transfer against the Contractor's own bank account. The Contractor shall maintain security and quality controls over the design, printing, and mailing of checks, as well as any fraud prevention features of checks. Additional requirements related to payments are listed in Section C.3 of the Contract. These claims paid by the Contractor will be reimbursed by the State's Office of Business and Finance (OBF) upon receiving sufficient documentation and reports from the Contractor to validate/justify the accuracy of the requested reimbursement for paid claims. The State will only reimburse the Contractor for paid claims. Claims that have been processed and adjudicated but not yet paid by the Contractor to pharmacies will not be reimbursed by the State.
- h. The Contractor shall follow the State of Tennessee's law(s) surrounding prompt payment to providers. In the absence of a prompt payment law for PBMs, the Contractor shall pay providers for 100% of all "clean" claims within the lesser of 30 days or the contracted turnaround time with the pharmacy.
- i. During the Spring of 2013, the Tennessee General Assembly passed legislation (Public Chapter 408, Senate Bill 63) See <http://state.tn.us/sos/acts/108/pub/pc0408.pdf> This requires the State



Benefits Administration office to compile a report each July 1 using data from various audit reports completed for us during the year. Benefits Administration will require the participation and timely assistance of the contractor under this contract to work with the actuaries and benefits analysts both in and outside the state to ensure that each report is completed timely. Please note that item #5 in the URL provided above requires a "reconciliation of the pharmacy benefits manager's payments to pharmacies with the state's reimbursement to the pharmacy benefits manager."

A.7. Pharmacy Network

- a. The Contractor shall establish and maintain its broadest available national pharmacy provider network and a statewide Any Willing pharmacy provider network of retail, 90-day-at-retail, mail order, and specialty pharmacies. The network shall be adequate to provide covered pharmacy services and pharmacy location sites available and accessible in accordance with the Terms and Conditions as set forth by the State and in compliance with Tennessee Code Annotated Section 56-7-2359. The Contractor shall provide this said network through the entire term of the contract, including term extensions.
- b. The Contractor shall execute pharmacy provider agreements with Any Willing pharmacy providers for retail, mail and specialty pharmacies that maintain all federal, state and local licenses, certifications, and permits, without restriction, required to provide pharmaceutical services and shall comply fully with all applicable laws and regulations.
- c. The Contractor shall provide a list of the individual pharmacies (including at a minimum: name, NCPDP number, NPI number, address, city, state, zip code, and telephone number) participating in the retail, 90-day-at retail, mail, and specialty networks on the Contractor's website at least thirty (30) days prior to the go-live date. The Contractor shall update the lists at least quarterly, and these lists shall appear in a prominent place on the contractor's website for State of TN plan members. Such list shall be easy to locate and utilize for all public sector plan members.
- d. The Contractor shall not require the State to mandate the use of mail order pharmacies.
- e. Retail Network:
 - (1) 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 Public Sector Plan members, on average, live within one and one half (1.5) miles of a retail pharmacy participating in the Contractor's network; in suburban areas, at least ninety percent (90%) of Public Sector Plan members, on average, live within three (3) miles of a retail pharmacy participating in the Contractor's network; and in rural areas, at least ninety percent (90%) of Public Sector Plan members, on average, live within ten (10) miles of a retail pharmacy participating in the Contractor's network. The Contractor shall justify and document all exceptions, which are subject to prior written approval by the State.
- f. 90-day-at-Retail Network:
 - (1) In accordance with Any Willing Pharmacy Act (codified at TCA § 56-7-2359), the Contractor shall allow any willing network retail pharmacies that agree with the Contractor's terms and conditions for mail order pharmacy to participate in a 90-day-at-retail network. Contractor must create the 90 day at Retail network for the state-sponsored plans; contractor must not under any circumstances attempt to direct plan members to any pharmacy (either a specific retail pharmacy or the contractor's mail order pharmacy). Neither the state nor the PBM may engage in any sort of influence as to which particular pharmacy a member uses to fill a prescription, with the exception of specialty drugs referenced in section A.7.h.



g. Mail Order Network:

- (1) The mail order pharmacy shall possess sufficient staff and facilities capable of mailing ninety-five percent (95%) or more of all Public Sector Plan member prescription orders filled from "clean" prescriptions not requiring pharmacy intervention within two (2) business days and ninety-nine and nine-tenths percent (99.9%) of all prescriptions mailed to eligible Public Sector Plan members shall be dispensed with the correct drug strength and dosage form. The mail order pharmacy shall possess a current license to dispense controlled drugs (Schedule 2, 3, 4 and 5 substances).
- (2) The Contractor's mail order pharmacy will not be required to dispense prescriptions for greater than a ninety (90) day supply of covered drugs, per prescription or refill, subject to the professional judgment of the dispensing pharmacist, limitations imposed on controlled substances, and manufacturer's recommendations. Exceptions to the ninety day limit include medications that may be packaged by the drug manufacturer in quantities of just over 90 days and that do not lend themselves to being split by the pharmacist (e.g. insulins); in those instances, the mail order pharmacy may fill using the packaging as is and charge a ninety day copayment to the plan member. Prescriptions may be refilled providing the prescription states that refills remain. All prescriptions will be filled in accordance with Tennessee state laws and regulations.
- (3) The Contractor shall guarantee that MAC pricing will apply at mail for generic medications.
- (4) The Contractor shall guarantee that the AWP applied to mail order claims must be the actual National Drug Code-11 of the package size dispensed.
- (5) The PBM mail order service shall inform the member, the prescriber, and the State if it substitutes products that will result in a member co-pay or plan cost that is greater than the co-pay or plan cost that would have been incurred had the prescription been dispensed as written. The Contractor shall only engage in such substitutions when there are widespread marketplace drug availability issues with the more cost effective product, if there is a member safety issue or if there is a drug interaction or efficacy issue – and only with prescriber approval.
- (6) The mail order pharmacy shall communicate to the member, by phone or e-mail, any delays, beyond three (3) business days, in delivery of prescriptions. Members shall be notified of such delays within twenty-four (24) hours of the discovery of the delay.
- (7) The mail order pharmacy shall provide members refunds for monies owed back to them instead of maintaining credits at the mail facility.
- (8) The State will not pay any outstanding balances owed by Public Sector Plan members to the Contractor or its network pharmacy providers.
- (9) The Contractor shall obtain open refill files from the State's current mail order vendors if available.
- (10) The Contractor shall maintain a secure website supporting the mail order function, which allows members to access their pharmacy claims and request and pay for refills online. Said website shall be operational no later than thirty (30) days prior to the go-live date.

h. Specialty Network:

- (1) The specialty pharmacy network shall be the preferred pharmacy provider of certain drugs. The specialty pharmacy network shall guarantee more favorable reimbursement rates than



the retail, mail and 90-day at retail networks on the designated products, in the aggregate, and possess unique clinical monitoring, member assistance, and distribution capabilities.

- (2) The Contractor or other third-party specialty pharmacy that has contracted with the Contractor may provide specialty drugs. The Contractor shall add new specialty products and the pricing for these products to the list of specialty drugs.
- (3) Unless otherwise directed by the State, all drugs placed on the Contractor's specialty drug list shall meet the definition of "specialty drugs" in the Definitions section of this contract. The drug must meet at least two of the first four criteria (a thru d) and the final criteria (e).
- (4) Unless otherwise directed by the State, the Contractor shall limit specialty drugs to no more than a thirty (30) day supply, which it shall provide exclusively via specialty network pharmacies. The contractor must solicit pharmacies inside the state of Tennessee to join their specialty pharmacy network, per the Any Willing Provider law codified at TCA § 56-7-2359 (even if the contractor operates its own specialty pharmacy). Further, contractor understands and warrants that neither the Contractor nor the Contractor's staff will attempt to steer plan members to utilize any particular pharmacy within the Specialty Pharmacy Network, so long as plan members do utilize a pharmacy in said network for their specialty medications.
- (5) Contractor understands that the sole administrative fee (PMPM) paid to the contractor monthly constitutes all services payable under this contract, including but not limited to specialty drug management (step therapy, first fill counseling, recalls, member adherence education, prior authorization, and similar industry standard PBM activities that relate to specialty drug management.)
- (6) The contractor shall guarantee that the AWP applied to specialty claims will be the actual NDC-11 of the package size dispensed.
 - i. The Contractor shall lock members who meet the Contractor's lock-in guidelines into just one network pharmacy and one prescriber. The Contractor's lock-in guidelines shall be provided to the State for approval during plan implementation.
 - j. The Contractor shall annually provide the State with a GeoNetworks® report showing service and geographic access for the retail network and the 90-day-at-retail. The State will review the pharmacy network structure and shall inform the Contractor in writing of any deficiencies. The State and Contractor shall then mutually develop a plan of action to correct said deficiencies within sixty (60) days from the date the Contractor was first notified of the problem.
 - k. The Contractor shall generate and deliver to the State, within five (5) working days of the end of each contract quarter, a Quarterly Network Changes Report. This report shall include all additions to the network and all pharmacies no longer participating in the network.

A.8. Formulary Management

- a. The Contractor shall design, develop, implement, administer and maintain the Public Sector Plan formulary in compliance with coverage defined in the Plan Documents. The formulary shall include FDA approved drugs that have been evaluated for inclusion by the Contractor's Pharmacy and Therapeutics (P&T) Committee. The Contractor shall be the exclusive formulary administrator for the prescription drug benefit delivered under this contract during its term.
- b. On the date the Contractor assumes full responsibility for the pharmacy benefits program, the Contractor shall assume responsibility for administering and maintaining the formulary, including the State's existing PA criteria and clinical programs.



- c. The Contractor shall implement the formulary within five (5) working days after receipt of the State's written approval. The Contractor shall allow formulary customizations at the State's request at no additional cost to the State, including the ability to add over-the-counter (OTC) products. The Contractor shall implement customized formularies within fifteen (15) working days after receipt of the State's written request.
- d. The Contractor shall monitor Public Sector Plan formulary compliance, report compliance information to the State quarterly, and provide suggestions for improving formulary compliance.
- e. The Contractor shall implement changes to the formulary, Step Therapy, PA and other clinical edit requirements within thirty (30) business days of the State's approval or request. Additional time, beyond thirty (30) business days, may be granted with the state's prior written approval. Changes shall include modifications to the POS system and all supporting systems and documents. The Contractor shall notify pharmacy providers and affected plan members in writing at least thirty (30) days prior to the implementation, unless the Contractor and State mutually agree to a shorter notification time. The State must provide prior written approval for all pharmacy provider and member notifications.
- f. The Contractor shall not implement or administer any program that results in the therapeutic switching of members from lower net cost products to higher net cost products. The only exceptions are for member safety or efficacy issues or, upon notification to the State and with prescriber approval, in response to widespread marketplace drug availability issues with the more cost effective product.
- g. Final decisions for inclusion or exclusion from the Public Sector Plan formulary shall be at the sole discretion of the State. At the time of contract implementation, the State only excludes fertility medications and weight loss medications from coverage; however, the State reserves the right to add to or amend this coverage in the future.
- h. The Contractor shall work with state staff to reduce the use of coupons or drug cards utilized at retail pharmacies. Specifically, the contractor, within the first 90 days after go-live, and annually thereafter if needed, shall review the previous calendar year of claims and rank the top 25 drugs by net cost (cost to the plan or state). For any drug that shows up in the list and whose manufacturer currently issues coupons or drug cards in order to lower the plan member's out of pocket cost, the Contractor shall determine the manufacturer of said drug and bring to the state a proposal for how to reduce the use or eliminate the use of said coupons or drug cards.
- i. Formulary Design and Development:
 - (1) Based on the recommendations by the Contractor's Pharmacy and Therapeutics (P&T) Committee, the Contractor shall design the Public Sector Plan formulary to (i) maximize the prescribing and dispensing of safe and clinically effective drugs within each therapeutic class that are the most clinically effective as well as the most cost-effective (ii) ensure that the more costly drugs, which do not have any significant clinical or therapeutic advantage over others in their class, are used only when medically necessary; have a higher formulary tier; and have a higher member cost share (in certain instances, these drugs may be excluded from the formulary) and (iii) ensure that ninety-five percent (95%) or more of mail order prescriptions and ninety percent (90%) or more of retail prescriptions for multi-source drugs will be dispensed with a generic product.
 - (2) The Contractor's P&T formulary review process shall be an evidence-based review of clinical guidelines and medical literature to identify which agents and classes of drugs shall be included on the formulary. Within the classes of drugs determined to be included on the



formulary, the Contractor shall determine which drugs within each class are safe, clinically effective, cost rational and provide equivalent clinical outcomes. The Committee's recommendations for inclusion on the formulary 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. The Contractor shall, at the State's request, provide the State documentation describing the formulary review process, logic and methodology utilized by the Contractor's P&T Committee.

- (3) The Contractor shall identify therapeutic alternatives and opportunities for savings and report these opportunities at the quarterly review meetings with the State. The Contractor shall also present recommendations at the quarterly review meetings concerning therapeutic categories that should be avoided with regard to inclusion on the Public Sector Plan formulary, if applicable.
- (4) The Contractor may modify drugs included on the formulary as a result of factors including, but not limited to, medical appropriateness, manufacturer rebate arrangements, and patent expirations. The Contractor shall notify the State of modifications to the formulary, which will include a statement as to the reason for the modification. In the event that one of the top twenty drugs (by prescription volume) utilized by eligible members is being removed, the Contractor shall provide a more detailed analysis justifying the proposed removal of the drug from the formulary including financial analysis, member disruption analysis and member and pharmacy provider communication strategy.
- (5) Upon review and approval by the State, the Contractor shall implement formulary management programs, which may include cost containment initiatives, such as therapeutic interchange programs; communications with eligible members, participating pharmacies and/or physicians (including communications regarding generic substitution programs); and financial incentives to participating pharmacies for their participation.
- (6) The Contractor shall design, develop, implement, administer and maintain a listing of quantity limits for certain preferred and non-preferred drugs. The Contractor shall base this list on therapeutic best practices (current clinical guidelines) or opportunities to reduce the cost of the most appropriate dosage form. The Contractor shall include drugs and quantities on the quantity limits listing in the formulary documents and shall code these limits and pharmacy messaging into the POS system.
- (7) The Contractor shall ensure the formulary is readily available on the Internet for both prescribers and members and that prescribers and members can easily identify utilization restrictions, or formulary alternatives for non-formulary or high-cost products.
- (8) The Contractor shall coordinate its formulary development process and criteria with the Contractor's clinical program requirements (PA, Step Therapy, etc.) to ensure consistent processes and minimize member or prescriber impact.
- (9) The Contractor shall ensure that the Public Sector Plan pharmacy program and POS system include provisions for the dispensing of an emergency supply (i.e. early refill, member lost prescription, vacation supply, dose increase, etc.), as described and determined by the Plan Document.

A.9 Benefit Coverage/Plan Design

- a. The Contractor shall support and administer the following if requested by the State:
 - (1) Any updated benefit plan design;
 - (2) Co-pays/Co-insurance at retail, 90-day-at-retail, mail and specialty;
 - (3) Mixed co-pays at retail and mail (fixed dollar + %);



- (4) Minimum/Maximum amounts with co-insurance;
- (5) Annual Out-Of-Pocket maximums per person and per family;
- (6) Out-Of-Pocket maximum per Rx;
- (7) Deductibles on brand name drugs only;
- (8) Deductibles based on network (deductible applies to 30-day retail only);
- (9) Therapeutic Class "Maximum Allowable Charges";
- (10) Therapeutic co-pays/co-insurance for specific drug classes such as asthma and diabetes;
- (11) Co-pays/Co-insurance based on previous drug trials (e.g., higher co-pay if claims history does not include trial of first-line/preferred drug/drug class);
- (12) Co-pays/Co-insurance based on place of service (e.g., incentives to use preferred retail pharmacies, specialty pharmacies, etc.);
- (13) Co-pays/Co-insurance dependent on member's behavior (e.g. enrollment or stratification level in a disease management program); and
- (14) Co-pays/Co-insurance on the days supplied (e.g., a mail claim processed for a thirty (30) day supply).
- (15) Following requirements of the Patient Protection and Affordable Care Act (PPACA), provide for various coverages and benefit exceptions (not an all-inclusive list; rather, a summary of examples):
 - i. Aspirin: zero copay for ages ≥ 45 , generic only, OTC requires prescription
 - ii. Iron Supplements: ages 0-1; no PA; no quantity limits; brand, generic, and OTC requires prescription;
 - iii. Oral Fluorides: ages 0-6; no PA; no quantity limits; brand, generic, and OTC requires prescription
 - iv. Folic Acid: Females 0-55 only; no PA; quantity limit of 100 units per fill; generic only; OTC requires prescription
 - v. Tobacco Cessation: zero copay; limit of 2, 12 week courses of treatment (168 days); cover generic Zyban, Chantix, and nicotine replacement products patches, gum, and lozenges (inhaler not covered), Rx or OTC requires prescription
 - vi. Immunizations at zero copay – "A" and "B" rated recommendations by the USPSTF.
 - vii. Vitamin D – both genders, ages ≥ 65 ; brand and generic, no PA, OTC requires prescription
 - viii. Oral Contraceptives, emergency contraceptives, injectables; zero copay, generic only and single source brands; no PA; requires prescription.

A.10. Patient Protection & Affordable Care Act (PPACA)

The Contractor will be responsible for ensuring that all pharmaceutical benefits and programs offered by the State and administered by the Contractor meet all current and future requirements of the federal Affordable Care Act, including benefit design, formulary design and management, copay and/or coinsurance structure, appeals of all levels and any and all associated costs.

