CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00316		DR-11-32647-00-316	07

Contractor Legal Entity Name	Edison Vendor ID
Cariten Health Plan, Inc.	0000093686

Amendment Purpose & Effect(s)

Extends Term for the Provision of Special Needs Plan (SNP) for Medicare/Medicaid Dual Eligible Enrollees

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

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$ 0.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
TOTAL:					**$0.00**

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

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

OCR USE

Speed Chart (optional)

Account Code (optional)

AMENDMENT #7
OF CONTRACT DR-11-32647-00-316
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
CARITEN HEALTH PLAN, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the 'State" or "TennCare" and Cariten Health Plan, Inc., hereinafter referred to as the "Contractor." It is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

1. **Contract Section A.1 shall be amended to add the following to existing definitions:**

Care Coordinator – The individual who has primary responsibility for performance of care coordination activities for a CHOICES member as specified in the Contractor Risk Agreement and meets the qualifications specified in the Contractor Risk Agreement.

Contractor Risk Agreement (CRA) – The Contract between TennCare Managed Care Organizations and TennCare regarding requirements for operation and administration of the managed care TennCare program, including CHOICES and ECF CHOICES.

Employment and Community First (ECF) CHOICES – A managed long-term services and supports program that offers home and community-based services to eligible individuals with intellectual and developmental disabilities enrolled in the program in order to promote competitive employment and integrated community living as the first and preferred option. The ECF CHOICES program will begin implementation at a date to be determined by TENNCARE, but no sooner than July 1, 2016.

Support Coordinator – The individual who has primary responsibility for performance of support coordination activities for an ECF CHOICES member as specified in the Contractor Risk Agreement and meets the qualifications specified in the Contractor Risk Agreement.

TennCare CHOICES in Long-Term Care (CHOICES) – A program in which long-term care services for elders and/or persons with physical disabilities are integrated into TennCare's managed care delivery system.

2. **Contract Section A.2.b.6 shall be deleted in its entirety and replaced with the following:**

A.2.b.6. The Contractor shall be responsible for providing care coordination for all Medicare and Medicaid services for all FBDE members, pursuant to this Contract and to policies and protocols developed by TennCare. The Contractor shall coordinate TennCare benefits not covered by the Contractor with the FBDE member's TennCare MCO. The Contractor shall be responsible for the following:

a. Providing notification within two (2) business days from the anchor date to a FBDE member's TennCare MCO of all FBDE members' inpatient admissions, including planned and unplanned admissions to the hospital or a SNF, as well as observation days and emergency department visits. The Contractor shall report each inpatient admission, observation day, and emergency department visit separately. The Contractor's implementation of emergency department visit notifications will occur at a later date to be determined by TennCare.

b. Coordinating with a FBDE member's TennCare MCO regarding discharge planning from any inpatient setting when Medicaid LTSS (NF or HCBS) or Medicaid home health or private duty nursing services, may be needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective and integrated setting; and follow up with a FBDE member and the member's TennCare MCO following observation days and emergency department visits to address member

needs and coordinate Medicaid benefits, as appropriate. Discharge planning shall meet minimum requirements as specified by TennCare in policy or protocol.

c. Coordinating with a FBDE member's TennCare MCO regarding CHOICES or ECF CHOICES LTSS that may be needed by the member; however, the Contractor shall remain responsible for ensuring access to all Medicare benefits covered by the Contractor, including SNF and home health, and shall not supplant such medically necessary covered services with services available only through TennCare.

d. Coordinating with a FBDE member's TennCare MCO Care Coordinator or Support Coordinator, as applicable, and ensuring timely access to medically necessary covered Medicare benefits needed by a FBDE member enrolled in the CHOICES or ECF CHOICES program.

e. Participating upon request in needs assessments and/or the development of an integrated person-centered plan of care or person-centered support plan, as applicable, for a TennCare CHOICES or ECF CHOICES member, encompassing Medicare benefits provided by the Contractor as well as Medicaid benefits provided by the TennCare MCO.

f. Coordinating with a FBDE member's TennCare MCO and ensuring timely access to medically necessary covered Medicare benefits needed by a FBDE member.