A.11. Clinical Programs

- a. The Contractor shall utilize prescription drug claims data to enhance:
 - (1) Drug utilization review;
 - (2) Clinical management initiatives;
 - (3) Therapeutic management initiatives; and
 - (4) Gaps in care analysis
- b. The Contractor's clinical program offering shall include:



- (1) An evidenced-based approach;
 - (2) Compliance (poor adherence);
 - (3) Utilization management programs;
 - (4) Information available via the web;
 - (5) Outcomes data (savings and member impact); and
 - (6) Custom programs based on the State's specific utilization
- c. The Contractor shall provide clinical, utilization management programs specific for specialty drugs/self-administered injectable medications. A clinician shall be available, through the specialty network pharmacy, to patients taking specialty medications twenty-four (24) hours a day, seven (7) days a week.
- d. The Contractor shall provide a Therapeutic Substitution and Generic Dispensing Program with provisions for written, phone, and/or face-to-face contact with prescribing physicians and plan members in order to advise them of the potential saving resulting from substituting a costlier drug with a lower cost medically appropriate alternative drug. The Contractor shall report results of the program to the State on an annual basis. The Contractor shall receive approval from the State prior to implementing member-targeted activities.
- e. The Contractor shall maintain a Generic Dispensing Rate (GDR) of 80.0% or higher during the term of this contract.
- f. The Contractor shall only communicate with members about pharmacotherapy alternatives or alternative places of service when a change will save both the member and State monies (net of co-pays).
- g. Step Therapy
- (1) The Contractor shall administer and maintain a Step Therapy program that promotes the use of the most cost-effective drug therapy for a specific indication, regardless of drug class.
 - (2) At the State's request, the Contractor shall implement a Step Therapy program, targeting all brands, for the following drug classes: Proton Pump Inhibitor's (PPIs), Angiotensin II Receptor Blockers (ARBs), Angiotensin-Converting Enzyme (ACE) Inhibitors, Cholesterol lowering medications, Antidepressants, Antihyperlipidemics, Pain (Rheumatoid Arthritis/Osteoarthritis), Antiasthmatics, and Narcotic and central analgesics. At the State's request, additional drug classes may be targeted for Step Therapy at any time during the term of the contract and shall be implemented by the Contractor at no cost to the State.
 - (3) As the formulary is re-evaluated and/or expanded, the Contractor shall develop proposed Step Therapy criteria for non-preferred drugs and certain preferred drugs and present those criteria to the State for review and input (e.g. Non-steroidal Anti-inflammatory Drugs). The Contractor shall base these recommendations on therapeutic best practices and drive utilization to the most cost effective agents or classes.
 - (4) The Contractor shall describe the drugs and the criteria included in the Step Therapy program on all formulary documents. The Contractor shall code these criteria into the POS system such that the system shall have an edit on all drugs in the target classes that pharmacy providers submit for dispensing. Before the new drug may gain approval through a PA, the Contractor shall review the claims history of prior use of a more cost-effective drug and approve the PA only if such evidence is present.
- h. Prior Authorization (PA)



- (1) The Contractor shall fully disclose, in writing, all PA criteria and procedures to the State during plan implementation.
- (2) The Contractor's POS system shall determine whether a prescribed drug requires PA and if so, ensure that the member received the necessary approval prior to authorizing the transaction and permitting reimbursement. All PA services shall be provided at no additional cost to the State.
- (3) The Contractor shall offer within 18 months of go-live (by July 1, 2016 for a January 1, 2015 start date) to prescribing physicians an online prior authorization portal whereby the physician can go online to initiate a prior authorization request via secure. Providing this information strictly via telephone or CSR does not exempt the Contractor from this requirement.
- (4) The Contractor shall ensure that Call Center staff evaluates ninety-nine percent (99%) of PA requests and notifies the prescribing physician within twenty-four (24) hours, in writing or via phone or fax. The Contractor shall implement an agreed upon set of edits and PA criteria on the go-live date. Additional PA edits may be implemented at the State's direction at any point during the term of this Contract without additional cost to the State.
- (5) The Contractor shall submit a quarterly PA report, which includes PA statistics including, but not limited to, the number of PAs submitted, the number approved and denied and the purpose of the PA (clinical edit, emergency override, etc.).
 - i. The State has the ability to "opt-out" of any clinical program.
 - j. Prior to implementing any program or service for which the Contractor receives external funding, the Contractor shall disclose the details of such program and such sources of external funding to the State. The State shall have the authority to opt-out of any such program that the State determines is not in the best interest of its members.
 - k. At the State's request, the Contractor shall support the State's efforts to develop a Medication Therapy Management (MTM) program. Such assistance shall include providing requested member pharmacy data, communicating with and educating participating network pharmacies, and assisting in the identification of members who should receive MTM services.

A.12. Prospective/Concurrent Drug Utilization Review (DUR)

- a. The Contractor shall furnish a fully automated Prospective/Concurrent Drug Utilization Review system that meets all applicable state and federal requirements. The DUR function shall meet minimum federal DUR regulations as well as the additional specifications in Contract Section A.11. and be flexible enough to accommodate any future edit changes required by the State. The Contractor shall recommend to the State, annually at review meetings, new DUR edits that improve quality and reduce pharmacy program costs.
- b. Prior to authorizing claims and permitting reimbursement, the Contractor's system shall provide DUR services that apply State-approved edits to all claims. The edits shall provide clinically appropriate information described in section A.12.c to the dispensing pharmacist.
- c. The Contractor's POS system shall apply the results of DUR processing in the claim adjudication process. Claims that reject as a result of 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 which meets all applicable state and federal requirements but shall make any modifications required by the State. The Contractor's system shall include the following minimum DUR features at installation:



- (1) Potential Drug Problems Identification - The Contractor's system shall perform automated DUR functions. The system shall automatically identify and report issues to the pharmacy provider including, but not limited to:
 - i. Problems that involve potential drug overutilization;
 - ii. Problems that involve therapeutic duplication of drugs when the submitted claim is associated with other drugs or historical claims identified for a given member;
 - iii. Problems that involve drug use contraindicated by age, gender and presumed diagnosis codes on historical claims for a given member;
 - iv. Problems that involve drug use contraindicated by other drugs on current or historical claims for a given member (drug-to-drug interactions);
 - v. The level of severity of drug-to-drug interactions;
 - vi. Potentially incorrect drug dosages or a change to the quantity per prescription to ensure the most cost-effective strength is dispensed;
 - vii. Potentially incorrect drug treatments;
 - viii. Potential drug abuse and/or misuse based on a given member's prior use of the same or related drugs; and
 - ix. Early refill conditions and provide, at the drug code level, the ability to deny these claims. The Contractor shall customize refill-too-soon edits.
- (2) POS Pharmacy Provider Cancel or Override Response to DUR Messages – Prior to the final submission of POS pharmacy claims, the Contractor's system shall automatically generate 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 by the pharmacy.
- (3) Flexible Parameters for Generation of DUR Messages - The Contractor's system shall have the ability to transmit new or revised DUR messages and to define the DUR criteria that activate these messages.
- (4) DUR Member Profile Records - The Contractor's system shall provide and maintain member profiles for DUR processing of submitted claims. The Contractor shall base member profiles on presumed diagnoses from pharmacy claims and other data available.
- (5) Disease/Drug Therapy Issues Screening - The DUR system shall have the capability to screen for drug therapy concerns by specific drugs relative to high-risk diseases, to include but not limited to: cardiovascular disease; diabetes; psychiatric disease; and respiratory disease.
- (6) Patient Counseling Support - The Contractor's system shall present DUR results to pharmacy providers in a format that supports their ability to advise and counsel members appropriately.

A.13. Retrospective Drug Utilization Review (Retro-DUR)

- a. The Contractor shall provide a Retrospective Drug Utilization Review (Retro-DUR) program supported by licensed clinical pharmacists. The Contractor shall develop, maintain and update a set of evidence-based clinical criteria, which the Contractor shall use to detect potential problems such as poly-pharmacy 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. The Contractor's Retro-DUR system shall:
 - (1) Provide provider practice analyses that includes identification of key performance indicators such as generic dispensing rate, controlled substances, formulary compliance, etc.;
 - (2) Trend providers' prescribing habits and identify those who practice outside of their peers' norm;



- (3) Identify patients who may be abusing resources through poly-pharmacy utilization patterns or visiting multiple providers;
 - (4) Identify patients with excessive use of controlled substances or other highly abused medications;
 - (5) Produce reports that detail patient and prescriber trends and that identify potential quality of care problems and/or potential fraud and abuse; and
 - (6) Have in place an intervention process and a system for tracking prescriber response to the interventions.
- b. The Contractor shall utilize the evidence-based clinical criteria to conduct quarterly prescriber and member profile reviews. The State and the Contractor shall mutually agree on the number of member and prescriber profile reviews to be conducted at the quarterly review meeting. The Contractor will notify the State in writing of the focus of, and methodology to be used in, the profile reviews at least thirty (30) days prior to the initial review start date.
- c. The Contractor shall complete quarterly prescriber and member profile reviews and distribute results/interventions, as recommended by the Clinical Pharmacist, to prescribers within ninety (90) days of the end of the quarter. The Contractor shall implement interventions designed to address problems identified during profile reviews. These interventions may include mailings, phone calls, faxes, or face-to-face visits. Other interactions may occur after receiving approval from the State. Mailings shall consist of an intervention letter to the prescriber and/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. The State will approve any summaries, correspondence or other documents produced as a result of the review process prior to their distribution.
- d. The Contractor shall maintain a system capable of tracking all interventions and determining cost savings related to the specific interventions.
- e. DUR and Retro-DUR Reporting
- (1) The Contractor shall have a qualified DUR Clinical Pharmacist, designated to the Public Sector Plan, prepare presentations and attend meetings with the State to present DUR and Retro-DUR data, findings, utilization, and recommendations for improvement. Such presentations shall occur up to four (4) times annually, as requested by the State. The Contractor shall present, at a minimum, the following reports/information for each of the State sponsored plans, which shall convey rolling twelve (12) month trends:
 - i. Utilizing-members data;
 - ii. Utilization by age demographics;
 - iii. Utilization by top twenty (20) therapeutic classes determined both by number of claims and by payment amount;
 - iv. Top twenty (20) drugs as ranked by claim count and by total payment;
 - v. DUR data including totals of DUR messages sent and savings associated with the top twenty (20) drugs associated with each DUR edit;
 - vi. Retro-DUR reviews, summary of the interventions and estimated cost savings information as associated with both member and provider profile review and interventions;
 - vii. Distribution of Clinical Alerts as prepared monthly by the Contractor's Clinical Management staff; and
 - viii. Any additional reports included in the Contractor's standard DUR reporting package.
 - (2) The Contractor shall report quarterly the outcomes of the Retro-DUR initiatives. The Contractor's system shall track the impact of DUR initiatives by comparing specified data elements pre- and



post-intervention. At the State's request, 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:

- a. Drug change within a sixty (60) or ninety (90) day period of the intervention, or within another time period as otherwise directed by the State;
- b. Total number of drugs pre- and post- intervention;
- c. Change in dose/dosing frequency of medication within a sixty (60) or ninety (90) day period of intervention or within another time period as otherwise directed by the State;
- d. Daily dose of drug in question pre- and post-intervention;
- e. Assessment of various interactions (as relevant to the activity) pre- and post-intervention which may include drug-to-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;
- f. Compliance with national guidelines (e.g. percentage of patients with CHF on beta-blocker, diuretic, etc.) depending on the disease state targeted by the Retro-DUR initiative;
- g. Generic medication utilization;
- h. Emergency supply frequency;
- i. Formulary compliance; and
- j. Patient adherence as defined by medication possession ratio.

A.14. Financials

- a. Other than those addressed in this contract, the Contractor shall not collect any additional fees, rebates, premiums, or revenue from the State of Tennessee.
- b. Ingredient Cost
 - (1) The Contractor shall guarantee the AWP used to price claims will be the one associated with the actual NDC-11 submitted by the pharmacy, and used to fill the prescription. The Contractor shall communicate any exceptions to this rule (e.g., compound prescriptions, etc.) to the State in writing and such exceptions shall be mutually agreed upon by both parties.
 - (2) If using various sources to price claims, the Contractor shall use the AWP that provides the lowest price available.
 - (3) The Contractor shall guarantee that in the event there are changes in the marketplace to the baseline measure used for the ingredient costs of drugs (e.g. AWP) the Contractor shall adjust accordingly to provide an equivalent price. The Contractor shall provide notice to the State and the conversion shall be agreed upon in writing before any changes are made.
 - (4) The Contractor shall apply a MAC-list at mail pharmacies and at 90-day-at-retail network pharmacies for generic medications. The list will have prices equivalent to or lower than the MAC-list applied to retail claims. The Contractor shall use the same MAC list for network pharmacies and the State and shall provide the most current MAC list to the State on a quarterly basis in a spreadsheet format.
 - (5) The Contractor shall utilize a brand/generic indicator based on data elements available from only one nationally recognized source like First DataBank, Medi-Span, etc. unless a change in the indicator will lower the price for the State or the State agrees that the change is acceptable.



- (6) The Contractor shall guarantee that actual reimbursement rate, in the aggregate, to network pharmacies for pharmaceuticals will not exceed the guaranteed discount off AWP, plus the negotiated dispensing fee.
- (7) The Contractor shall apply "lowest-of-pricing" logic at retail, mail, 90-day-at-retail, and specialty pharmacies, which means that the plan and plan members will pay the lesser of (i) co-pay/co-insurance, (ii) contracted rate (discounted average wholesale price (AWP)), or maximum allowable cost (MAC), if available) plus dispensing fee or (iii) Usual and Customary (U & C). In no event will the member or plan cost share be greater than the contracted cost.
- (8) The Contractor shall not charge a minimum co-pay/co-insurance for any mail, retail, 90-day-at-retail, or specialty pharmacy claims.
- (9) The Contractor shall guarantee that the terms offered for mail claims shall not vary based on the days supply (i.e., claims processed for less than a 90-day supply).
- (10) The Contractor shall provide, during the first quarter of each calendar year, an annual reconciliation between the average network discounts achieved and the guaranteed average discount amounts for retail, 90-day-at-retail, mail and specialty for the previous calendar year.

c. Dispensing Fees

- (1) The Contractor shall provide, during the first quarter of each calendar year, an annual reconciliation between the dispensing fees paid and the guaranteed maximum average dispensing fee amount for the previous calendar year.
- (2) The Contractor shall adhere to the additional requirements related to dispensing fees listed in Section C.3 of the Contract.

d. The Contractor shall adhere to rate guarantee requirements listed in Section C.3 of the Contract.

A.15. Pharmacy Rebates

- a. "Rebates" include all revenue received by the Contractor from outside sources related to the Public Sector Plan's utilization or enrollment in programs (collectively the "Total Manufacturer Value"). These would include but are not limited to access fees, market share fees, rebates, formulary access fees, data fees, administrative fees and marketing grants from pharmaceutical manufacturers, wholesalers and data warehouse vendors. Rebates will also exclude purchase discounts (e.g. prompt pay discounts) from mail and specialty products.
- b. Any actions, approved by and implemented at the request of the State, which negatively affect the Contractor's guaranteed rebate amounts, may result in a contract amendment to the Contractor's guaranteed rebate amount. The Contractor shall substantiate the proposed adjustment, and the State must approve the adjustment through a contract amendment. The Contractor shall cooperate with the State by providing any requested documentation to the State, which may be necessary to substantiate the adjustment.
- c. The Contractor shall adhere to the additional requirements related to pharmacy rebates listed in Section C.3 of the Contract.
- d. The State will audit the rebates that are accrued and paid to the state. Contractor shall pass all Rebates through to the plan. Rebates shall be 100% auditable to the NDC level. The Contractor shall provide, with each pharmacy rebate check presented to the State, a report showing the amount of the check broken down by the groups that comprise the total check amount (e.g.



currently funder accounts 55000 State Actives, 56000 Local Education Actives, 58000 Local Government Actives, 51000 State Retirees, 52000 Local Education Retirees, and fund 53000 Local Government Retirees), as well as the calendar quarter that the various rebate amounts are attributable to.

A.16. Market Check Provision

- a. The Contractor shall provide "Most Favored Nation" (MFN) terms wherein it shall not provide any similar account more favorable pricing terms than that provided to the State of Tennessee during the contract. During the resulting contract term, if there are changes to any of the MFN measurement components or methodology and those changes are reasonably designed to achieve greater comparability under this provision, then the parties will negotiate in good faith to seek an appropriate solution. Further, the Contractor must agree to a "market check" provision to compare the economics of the resultant contract. The Contractor shall provide one (1) financial terms market check during the five (5) year contract term. The market check will be performed at month twenty-five (25) to comparable arrangements in the marketplace for the purpose of recommending adjustments necessary to restore and maintain competitive advantage. If financial benchmark pricing indicates that the State's financial terms are no longer competitive, the Contractor shall offer improved pricing.

A.17. Data Integration and Technical Requirements

- a. The Contractor shall maintain an electronic data interface with the State's Edison (PeopleSoft ®) System, for the purpose of processing State member enrollment information. The Contractor shall be responsible for providing and installing the hardware and software necessary. When the Contractor requires the exchange of Protected Health Information (PHI) with the State of Tennessee, the State requires the use of second level authentication. This is accomplished using the State's standard software product, which supports Public Key Infrastructure (PKI). The Contractor shall design a solution, in coordination with the State, to connect to the State's Secure File Transfer Protocol (SFTP) server using a combination of the password and the authentication certificate. The initial sign-on and transmission testing will use a password. Certificate testing may also be performed during the test cycle. Subsequent production sign-on will be done using the authentication certificate. The Contractor will then download the file and decrypt the file in its secure environment. Additionally, federal standards require encryption of all electronic protected health data at rest as well as during transmission. The State of Tennessee uses public key encryption with Advanced Encryption Standard (AES) to encrypt PHI. If the State adopts a different or additional encryption standard or tool in the future, the Contractor is expected, with adequate notice, to cooperate with the State to maintain the security of protected information according to all applicable State and Federal standards.
- b. Notwithstanding the requirement to maintain enrollment data, the Contractor shall not initiate data changes to the system without the State's approval. This prohibition shall include, but not necessarily be limited to: initiation, termination, and/or changes of coverage.
- c. At least thirty (30) days prior to the go-live date specified in contract section A.31, the Contractor shall load, test, verify and make available online for use the state's eligibility information. The Contractor shall certify, in writing, to the State that the Contractor understands and can fully accept and utilize the eligibility files as provided by the State. The Contractor must not ask State to re-issue another file with the changes included; rather, Contractor must understand and express so that Contractor can and will make manual changes to the file as needed and requested by the State.

A.18 Data and Information Technology



- a. The Contractor shall maintain, in its computer system, in-force enrollment records of all Public Sector Plan members. Specifically, the Contractor shall perform the following tasks:
- (1) Daily Enrollment Update: To ensure that State plan members' enrollment records remain accurate and complete, the Contractor commits to retrieve, via secure medium (see A.17.a), daily enrollment data electronic transfer files from the State, in the State's Edison 834 file format (see Contract Attachment C), for members who are maintained in the State's Edison System [files will include full population records for all members and will be in the format of ANSI ASC X12N, Version 005010X220, with a few fields being customized by the state]. Contractor understands and agrees that daily eligibility files will be provided to the Contractor by the State and that on occasion; the Contractor will be required and must agree to make manual changes to the eligibility file (e.g. a request may come across from the State if a data element is preventing the file from loading in the Contractor's system.) Contractor must make the manual change requested by the State and not ask the State to reissue another eligibility file.
 - (2) The Contractor shall complete and submit to the State a *Daily File Transmission Statistics Report* (current format shown in Attachment F), within twenty-four (24) hours of receipt of the file. The Contractor shall submit this report via email to designated State staff. Alternatively, if the Contractor has their own system-generated report that provides substantially the same information that the State has requested, the Contractor may provide such report electronically to the State.
 - (3) The Contractor and/or its subcontractors, as applicable, shall post ninety-eight percent (98%) of electronically transmitted enrollment updates within one (1) business day of receipt of the daily file and one hundred percent (100%) shall be posted within five (5) business days of receipt of the daily file.
 - (4) The Contractor and/or its subcontractors, as applicable, shall resolve all discrepancies identified by the processing of the enrollment file within five (5) business days of receipt of the file from the State.
- b. The Contractor shall add new groups to all systems within three (3) business days of receipt of necessary documents.
- c. State Enrollment Data Match: Upon request by the State, not to exceed four (4) times annually, the Contractor shall submit to the State, in a secure manner, its full file of State members, by which the State may conduct a data match against the State's Edison database. The purpose of this data match will be to determine the extent to which the Contractor is maintaining its database of State members.
- (1) The State will communicate results of this match to the Contractor, including any Contractor requirements, and associated timeframes, for resolving the discrepancies identified by the data match.
- d. The Contractor shall maintain a duplicate set of all records relating to the pharmacy payments in electronic medium, usable by the State and Contractor for the purpose of disaster recovery. Such duplicate records are to be stored at a secure, fire, flood, and theft-protected facility located away from the storage location of the originals. The Contractor shall update duplicate data processing records, at a minimum, on a daily basis and shall retain said records for a period of sixty (60) days from the date of creation. Upon notice of termination or cancellation of this contract, the Contractor shall convey the original and the duplicate data processing records medium and the information they contain to the State on or before the date of termination or cancellation.



- (1) Contractor will provide the State's Decision Support Services (DSS) vendor with all necessary State of Tennessee plan data, data layouts, and data dictionaries in a timely manner and in the formats, layouts and specifications specified by the DSS vendor in Attachment D.
 - (2) Contractor will submit complete and accurate data to the State's DSS vendor by the 15th day after the end of each month. Complete and accurate data is defined to be data that:
 - i. contains records for all activity (e.g., pharmacy claims data, program participation) within the specified time periods.
 - ii. has the same format and content as the agreed-upon record layout and data dictionary.
 - iii. does not have unreported changes in either format or content.
 - iv. is submitted in a single record format.
 - (3) Contractor will provide the data files at no charge to the State or the State's DSS vendor.
 - (4) If Contractor's contract with the State is terminated, Contractor will continue to provide run-out pharmacy claims data to the State's DSS vendor until the end of the agreed-upon run-out period.
 - (5) Contractor will provide the data without any restrictions on its use.
 - (6) Contractor will ensure that production data matches the test data in format, layout, and content.
 - (7) Contractor will update valid values and maps in a timely manner and notify the State's DSS vendor of any such updates at least 10 working days before the scheduled data submission date.
- e. The Contractor shall adhere to the additional requirements related to the State's DSS vendor listed in Section C.3. of the Contract.
- f. For each quarter of the contract term, and any extensions thereof, claims data shall meet the quality standards detailed in the Liquidated Damages section of this contract, as measured and reported by the State's health care decision support system vendor on either a monthly or quarterly basis
- g. The Contractor shall provide transmittal of pharmacy data via secure medium to any additional third parties including the State's Third Party Administrator(s) (TPAs), Health Management contractor(s), Mental Health/Substance Abuse contractor(s) or any other vendor or state fiduciary as identified by the State. Unless otherwise directed by the State, the Contractor shall provide, at no additional charge, daily data feeds of pharmacy claims to the third parties during the term of the contract and following the term of this contract until all claims incurred during the term of this contract have been paid. This data shall be provided in the format specified by the State. If so directed by the State, the Contractor will be required to pass a regular file to the State's TPAs showing an accumulator file of prescription drug payments by individual. Conversely, the Contractor will be required to receive similar files from the State's TPAs for the same reason: to allow the state-sponsored plans to remain compliant with the Affordable Care Act which limits the total medical and pharmaceutical out-of-pocket amounts that an individual can be subjected to each calendar year. Contractor will be expected to receive and send data and work with the State and its other Contractors on a regular basis to this end. Contractor shall provide an adherence report on various drug classes to the state's wellness vendor on at least a quarterly basis or monthly if requested by the state. State and contractor will work together on the report makeup but it shall include, at a minimum the member's Edison ID number, first and last name, date of birth, adherence condition (e.g. high blood pressure), and their medication



possession ratio (MPR) in two time periods to aid the wellness contractor in determining which members are adherent and which are not.

- h. The Contractor shall load all current PAs, overrides, and open refills (mail and retail) that exist for current members from all existing PBMs no later than thirty (30) days prior to the go-live date.
- i. At the State's request, the Contractor shall accept at least one (1) year of historical data from the current PBM contractor. This includes, but is not limited to, pharmacy claims history, provider data, recipient data, preferred drug list, PAs, refills, lock-in and reference data. If requested, the data will be used to transfer prescriptions to the Contractor's mail and specialty pharmacy.
- j. The Contractor shall store claims data online for a minimum of twenty-four (24) months post-adjudication.
- k. The Contractor shall agree to transfer to the State, within sixty (60) days of notice of termination, all required data and records necessary to administer the plan(s)/program(s), subject to state and federal confidentiality considerations. The transfer may be made electronically via secure medium, in a file format to be determined based on the mutual agreement between State and the Contractor.

A.19 Business Continuity/Disaster Recovery Plan

- a. Regardless of the architecture of its Systems, the Contractor shall develop and be continually ready to invoke a business continuity and disaster recovery (BC-DR) plan. The BC-DR plan shall encompass all Information and Communications Technology as defined in this Contract. At a minimum the Contractor's BC-DR plan shall address the following scenarios:
 - i. Central and/or satellite data processing, telecommunications, print and mailing facilities and functions therein, hardware and software are destroyed or damaged;
 - ii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
 - iii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that compromise the integrity of data maintained in a live or archival system; and
 - iv. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System (i.e., causes unscheduled System Unavailability).
- b. The Contractor shall provide the State results of the most recent test of its BC-DR plan thirty (30) days prior to the go-live date.
- c. The Contractor shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the State that it can restore system functions per the standards outlined in this Section of the Contract. The Contractor shall submit an annual BC-DR Results Report to the State (see Contract Attachment E).
- d. In the event that the Contractor fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Contractor shall submit to the State a Corrective Action Plan that describes how the failure will be resolved. The Contractor shall deliver the Corrective Action Plan within ten (10) business days of the conclusion of the test.



A.20 HIPAA Compliance

- a. The Contractor shall maintain staff responsible for ensuring HIPAA compliance and resolving HIPAA issues related to this contract.
- b. The Contractor shall ensure that the electronic data processing (EDP) environment (hardware and software), data security, and internal controls meet all present standards, and will meet all future standards, required by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 and implementing regulations, including all amendments to such law and regulations.

A.21 Privacy & Confidentiality

- a. These privacy and confidentiality standards apply to all forms of assistance that the Contractor provides.
- b. The Contractor shall develop, adopt, and implement standards, which are, at a minimum, compliant with the HIPAA statute and the HIPAA privacy and security rules in 45 Code of Federal Regulations Part 164, to safeguard the privacy and confidentiality of all information about members. For example, the Contractor shall ensure that it does not have completed documents or other types of forms sitting in public view, left in unsecure boxes or files, or left unattended in any off-site location (e.g., in an automobile, etc.). The Contractor's procedures shall include but not be limited to safeguarding the identity of members as plan members and preventing the unauthorized disclosure of information. The Contractor will comply with the HIPAA as amended by the HITECH Act (part of the American Recovery and Reinvestment Act, Public Law 111-5), and all implementing regulations including new amendments when they become effective.
- c. The Contractor shall not use or further disclose protected health information (PHI) other than as permitted or required by HIPAA and the Business Associate Agreement; or as required by law. Use of PHI for payment, treatment, or health care operations may include disclosure only as permitted by HIPAA, including HIPAA's "minimum necessary" standard. The Contractor shall use appropriate safeguards to prevent the unauthorized use or disclosure of the PHI. Contractor shall report to the State any unauthorized use or disclosure of PHI as soon as possible. Contractor shall comply with the HIPAA Breach Notification Rules found in Part 45, Section 164.400 et seq of the Code of Federal Regulations, and shall cooperate with the State in responding to any unauthorized use or disclosure of PHI related to this contract.
- d. The Contractor shall mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or disclosure of PHI by the Contractor in violation of the requirements of the federal privacy rule.
- e. The Contractor shall provide access to PHI in a "designated record set" in order to meet the requirements under 45 CFR §164.524.
- f. The Contractor shall make any amendment(s) to PHI in a "designated record set" pursuant to 45 CFR §164.526.
- g. The Contractor shall document such disclosures of PHI and information related to such disclosures as would be required to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528.
- h. The Contractor shall (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits, (ii) report to the State any security incident



(within the meaning of 45 CFR § 164.304) of which the Contractor becomes aware, and (iii) ensure that any Contractor employee or agent, including any subcontractor, agrees to the same restrictions and conditions that apply to the Contractor with respect to such information.

- i. The Contractor shall not sell Public Sector Plan member or prescriber information or use member or prescriber identified information for advertising, marketing, promotion or any activity intended to influence sales or market share of a pharmaceutical product.
- j. At the request of the State, the Contractor shall offer credit protection for those times in which a member's PHI, PII or Payment Card Information (PCI) is disclosed or thought to have been disclosed in a Breach, consistent with the definition set forth in 45 CFR 164.402, caused or permitted by Contractor's acts or omissions.

A.22. Provider Education

- a. At the State's request, the Contractor shall develop and implement educational programs and notification processes for the Public Sector Plan prescriber and pharmacy provider community. The Contractor shall design these programs and processes with the goal of improving awareness of Public Sector Plan pharmacy program policies and procedures and increasing formulary compliance rates. Educational initiatives shall include, but not be limited to: pharmacy provider and prescriber letters, formulary distribution, POS messaging, training sessions, website postings of the formulary and other educational materials. The Contractor shall implement agreed upon communication strategies through direct involvement with prescribers and pharmacy providers via a combination of site visits, telephone support, internet-based application, and direct mail.
- b. Educational topics may include, but not be limited to: PA criteria and processes; how to access and use the formulary; POS edits; Step Therapy criteria and processes; quantity level limits; and specialty medication processes.
- c. The Contractor shall ensure that all prescribers and pharmacy providers have timely and complete information about all drugs on the Public Sector Plan formulary. The Contractor shall make such information available through written materials, Internet sites, and electronic personal data assistants (PDA).
- d. The Contractor shall develop and produce letters and other program materials to be shared with prescribers and pharmacy providers. Such materials shall contain information related to the operation of the Public Sector Plan pharmacy program. The Contractor shall prepare and maintain a document suitable for printing or posting to the State website, which provides the formulary and all applicable drug PA criteria including Step Therapy algorithms. The Contractor shall obtain prior written approval from the State for all materials.
- e. The Contractor shall distribute all PA Call Center toll-free telephone numbers, facsimile numbers, web addresses and e-mail addresses, as well as the appropriate mailing address for PA requests, at all prescriber and pharmacy provider training sessions and education programs.
- f. Annually, the Contractor shall offer recommendations to the State regarding provider education.

A.23. Appeals

- a. The Contractor shall maintain a formal three (3) level grievance procedure, by which members and providers may appeal decisions and disputes regarding pharmacy administration and pharmacy benefit coverage. This process must include at the third level an Independent Review Organization (IRO) as required by the Patient Protection and Affordable Care Act (hereinafter referred to as PPACA). The Contractor shall comply with the appeals provisions set forth in the



State's Plan Document. Certain pharmacy issues are not appealable including, but not limited to, co-pay/co-insurance amounts, formulary decisions, and network coverage.

- b. At least thirty (30) days prior to the go-live date, the Contractor shall provide to the State information describing in detail the Contractor's grievance procedures. The State reserves the right to review the procedure and make recommendations, where appropriate.
- c. The Contractor shall decide pre-service appeals within thirty (30) days and post-service appeals within sixty (60) days. The Contractor shall offer an expedited appeals process. If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed medications, then a request for an expedited consideration may be submitted by the member, their duly authorized representative or treating physician. The Contractor shall determine if the request qualifies for an expedited review and shall respond with seventy-two (72) hours.
- d. The Contractor shall include notification of a member's right to appeal in any member communications regarding pharmacy benefit coverage decisions.
- e. At the state's request the Contractor shall provide quarterly reports to the State showing appeal activity at the first, second, and third level of appeals as well as the outcome. Such reports should, at a minimum, include member name, reason for appeal or type of appeal, medication name, date appeal was initiated by the member, the date that it was approved or denied by the Contractor, and reason for approval or denial by the Contractor or the I.R.O.
- f. The Contractor shall respond to all inquiries in writing from the State within one (1) week after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State.

A.24. Customer Services

- a. The Contractor shall operate and maintain a dedicated toll-free customer service phone line manned by qualified benefits specialists for State Public Sector Plan member and pharmacy provider inquiries twenty-four (24) hours a day, seven days a week. Contractor personnel shall be trained to answer questions regarding all aspects of the State's pharmacy benefit including, but not limited to, eligibility, plan design, participating pharmacies, clinical programs, clinical management programs, mail order pharmacy, and the specialty network. The Contractor's toll-free customer service line shall be open and staffed with trained staff at last two (2) weeks prior to go-live.
- b. The Contractor's Call Center and Call Center representatives/operators shall be located in the United States.
- c. The Call Center shall have call management systems and communications infrastructure that can manage the potential call volume and achieve the performance standards described in this Contract.
- d. The Contractor's call management systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes where applicable, in response to program, benefit or enrollment changes.
- e. The Contractor's call center shall be equipped with TDD (Telephone Device for the Deaf) or TTY (Teletype) in order to serve the hearing impaired population.
- f. The Contractor's Call Center shall have at least one member services representative who is bilingual in English and Spanish available twenty-four (24) hours a day, seven days a week.



- g. The Contractor's call center shall maintain a first call resolution rate of 92% or greater.
- h. The Contractor shall maintain an Average Speed of Answer (ASA) of 30 seconds and after answering the call the Contractor may only put callers on hold in order to (a) make outbound calls as necessary or (b) to research a caller's issue.
- i. The Contractor's Call Center shall maintain a blocked call rate of less than one percent (1%) per quarter.
- j. The Contractor's Call Center shall maintain an Abandoned Call rate of not more than three percent (3%).
- k. The Contractor shall close 95% of open call issues within five business days.
- l. The Contractor shall provide customer service/call center statistics for Public Sector Plan members to the State on a quarterly basis.
- m. The Contractor's call management systems shall provide greeting messaging when necessary. The Contractor may play canned music for the callers while they are on hold; the Contractor may also play messages about clinical programs that the State has adopted, and other subjects as approved by the State. The Contractor shall not play advertising or informational messages for callers while they are on hold unless approved in advance and in writing by the State (or the State directs the Contractor to play certain messages). Additionally, the Contractor's systems shall provide a message that notifies callers that calls may be monitored by the Contractor and the State for quality control purposes.
- n. The Contractor's call management system shall record and index all calls such that the Contractor can easily retrieve recordings of individual calls based on the phone number of the caller, the caller's name, the date/time of the call, or the Call Center representative who handled the call. The Contractor shall provide a full recording of each call upon the State's request, using only the member's name or identifier to locate the call(s).
- o. The Contractor shall have the ability to allow the State to monitor pre-recorded calls from a remote location.
- p. The system shall transfer calls to other telephone lines as necessary and appropriate, including transfers to Benefits Administration's Service Center and other external Call Centers, as designated by the State.
- q. The Contractor may use an automated interactive voice response (IVR) system for managing inbound calls, provided that the caller always has the ability to leave the IVR system and wait in queue in order to speak directly with a live-voice representative rather than continue through additional prompts. The Contractor shall not have more than one level of menu choices unless approved in advance and in writing by the State. The Contractor's call decision tree and menu are subject to State review and approval.
- r. The Contractor shall inform callers of their likely wait times as they enter the queue. Additionally, the Contractor shall have voice-mail capabilities such that Callers can record messages when all Call Center representatives/operators are occupied tending to other callers. The Contractor shall also provide a "dial back" option that allows callers to receive a call back from the next available Call Center representative.
- s. The Contractor shall have the ability to make outbound calls without interrupting the ability of callers to continue to access the Call Center.



- t. The call management system shall enable the logging of all calls, including:
- (1) The caller's identifying information (e.g., employee ID);
 - (2) The call date and time;
 - (3) The reason for the call (using a coding scheme approved by the State in advance and in writing);
 - (4) The Call Center representative/operator that handled the call;
 - (5) The length of call; and
 - (6) The resolution of the call (and if unresolved, the action taken and follow up steps required).

Additionally, the call management systems shall maintain a history of correspondence and call transactions for performance management, quality management and audit purposes. This history will contain the actual information, a date/time stamp that corresponds to when the transaction took place, the origin of the data management transaction (the State and/or one of its Agent(s), the Customer, etc.) and the Contractor representative/operator that processed the transaction.

- u. The Contractor shall provide members and pharmacy providers with an option on the toll-free telephone number to immediately consult with a licensed pharmacist between the hours of 7am – 7pm CST Monday through Friday. Outside of the hours of 7am – 7pm CST Monday through Friday, members and pharmacy providers will have an option to receive a call back from a pharmacist within one (1) hour. This Help Desk shall be available twenty-four (24) hours a day, seven days a week to respond to questions and problems from pharmacy providers and members. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations.
- v. The Contractor's customer service representatives shall have access to an application, which allows them to review alternative drug therapies (i.e., formulary status, generic alternatives available, etc.) and run "test claims" for members who may request this information.
- w. The Contractor shall maintain a full service staff to respond to inquiries, correspondence, complaints, and problems. The Contractor shall answer, in writing, ninety-five percent (95%) of written (mail and e-mail) inquiries from members concerning requested information, including the status of claims submitted and benefits available through the pharmacy program within five (5) business and one hundred percent (100%) within ten (10) days.

A.25. Member Communication/Materials

- a. The Contractor shall, in consultation with and following approval by the State, print and distribute all pharmacy benefit member enrollment materials such as I.D. cards, welcome packets, network directories, letters, administrative forms and manuals.
- b. Unless otherwise specified, the Contractor shall be responsible for all costs related to the design, development, revision, printing, and distribution of all materials that are required to be produced under the terms of the Contract. The Contractor shall ensure that up-to-date versions of all printed materials can be downloaded from its website. This provision excludes enrollment forms, which are the State's responsibility.
- c. At the State's request, the Contractor shall notify members, in writing, of any pharmacy benefit plan changes (i.e. changes to co-pays/co-insurance, formulary changes, etc.) no less than thirty (30) days prior to the implementation of the change.
- d. Postage and production costs incurred by the Contractor, which are the direct result of communications requested by the State for benefit plan changes that have been initiated by the State, shall be treated as pass-through costs. Such costs shall be billed on a monthly basis to



the State in addition to regular invoices and shall include substantiating documentation, including a line-item description of the postage and production costs incurred by the Contractor.