g. Accepting and processing in a timely manner referrals for case management and/or disease management from a FBDE member's MCO, including a CHOICES or ECF CHOICES member's TennCare MCO Care Coordinator or Support Coordinator, as applicable.

h. Coordinating with each TennCare MCO operating in the Grand Region where the Contractor operates in the MCO's implementation of its nursing facility diversion program to 1) facilitate appropriate communication among the Contractor's providers (including hospitals and physicians) and the member's TennCare MCO; 2) provide training for the Contractor's key staff and providers regarding NF diversion and HCBS alternatives; 3) identify members who may be candidates for diversion (both CHOICES and ECF CHOICES members and non-CHOICES and non-ECF CHOICES members who may need NF services and qualify for CHOICES or ECF CHOICES upon hospital discharge or exhausting a Medicare SNF benefit); and 4) carry out follow-up activities to help sustain community living.

i. Referring to a FBDE member's TennCare MCO any FBDE member receiving SNF services that may be a candidate for transition to the community and coordinating with the FBDE member's TennCare MCO to facilitate timely transition, as appropriate, including coordination of services covered by the Contractor and services covered only by the TennCare MCO.

j. Including as part of the Contractor's SNP Model of Care, training for staff and providers regarding the following:

(1) The Contractor's responsibility for coordination of Medicare and Medicaid benefits for FBDE members;

(2) The Contractor's policies and processes for coordination of Medicare and Medicaid benefits for FBDE members; and

(3) The target populations for TennCare managed long-term services and supports programs, including the CHOICES and ECF CHOICES program.

(4) Benefits covered under the TennCare program, including the CHOICES and ECF CHOICES program.

3. **Contract Section A.2.b.8 shall be deleted in its entirety and replaced with the following:**

A.2.b.8. The Contractor agrees to include the disclaimer set out below either annually in a written notice or on any marketing materials concerning benefits sent to members in order to reduce any potential confusion between the scope of the Plan and the scope of the members TennCare benefits.

Notice: TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits.

Additionally, all instances in the Contractor's marketing materials that include reference to more, extra, or additional Medicare benefits, or use similar language to indicate the receipt of benefits above and beyond traditional Medicare benefits must explicitly state that such increased benefits are applicable to Medicare only and do not indicate increased Medicaid benefits to avoid potential member confusion.

4. **Contract Section A.2.g. shall be deleted in its entirety and replaced with the following:**

A.2.g. The Contractor shall, upon prior review and approval by the Centers for Medicare and Medicaid Services (CMS), submit to TennCare for review and prior written approval, all marketing materials, items, layouts, plans, etc. that will be distributed directly or indirectly to FBDE members or potential FBDE members for the purposes of soliciting and/or maintaining enrollment in the Contractor's plan. The Contractor shall include in its submission, documentation of CMS approval of such materials, items, layouts, plans, etc. The Contractor shall be strictly prohibited from using any eligibility or enrollment information that has been provided by TennCare for purposes of coordinating benefits for members for any marketing activities or to solicit additional members for enrollment in its D-SNP.

5. **Contract Section A.3.a. shall be deleted in its entirety and replaced with the following:**

A.3.a. **TennCare's Cost Sharing Obligations.** Federal law imposes certain cost sharing responsibilities on TennCare for its Dual Eligible members. These cost sharing obligations include costs for premiums, deductibles and co-insurance or co-payment amounts. For FBDE members not enrolled in the PACE Program or an integrated dual demonstration for FBDEs, TennCare shall continue to make these payments directly to the federal government (in the case of premiums) or providers (in the case of deductibles or coinsurance) in accordance with federal law, the TennCare State Plan and TennCare Rules. No payments of these sums shall be made to the Contractor. Any of the Contractor's subcontractors or providers who attempt to file claims for co-payments or co-insurance allowed by law shall be required to become registered TennCare providers, according to the procedures developed by TennCare. These procedures may be found on the TennCare website. The Plan will notify its network providers that they shall not bill enrollees for benefits provided, unless direct billing is permitted under State and Federal law.

Additionally, the Contractor shall adhere to the following requirements regarding balance billing for enrollees under this Contract:

1. The Contractor shall educate its network providers about balance billing protections for full benefit dual eligible enrollees and for QMBs, including that such protections apply regardless of whether TennCare is liable to pay full Medicare cost sharing amounts. The Contractor shall instruct providers to either accept Contractor

payment or bill the State for applicable cost sharing and accept the State's payment as payment in full;

2. The Contractor shall specify in provider agreements a requirement that providers shall not bill FBDE members for covered Medicare benefits provided, except in accordance with State and Federal law, and

3. The Contractor shall monitor provider compliance with balance billing rules and shall coordinate with TennCare or a FBDE member's TennCare MCO to promptly address any instance where the Contractor's provider is billing a FBDE member for covered Medicare benefits. The Contractor shall provide targeted provider outreach, including identifying problem areas received through Contractor grievance process and CMS tracking data.

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

B. This Contract shall be effective for the period commencing January 1, 2013 and ending on December 31, 2017.

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

IN WITNESS WHEREOF,

CARITEN HEALTH PLAN, INC.

Douglas E Haaland 6/17/2016

SIGNATURE **DATE**

DOUGLAS E. HAALAND, MARKET PRESIDENT

PRINTED NAME AND TITLE OF SIGNATORY (above)

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

Larry B. Martin/CD 6/22/2016

Larry B. Martin, Commissioner **DATE**

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00316		DR-11-32647-00-316	06

Contractor Legal Entity Name	Edison Vendor ID
Cariten Health Plan, Inc.	0000093686

Amendment Purpose & Effect(s)

Amends Scope and Extends Term for the Provision of Special Needs Plan (SNP) for Medicare/Medicaid Dual Eligible Enrollees

Amendment Changes Contract End Date: ☒ YES ☐ NO **End Date:** December 31, 2016

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$ 0.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
TOTAL:					**$0.00**

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

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

OCR USE

Speed Chart (optional)

Account Code (optional)

AMENDMENT #6
OF CONTRACT DR-11-32647-00-316
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
CARITEN HEALTH PLAN, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the 'State" or "TennCare" and Cariten Health Plan, Inc., hereinafter referred to as the "Contractor." It is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

1. Contract Section A.2.b.6.b is deleted in its entirety and replaced with the following:

b. Coordinating with a FBDE member's TennCare MCO regarding discharge planning from any inpatient setting when Medicaid LTSS (NF or HCBS) or Medicaid home health or private duty nursing services, may be needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective and integrated setting; and follow up with a FBDE member and the member's TennCare MCO following observation days and emergency department visits to address member needs and coordinate Medicaid benefits, as appropriate. Discharge planning shall meet minimum requirements as specified by TennCare in policy or protocol.

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

B. This Contract shall be effective for the period commencing January 1, 2013 and ending on December 31, 2016.

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 January 1, 2016. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

CARITEN HEALTH PLAN, INC.

Douglas E Haaland 6/25/2015

SIGNATURE **DATE**

DOUGLAS E. HAALAND

PRINTED NAME AND TITLE OF SIGNATORY (above)

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

Larry B. Martin/cds 6/25/2015

Larry B. Martin, Commissioner **DATE**

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00316		DR-11-32647-00-316	05

Contractor Legal Entity Name	Edison Vendor ID
Cariten Health Plan, Inc.	0000093686

Amendment Purpose & Effect(s)
Amends Scope for the Provision of Special Needs Plan (SNP) for Medicare/Medicaid Dual Eligible Enrollees

Amendment Changes Contract End Date: ☐ YES ☒ NO **End Date:** December 31, 2015

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$ 0.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
TOTAL:					$0.00

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

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

Speed Chart (optional)	Account Code (optional)

OCR USE

AMENDMENT #5
OF CONTRACT DR-11-32647-00-316
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
CARITEN HEALTH PLAN, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the 'State" or "TennCare" and Cariten Health Plan, Inc., hereinafter referred to as the "Contractor." It is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

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

   a. **Service Area.** The Plan shall specify its service area as Statewide, a specific Grand Region or regions of the state, or other specific geographic criteria (i.e., specific counties or metropolitan areas). The service area for this contract shall be the following counties:

   Anderson, Bedford, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Cumberland, Davidson, DeKalb, Dickson, Fayette, Franklin, Grainger, Greene, Grundy , Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Madison, Marion, Marshall, McMinn, Monroe, Morgan, Putnam, Rhea, Roane, Rutherford, Scott, Sequatchie, Sevier, Shelby, Sullivan, Tipton, Unicoi, Union, Warren, Washington, White, Williamson, and Wilson.