- e. The Contractor shall ensure communications sent to members are specific to the State's plan design and not simply a rebranding/repackaging of standard book-of-business member materials. Member Handbooks shall be customized for each of the health plan options currently available to plan enrollees from one plan year to the next: e.g. Standard PPO, Partnership PPO, and Limited PPO including the specific copays for the different drug tiers. Member Handbooks for the first plan year of the contract shall be mailed out to the entire plan membership no later than twenty-one (21) days prior to benefit go-live. Thereafter, as new plan members join the program, they should receive a member handbook and ID card no later than ten (10) days from the date their initial enrollment was passed to the contractor on the Edison 834 eligibility file. Further, member handbooks shall only be issued to plan members who transition from one health plan option to another during each fall's Open Enrollment (a change in health plan necessitates a new member handbook, as the drug copayments will change). Such new customized member handbooks must be mailed no later than December 15th of each calendar year to this subset of plan members. Exemption of incidental pieces such as newsletters and health promotional pieces will be considered by the State if the Contractor guarantees that pieces will be generic in nature and do not address State Plan eligibility issues or specific coverage issues.
- f. The Contractor shall have the exclusive responsibility to write, edit, and arrange for clearance of materials (such as securing full time use of a stock photograph used in brochures for perpetuity) for any and all materials contemplated under this Contract.
- g. The Contractor shall distribute materials that are culturally sensitive and professional in content, appearance, and design.
- h. All materials produced by (or at the direction of) the Contractor for use in the course of this Contract are subject to prior, written approval by the State. The Contractor shall provide the State with draft versions of all communications materials and letters at least fourteen (14) days prior to planned printing, assembly and/or distribution (including web posting). The Contractor shall not distribute any materials until the State issues written approval to the Contractor for the respective materials. The Contractor recognizes and agrees that for any and all communication pieces mailed out by the contractor to the state plan membership, the State has and retains the ability to edit and customize such letters or communications (for example, the State may wish to include our BHO/EAP telephone number and ParTNers for Health logo on any letter mailed out to members with a first fill of a particular type of antipsychotic or central nervous system affecting drug).
- i. The Contractor shall provide electronic templates of all finalized materials in a format that the State can easily alter, edit, revise, and update, as well as hard copy.
- j. The Contractor shall, to the extent practicable, use relatively large and legible fonts in its materials. Additionally, the Contractor shall make maximum use of graphics to communicate key messages to populations with limited literacy or limited English proficiency. The Contractor shall also prominently display the Call Center's telephone number in large, bolded typeface and hours of operation on all materials.
- k. Unless otherwise approved in advance by the State, the Contractor shall design all printed materials at the sixth (6.0) grade reading level or lower using the Flesch-Kincaid Index or other suitable metric that the State approves in advance and in writing. The Contractor shall evaluate materials using the entire text of the materials (except return addresses). When submitting draft materials to the State for approval, the Contractor shall provide a certification of the reading level of each piece of material.



- l. The Contractor shall update printed and Web-based versions of all materials no less than quarterly. However, the Contractor shall produce corrected versions of the individual materials at the State's direction. Reimbursement for member materials containing an error, which were approved by the State, shall occur as outlined in Section C.3 of the contract.
- m. The State has the final approval on any and all communication materials that the contractor wishes to mail to members and a copy must be provided to the State for review and approval. Any future revisions and deviations will require State approval.
- n. Member Identification Cards
 - (1) The Contractor shall provide eligible members with identification cards and shall establish a process that allows enrollees to request replacement cards. The cost of creating and mailing I.D. cards shall be borne by the Contractor. The ID card shall bear in color the state's "ParTNeRS for Health" logo. The state has the final approval of ID card appearance and text, including the use or partial use of any contractor's name, if applicable. The state reserves the right to request the contractor to change the look, appearance, and text of the pharmacy ID cards at any time during the term of this contract with provision of 30 days' notice to the contractor.
 - (2) Initial member identification cards must be mailed to all eligible members no later than twenty-one (21) days prior to the go-live date. Thereafter, I.D. cards shall be mailed to eligible members no later than ten (10) days from receipt of the new enrollment or change in enrollment. Identification cards shall contain unique identifiers for each member, which shall be the employee's unique ID provided on the monthly eligibility system, known as the "Edison ID." Such identifier shall NOT be the member's Federal Social Security Number. Contractor acknowledges and agrees that the number used on the pharmacy ID card will be the number exactly as provided in the eligibility file (i.e. the full 8 digit number with leading zeroes and no additional characters.)
 - (3) On an annual basis, at least two months prior to the State's Open Enrollment period, the Contractor shall provide to the State, in electronic format, information regarding the pharmacy benefit. Such information shall include a network list, toll-free customer service number, website, website logon information, information on the retail, 90-day-at retail, mail, and specialty networks, current formulary, clinical program policies and procedures (Step Therapy, PA, etc.), a confidentiality statement, procedures for accessing services, and other updates and/or changes that may be helpful to the State's members.
 - (4) The Contractor shall mail a welcome packet to all members no later than twenty-one (21) days prior to go-live. Thereafter, all members shall receive a welcome packet within ten (10) days of receipt of their enrollment in the Public Sector Plan pharmacy program. The welcome packet shall include, at a minimum, an I.D. card, a network list, toll-free customer service number, website, website logon information, information on the retail, 90-day-at retail, mail, and specialty networks, current formulary, clinical program policies and procedures (Step Therapy, PA, etc.), and a confidentiality statement.
- o. The Contractor shall use first class rate for all mailings, unless otherwise directed by the State.

A.26. Website

- a. The Contractor shall have available an up-to-date website dedicated to the State's Public Sector Plan pharmacy benefit. The website shall be available on the Internet and fully operational, with the exception of member data/Protected Health Information at least twenty-one (21) days prior to the commencement of claims processing. The Contractor shall design the website to aid



prescribers, pharmacists and members in all aspects of the pharmacy program. The Contractor shall update documents posted to the website within five (5) business days of the State's approval of changes to said documents.

- b. The Contractor shall submit the text and screenshots of the website to the State for review and approval at least one (1) month prior to the commencement of claims processing. Additionally, the Contractor shall obtain prior, written approval from the State for any links from the site to a non-governmental website or webpage.
- c. The Contractor shall have the responsibility to "host" the website on a non-governmental server, which shall be located within the United States. The Contractor shall have adequate server capacity and infrastructure to support the likely volume of traffic from plan members without disruption or delay.
- d. In addition to the Contractor's own website where this information may also be incorporated and found once a member logs in, the Contractor shall maintain a pharmacy "splash" page that the contractor maintains and regularly updates as new forms or lists become outdated and new ones are available. Such a webpage will contain pdfs of documents such as (but not limited to) the State of Tennessee preferred drug list (PDL), a list of medications requiring prior authorization as well as directions on how to go about doing that; a list of medications with quantity limits and a listing of those medications and their respective limits; a list of specialty medications; a list of medications subject to step therapy requirements and what the step drugs are; a list of the Retail 90 nationwide network pharmacies (in state alpha order, then by city alpha order), a list of the pharmacies in the specialty drug network, a letter explaining the state's COB process, detail for each of the various plan options offered by the state what the members' copayments would be for 30 and 60 day drugs, and other similar PDFs. All of this would be available on a contractor-maintained "splash" page without it being necessary for the member to log in. In addition, if a member desired to check their individual claims history, there would also be a place where the member could log in and it would take them to the contractor's main website. Both locations would carry in color at the top of the page the State's "ParTNers for Health" logo.
- e. The website shall be a cobranded website with the Contractor's logo and the State's "ParTNers for Health" logo both displayed in a prominent location on every page. At a minimum, the website shall be updated quarterly to include:
 - (1) a current listing of the most recent formulary or preferred drug list (with a prominent effective date shown on page 1 of the PDL);
 - (2) a list of all pharmacies in the national network whereby members can fill a 30 day prescription;
 - (3) a list of all pharmacies participating in the special 90 day at retail network;
 - (4) a list of all specialty pharmacies (especially those in Tennessee). These listings shall include pharmacy name, address, city, state, zip code, and phone number;
 - (5) a list of all pharmacies participating in the nationwide vaccine network for flu and pneumonia shots at \$0 copay;
 - (6) a separate list of drugs that are considered "specialty drugs" that the member may only obtain in 30 day supply increments, and a list of drugs that require PA, and a list of drugs that have quantity limits or step therapy requirements.
- f. In association with the State's annual open enrollment period (generally Oct 1-Nov 1), the Contractor shall update the website, no later than 2 weeks prior to the first day of the open



enrollment period, with all information, documents, and pharmacy related benefits pertinent to each new plan year.

- g. To ensure accessibility among persons with a disability, the Contractor's website shall comply with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) and implementing regulations at 36 CFR 1194 Parts A-D.
- h. Unless otherwise approved by the State, the website shall contain a home page with general pharmacy information with links to dedicated areas for prescribers, pharmacists and members. The Contractor shall utilize appropriate security measures, including password protection, to ensure the protection of member data/PHI. Each area of the website shall contain information that shall answer the most common questions that each group would ask and documents required by each group to utilize the Public Sector Plan pharmacy benefit. This shall include, but is not limited to a:
 - (1) Prescriber Page, which includes, but is not limited to:
 - i. An interactive formulary, complete with hot-links from drugs to the PA criteria established for those drugs and also linked to drug specific PA 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 formulary;
 - iii. Procedures for obtaining PAs, Call Center hours of operation and contact numbers;
 - iv. Printable education material specific to prescribers.
 - (2) Pharmacist Page, which includes, but is not limited to:
 - i. An interactive inquiry system using pharmacy providers' identifying number (i.e. NCPDP, NPI, etc) to verify the status of pending payments, and other supported function(s) as deemed necessary by the State;
 - ii. An online listing of the Contractors MAC drug list;
 - iii. Printable online pharmacy handbook and Provider Education Material specific to Pharmacists;
- i. The website shall also have the following services/capabilities:
 - a. E-mail notification of next refill to member, and
 - b. Cost comparison on the web, along with alternatives.

A.27. Reporting & Systems Access

- a. The Contractor shall, upon State request, submit monthly operational/performance reports by which the State can assess the Public Sector Plan's activity and performance. The Contractor shall submit reports electronically, and shall include information such as enrollment, utilization, prescription sources and types, plan expenses, member demographic information and other information as requested by the State. All standard reports shall be distributed to the State within forty-five (45) days of the end of the previous month.
- b. The Contractor shall provide access to any online reporting system (e.g. eligibility system and claims history system) to a variety of State employees in the Division of Benefits Administration no later than one (1) month prior to the system go-live date. Additional users must be added at any time at the State's request, with no limit to the number of users. The State requires that our entire Benefits Administration Service Center staff (which handles eligibility issues) receive training and access to the eligibility system and the claims history reporting system prior to go-



live. In addition, the State's Billing Team will need claims reporting access as well. The State will provide the Contractor with a list of the names, telephone numbers, and email addresses and specify to the Contractor what kind of access the State requires for our employee: read only, update, etc. and to which system (eligibility, claims history and detail. or both). The Contractor shall train Benefits Administration staff with access to the Contractor's system on all Contractor systems and tools no later than one (1) month prior to the go-live date. The Contractor will provide State staff, during implementation, all training on Contractors systems and reporting tools no later than one (1) month prior to the go-live date. This training must be conducted on-site at the State of Tennessee Benefits Administration offices.

- c. To maintain the privacy of personal health information, the Contractor shall provide to the State a method of securing e-mail for daily communications between the State and the Contractor. The Contractor shall set up TLS (Transport Layer Security) with the state.
- d. At the State's request, the Contractor shall provide reporting specific to the activity and outcomes associated with all of the utilization management tools and programs provided by the Contractor. The Contractor shall deliver such reports to the State within five (5) business days of the State's request.
- e. The Contractor shall provide the State access to an ad-hoc reporting liaison to assist in the development of reports that cannot be generated using the Contractor's standard reporting package. The Contractor shall deliver such reports to the State within five (5) business days of the State's request. If requested by the State, the Contractor shall deliver up to ten (10) reports annually deemed as "urgent" by the State within twenty-four (24) hours at no additional cost to the State.
- f. The contractor, as requested by the state, shall generate a file of members on a monthly basis with a first fill during the previous month for any antidepressant or anti-anxiety medication. Contractor shall, if this provision is executed, share via secure server or email this list of plan members and Edison ID numbers with the State's EAP/BHO vendor so that said vendor may communicate with the identified members on the State's behalf by notifying them of the EAP/BHO program and its associated benefits.
- g. The Contractor shall provide the State a Compliance Report, no later than sixty (60) days following the end of each quarter, which captures performance related to the requirements outlined in the Liquidated Damages section of the Contract.
- h. The Contractor shall provide the State a report, no later than sixty (60) days following the end of each quarter, illustrating the Contractor's compliance with financial terms inclusive of AWP (or its equivalent), discounted ingredient cost and dispensing fees.
- i. The Contractor shall provide the State a report, no later than sixty (60) days following the end of each quarter, illustrating the rebate payments due to the State summarized at the NDC-11 or NDC-9 level.
- j. The Contractor shall assess on a quarterly and an annual basis the prevalence and incidence of potential opioid abuse within the insured State Group Plan population and provide a written narrative with facts and data/numbers to the State on a quarterly and annual basis. This report shall also include a detailed monitoring of providers to understand where the risk is the greatest. If, at any time, the State determines that this information is no longer useful, the State may direct the Contractor to cease assessment, measurement, and reporting.
- k. The Contractor shall provide the State a monthly report describing open service issues at the plan level.



- I. Within thirty (30) days of the contract start date, the Contractor shall provide the State the most recent copy of the Contractor's SSAE-16 / SOC-1 report (formerly known as a SAS 70 report). Thereafter, a copy shall be provided to the State annually. In addition, state auditors may throughout the course of the year request an interim or bridge report to cover a more recent time period since the last full 12 month report was issued. Benefits Administration staff will reach out directly to the Contractor to request such report(s) and will require them within fourteen (14) calendar days.
- m. The contractor, each calendar year, shall provide the State with its most recent financial/credit report.

A.28. Member Satisfaction Survey

The Contractor shall perform, following review and approval by the State, member satisfaction surveys. The Contractor shall conduct the survey once annually during each calendar year at a time mutually agreed upon by the State and the Contractor and shall involve a statistically valid random sample of members. The State reserves the right to review and mandate changes in the survey if it feels are necessary to obtain valid, reliable, unbiased results. Those changes may include, but are not limited to, changes in the research design, units of analysis or observation, study dimension, sample size, sample frame, sample method, coding, or evaluation method. Based upon the results of the survey, the Contractor and the State will jointly develop an action plan to correct problems or deficiencies identified through this activity.

A.29. Audits and Fraud

- a. With provision by the State of thirty (30) days notice, and with the execution of any applicable third party confidentiality agreements, the State or its qualified authorized auditor (experienced in conducting pharmacy audits) has the right to examine and audit the services, pricing (including rebates), and any provision of this contract to ensure compliance with all program requirements and contractual obligations. For the purpose of audit requirements, Contractor shall include its parents, affiliates, subsidiaries and subcontractors. All eligibility and claims data belong to the State. The State has sole authority to determine who to choose for any kind of audit: financial, pharmacy rebates, or other. This includes state employees, state staff from the Comptroller's audit staff, and consulting staff under contract with the Division of Benefits Administration. This audit right extends to any subcontractors of the PBM (e.g. rebate processor). If the State contracts with a private entity to conduct an audit of Contractor, the State will require the auditing entity to negotiate a reasonable non-disclosure agreement with the Contractor that will ensure that the auditor is independent, has no conflict of interest with Contractor and has acceptable procedures in place to ensure that no information derived from the audit of Rebate or network pharmacy contracts is used in or accessible to any consulting function the auditor may provide.
- b. At the State's discretion, the State or a qualified authorized designated representative may perform such examination and audits. The State is responsible for the cost of the authorized third party representative for such audits.
- c. The Contractor shall provide access, with thirty (30) days notice from the State, at any time during the term of this contract, and for three years after final contract payment (longer if required by law), to the State's authorized independent auditor to audit the services provided under this contract.
- d. The State has the right to audit more than once per year if the audits are different in scope or for different services. The State also has the right to perform additional audits during the year of



similar scope if requested as a follow-up to ensure significant/material errors found in an audit have been corrected and are not recurring or if additional information becomes available to warrant further investigation. The State has the right to audit as often as it deems necessary and if the State Comptroller's Audit staff deems it necessary. Further, any claims extract provided to the State Comptroller's Audit staff for their audit purposes **must** include, among other standard fields, the adjudicated date (date the pharmacy was paid by the PBM) for each individual claim.

- e. The Contractor shall comply with the new law passed in April 2013 and codified at <http://state.tn.us/sos/acts/108/pub/pc0408.pdf>. This requires the State Benefits Administration office to compile a report each July 1 using data from various audit reports completed for us during the year and publish the results in a report every July 1st to the Tennessee Speakers of the House and Senate, the Comptroller of the Treasury, and members of the Tennessee General Assembly. Benefits Administration will require the participation and timely assistance of the contractor under this contract to work with the actuaries and benefits analysts both in and outside the state to ensure that each report is completed timely. Please note that item #5 in the URL provided above requires a "reconciliation of the pharmacy benefits manager's payments to pharmacies with the state's reimbursement to the pharmacy benefits manager which requires the Department of Finance & Administration to conduct various audits and similar activities throughout the year and publish the results in a report every July 1st to the Speakers of the House and Senate, to the Comptroller of the Treasury, and to members of the General Assembly.
- f. The State will have access to any data necessary to ensure the Contractor is complying with all contract terms, which includes but is not limited to, one hundred percent (100%) of claims data, which includes at least all NCPDP fields from the most current version and release; retail pharmacy contracts; pharmaceutical manufacturer; mail and specialty pharmacy contracts to the extent they exist with other vendor(s); utilization management reviews; clinical program outcomes; appeals; information related to the reporting and measurement of Liquidated Damages; etc.
- g. Pharmacy rebate audits can include, but are not limited to, review and examination of manufacturer rebate contracts, rebate payments, special discounts, fee reductions, incentive programs or the like with pharmacy manufacturers, and program financial records as necessary to perform an accurate and complete audit of rebates received by the State. Upon request by the State, or its designated authorized independent auditor, the Contractor shall provide full disclosure of rebates received by the Contractor, its affiliates, subsidiaries, or subcontractors on behalf of the State. This disclosure shall include line item detail by NDC-11 and line item detail by pharmaceutical manufacturer showing actual cost remitted and other related claim and financial information as needed to satisfy the scope of the audit. 100% of all drugs dispensed and paid for under this contract from the go-live date on January 1, 2015 until the termination of benefits under this contract shall be included in any kind of pharmacy audit, regardless of tier level (generic, preferred brand, or nonpreferred brand or absence of a tier assignment), and without regard to enrollment plan type, number of members enrolled in said plan, copayment assigned by the state (or lack thereof), spread or differential between drug tier copayments, or any kind of utilization.
- h. The Contractor shall disclose to the State's authorized independent auditor any administrative fees or other reimbursements received in connection with any rebates, discounts, fee reductions, incentive programs, or the like received by Contractor as a result of the drug manufacturer payments, which include volume of pharmaceutical use by, or on behalf of, the State. In addition, the Contractor shall, upon request by the State, disclose fees or other reimbursements received in connection with any grants, educational programs or other incentive programs received by the Contractor on behalf of the State.