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 31, 2014. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

CARITEN HEALTH PLAN, INC.

Douglas E Haaland 8/27/2014

SIGNATURE **DATE**

DOUGLAS E HAALAND, MARKET PRESIDENT, MID SOUTH REGION - HUMANA

PRINTED NAME AND TITLE OF SIGNATORY (above)

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

Larry B. Martin/cs 8/28/2014

Larry B. Martin, Commissioner **DATE**

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00316		DR-11-32647-00-316	04

Contractor Legal Entity Name	Edison Vendor ID
Cariten Health Plan, Inc.	0000093686

Amendment Purpose & Effect(s)
Amends Scope for the Provision of Special Needs Plan (SNP) for Medicare/Medicaid Dual Eligible Enrollees

Amendment Changes Contract End Date: ☒ YES ☐ NO **End Date:** December 31, 2015

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$ 0.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
TOTAL:					**$0.00**

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

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

Speed Chart (optional)

Account Code (optional)

OCR USE

AMENDMENT #4
OF CONTRACT DR-11-32647-00-316
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
CARITEN HEALTH PLAN, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the 'State" or "TennCare" and Cariten Health Plan, Inc., hereinafter referred to as the "Contractor." It is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

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

A.1. DEFINITIONS:

The following terms are defined for purposes of this Contract only:

Anchor Date – The date of receipt of notification by the Contractor of upcoming (i.e., planned) or current inpatient admissions and current or recently completed observation days or emergency department visits. The anchor date is not included in the calculation of days within which the Contractor is required to take action.

Business Day – Monday through Friday, except for State of Tennessee holidays.

Confidential Information - Any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is supplied by TennCare to the Contractor under this Contract. Any information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, relating to individuals enrolled in the TennCare program ("TennCare enrollees"), or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained through the Contractor's performance under this Contract, shall also be treated as "Confidential Information" to the extent that confidential status is afforded such information under state and federal laws or regulations. All confidential information shall not be subject to disclosure under the Tennessee Public Records Act.

Cost Sharing Obligations - Medicare deductibles, premiums, co-payments and coinsurance that TennCare is obligated to pay for certain Medicare beneficiaries (QMBs, SLMB-Plus's, and Other Medicare/Medicaid Dual Eligibles). For SLMB-Plus's and Other Medicare/Medicaid Dual Eligibles, TennCare is not required to pay Medicare coinsurance on those Medicare services that are not covered by TennCare unless the enrollee is a child under 21 or an SSI beneficiary. No Plan can impose cost sharing obligations on its members which would be greater than those that would be imposed on the member if they were not a member of the Plan.

Dual Eligible - As used in this Contract, a Medicare enrollee who is also eligible for TennCare and for whom TennCare has a responsibility for payment of Medicare Cost Sharing Obligations under the State Plan. For purposes of this Contract, Dual Eligibles are limited to the following categories of recipients: QMB Only, QMB Plus, SLMB Plus, and Other Full Benefit Dual Eligible ("FBDE").

Dual Eligible Member - An enrollee who is Dual-Eligible and is enrolled in a Plan.

Encounter - A Medicare Part C covered service or group of covered services, as defined by the MA-SNP Agreement, delivered by a health care service provider to a Dual Eligible Member during a visit between the Dual Eligible Member and health care service provider.

Encounter Data - In the context of the MA Agreement, data elements from an Encounter service event for a fee-for-service claim or capitated services proxy claim.

Full Benefit Dual Eligible (FBDE) - An individual who is eligible both for Medicare Part A and/or Part B benefits and for TennCare benefits [services], including those who are categorically eligible and those who qualify as medically needy under the State Plan.

Individually Identifiable Health Information – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

MA Agreement - The Medicare Advantage Agreement between the Contractor and CMS to provide Medicare Part C and other health plan services to the Contractor's members.

Marketing - Shall have the meaning established under 45 CFR § 164.501 and includes the act or process of promoting, selling, leasing or licensing any TennCare information or data for profit without the express written permission of TennCare.

Observation – Observation services include short-term ongoing treatment and assessment for the purpose of determining whether a member can be discharged from the hospital or will require further treatment as an inpatient.

Personally Identifiable Information (PHI) – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

Protected Health Information/Personally Identifiable Information (PHI/PII) (45 C.F.R. § 160.103; OMB Circular M-06-19 located at http://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2006/m06-19.pdf) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

Qualified Medicare Beneficiary (QMB) - An individual who is entitled to Medicare Part A, who has income that does not exceed one hundred percent (100%) of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid Payment of Medicare Premiums, Deductibles, Coinsurance, and Co-payments (except for Medicare Part D). Collectively, these benefits [services] are called "QMB Medicaid Benefits [Services]." Categories of QMBs covered by this Contract are as follows:

> QMB Only – QMBs who are not otherwise eligible for full Medicaid.
>
> QMB Plus – QMBs who also meet the criteria for full Medicaid coverage and are entitled to all benefits [services] under the State Plan for fully eligible Medicaid recipients.

Specified Low-Income Medicare Beneficiary (SLMB) PLUS - An individual entitled to Medicare Part A who has income that exceeds 100% FPL but less than 120% FPL, and whose resources do not exceed twice the SSI limit, and who also meets the criteria for full Medicaid coverage. Such individuals are entitled to payment of the Medicare Part B premium, as well as full State Medicaid benefits.

Special Needs Plan (SNP) or Plan - A type of Medicare Advantage plan that also incorporates services designed for a certain class of members. In the case of this Contract the special class of

members are persons who are both Medicare and Medicaid Dual eligible. These plans must be approved by CMS. A SNP plan may also provide Medicare Part D drug coverage.

SSA-supplied Data – information, such as an individual's social security number, supplied by the Social Security Administration to the State to determine entitlement or eligibility for federally-funded programs (Computer Matching and Privacy Protection Agreement, "CMPPA" between SSA and F&A; Individual Entity Agreement, "IEA" between SSA and the State).

State Plan - The program administered by TennCare pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

Subcontract - An agreement between the MA Health Plan and a third party under which the third party agrees to accept payment for providing health care services for the MA Health Plan's members.

Subcontractor - A third party with which the MA Health Plan has a subcontract.

TennCare - The medical assistance program administered by Tennessee Department of Finance and Administration, Bureau of TennCare pursuant to Title XIX of the Social Security Act, the Tennessee State Plan, and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare MCO - A Managed Care Organization (MCO) under contract with the State to provide TennCare benefits.

2. Contract Section B shall be deleted in its entirety and replaced with the following:

   B. This Contract shall be effective for the period commencing June 30, 2011 and ending on December 31, 2015.

3. Contract Sections A.2.b.6.a and A.2.b.6.b. are deleted in their entirety and replaced with the following:

   A.2.b.6.a. Providing notification within two (2) business days from the anchor date to a FBDE member's TennCare MCO of all FBDE members' inpatient admissions, including planned and unplanned admissions to the hospital or a SNF, as well as observation days and emergency department visits. The Contractor shall report each inpatient admission, observation day, and emergency department visit separately. The Contractor's implementation of emergency department visit notifications will occur at a later date to be determined by TennCare.

   A.2.b.6.b. Coordinating with a FBDE member's TennCare MCO regarding discharge planning from any inpatient setting when Medicaid LTSS (NF or HCBS) or Medicaid home health or private duty nursing services, may be needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective and integrated setting; and following up with a FBDE member or their authorized representative and the member's TennCare MCO following observation days and emergency department visits to address member needs and coordinate Medicaid benefits, as appropriate.