- i. The Contractor shall provide reasonable cooperation with requests for information, which includes but is not limited to the timing of the audit, deliverables, data/information requests and the Contractor's response time to the State's questions during and after the process. The Contractor shall also provide a response to all "findings" received within thirty (30) days, or at a later date if mutually determined to be more reasonable based on the number and type of findings.
- j. The State is not responsible for time or any costs incurred by the Contractor in association with an audit including, but not limited to, the costs associated with providing reports, documentation, systems access, or space.
- k. Audits shall include third party confidentiality agreements between the auditor and the party being audited. The State shall provide at least thirty (30) days notice and all parties involved shall sign and execute applicable third party confidentiality agreements prior to such an examination and audit.
- l. If the outcome of the audit results in an amount due to the State, one hundred percent (100%) of the payment of such settlement will be made by the Contractor within thirty (30) days of the Contractor's receipt of the final audit report. The Contractor shall also pay the State interest on the overcharge by multiplying the amount of the overcharge by the Tennessee State Pooled Investment Fund's Gross Total Portfolio Average Earnings Rate for the month(s) in the overcharge period, times the number of days in the overcharge period(s), divided by 365 days/year. Any amount due the State which is not paid by the Contractor within (30) days of the Contractor's receipt of the final audit report shall be subject to a compounding interest penalty of one percent (1%) per month. The Contractor may submit written comments on the audit report including explanations of or objections to the findings of the audit report. The State, in its sole discretion, may amend the audit findings or adhere to the original findings. The thirty (30) day payment period would be suspended and would not run between the time the State receives Contractor's comments and the time the State responds.
- m. The Contractor is expected to assist the State in identifying fraud and perform fraud investigations of members and providers, in consultation with the State, for the purpose of recovery of overpayments due to fraud. Reviews shall include all possible actions necessary to locate and investigate cases of potential, suspected, or known fraud and abuse. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall simultaneously inform the State and the Division of State Audit, in the Office of the Comptroller of the Treasury. The State will review the information and inform the Contractor whether it wishes the Contractor to:
 - (1) Discontinue further investigation if there is insufficient justification; or
 - (2) Continue the investigation and report back to the State and the Division of State Audit; or
 - (3) Continue the investigation with the assistance of the Division of State Audit; or
 - (4) Discontinue the investigation and turn the Contractor's findings over to the Division of State Audit for its investigation; or
 - (5) The Division of State Audit may request a full claims extract for their audit purposes at any time throughout the term of the contract. Contractor shall work with State Audit to supply them a full claims extract including (but not limited to) such variables as date filled, pharmacy name, address, and phone number, drug name and NDC, quantity dispensed, gross cost, plan cost, member cost, prescriber name and national provider identification



number (NPI), adjudicated (paid date; the date that the actual pharmacy was paid) – all for each claim processed under this contract and provided in any claims extract to the Division of State Audit.

- n. The Contractor shall refer all media and legislative inquiries of any type to Benefits Administration, which will have the sole and exclusive responsibility to respond to all such queries. However, the Contractor shall respond directly to audit requests from the Comptroller, to audit requests from divisions within the Department of Finance & Administration, and to subpoenas related to this contract; in all such instances, the Contractor shall copy the Benefits Administration on all correspondence.

A.30. Pharmacy Audits

- a. The Contractor shall audit at least 5% of network pharmacies in Tennessee annually. The same audits performed on the Contractor's retail pharmacy network will be conducted on the mail order and specialty pharmacies.
- b. The Contractor shall establish and maintain a process to detect and prevent errors, fraud or abusive pharmacy utilization by members, pharmacies or prescribers. The Contractor shall contact pharmacies with aberrant claims or trends to gain an acceptable explanation for the finding or to submit a corrected claim. The Contractor shall develop a trend or log of aberrancies that shall be shared with the State – upon the State's request. Each quarter or upon the State's request, the Contractor shall summarize findings from the mutually agreed upon reports and share with the State to address program revisions.
- c. The State may 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 the State within ninety (90) days of the date the Contractor assumes full responsibility for the pharmacy benefits program start date.

A.31. Due Dates for Project Deliverables

Unless otherwise specified in writing by the State, the Contractor shall adhere to the following schedule for the deliverables and milestones for which it is responsible under this Contract, as applicable:

Handwritten notes:
 ABM
 LEGAL REVIEW

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
Plan Implementation		
1. Pharmacy benefit go-live	A.3.a	January 1, 2015
2. Kick-off meeting for all key Contractor staff	A.3.d	Within 30 days after Contract start date
3. Implementation plan and timetable	A.3.e	30 days after Contract start date
4. On-site implementation meeting	A.3.f	August 15, 2014 (On or before)
5. State readiness review	A.3.g	November 1, 2014 (On or before)
6. Call center onsite visit	A.3.j	November 1-30, 2014 and again after go live, January 1-30, 2015



	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
7.	Implementation Performance Assessment	A.3.l	February 15, 2015 (On or before)
Staffing			
8.	Account Team satisfaction survey	A.4.g	Annually in January
POS Claims Adjudication			
9.	Business continuity/Disaster Recovery results	A.19.b and A.19.c	December 1, 2014, and annually thereafter.
Pharmacy Network			
10.	Network lists available on website	A.7.c	December 1, 2014
11.	Updated network lists	A.7.c	Quarterly after go-live
12.	Mail order website operational	A.7.g.(10)	December 1, 2014
13.	GeoNetworks® report	A.7.j	Annually in January
14.	Quarterly network changes report	A.7.k	Within five (5) working days of the end of each quarter following go-live
Formulary Management			
15.	Formulary compliance report	A.8.d	Quarterly after go-live
Clinical Programs			
16.	Therapeutic substitution and generic dispensing program reporting	A.11.d	Annually in January
17.	Disclosure of PA criteria and procedures	A.11.h.(1)	December 1, 2014 (On or before)
18.	Prior Authorization (PA) Reporting	A.11.h.(5)	Quarterly after go-live
Retro-DUR			
19.	Profile review focus and methodology	A.13.b	30 days prior to initial review start date
20.	DUR and Retro-DUR presentations	A.13.e.(1)	Up to four (4) times annually, as requested by the State
21.	Retro-DUR Outcomes	A.13.e.(2)	Quarterly after go-live
Financials			
22.	Annual ingredient cost reconciliation	A.14.b.10	Annually during the first quarter of each calendar year for the previous calendar year
23.	Dispensing fee annual reconciliation	A.14.c.(1)	Annually during the first quarter of each calendar year for the previous



Deliverables/Milestones:		Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates: calendar year
24.	Rate Guarantees	C.3.n	Within 90 days following each quarter
Pharmacy Rebates			
25.	Rebate and administrative fee reporting	C.3.q	Quarterly after go-live
26.	Rebate annual reconciliation	C.3.r	First quarter each calendar year
Data Integration & Technical Requirements			
27.	Eligibility file acceptance	A.17.c	December 1, 2014
28.	Daily enrollment update	A.18.a.(1)	Daily after go-live
29.	Daily File Transmission Statistics Report	A.18.a.(2)	Within 24 hours of receipt of weekly file
30.	State enrollment data match	A.18.c	Up to four (4) times annually, as requested by the State
31.	Duplicate data processing records	A.18.e	On or before the go-live of contract termination or cancellation
32.	Claims data transmission to DSS vendor	A.18.e.(2)	15 days following the end of each calendar month
33.	Claims data transmission to third parties	A.18.h	Daily, unless otherwise directed by the State
34.	Load PAs, overrides, and open refills	A.18.i	December 1, 2014
35.	Claims data transmission to State	A.18.l	Within 60 days of notice of termination
Provider Education			
36.	Provider education recommendations	A.22.f	Annually in January
Appeals			
37.	Contractor grievance procedures	A.23.b	December 1, 2014
Customer Services			
38.	Customer service/call center statistics	A.24.l	Quarterly after go-live
Member Communication/Materials			
39.	I.D. cards	A.25.n.(2)	December 10, 2014
40.	Open Enrollment information	A.25.n.(3)	Annually in August
41.	Initial welcome packets	A.25.n.(4)	December 10, 2014
42.	Ongoing welcome packets	A.25.n.(4)	Within 10 days of receipt of enrollment



Deliverables/Milestones:		Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
Website			
43.	Website go-live	A.26.a	December 10, 2014
44.	State review of website	A.26.b	December 1, 2014
Reporting and Systems Access			
45.	Operational/Performance reports	A.27.a	Monthly, within 15 days of the end of the previous month
46.	Reporting system access	A.27.b	December 1, 2014
47.	Eligibility system access	A.27.b	December 1, 2014
48.	State staff systems training	A.27.b	December 1, 2014
49.	Compliance report	A.27.g	60 days following the end of each quarter after go-live
50.	Financial terms compliance report	A.27.h	60 days following the end of each quarter after go-live
51.	Rebate payments report	A.27.i	60 days following the end of each quarter after go-live
52.	Open service issues	A.27.k	Monthly after go-live
53.	SSAE 16 / SOC-1 report	A.27.l	Within thirty (30) days of the contract start date and annually thereafter (in addition to periodic requests for bridge reports from State Audit)
Member Satisfaction Survey			
54.	Member satisfaction survey	A.28	Annually
Pharmacy Audits			
55.	Network pharmacy audits	A.30.a	Annually
56.	Aberrancy findings	A.30.b	As requested by the State
57.	Field audit staff	A.30.c	January 31, 2014

A.32. Definitions

- a. **Administrative Fee** – The fee for pharmacy benefit management services paid by the State to the Contractor. The administrative fee is the only compensation due the Contractor under the contract if a transparent pass-through pricing model is selected by the State. The contractor's monthly compensation is a function of the contractor's administrative fee multiplied by the number



of participating members per month (PMPM). The State recognizes that clinical program fees are not included in the administrative fee. The State also recognizes that the Contractor may make a margin on mail and specialty drugs that it dispenses out of its own pharmacies.

- b. **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 Medi-Span.
- c. **Brand Drug** – The innovator drug product submitted to the FDA for approval. A brand drug is a drug produced and distributed with patent protection or after the patent protection has ended, represents the original innovator drug before patent protection ended.
- d. **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.
- e. **Coinsurance** – That percentage of the charge for each drug dispensed to the member that is the responsibility of the member.
- f. **Compound Prescription** – A prescription that is not commercially available in the strength or quantity prescribed by the physician and meets the following criteria: two (2) or more solid, semi-solid, or liquid ingredients, at least one of which is a covered drug that are weighed and measured then prepared according to the prescriber's order.
- g. **Copayment** - That portion of the charge (flat dollar amount) for each drug dispensed to the member that is the responsibility of the member.
- h. **Day(s)** – Calendar day(s) unless otherwise specified in the Contract.
- i. **DEA Number** - A Drug Enforcement Agency 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 as a prescriber identifier.
- j. **Denied Claim** – A claim that is not paid for reasons such as eligibility, coverage rules etc.
- k. **DESI Drug** - A drug that has been designated as experimental or ineffective by the Food and Drug Administration (FDA).
- l. **Disaster** - A negative event or act of nature that significantly disrupts business operations for more than twenty-four (24) hours.
- m. **Discounts** – The percentage difference between the applicable AWP for a covered service and (i) the maximum allowable cost ("MAC"), where applicable, or (ii) the contractor's negotiated reimbursement amount with a participating pharmacy for prescription drugs, OTCs and other services provided by such pharmacy to members. The discount excludes the dispensing fee, copayment and sales tax, if any.
- n. **Dispensing Fee** – An amount paid by the contractor to a participating pharmacy per claim for providing professional services necessary to dispense medication to a member.
- o. **DSS** - A decision support system is a database and query tool.
- p. **Drug Utilization Review (DUR)** - A point of sale claim edit to facilitate drug utilization review objectives.
- q. **Formulary** – The list of clinically appropriate, cost-rational prescription drugs covered by the SHBP/SEHBP (state health benefit plan/state employee health benefit plan), organized into different 'tiers' or levels indicating how much the member cost share (copayment/coinsurance) will be for each drug.
- r. **Generic Code Number (GCN)** - A standard number assigned by First DataBank (a drug pricing service) to each strength, formulation, and route of administration of a drug entity.



- s. **Generic Drug** –A prescription or an OTC drug that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA or a drug that is lawfully marketed as a DESI drug. Generics shall include all drugs with an approved Abbreviated New Drug Application ANDA, single-source generics drugs, multi-source generic drugs, products involved in patent litigation, house generic drugs and generic drugs that may only be available in limited supply..
- t. **Generic Product Identifier (GPI)** – A six-digit code, which includes all drugs sharing the same chemical composition, in the same strength, in the same form and that are administered via the same route.
- u. **HIPAA** - Health Insurance Portability and Accountability Act of 1996 at 45 Code of Federal Regulations Sections 160 and 164.
- v. **Ingredient Cost** – Will be defined for the State contract according to the criteria below:
1. For retail, ingredient cost means the lowest of
 - U&C Price;
 - MAC, where applicable; or
 - AWP less all applicable discounts or other applicable reimbursement amounts negotiated with the participating retail pharmacy and that adheres to the guaranteed AWP discount percentage set forth in the contractor's pricing.
 2. For brands, the contractor's mail order and specialty pharmacies, ingredient cost means the discounted price using the guaranteed AWP discount percentage set forth in the Price Schedule(s).
 3. For generics, the contractor's mail order and specialty pharmacies, ingredient cost means the lower of the MAC, where applicable, or the discounted price using the default AWP discount percentage set forth in the Price Schedule(s). Ingredient cost does not include the dispensing fee, the copayment, coinsurance, deductibles or sales tax, if any.
- w. **Identical, Related or Similar (IRS)** - Drugs that are identical, related or similar to drugs identified as LTE (less than effective) by the FDA.
- x. **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".
- y. **Less Than Effective (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.
- z. **Mail Order Service** – A service whereby medications are delivered via mail. Mail order is typically used for maintenance drugs taken by members on a regular basis, such as medication to reduce blood pressure or treat asthma, diabetes, or a chronic heart condition.
- aa. **Maximum Allowance Cost (MAC)** – A cost management program that sets upper limits on the payment for equivalent drugs available from multiple manufacturers. It is the highest unit price that will be paid for a drug and is designed to increase generic dispensing, to ensure the pharmacy dispenses economically, and to control future cost increases.
- bb. **MAC List** – A list of multi-source drugs that are reimbursed at an upper limit per unit price. The list is developed and maintained by the contractor and is usually reviewed quarterly but individual drug prices may be adjusted more frequently. MAC lists vary among PBMs. Considerations for inclusion on the MAC list include: availability of the generic drug from multiple manufacturers; clinical implications of generic substitution; national availability of generic versions; price differences between the brand and generic; therapeutic equivalence; and volume of claims.
- cc. **Member** - Any person who has enrolled in the public sector plan in accordance with State of Tennessee Rules and Regulations.
- dd. **Multi-source (MS)** - Brands and generics available from more than one source.



- ee. **National Council of Prescription Drug Programs (NCPDP)** - A not-for-profit ANSI-Accredited Standards Development Organization.
- ff. **National Drug Code (NDC or NDC-11)** – A universal product identifier. The National Drug Code (NDC) Number is a unique, eleven-digit, three-segment number that identifies the labeler/vendor, product, and trade package size.
- gg. **National Provider Identification Number (NPI)** - A 10-position, intelligence-free numeric identifier (10-digit number). The numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.
- hh. **Paid Claim** – A claim that meets all plan established coverage criteria and is paid by the PBM and submitted to the plan for reimbursement.
- ii. **Pass-Through Transparent Pricing** – An arrangement whereby the client receives the full value (100%) of the contractor's negotiated discounts and dispensing fees at retail, and the full value of rebates. The contractor's only profits are the administrative fee, and any margin they make for mail prescriptions and specialty prescriptions. All financial negotiated retail pharmacy contracts and rebate contracts are fully disclosed to and auditable by the client. The client is protected in this model by requiring guaranteed discounts, fees, and rebates from the PBM Contractor. Discounts and rebates achieved on the client's behalf that exceed the financial guarantees are payable to the client. Dispensing fees that are paid lower than the guaranteed are also passed through to the client. Hence, the financial guarantees are the minimum discounts and rebates the client will achieve and the maximum dispensing fees and administrative fees the client will pay.
- jj. **PPACA** – the federal Patient Protection and Affordable Care Act, Public Law 111-148.
- kk. **PEMPM** - Per enrolled member per month
- ll. **Pharmacy Benefit Manager (PBM)** – A vendor who provides a set of core pharmacy benefit services to a client.
- mm. **Pharmacy and Therapeutics (P&T) Committee** - A panel of experts consisting of physicians, pharmacists and clinical experts who assist PBMs in developing formularies and preferred drug lists which are clinically appropriate and cost rational.
- nn. **Physician Profiling**- A means of comparing prescribing behaviors (or other medical orders) among doctors in order to benchmark and/or improve quality of care by providing physicians with meaningful information on their clinical performances. Hence, the success of profiling should be measured by evidence of improvement over time in the structures, processes, and outcomes of care. Physician information is often sorted by specialty or diagnosis, and profiling can be used in a managed care setting as an incentive for quality improvement. Physicians are often give data such as that listed below at monthly or quarterly intervals:
- Formulary compliance
 - Generic utilization
 - mail/retail
 - top drugs by cost
 - top drugs by # of prescriptions
 - total prescriptions
 - total cost to the plan
- oo. **PMPM** - Per member per month
- pp. **Protected Health Information (PHI)** - As defined in HIPAA (45 C.F.R. §§ 160 and 164).
- qq. **POS** - Point-of-Sale.
- rr. **Prior Authorization (PA)** - A program requirement where certain therapies must gain approval before payment can be authorized.



- ss. **Rebates** - All revenue received by the Contractor from outside sources related to the Plan's utilization or enrollment in programs (collectively the "Total Manufacturer Value"). Also, the amounts paid to the contractor (i) pursuant to the terms of an agreement with a pharmaceutical manufacturer, (ii) in consideration for the inclusion of such manufacturer's drug(s) on the contractor's formulary, and (iii) which are directly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain prescription drugs by members. These would include but are not limited to access fees, market share fees, rebates, formulary access fees, administrative fees and marketing grants from pharmaceutical manufacturers, wholesalers and data warehouse vendors. Rebates will also exclude purchase discounts (e.g. prompt pay discounts) from mail and specialty products.
 - tt. **Retail Pharmacy** – A retail pharmacy establishment at which prescription drugs are dispensed by a registered pharmacist under the laws of each state.
 - uu. **Retail Pharmacy 90-Day Network** – A network retail pharmacy that offers a 90-day supply of medications for chronic conditions also known as maintenance medications. The discounts, dispensing fees and rebates are significantly better than retail and similar to mail.
 - vv. **Retro-DUR - Retrospective Drug Utilization Review** - A post payment claims analysis to facilitate drug utilization review objectives.
 - ww. **RFP** - Request for Proposal.
 - xx. **Single-Source (SS)** - Brands and generics only available from one manufacturer.
 - yy. **Specialty Drugs** – specialty drugs must meet at least two of the first four criteria (a thru d) below and the final criteria (e).
 - a. Produced through DNA technology or biological processes
 - b. Targets a chronic and complex disease
 - c. Route of administration could be inhaled, infused or injected
 - d. Unique handling, distribution and/or administration requirements
 - e. Requires a customized medication management program that includes medication use review, patient training, and coordination of care and adherence management for successful use such that more frequent monitoring and training is required.
- Specialty Pharmacy** – a pharmacy that dispenses specialty drugs (see definition) to patients focusing on additional services such as enhanced clinical management, increased adherence, guideline management, and enhanced distribution services.
- zz. **Spread** - A term applicable to traditional pricing. The concept supports the PBM vendor retaining the differential between negotiated contracts and financial terms offered to the client. For example, the PBM may have a higher discount with pharmacies than it offers to its clients and retain the difference or "spread" as profit. With the traditional model, the "spread" represents the PBMs profit, but the actual amount of this profit may not be fully disclosed to the client.
 - aaa. **Step Therapy** - The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug, and stepping up through a sequence of alternative drug therapies as preceding treatment option fails. Step Therapy programs apply coverage rules at the point of service when a claim is adjudicated. If a claim is submitted for a second-line drug and the Step Therapy rule was not met, the claim is rejected, and a message is transmitted to the pharmacy indicating that the patient should be treated with the first-line drug before coverage of the second-line drug can be authorized.
 - bbb. **Subcontract** - An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the State under the terms



of this Contract, when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Contract.