4. Contract Section A.2.b.11 is deleted in its entirety and replaced with the following:

   A.2.b.11. The Contractor shall participate in meetings as requested by TennCare to discuss the program and its operations, and to address performance issues and concerns. The Contractor shall be required to have appropriate staff attend certain on-site meetings

held at TennCare offices or at other sites as requested and designated by TennCare. TennCare shall notify the Contractor in writing of any specific performance deficiencies and request corrective action. The Contractor shall respond in writing with a corrective action plan within thirty (30) calendar days of receipt of such notification and implement and monitor the plan upon approval by TennCare. Additionally, both Parties agree to cooperate in carrying out the activities described in any applicable Corrective Action Plan mandated by CMS.

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

A.2.a. Service Area. The Plan shall specify its service area as statewide, a specific Grand Region or regions of the State, or other specific geographic criteria (i.e., specific counties or metropolitan areas). The service area for this contract shall be the following counties:

Anderson, Bedford, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Cumberland, Davidson, DeKalb, Dickson, Fayette, Franklin, Grainger, Greene, Grundy , Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Madison, Marion, Marshall, Maury, McMinn, Monroe, Morgan, Putnam, Rhea, Roane, Rutherford, Scott, Sequatchie, Sevier, Shelby, Sullivan, Tipton, Unicoi, Union, Warren, Washington, White, Williamson, Wilson

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 June 30, 2014. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

CARITEN HEALTH PLAN, INC.

Douglas E Haaland 6/16/14

SIGNATURE **DATE**

DOUGLAS E HAALAND, MARKET PRESIDENT, MID SOUTH REGION, HUMANA

PRINTED NAME AND TITLE OF SIGNATORY (above)

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

Larry B. Martin /cD 6/18/2014

Larry B. Martin, Commissioner **DATE**

CONTRACT AMENDMENT

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00316		DR-11-32647-00-316	03

Contractor Legal Entity Name	Edison Vendor ID
Cariten Health Plan, Inc.	0000093686

Amendment Purpose & Effect(s)
Amends Scope for the Provision of Special Needs Plan (SNP) for Medicare/Medicaid Dual Eligible Enrollees

Amendment Changes Contract End Date: ☒ YES ☐ NO **End Date:** December 31, 2014

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$ 0.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
TOTAL:					**$0.00**

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

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

Speed Chart (optional)

Account Code (optional)

OCR USE

AMENDMENT #3
OF CONTRACT DR-11-32647-00-316
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
CARITEN HEALTH PLAN, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the 'State" or "TennCare" and Cariten Health Plan, Inc., hereinafter referred to as the "Contractor." It is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

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

   A.2. e. **Provider Network Information.**

   The Contractor shall submit a quarterly Provider Enrollment File report that includes information on all providers of the SNP Plan's covered health benefits. This includes but is not limited to, PCPs, physician specialists, hospitals and home health agencies. The report shall include contract providers as well as all non-contract providers with whom the Contractor has a relationship. This list need not include retail pharmacies. The Contractor shall submit this report by the 15th of the following months: February, May, August and November. Each quarterly Provider Enrollment File shall include information on all providers of health benefits and shall provide a complete replacement for any previous Provider Enrollment Files submission. Any changes in the provider's contract status from the previous submission shall be indicated in the file generated in the quarter the change became effective and shall be submitted in the next quarterly file. The provider network information shall be updated regularly as specified by TennCare. Contractor will contact TennCare's Office of Provider Networks for the proper format for the submission.

   The Contractor shall develop a network of providers that specifically targets overlap of providers in its network with providers that are also enrolled with one or more TennCare MCOs in order to ensure seamless access to care for FBDE members across the Medicare and Medicaid programs.

   The Contractor shall not enter into contracts with any providers which contain clauses or payment methodologies that have the intent or effect of 1) limiting those providers' participation in any other integrated or coordinated program of care for FBDEs, including but not limited to, a TennCare Waiver demonstration program, any other D-SNP program, or any program connected to or administered by a TennCare MCO, or 2) limiting a FBDE beneficiary's choice of Medicare providers. If the Contractor violates the provisions of this section A.2.e, such action shall be grounds for immediate termination of this contract pursuant to section D.4. Termination for Cause.