- ccc. **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 the State under the terms of this Contract.
- ddd. **Total Manufacturer Value** – See Rebates
- eee. **Transparent** – An arrangement pursuant to which the contractor discloses all sources of revenue, including revenue from network pharmacy contracts and from prescription drug manufacturers, directly attributable to and specifically derived from utilization of prescription drugs by the contractor's plan members. Pass-through transparent pricing is fully auditable by the client including all pharmacy and drug manufacturer contracts. Traditional transparent pricing discloses retention of spread but usually does not permit auditing of pharmacy or drug manufacturer contracts nor does it usually disclose the exact dollar amount of the spread retained by the PBM.
- fff. **Usual and Customary (U&C)** - Retail price charged by a participating pharmacy for the particular drug in a cash transaction on the date the drug is dispensed, as reported by the retail pharmacy.
- ggg. **URAC** – URAC is an independent, nonprofit organization that promotes health care quality through its accreditation and certification programs. Originally, URAC was incorporated under the name "Utilization Review Accreditation Commission." However, that name was shortened to just the acronym "URAC" in 1996 when URAC began accrediting other types of organizations such as health plans and preferred provider organizations.
- hhh. **Wholesale Acquisition Cost (WAC)** – List price for wholesalers, distributors and other direct accounts before any rebates, discounts, allowances or other price concessions that might be offered by the supplier of the product.

B. CONTRACT TERM:

PR *ONLINE* *1/10/15* *IBM*

This Contract shall be effective for the period commencing on December 15, 2014 and ending on June 30, 2020. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period. The Contractor understands that they shall provide staff for an implementation period to last from the time of contract award until benefits go-live on January 1, 2015, and that the Contractor shall not collect any form of payment or administrative fees during this time. Conversely, for a period of six (6) months after the contract terminates, the Contractor shall continue to process and pay any claims that may arrive in any form as long as said claims are for a date of service within the term of this contract, and with the understanding that the Liquidated Damages stated in Attachment B shall not apply during this six (6) month period.

C. PAYMENT TERMS AND CONDITIONS:

- C.1. **Maximum Liability.** In no event shall the maximum liability of the State under this Contract exceed Seventeen Million, Seven Hundred Twenty-Six Thousand Dollars (\$17,726,000.00). The payment rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the 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, beginning no earlier than January 1, 2015, 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:

Service Description	Amount (per compensable increment)				
	1/1/15 – 12/31/15	1/1/16 – 12/31/16	1/1/17 – 12/31/17	1/1/18 – 12/31/18	1/1/19 – 12/31/19
FEES (Guaranteed Maximum PMPM)					
Administration Fee Per Member Per Month	Amount Per Member Per Month	Amount Per Member Per Month	Amount Per Member Per Month	Amount Per Member Per Month	Amount Per Member Per Month
Clinical Fee Per Member Per Month	Amount Per Member Per Month	Amount Per Member Per Month	Amount Per Member Per Month	Amount Per Member Per Month	Amount Per Member Per Month
DISPENSING FEES (Guaranteed Maximum Average Per Claim)					
Retail – Brand	Amount Per Claim	Amount Per Claim	Amount Per Claim	Amount Per Claim	Amount Per Claim
Retail – Generic	Amount Per Claim	Amount Per Claim	Amount Per Claim	Amount Per Claim	Amount Per Claim
90-Day Retail – Brand	Per Claim	Per Claim	Per Claim	Per Claim	Per Claim
90-Day Retail – Generic	Per Claim	Per Claim	Per Claim	Per Claim	Per Claim
Mail – Brand	Per Claim	Per Claim	Per Claim	Per Claim	Per Claim



Service Description	Amount (per compensable increment)				
	1/1/15 – 12/31/15	1/1/16 – 12/31/16	1/1/17 – 12/31/17	1/1/18 – 12/31/18	1/1/19 – 12/31/19
Mail – Generic	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim
All Brand Specialty Pharmacy Claims	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim
RETAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)					
Brand	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████
Generic	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████
90-DAY RETAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)					
Brand	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████
Generic	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████
MAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)					
Brand	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████
Generic	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████
SPECIALTY NETWORK DISCOUNTS (Guaranteed Minimum Average)					
All Brand Specialty Pharmacy Claims	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████	AWP minus ██████████
REBATES PER CLAIM (Guaranteed Minimum Average)					
All Retail Claim Basis (Brand & Generic)	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim
All 90-Day Retail Claim Basis (Brand & Generic)	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim



Service Description	Amount (per compensable increment)				
	1/1/15 – 12/31/15	1/1/16 – 12/31/16	1/1/17 – 12/31/17	1/1/18 – 12/31/18	1/1/19 – 12/31/19
All Mail Claim Basis (Brand & Generic)	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim
All Brand Specialty Pharmacy Claims	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim	██████████ Per Claim

- c. The State reserves the right to review files prior to issuing payment and to hold or adjust any payment that is not satisfactory to the State. If the Contractor submits a claims payment request and the State overpays the claim, then the State may withhold the overpaid monies.
- d. After award of this Contract, the Contractor shall use the post-settlement AWP for this Contract's pricing terms.
- e. If the contractor elects to conduct subrogation activities on the state account, the State authorizes the Contractor to retain monies received through subrogation, on a per patient basis, of no more than five percent (5%) of the gross recoveries received. However, if the Contractor subcontracts the subrogation function to a subcontractor that is not an organizational unit, affiliate, subsidiary, or parent company, then the Contractor may instead request reimbursement from the State for the subcontracted costs incurred for subrogation activities. Such reimbursement shall be in lieu of rather than in addition to the five percent (5%) retention allowance described above.
- f. The State will fund the Contractor for the total issue amount of the payments, net of cancellations, voids or other payment credit adjustments, weekly provided the Contractor's payment process includes timely settlement of ACH transactions. Unless otherwise mutually agreed to in writing by the parties, the Contractor shall notify the State of the week's funding requirement amount. The funding option for the State will include either receiving an ACH debit from the Contractor to a designated State bank account, or wire transfer of funds to the Contractor's designated bank account. The parties shall mutually agree in writing upon the funding option. The Contractor acknowledges and agrees that since the State intends to fund payments at the time of issuance, the State will not maintain a separate bank account or an escrow account with the Contractor or to otherwise pre-fund an account.
- g. The State will fund the Contractor monthly for the administration fee based on the State's record of eligible members as of the first day of the month.

The Contractor shall guarantee that the dispensing fee per claim is based on paid claims only not claims that are reversed or rejected.
- h. The Contractor shall reconcile, within ten (10) working days of receipt, payment information provided by the State (e.g. upon providing the State with a monthly invoice and the Contractor receives payment for this invoice, if the Contractor has questions or concerns about payment, Contractor must do so within 10 days). Upon identification of any discrepancies, the Contractor shall immediately advise the State.
- i. The Contractor shall guarantee that U&C priced claims will not be assessed a dispensing fee.
- j. The Contractor shall guarantee that the average dispensing fee per claim, if any, shall not exceed the guaranteed maximum average.



- k. The Contractor shall guarantee that all discounts and services and administrative fees are guaranteed for the life of this contract, including any optional contract extensions executed by the State.
- l. The Contractor shall guarantee that the terms presented are for the entire contract period, including any optional contract extensions, and do not require the State to implement any plan designs or programs that are different from the plan design and programs currently in place.
- m. The Contractor shall guarantee that the terms presented are State-specific, not book-of-business averages or discount guarantees.
- n. The contractor shall guarantee that the guaranteed discount off AWP shall not exclude any products from the calculations (e.g., zero balance claims, U&C claims, those generics during their exclusivity period, "specialty" drugs processed at retail), with the exception of compounds and powders, which shall be excluded.
- o. The Contractor shall individually measure the guaranteed minimum average discounts and fees for the retail networks, mail pharmacy program, specialty network and 90-day-at retail pharmacy network. Over performance in one network area shall not offset under performance in other network areas. The Contractor shall individually measure specific brand discounts, generic discounts and dispensing fee components of each contract guarantee. Over performance in one contract area will not offset under performance in other contract areas. The Contractor shall measure guaranteed financial contract terms within ninety (90) days following each quarter and reconcile with the State annually during the first quarter of the following calendar year. The Contractor shall reimburse the State the difference between actual average discounts and fees and the guaranteed minimum average discounts and fees by cash or check only. Credits to the Plan are not acceptable unless otherwise agreed upon by both Parties in writing.
- p. The Contractor shall pay to the State one hundred percent (100%) of the Total Manufacturer Value collected based, directly or indirectly, on the State's claims. The Contractor shall provide the State with the greater of (i) one hundred percent (100%) of the Total Manufacturer Value, or (ii) the guaranteed rebates.
- q. The Contractor shall pay out to the State all Total Manufacturer Value earned by the State during the entire term of this contract regardless of termination of said Contract.
- r. The Contractor shall remit to the State no less frequently than quarterly a check for all Total Manufacturer Value obtained on behalf of the State due to the use of pharmaceuticals by members of the Public Sector Plans for the rebates accrued during the claim period ending six (6) months prior to the rebate payment date. Rebate and administrative fee reporting shall also be submitted quarterly based on the State's NDC-11 or NDC-9 utilization to demonstrate the level of rebate pass-through pricing.
- s. No later than the first quarter of each calendar year of the contract, the Contractor shall complete an annual reconciliation between the percentage of rebates paid and the guaranteed average amount, in aggregate. If the outcome of the reconciliation results in an amount due to the State, one hundred percent (100%) of the payment will be made by the Contractor within thirty (30) days of the completion of the reconciliation. Please reference Contract Section A.18.d. (1)- (7).

The State currently uses the Advantage Suite DSS system from Truven Health Analytics.

- t. If error(s) in member materials, previously approved by the State in writing, are detected after the materials have been mailed, the State will reimburse the Contractor for the production and postage cost of mailing the corrected version.



u. The State shall reimburse the Contractor for the following, selected actual costs in the performance of this Contract:

- (1) Postage. The State shall reimburse the Contractor for the actual cost of postage for mailing materials produced at the specific request of the State. Postage for materials and mailings referenced in the contract (i.e. ID cards, welcome packets, etc.) are the sole responsibility of the Contractor.
- (2) Printing / Production (refer to *pro forma* Contract Section A.25.d.). Subject to compliance with Section E.8. of this Contract, the State shall reimburse the Contractor an amount equal to the actual net cost of document printing / production as required and authorized by the State and as detailed by the Contract Scope of Service.

Notwithstanding the foregoing, the State retains the option to authorize the Contractor to deliver a product to be printed, approve and accept the product but not use the Contractor to print the material. In those situations, the State shall have the discretion to use other printing and production services at its disposal.

- v. The contractor shall reimburse, when necessary and appropriate, monies to plan members when an overpayment has occurred by the plan member.
- w. The contractor shall maintain the 30 day and 90 day supply limits for plan members as appropriate; however, in certain circumstances where members are vacationing or traveling for longer periods of time the State – at its sole discretion – may grant a courtesy override depending on the individual circumstances. The Contractor in any such instance shall contact the State to inquire if an extended supply or courtesy vacation override may be approved. In these instances, the Contractor shall make special provision for the member to pay the applicable number of copayments (e.g. if gone for 6 months, then 2, 90 day copayments would apply). Further, the Contractor shall keep detailed records related to such in its POS and financial systems in case of audit.

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

C.5. Invoice Requirements. The Contractor shall invoice the State only for completed increments of service and for the amount stipulated in Section C.3, above, and as required below prior to any payment.

- a. The Contractor shall submit invoices for clinical fees no more often than monthly, with all necessary supporting documentation, to:

Sylvia Chunn, Procurement & Contracting Manager
Tennessee Department of Finance & Administration
Benefits Administration Division
William R. Snodgrass Tennessee Tower
312 Rosa L Parks Avenue, Suite 1900
Nashville, Tennessee 37243

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

- (1) Invoice/Reference Number (assigned by the Contractor);
- (2) Invoice Date;
- (3) Invoice Period (period to which all invoiced charges are applicable);
- (4) Contract Number (assigned by the State to this Contract);
- (5) Account Name: Finance & Administration, Benefits Administration Division;



- (6) Account/Customer Number (uniquely assigned by the Contractor to the above-referenced Account Name);
- (7) Contractor Name;
- (8) Contractor Federal Employer Identification Number or Social Security Number (as referenced in this Contract);
- (9) Contractor Contact (name, phone, and/or fax for the individual to contact with billing questions);
- (10) Contractor Remittance Address;
- (11) Complete Itemization of Charges, which shall detail the following:

- i. Service or Milestone Description (including name /title as applicable) of each service invoiced;
- ii. Number of Completed Units, Increments, Hours, or Days as applicable, of each service invoiced;
- iii. Applicable Payment Rate (as stipulated in Section C.3.) of each service invoiced;
- iv. Amount Due by Service; and
- v. Total Amount Due for the invoice period.

c. The Contractor understands and agrees that an invoice to the State under this Contract shall:

- (1) include only charges for service described in Contract Section A and in accordance with payment terms and conditions set forth in Contract Section C;
- (2) not include any future work but will only be submitted for completed service; and
- (3) not include sales tax or shipping charges.

d. The Contractor agrees that timeframe for payment (and any discounts) begins when the State is in receipt of each invoice meeting the minimum requirements above.

e. The Contractor shall complete and sign a "Substitute W-9 Form" provided to the Contractor by the State. The taxpayer identification number contained in the Substitute W-9 submitted to the State shall agree to the Federal Employer Identification Number or Social Security Number referenced in this Contract for the Contractor. The Contractor shall not invoice the State for services until the State has received this completed form.

C.6. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice, or matter in relation thereto. A payment by the State shall not be construed as acceptance of any part of the work or service provided or as approval of any amount invoiced.

C.7. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute proper remuneration for compensable services.

C.8. Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any Contract between the Contractor and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the Contractor.

C.9. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following documentation properly completed.

- a. The Contractor shall complete, sign, and present to the State an "Authorization Agreement for Automatic Deposit (ACH Credits) Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once said form is received by the State, all



payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee shall be made by Automated Clearing House (ACH).

- b. The Contractor shall complete, sign, and present to the State a "Substitute W-9 Form" provided by the State. The taxpayer identification number detailed by said form must agree with the Contractor's Federal Employer Identification Number or Tennessee Edison Registration ID referenced in this Contract.

D. STANDARD TERMS AND CONDITIONS:

- D.1. Required Approvals. The State is not bound by this Contract until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).
- D.2. Modification and Amendment. This Contract may be modified only by a written amendment signed by all parties hereto and approved by both the officials who approved the base contract and, depending upon the specifics of the contract as amended, any additional officials required by Tennessee laws and regulations (said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).
- D.3. Termination for Convenience. The Contract may be terminated by either party by giving written notice to the other, at least thirty (30) days before the effective date of termination. Should the State exercise this provision, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Should the Contractor exercise this provision, the State shall have no liability to the Contractor except for those units of service which can be effectively used by the State. The final decision as to what these units of service are, shall be determined by the State. In the event of disagreement, the Contractor may file a claim with the Tennessee Claims Commission in order to seek redress.
- D.4. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to terminate the Contract and withhold payments in excess of fair compensation for completed services.
 - a. The State will provide notification of termination for cause in writing. This notice will: (1) specify in reasonable detail the nature of the breach; (2) provide the Contractor with an opportunity to cure, which must be requested in writing no less than 10 days from the date of the Termination Notice; and (3) shall specify the effective date of termination in the event the Contractor fails to correct the breach. The Contractor must present the State with a written request detailing the efforts it will take to resolve the problem and the time period for such resolution. This opportunity to "cure" shall not apply to circumstances in which the Contractor intentionally withholds its services or otherwise refuses to perform. The State will not consider a request to cure contract performance where there have been repeated problems with respect to identical or similar issues, or if a cure period would cause a delay that would impair the effectiveness of State operations. In circumstances where an opportunity to cure is not available, termination will be effective immediately.
 - b. Notwithstanding the foregoing, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.



D.5. Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, each shall contain, at a minimum, sections of this Contract below pertaining to "Conflicts of Interest," "Nondiscrimination," and "Records" (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime contractor and shall be responsible for all work performed.

D.6. Conflicts of Interest. The Contractor warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed relative to this Contract.

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

D.7. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Contractor shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.8. Prohibition of Illegal Immigrants. The requirements of *Tennessee Code Annotated*, Section 12-4-124, *et seq.*, addressing the use of illegal immigrants in the performance of any Contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

- a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment A, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the Contractor and made available to state officials upon request.
- b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the Contractor and made available to state officials upon request.
- c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.
- d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of *Tennessee Code Annotated*, Section 12-4-124, *et seq.* for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a



period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Contract.

- e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.

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

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

- D.14. State Liability. The State shall have no liability except as specifically provided in this Contract.
- D.15. Force Majeure. The obligations of the parties to this Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, natural disasters, riots, wars, epidemics, or any other similar cause.
- D.16. State and Federal Compliance. The Contractor shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.
- D.17. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees



hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.

- D.18. Completeness. This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.
- D.19. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.
- D.20. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

E. SPECIAL TERMS AND CONDITIONS:

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

The State:

Sylvia Chunn, Procurement & Contracting Manager
Tennessee Department of Finance & Administration
Benefits Administration Division
William R. Snodgrass Tennessee Tower
312 Rosa L. Parks Avenue, Suite 2600
Nashville, Tennessee 37243
Sylvia.Chunn@tn.gov
Telephone: 615.253.8358
Fax: 615.253.8556

The Contractor:

Robert Wallace
CaremarkPCS Health, L.L.C.
2401 Cherahala Blvd.
Knoxville, TN 37932
Robert.Wallace3@CVSCaremark.com
Telephone: 865-769-5946
FAX: 480-860-3624

With a copy to:

CVS Health
Vice President and Senior Counsel,
Health Care Services
2211 Sanders Road, 10th Floor
Northbrook, Illinois 60062
Telephone: 847-559-4700
FAX: 847-559-4879



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. Insurance. The Contractor shall carry adequate liability and other appropriate forms of insurance.
- a. The Contractor shall maintain, at minimum, the following insurance coverage:
- (1) Workers' Compensation/ Employers' Liability (including all states coverage) with a limit not less than the relevant statutory amount or one million dollars (\$1,000,000) per occurrence for employers' liability whichever is greater.
 - (2) Comprehensive Commercial General Liability (including personal injury & property damage, premises/operations, independent contractor, contractual liability and completed operations/products) with a bodily injury/property damage combined single limit not less than one million dollars (\$1,000,000) per occurrence and two million dollars (\$2,000,000) aggregate.
 - (3) Automobile Coverage (including owned, leased, hired, and non-owned vehicles) with a bodily injury/property damage combined single limit not less than one million dollars (\$1,000,000) per occurrence.
- b. At any time State may require the Contractor to provide a valid Certificate of Insurance detailing Coverage Description; Insurance Company & Policy Number; Exceptions and Exclusions; Policy Effective Date; Policy Expiration Date; Limit(s) of Liability; and Name and Address of Insured. Failure to provide required evidence of insurance coverage shall be a material breach of this Contract.
- E.6. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be



disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

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

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

- E.7. HIPAA and HITECH Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA) and their accompanying regulations.
- a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and HITECH and their accompanying regulations, and shall comply with all applicable HIPAA and HITECH requirements in the course of this Contract including but not limited to the following:
 - (1) Compliance with the Privacy Rule, Security Rule, Notification Rule;
 - (2) The creation of and adherence to sufficient Privacy and Security Safeguards and Policies;
 - (3) Timely Reporting of Violations in Use and Disclosure of PHI; and
 - (4) Timely Reporting of Security Incidents.
 - b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and HITECH and its regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA and HITECH.
 - c. The State and the Contractor will 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. This provision shall not apply if information received by the State under this Contract is NOT "protected health information" as defined by HIPAA, or if HIPAA permits the State to receive such information without entering into a business associate agreement or signing another such document.
- E.8. Printing Authorization. The Contractor agrees that no publication coming within the jurisdiction of *Tennessee Code Annotated*, Section 12-7-101, *et. seq.*, shall be printed pursuant to this contract unless a printing authorization number has been obtained and affixed as required by *Tennessee Code Annotated*, Section 12-7-103 (d).
- E.9. 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.10. Competitive Procurements. This Contract provides for reimbursement of the cost of goods, materials, supplies, equipment, or contracted services. Such procurements shall be made on a competitive basis, where practical. The Contractor shall maintain documentation for the basis of each procurement for which reimbursement is paid pursuant to this Contract. In each instance where it is determined that use of a competitive procurement method was not practical, said documentation shall include a written justification, approved by the Commissioner of Finance and Administration, for such decision and non-competitive procurement.
- E.11. State Furnished Property. The Contractor shall be responsible for the correct use, maintenance, and protection of all articles of nonexpendable, tangible, personal property furnished by the State for the Contractor's temporary use under this Contract. Upon termination of this Contract, all property furnished shall be returned to the State in good order and condition as when received, reasonable use and wear thereof excepted. Should the property be destroyed, lost, or stolen, the Contractor shall be responsible to the State for the residual value of the property at the time of loss.
- E.12. 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.13. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:



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

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

- E.14. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's proposal responding to RFP # 31786-00121 (Attachment 6.3, Section B, Item B.15.) 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 Business Diversity Enterprise in form and substance as required by said office.

- E.15. 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 as outlined in Contract Attachment B. The State shall notify the Contractor of amounts to be assessed as Liquidated Damages. The parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for a Breach by Contractor as said amounts are likely to be uncertain and not easily proven. Contractor hereby represents and covenants it has carefully reviewed the Liquidated Damages contained in above referenced, Attachment B and agree that said amounts represent a reasonable relationship between the amount and what might reasonably be



expected in the event of Breach, and are a reasonable estimate of the damages that would occur from a Breach. It is hereby agreed between the parties that the Liquidated Damages represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the liquidated damage amount is in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or other section of this Contract.

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

The State may conduct "secret shopper" and other monitoring activities during the operation of this Contract. The State may also assess liquidated damages for breaches of contract that it discovers during these and other activities as outlined in Contract Attachment B.

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

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

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

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



all expenses incurred by the State which exceed the amount the State would have paid Contractor under this Contract. Contractor agrees to cooperate with the State in the event of a Contract Termination or Partial Takeover.

- (5) Opportunity to Cure – In the event of Contractor Breach as referenced above in Sections (3) and (4) the State may provide the Contractor the opportunity to cure as referenced in Contract Section D.4. The Contractor must present the State with a written request detailing the efforts it will take to resolve the problem and the time period for such resolution. This opportunity to "cure" shall not apply to circumstances in which the Contractor intentionally withholds its services or otherwise refuses to perform. The State will not consider a request to cure contract performance where there have been repeated problems with respect to identical or similar issues, or if a cure period would cause a delay that would impair the effectiveness of State operations. In circumstances where an opportunity to cure is not available, termination will be effective immediately.

- 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.16. Negligent, Reckless, or Willful Acts of Omission.

The Contractor shall have responsibility for overpayments resulting from the negligent, reckless, or willful acts or omissions of the Contractor, its officers, agents or employees, regardless of whether or not such overpayments can be recovered by the Contractor. The Contractor shall repay the State the amount of any such overpayment within thirty (30) calendar days of discovery of the overpayment. Overpayments due to provider fraud or fraud of any other type, other than fraud by employees or agents of the Contractor, will not be considered overpayments for purposes of this Section. The Contractor shall assist in identifying fraud and make reasonable efforts, in consultation with the State, to recover overpayments due to fraud.

E.17. Tennessee Department of Revenue Registration. The Contractor shall be registered with the Department of Revenue for the collection of Tennessee sales and use tax. This registration requirement is a material requirement of this Contract.

E.18. Confidential and Proprietary Information. The State agrees to protect, to the fullest extent permitted by state law, the confidentiality of information expressly identified by the Contractor as confidential and proprietary, including information that would allow a person to obtain unauthorized access to confidential information or to electronic information processing systems owned by or licensed to the State to the extent permitted by the Tennessee Public Records Act.

E.19. Limitation of Liability. The parties agree that the Contractor's liability under this Contract shall be limited to an amount equal to two (2) times the Maximum Liability amount detailed in section C.1. and as may be amended, PROVIDED THAT in no event shall this section limit the liability of the Contractor for intentional torts, criminal acts, or fraudulent conduct.



- a. The State acknowledges the Contractor does not manufacture the drugs dispensed hereunder or make prescribing decisions. Therefore, Contractor makes no warranties of merchantability or fitness for a particular purpose; and
- b. The State acknowledges that Contractor does not establish AWP or other available industry pricing benchmark methodologies (e.g., "Wholesale Acquisition Costs" or "WAC"), and Contractor shall have no liability to the State arising from the use of Medi-Span or any other nationally available reporting service.

LEGAL
REVIEW
12/10

IN WITNESS WHEREOF,

CAREMARKPCS HEALTH, LLC:

Bruce Lyons 12/7/14
 BRUCE LYONS, SVP SALES DATE

BRUCE C LYONS SVP
 PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

STATE OF TENNESSEE,
 STATE INSURANCE COMMITTEE,
 LOCAL EDUCATION INSURANCE COMMITTEE,
 LOCAL GOVERNMENT INSURANCE COMMITTEE:

Larry B. Martin 12-10-2014
 LARRY B. MARTIN, CHAIRMAN DATE



CONTRACT
ATTACHMENT A

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	43652
CONTRACTOR LEGAL ENTITY NAME:	CaremarkPCS Health, L.L.C.
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	[REDACTED]

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.



Bruce C Lyons

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.

BRUCE C LYONS, SVP

PRINTED NAME AND TITLE OF SIGNATORY

1/15/15

DATE OF ATTESTATION



**CONTRACT
ATTACHMENT B**

LIQUIDATED DAMAGES

The Contractor shall pay to the State the indicated total dollar assessment upon notification by the State that an amount is due, through the term of the contract.

All performance guarantees will be measured on a Plan-specific basis rather than the Contractor's book of business (BOB).

1. Program Go-Live Date	
Guarantee	The pharmacy benefit for the Public Sector Plans shall take effect (i.e. "go-live") and be fully operational on the go-live date specified in Contract Section A.31. Operational is defined as the ability to accurately enroll members, accept and process POS claims, accept and process mail order prescriptions, and provide all other PBM services outlined in the contract.
Assessment	Twenty-five thousand dollars (\$25,000) for every day beyond the target date that the program is not operational. \$200,000 maximum.
Measurement	Measured, reported, and reconciled no later than three (3) months after go-live date.
2. Implementation Plan	
Guarantee	The Contractor shall provide a project implementation plan, as required in Contract Section A.3, to the State no later than thirty (30) days after contract start date, which includes all tasks with deliverable dates necessary to install the program by the go-live date.
Assessment	One thousand dollars (\$1,000) for each day beyond the deadline that the plan is not provided to the State. \$20,000 maximum.
Measurement	Measured, reported, and reconciled no later than three months after go-live of the new pharmacy benefit.
3. Operational Readiness	
Guarantee	The Contractor shall resolve all findings identified by the State during its operational readiness review, as required in Contract Section A.3.g, prior to go-live date.
Assessment	Ten thousand dollars (\$10,000) if the standard is not met.
Measurement	Measured and reported no later than three (3) months after go-live date.
4. Plan Design	
Guarantee	Plan design as required in the Plan Document will be implemented correctly, as required in Contract Section A.3.g.
Assessment	Twenty-five thousand dollars (\$25,000) if the standard is not met.
Measurement	Measured and reported no later than six (6) months after go-live date.
5. Eligibility Set-Up	
Guarantee	As required in Contract Section A.17.c, eligibility information will be loaded, tested, verified and available online for use no later than thirty (30) days prior to the go-live date specified in Contract Section A.30.
Assessment	Ten thousand dollars (\$10,000) for each day beyond the date specified in Contract Section A.31. \$100,000 maximum.
Measurement	Measured, reported, and reconciled no later than three (3) months after go-live date.
6. Implementation Satisfaction	
Guarantee	The Contractor's overall rating on the implementation performance assessment completed by the State, as required in Contract Section A.3.1, will be noted as met or exceeded expectations or the equivalent of the same measure on any other scale used.



Assessment	Ten (\$10,000) if the standard is not met.
Measurement	Measured, reported, and reconciled no later than three (3) months after go-live date.
7. Key Staff Vacancies	
Guarantee	As required in Contract Section A.4.k, if any key positions become vacant, the Contractor shall employ an adequate replacement within sixty (60) days of the vacancy unless the State grants an exception to this requirement.
Assessment	One-thousand dollars (\$1,000) for each week beyond sixty (60) days that the vacancy is not filled. \$20,000 annual maximum
Measurement	Measured, reported, and reconciled annually.
8. Staff Availability	
Guarantee	As required in Contract Section A.4.b, the Account Team shall be available for consultation with the State during the hours of 8:00 a.m. to 4:30 p.m. Central Standard Time, Monday through Friday.
Assessment	One-thousand dollars (\$1,000) per occurrence. \$20,000 annual maximum.
Measurement	Measured, reported, and reconciled annually.
9. POS System Availability	
Guarantee	POS system, used by contracted pharmacies to process pharmacy claims, as required in Contract Section A.5.1, shall be accessible and operational ninety-nine point five percent (99.5%) of the time.
Assessment	Five-thousand dollars (\$5,000) for each quarter the percentage falls below ninety-seven percent (97%).
Measurement	Measured and reported quarterly; reconciled annually.
10. POS System Processing	
Guarantee	As required in Contract Section A.5.d, the Contractor shall process ninety-nine and a half percent (99.5%) of POS claims on a daily basis within five (5) 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. For this calculation the number of claims processed within five (5) seconds during each twenty-four (24) hour period shall be the numerator and the number of claims processed during each twenty-four (24) hour period shall be the denominator. The Contractor's measure shall reflect the time required for all procedures required to complete claim adjudication.
Assessment	Five-thousand dollars (\$5,000) for each quarter the percentage falls below 99.5%.
Measurement	Measured and reported quarterly; reconciled annually.
11. Claims Processing Accuracy	
Guarantee	Claims processing accuracy, as required in Contract Section A.5.k, shall be ninety-eight percent (98%) or higher.
Assessment	Twenty-thousand dollars (\$20,000) for each quarter the percentage falls below ninety-eight percent (98%),
Measurement	Quarterly internal audit performed by the carrier on a statistically valid sample. Measured and reported quarterly; reconciled annually.
12. Claims Payment Accuracy	
Guarantee	Claims payment accuracy, as required in Contract Section A.6.e, shall be ninety-eight percent (98%) or higher.
Assessment	Twenty-thousand dollars (\$20,000) for each quarter the percentage falls below ninety-eight percent (98%).
Measurement	Quarterly internal audit performed by the carrier on a statistically valid sample. Measured and reported quarterly; reconciled annually.
13. Claims Payment Turnaround	
Guarantee	As required in Contract Section A.6.h, 100% of direct reimbursement "clean" claims (both electronically through POS means or through member submitted paper claims) will be paid within the lesser of 30 days or the contracted



	turnaround time with the pharmacy.
Assessment	Non-Investigated Claims (clean): Twenty thousand dollars (\$20,000) for each quarter the percentage falls below the required minimum standard of ninety-five percent (95%) within ten (10) days. Quarterly Guarantee. All Claims: \$ Twenty-thousand dollars (\$20,000) for each quarter the percentage falls below the required minimum standard of one hundred percent (100%) within thirty (30) days.
Measurement	Quarterly internal audit performed by the carrier on a statistically valid sample. Measured and reported quarterly; reconciled annually.
14. Pharmacy Pricing	
Guarantee	One hundred percent (100%) of participating pharmacies will adhere to "lowest of" pricing, as required in Contract Section A.14.7.
Assessment	Twenty-five thousand dollars (\$25,000) for each quarter the percentage falls below one hundred percent (100%)
Measurement	Measured and reported quarterly; reconciled annually.
15. Guaranteed Minimum Discounts & Dispensing Fees	
Guarantee	As required in Contract Section C.3.n. the Contractor shall individually measure the guaranteed minimum average discounts and fees for the retail network, mail pharmacy program, specialty network, and 90-day-at retail pharmacy network and specific brand discounts, generic discounts and dispensing fee components of each contract guarantee. Over performance in one network area shall not offset under performance in other network areas.
Assessment	Difference between the guaranteed minimum discount and the actual discount.
Measurement	Measured and reported within ninety (90) days following each quarter; reconciled annually during the first quarter.
16. Network Access	
Guarantee	As required in Contract Section A.7.e.1, 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 Public Sector Plan members, on average, live within one and one-half (1.5) miles of a retail pharmacy participating in the Contractor's network; in suburban areas, at least ninety percent (90%) of Public Sector Plan members, on average, live within three (3) miles of a retail pharmacy participating in the Contractor's network; and in rural areas, at least ninety percent (90%) of Public Sector Plan members, on average, live within ten (10) miles of a retail pharmacy participating in the Contractor's network. Exceptions shall be justified, documented, and approved by the State.
Assessment	Fifty thousand dollars (\$50,000) if <u>ANY</u> of the above listed standards is not met, either individually or in combination.
Measurement	Measured annually by the GeoNetworks [®] report provided by the Contractor.
17. Formulary Implementation	
Guarantee	As required in Contract Section A.8.c, the Contractor's normal formulary will be implemented within five (5) working days after receipt of the State's written approval. Customized formularies will be implemented within ten (10) working days after receipt of the State's formal request.
Assessment	Five thousand dollars (\$5,000) each time the standard is not met. \$20,000 annual maximum.
Measurement	Measured, reported and reconciled annually.
18. Formulary Changes	
Guarantee	As required in Contract Section A.8.e, changes to the formulary, Step Therapy or PA requirements shall be implemented within fifteen (15) days of the State's approval or request. Changes shall include modifications to the POS system and all supporting systems and documents. Such changes to the program shall require pharmacy provider and affected plan member notification at least thirty (30) days prior to the implementation, unless the Contractor and State mutually



	agree to a shorter notification time.
Assessment	Five thousand dollars (\$5,000) each time the standard is not met. \$20,000 annual maximum.
Measurement	Measured, reported, and reconciled annually.
19. Generic Utilization	
Guarantee	As required in Contract Section A.11.e, the Contractor shall maintain a generic dispensing rate (GDR) annually during the term of this contract at a level of 80.0% or higher. The calculation used to determine this rate shall be: Number of generic scripts / the sum of all generic and brand scripts.
Assessment	\$75 for retail prescriptions and \$150 for mail prescriptions The shortfall will be calculated as the guaranteed fill rate for the year minus the actual fill rate for the year, separately for mail and retail. The calculation will be as follows: Total Paid Rx's for the year * (guaranteed fill rate minus the actual fill rate) * penalty amount.
Measurement	Measured, reported and reconciled annually.
20. Generic Substitution	
Guarantee	As required in Contract Section A.8.i.1, ninety-five percent (95%) or more of mail order prescriptions and ninety percent (90%) or more of retail prescriptions for multi-source drugs will be dispensed with a generic product.
Assessment	Twenty thousand dollars (\$20,000) for each year the standard is not met.
Measurement	Measured, reported and reconciled annually.
21. PA Evaluation	
Guarantee	As required in Contract Section A.11.h.4, the Contractor's call center staff shall evaluate ninety-nine percent (99%) of PA requests within twenty-four (24) hours.
Assessment	Five thousand dollars (\$5,000) for each quarter that the standard is not met.
Measurement	Measured and reported quarterly; reconciled annually.
22. Eligibility Posting	
Guarantee	Ninety-eight percent (98%) of electronically transmitted enrollment updates shall be posted within one (1) business day after receipt in specified format and one hundred percent (100%) posted within three (3) business days, as required in Contract Section A.18.a.3.
Assessment	One thousand dollars (\$1,000) per day for the first (1 st) and second (2 nd) working days out of compliance; Five thousand dollars (\$5,000) per working day thereafter. \$50,000 annual maximum.
Measurement	Measured and reported weekly; reconciled annually.
23. Eligibility Discrepancies	
Guarantee	Resolve all discrepancies (any difference of values between the State's database and the Contractor's database) identified by the processing of the enrollment file within five (5) business days of receipt of the file from the State, as required in Contract Section A.18.a.4.
Assessment	One thousand dollars (\$1,000) per day for the first (1 st) and second (2 nd) working days out of compliance; Five thousand dollars (\$5,000) per working day thereafter. \$50,000 annual maximum.
Measurement	Measured and reported quarterly; reconciled annually.
24. Group Additions	
Guarantee	New groups will be added to all systems within three (3) business days of receipt of necessary documents as required in Contract Section A.18.b.
Assessment	Five thousand dollars (\$5,000) for each instance that the standard is not met. \$25,000 annual maximum.
Measurement	Measured and reported quarterly; reconciled annually.
25. Enrollment Data Match	
Guarantee	The Contractor shall submit an Enrollment Data Match, not to exceed four (4) times annually, in an agreed upon format, within fourteen (14) calendar days of



	the request from the State, as required in Contract Section A.18.c.	
Assessment	Five thousand dollars (\$5,000) for each instance that the standard is not met.	
Measurement	Measured, reported, and reconciled annually.	
26. Enrollment Data Match Discrepancies		
Guarantee	The Contractor shall resolve the discrepancies identified in the Enrollment Data Match, within the specified timeframe(s) as required in Contract Section A.18.c.1.	
Assessment	Five thousand dollars (\$5,000) for each instance that the standard is not met.	
Measurement	Measured, reported, and reconciled annually.	
27. Claims Data Quality		
Guarantee	As measured by the State's Claims Data Management vendor (currently Truven Health Analytics), the Contractor's data submission to said vendor shall meet the following Data Quality measures as required in Contract Section A.18.g.	
Definition	Measure	Benchmark
	Date of birth	Data missing for ≤ 3% of claims
	Pharmacy provider ID missing	Data missing for ≤ 1.5% of claims
	NDC 11 missing	Data missing for ≤ 1.5% of claims
Assessment	Five thousand dollars (\$5,000) if <u>ANY</u> of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Measurement	Measured and reported by the State's Claims Data Management vendor quarterly; reconciled annually.	
28. Claims Data Submission		
Guarantee	The Contractor shall submit claims data to the State's data management vendor no later than fifteen (15) days following the end of each calendar month, or more frequently as mutually agreed to by both parties, as required in Contract Section A.18.d.1-7	
Assessment	One thousand dollars (\$1,000) per day for the first (1 st) and second (2 nd) working days out of compliance; Five thousand dollars (\$5,000) per working day thereafter. \$25,000 annual maximum.	
Measurement	Measured, reported and reconciled quarterly.	
29. Data Transmission to Third Party Vendors		
Guarantee	Unless otherwise directed by the State, the Contractor shall provide daily data feeds of pharmacy claims to the State's third party contractors during the term of the contract and following the term of this contract until all claims incurred during the term of this contract have been paid, as required in Contract Section A.18.h.	
Assessment	One thousand dollars (\$1,000) for each day the standard is not met. \$25,000 annual maximum.	
Measurement	Measured and reported monthly; reconciled annually	
30. Appeal Decisions		
Guarantee	Ninety-five percent (95%) of pre-service appeals shall be decided within thirty (30) days and ninety-five percent (95%) of post-service appeals within sixty (60) days, as required in Contract Section A.23.c.	
Assessment	Five thousand dollars (\$5,000) for each instance that the standard is not met. \$20,000 annual maximum.	
Measurement	Measured, reported, and reconciled annually.	
31. Customer Service		
Guarantee	The Contractor's toll-free customer service lines for members and pharmacy providers shall be open and staffed with trained staff at least two (2) weeks prior to go-live, as required in Contract Section A.24.a.	
Assessment	One thousand dollars (\$1,000) for each day the standard is not met.	