2. Contract Section B shall be deleted in its entirety and replaced with the following:

   B. This Contract shall be effective for the period commencing January 1, 2011 and ending on December 31, 2014.

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 June 15, 2013. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

CARITEN HEALTH PLAN, INC.

SIGNATURE DATE JUNE 6, 2013

DOUGLAS E HAALAND, MARKET PRESIDENT

PRINTED NAME AND TITLE OF SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE:

Commissioner DATE 6/13/2013

CONTRACT AMENDMENT

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00316		DR-11-32647-00-316	02

Contractor Legal Entity Name	Edison Vendor ID
Cariten Health Plan, Inc.	0000093686

Amendment Purpose & Effect(s)

Amends Scope for the Provision of Special Needs Plan (SNP) for Medicare/Medicaid Dual Eligible Enrollees

Amendment Changes Contract End Date: ☐ YES ☒ NO **End Date:** December 31, 2013

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$ 0.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
TOTAL:					**$0.00**

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

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

Speed Chart (optional)

Account Code (optional)

OCR USE

AMENDMENT #2
OF CONTRACT DR-11-32647-00-316
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
CARITEN HEALTH PLAN, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the 'State" or "TennCare" and Cariten Health Plan, Inc., hereinafter referred to as the "Contractor." It is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

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

A.2. e. **Provider Network Information.**

The Contractor shall submit a quarterly Provider Enrollment File report that includes information on all providers of the SNP Plan's covered health benefits. This includes but is not limited to, PCPs, physician specialists, hospitals and home health agencies. The report shall include contract providers as well as all non-contract providers with whom the Contractor has a relationship. This list need not include retail pharmacies. The Contractor shall submit this report by the 15th of the following months: February, May, August and November. Each quarterly Provider Enrollment File shall include information on all providers of health benefits and shall provide a complete replacement for any previous Provider Enrollment Files submission. Any changes in the provider's contract status from the previous submission shall be indicated in the file generated in the quarter the change became effective and shall be submitted in the next quarterly file. The provider network information shall be updated regularly as specified by TennCare. Contractor will contact TennCare's Office of Provider Networks for the proper format for the submission.

The Contractor shall develop a network of providers that specifically targets overlap of providers in its network with providers that are also enrolled with one or more TennCare MCOs in order to ensure seamless access to care for FBDE members across the Medicare and Medicaid programs.

The Contractor shall not enter into contracts with any providers for the delivery of services to FBDE members which contain clauses or payment methodologies that have the explicit intent or implicit effect of limiting the provider's participation in any TennCare demonstration for FBDEs or the TennCare program.

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 April 15, 2013. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

CARITEN HEALTH PLAN, INC.

Douglas E Haaland 4-3-2014

SIGNATURE **DATE**

DOUGLAS E. HAALAND

PRINTED NAME AND TITLE OF SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE:

Mark A. Emkes 4/8/2013

Mark A. Emkes, Commissioner **DATE**

CONTRACT AMENDMENT

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00316		DR-11-32647-00-316	01

Contractor Legal Entity Name	Edison Vendor ID
Cariten Health Plan, Inc.	0000093686

Amendment Purpose & Effect(s)

Amends Scope for the Provision of Special Needs Plan (SNP) for Medicare/Medicaid Dual Eligible Enrollees

Amendment Changes Contract End Date: ☐ YES ☒ NO **End Date:** December 31, 2013

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$ 0.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
TOTAL:					**$0.00**

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

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

OCR USE

Speed Chart (optional)	Account Code (optional)

AMENDMENT #1
OF CONTRACT DR-11-32647-00-316
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
CARITEN HEALTH PLAN, INC.

This Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the 'State" or "TennCare" and Cariten Health Plan, Inc., hereinafter referred to as the "Contractor." It is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

1. Contract section A.1 is amended by adding the following Definitions:

   Individually Identifiable Health Information – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

   Personally Identifiable Information (PHI) – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

   Protected Health Information/Personally Identifiable Information (PHI/PII) (45 C.F.R. § 160.103; OMB Circular M-06-19 located at http://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2006/m06-19.pdf) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

   SSA-supplied Data – information, such as an individual's social security number, supplied by the Social Security Administration to the State to determine entitlement or eligibility for federally-funded programs (Computer Matching and Privacy Protection Agreement, "CMPPA" between SSA and F&A; Individual Entity Agreement, "IEA" between SSA and the State).