Measurement	Measured, reported, and reconciled no later than three (3) months after go-live.
32. Telephone Coverage	
Guarantee	The Contractor shall provide uninterrupted telephone coverage for twenty-four (24) hours a day/seven (7) days a week for claims, systems and customer service and pharmacy provider inquiries, as required in Contract Section A.24.a. Excluded from this are contracted-planned down times or instances beyond contractor's control (e.g. weather).
Assessment	Twenty thousand dollars (\$20,000) for each quarter the standard is not met.
Measurement	Measured and reported quarterly; reconciled annually.
33. Average Speed of Answer (ASA)	
Guarantee	The Contractor shall maintain an ASA of 30 seconds and callers may not be placed on hold after the call is answered, as required in Contract Section A.24.h.
Assessment	Ten thousand dollars (\$10,000) each quarter the standard is not met.
Measurement	Based on Contractor's internal telephone support system reports. Measured and reported quarterly; reconciled annually.
34. First Call Resolution	
Guarantee	The Contractor shall maintain a first call resolution rate of 92% or greater.
Assessment	Ten thousand dollars (\$10,000) each quarter the standard is not met.
Measurement	Measured and reported quarterly; reconciled annually.
35. Open Inquiry Closure	
Guarantee	The Contractor shall close 95% of all open call issues within five (5) business days.
Assessment	Ten thousand dollars (\$10,000) each quarter the standard is not met.
Measurement	Measured and reported quarterly; reconciled annually.
36. Written Inquiries	
Guarantee	As required in Contract Section A.24.w, ninety-five percent (95%) of written inquiries (mail and e-mail) will be responded to within five (5) business days and one hundred percent (100%) will be responded to within ten (10) business days.
Assessment	Five thousand dollars (\$5,000) if the standard is not met. Annual guarantee.
Measurement	Measured, reported and reconciled annually.
37. Member Communications	
Guarantee	All materials, including but not limited to: ID cards and letters, produced by the Contractor shall be provided to the State for review and approval at least fourteen (14) days prior to planned printing, assembly, and/or distribution, as required in Contract Section A.25.h.
Assessment	One thousand dollars (\$1,000) for each instance that the standard is not met. \$25,000 annual maximum.
Measurement	The State will notify the Contractor of any such occurrence. Any amounts due for the Contractor's noncompliance with this pre-approval provision shall be paid annually upon request by the State.
38. Distribution of Member Handbook Information	
Guarantee	On an annual basis, at least two months prior to the State's open enrollment period, the Contractor shall provide to the State, in electronic format, information regarding the pharmacy benefit, as required in Contract Section A.25.n.3.
Assessment	If the aforementioned information is not distributed to the State as required, then the total assessment shall be Five thousand dollars (\$5,000) per year in which the standard is not met.
Measurement	Measured, reported, and reconciled annually.
39. Initial Member ID Card/Welcome Packet Distribution	
Guarantee	Ninety-five percent (95%) of welcome packets containing I.D. cards will be produced and mailed no later than twenty-one (21) days prior to go-live date, as required in Contract Section A.23.n.4.
Assessment	Twenty-five thousand dollars (\$25,000) if the standard is not met.



Measurement	Measured, reported, and reconciled no later than three (3) months after go-live date.
40. Distribution of Ongoing Member ID Card/Welcome Packet Guarantee	Ninety-five percent (95%) of welcome packets shall be produced and mailed within ten (10) days of receipt of complete and accurate eligibility information, as required in Contract Section A.23.n.2.
Assessment	Ten thousand dollars (\$10,000) per year in which the standard is not met.
Measurement	Measured, reported, and reconciled annually.
41. Website Guarantee	The Contractor's Public Sector Plan website shall be available on the internet and fully operational, with the exception of member data/Protected Health Information one (1) week prior to the commencement of claims processing, as required in Contract Section A.26.a.
Assessment	One thousand dollars (\$1,000) per day that the standard is not met.
Measurement	Measured, reported, and reconciled no later than three (3) months after go-live.
42. Member Satisfaction Survey Guarantee	The level of overall customer satisfaction, as measured annually by the State approved Member Satisfaction survey(s) required in Contract Section A.28, will be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and ninety percent (90%) in all subsequent year(s) within the contract term.
Assessment	Twenty thousand dollars (\$20,000) for each year that the standard is not met.
Measurement	Measured, reported, and reconciled annually.
43. URAC Accreditation Guarantee	As required in Contract Section A.2.d, the Contractor shall possess and maintain full Pharmacy Benefit Management accreditation status with URAC during the entire term of this contract.
Assessment	Twenty thousand dollars (\$20,000) if the standard is not maintained.
Measurement	Measured, reported, and reconciled annually.
44. Reporting Guarantee	The Contractor shall distribute to the State all reports required in Contract Sections A.1 through A.31 within the time frame specified in the Contract.
Assessment	One thousand dollars (\$1,000) for each report not delivered to the State within the time frame specified in the contract. \$25,000 annual maximum.
Measurement	Measured, reported, and reconciled annually.
45. Audit Recovery Guarantee	As required in Contract Section A.29.1, any amount due the State which is not paid by the Contractor within (30) days of the Contractor's receipt of the final audit report shall be subject to a compounding interest penalty of one percent (1%) per month.
Assessment	Compounding interest penalty of one percent (1%) per month for each month payment is not received.
Measurement	Measured, reported, and reconciled after each occurrence.
46. Privacy and Security of Protected Health Information Guarantee	In accordance with Contract Section E.7., the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act).
Assessment	Two thousand five hundred dollars (\$2,500) for the first violation, five thousand dollars (\$5,000) for the second violation and ten thousand dollars (\$10,000) for the third and any additional violations with a maximum cap at one hundred thousand dollars (\$100,000) annually. The assessment will be imposed on a



	per incident basis meaning regardless of how many members are impacted and the assessment will be levied on the graduated basis detailed above. ***In the event Contractor is responsible for Federal Penalties related to a Privacy or HIPAA violation, the State may, at their discretion waive any Liquidated Damages due the State in association with the same violation.***
Measurement	Measured, reported, and reconciled after each occurrence.



The ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3-Benefit Enrollment and
Maintenance (834), August 2006, ASC
X12N/005010X220
TN 834 - Field

Field	Data Type	Length	Sending Data Format	STTN Description	Comments
	Standard 834			NULL ()	
[REF_OF_02]	Standard 834			Edison ID (Employee ID)	Will be present on all records. This represents the Head of Contract (HOC)
	Standard 834			NULL ()	
	Standard 834			NULL ()	
[NM1_IL_09]	Standard 834			SSN	This is individual SSN
	Standard 834			NULL ()	
[NM1_IL_04]	Standard 834			First name	
[NM1_IL_05]	Standard 834			Middle name	
[NM1_IL_03]	Standard 834			Last name	
[DMG_02]	Standard 834			Birth Sequence Number	
[DMG_03]	Standard 834			Gender Code	
[INS_02]	Standard 834			Individual Relationship	
[DMG_04]	Standard 834			Marital Status Code	
[N3_01]	Standard 834			Address Information	See note below*
[N3_02]	Standard 834			Address Information	See note below*
[N4_01]	Standard 834			City Name	See note below*
[N4_03]	Standard 834			Postal Code	Substring first 5 characters - See note below*



[N4_03]	Standard 834	Postal Code	Substring last 4 characters - See note below*
[N4_02]	Standard 834	State	See note below*
[N4_04]	Standard 834	NULL ()	Will Default to US
[DMG_05]	Standard 834	Race or Ethnicity Code	
[PER_04]	Standard 834	Communication Number	No dashes, numbers only
[PER_06]	Standard 834	Communication Number	No dashes, numbers only
[PER_08]	Standard 834	Communication Number	No dashes, numbers only
	Standard 834	NULL ()	
	Standard 834	NULL ()	
[LUI_02]	Standard 834	Language Code	
[DTP_348_03]	Standard 834	348 - Health Coverage Begin Date	
[DTP_349_03]	Standard 834	349 - Health Coverage End Date	349 loop will only be present when end date exists. Otherwise, eligibility is open-ended(default 12/31/9999)
[HD_05]	Standard 834	Benefit Plan	
[INS_08]	Standard 834	Employment Status Code	
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A



[REF_1L_03]	Standard 834	TN Specific Information that is not defined on PeopleSoft Delivered 834 Benefit Program	Substring first three characters. **Used to derive Public Sector plan Type per contract (State, Local Gov, Local Edu.)
[REF_1L_04]	Standard 834	TN Specific Information that is not defined on PeopleSoft Delivered 834 Budget Code	First three characters are "ZZ:" and will need to be substringed out.
[HD_06]	Standard 834	Coverage Code	
[NM1_03]	Standard 834	Provide Name	
[NM1_09]	Standard 834	NPI	
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
	Standard 834	NULL ()	N/A
Processing Notes*:			
1) Mailing address following a [NM1*31*1] loop shall be loaded if available (Loop ID 2100C). Else, Residence address shall be loaded (Loop ID 2100A).			

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a Prescription Drug claims file for plan participants administered through <Data Supplier>. The data will be provided in a fixed-record length, ASCII file format. The data request consists of two layouts/records; A Drug Detail Record and a Trailer Record.

METHOD OF SUBMISSION

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

FREQUENCY OF SUBMISSION

The data will be submitted to Truven Health Analytics on a monthly basis.

TIMING OF SUBMISSION

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

Data Type: Drug Claims

Definitions:

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

Items for discussion

General

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

Financial Fields

Truven Health defines the relationship among financial fields as follows:

- Charge Submitted
- Not Covered Amount*



- = Charge Covered*
- Discount Amount
- = Allowed Amount
- Coinsurance
- Copayment
- Deductible
- Penalty/Sanction Amount*
- Third Party Amount
- = **Net Payment**

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



Corrections to paid claims

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

Void/Replacement

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

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

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

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



Adjustments

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

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

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

Denied Claims

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

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



DATA FORMATTING

Character Fields

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

Numeric Fields

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

Financial Fields

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

Invalid Characters

Please note that the following characters should not be included in the data or the descriptions in the data dictionary.

- *
!
?
%
_ (under score)
, (comma)

Drug Record



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



Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
11	Date Paid	80	89	10	Date	The date the claim or data record was paid.	MM/DD/CCYY format This is the check date.
12	Days Supply	90	93	4	Numeric	The number of days of drug therapy covered by the prescription.	
13	Deductible	94	103	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.	Format 9(8)v99 (2 – digit, implied decimal)
14	Dispensing Fee	104	113	10	Numeric	An administrative fee charged by the pharmacy for dispensing the prescription.	Format 9(8)v99 (2 – digit, implied decimal)
15	Family ID/Employee SSN	114	122	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.	The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
16	Formulary Indicator	123	123	1	Character	An indicator that the prescription drug is included in the formulary.	"Y" or "N"
17	Gender Code	124	124	1	Character	The member's gender code.	"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
18	Ingredient Cost	125	134	10	Numeric	The charge or cost associated with the pharmaceutical product.	Format 9(8)v99 (2 – digit, implied decimal)
19	Metric Quantity Dispensed	135	145	11	Numeric	The number of units dispensed for the prescription drug claim, as defined by the NCPDPD (National Council for Prescription Drug Programs) standard format.	Format 9(8)v99 (3 – digit, implied decimal)



Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
20	NDC Number Code	146	156	11	Character	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.	Please leave out the dashes.
21	Net Payment	157	166	10	Numeric	The actual check amount for the record	Format 9(8)v99 (2 – digit, implied decimal)
22	Network Paid Indicator	167	167	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level.	“Y” or “N”
23	Network Provider Indicator	168	168	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs.	“Y” or “N”
24	Ordering Provider ID	169	181	13	Character	The ID number of the provider who prescribed the drug.	The ID should be the physician’s DEA # or NPI. If these are not available, the Federal Tax ID (TIN) is preferred.
25	Ordering Provider Name	182	211	30	Character	The Name of the provider who referred the patient or ordered the test or procedure.	
26	Ordering Provider Zip Code	212	216	5	Character	The zip code of the provider who referred the patient or ordered the test or procedure.	
27	PCP Responsibility Indicator	217	217	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.	
28	Provider ID	218	230	13	Character	The identifier for the provider of service.	This must be the NCPDP (National Council for Prescription Drug Programs) number or NPI.



Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
29	Rx Dispensed as Written Code	231	231	1	Character	The NCPDP (National Council for Prescription Drug Programs) industry standard code that indicates how the product was dispensed.	
30	Rx Mail or Retail Code	232	232	1	Character	The Truven Health standard code indicating the purchase place of the prescription.	"M" for Mail, "R" for Retail
31	Rx Payment Tier	233	233	1	Character	Client-specific description for the payment tier of the drug claim.	Data Supplier will help Truven Health understand which fields to use in order to set this field for the customer. Examples of Rx Payment Tier are as follows: <ol style="list-style-type: none"> 1. Generic 2. Brand Formulary 3. Brand Non Formulary
32	Rx Refill Number	234	237	4	Numeric	A number indicating the original prescription or the refill number.	This is the refill number, not the number of refills remaining.
33	Sales Tax	238	247	10	Numeric	The amount of sales tax applied to the cost of the prescription.	Format 9(8)v99 (2 – digit, implied decimal)
34	Third Party Amount	248	257	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).	Format 9(8)v99 (2 – digit, implied decimal)
35	Discount	258	267	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.	Format 9(8)v99 (2 – digit, implied decimal)
36	Provider NPI Number	268	277	10	Character	The National Provider Identifier for the pharmacy.	
37	Funding Type Code	278	278	1	Character	Specifies whether the claim was paid under a fully or self-funded arrangement	"S" = Self-funded "F" = Fully-funded



Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
38	Account Structure	279	286	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Additional fields may be added to the layout if there is more than one component of the account structure.
39	HRA Amount	287	296	10	Numeric	The amount paid from the HRA to pay the provider.	Format 9(8)v99 (2 – digit, implied decimal)
40	HSA Amount	297	306	10	Numeric	The financial amount of the healthcare savings account for consumer-driven health plans	Format 9(8)v99 (2 – digit, implied decimal)
41	Compound Code	307	307	1	Character	Client-specific code for the compound of the drug.	Compound Codes will be identified in the Data Dictionary . Note that the NCPDP values include: '0' – Not Specified '1' – Not a Compound '2' – Compound
42	Excess Copayment Amount	308	317	10	Numeric	The amount paid by the patient outside of the flat copayment amount. Examples include when the patient chooses brand name instead of the generic alternative or non-formulary drug instead of the formulary option.	Format 9(8)v99 (2 – digit, implied decimal)
43	Tax Amount	318	327	10	Numeric	The amount charged by some states per drug claim.	Format 9(8)v99 (2 – digit, implied decimal)
44	Filler1	328	399	72	Character	Reserved for future use	Fill with blanks
45	Record Type	400	400	1	Character	Record Type Identifier	Hard Code 'D'



Drug Detail – Trailer Record

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





REPORTING REQUIREMENTS

As required by this Contract, the Contractor shall submit reports to the State. Reports shall be submitted electronically, in the format approved by the State, and shall be of the type and at the frequency indicated below. The State reserves the right to modify reporting requirements as deemed necessary to monitor contract implementation. The State will provide the Contractor with at least sixty (60) days' notice prior to implementation of a report modification.

Unless otherwise directed by the State, the Contractor shall submit reports as follows:

1. Monthly reports shall be submitted by the 15th of the following month;
2. Quarterly reports shall be submitted by the 20th of the following month; and
3. Annual reports shall be submitted within ninety (90) days after the end of the calendar year.

Reports shall include, at a minimum (not an all-inclusive list; refer to contract for all specifics):

1. **Account Team Satisfaction Survey**, submitted annually in January.
2. **Business Continuity/Disaster Recovery results**, December 1, 2014 and annually thereafter
3. **GeoNetworks Report**, submitted annually in January.
4. **Quarterly Network Changes Report**, submitted within five (5) working days of the end of each calendar quarter after go-live.
5. **Formulary Compliance Report**, submitted quarterly after go-live
6. **Therapeutic substitution and generic dispensing program report**, submitted annually in January.
7. **Prior Authorization (PA) reporting**, submitted quarterly after go-live
8. **Rebate and Administrative Fee reporting**, submitted quarterly after go-live
9. **Rebate Annual Reconciliation**, submitted during the first quarter of each calendar year.
10. **Financial Reporting**, quarterly at the end of each calendar quarter and annually during the first calendar quarter showing contractor's financial targets (e.g. AWP minus %, dispensing fees, etc.) and outcomes.
11. **Operational/Performance Reporting**, monthly within 15 days of the end of the previous month.
12. **Compliance Report (aka report card)**, submitted each calendar quarter showing for the previous quarter the contractor's outcome for each of the measurements in the



Liquidated Damages section of this contract, as well as any payment amount due for that quarter (if applicable).

13. **Rebate Payments report**, submitted at least 60 days following the end of each calendar quarter after go-live.
14. **SSAE 16 / SOC-1 report**, submitted within thirty (30) days of the contract start date, annually thereafter, and in addition to periodic bridge reports as requested by the state or State Audit.
15. **Pass Through Pricing Report**, submitted quarterly after go-live as referenced in Contract Section A.6.c.
16. **Other Reports**, as specified in this Contract and using templates prior approved in writing by the State.
17. **Adherence Report**, submitted quarterly (or monthly, if requested by the State) to the state's Wellness contractor. Adherence Report will contain, at a minimum, the member's Edison ID number, first and last name, date of birth, adherence condition (e.g. high blood pressure), and their medication possession ratio (MPR) in two time periods to aid the wellness contractor in determining which members are adherent and which are not. This adherence report will be for at least one drug class chosen by the state, or more classes as needed and requested by the State.



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BENEFITS ADMINISTRATION

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Larry B. Martin
COMMISSIONER

Laurie Lee
EXECUTIVE DIRECTOR

STATE OF TENNESSEE
DAILY FILE TRANSMISSION STATISTICS

Vendor: _____ Date: _____

Person completing this form: _____

Date File received from State: _____

Number of Records Received: _____

Date File processed by Vendor: _____

Number of Errors : _____

Date Errors Resolved: _____

Comments: _____