2. Contract section A.2.a. is amended by adding the following new language to the second paragraph:

   Bedford, DeKalb, Madison, Marshall, Maury, Montgomery, Robertson, Warren, and White

3. Contract section A.2.b.2 is deleted in its entirety and replaced with the following:

   2. The Contractor shall not be responsible for the provision or reimbursement of any Medicaid benefits, unless such benefits are also covered by the Contractor, in which case, the Contractor shall be responsible for the provision and reimbursement of such covered services in accordance with its summary of benefits, and for coordination of Medicaid benefits beyond the scope of its covered benefits as described in

A.2.b.6. TennCare's list of covered benefits is set forth in Attachment D, incorporated by reference.

4. Contract section A.2.b.6 is deleted in its entirety and replaced with the following:

6. The Contractor shall be responsible for providing care coordination for all Medicare and Medicaid services for all FBDE members, pursuant to this Contract and to policies and protocols developed by TennCare. The Contractor shall coordinate TennCare benefits not covered by the Contractor with the FBDE member's TennCare MCO. The Contractor shall be responsible for the following:

(a) Providing to a FBDE member's TennCare MCO, in accordance with policies and protocols established by TennCare, prompt notification (within two (2) business days) of all FBDE members' inpatient admissions (including but not limited to hospital and SNF).

(b) Coordinating with a FBDE member's TennCare MCO regarding discharge planning from any inpatient setting when Medicaid LTSS (NF or HCBS) or Medicaid home health or private duty nursing services, may be needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective and integrated setting.

(c) Coordinating with a FBDE member's TennCare MCO regarding CHOICES LTSS that may be needed by the member; however, the Contractor shall remain responsible for ensuring access to all Medicare benefits covered by the Contractor, including SNF and home health, and shall not supplant such medically necessary covered services with services available only through TennCare.

(d) Coordinating with a FBDE member's TennCare MCO Care Coordinator and ensuring timely access to medically necessary covered Medicare benefits needed by a FBDE member enrolled in the CHOICES program.

(e) Participating upon request in needs assessments and/or the development of an integrated person-centered plan of care for a TennCare CHOICES member, encompassing Medicare benefits provided by the Contractor as well as Medicaid benefits provided by the TennCare MCO.

(f) Coordinating with a FBDE member's TennCare MCO and ensuring timely access to medically necessary covered Medicare benefits needed by a FBDE member.

(g) Accepting and processing in a timely manner referrals for case management and/or disease management from a FBDE member's MCO, including a CHOICES member's TennCare MCO Care Coordinator.

(h) Coordinating with each TennCare MCO operating in the Grand Region where the Contractor operates in the MCO's implementation of its nursing facility diversion program to 1) facilitate appropriate communication among the Contractor's providers (including hospitals and physicians) and the member's TennCare MCO; 2) provide training for the Contractor's key staff and providers regarding NF diversion and HCBS alternatives; 3) identify members who may be candidates for diversion (both CHOICES members and non-CHOICES members who may need NF services and qualify for CHOICES upon hospital discharge or exhausting a Medicare SNF benefit); and 4) carry out follow-up activities to help sustain community living.

(i) Referring to a FBDE member's TennCare MCO any FBDE member receiving SNF services that may be a candidate for transition to the community and coordinating with the FBDE member's TennCare MCO to facilitate timely transition, as appropriate, including coordination of services covered by the Contractor and services covered only by the TennCare MCO.

(j) Including as part of the Contractor's SNP Model of Care, training for staff and providers regarding the following:

(1) The Contractor's responsibility for coordination of Medicare and Medicaid benefits for FBDE members;

(2) The Contractor's policies and processes for coordination of Medicare and Medicaid benefits for FBDE members; and

(3) Benefits covered under the TennCare program, including the CHOICES program.

5. The following are added as Contract sections A.2.b.9 through A.2.b.11.

9. The Contractor shall develop policies and procedures for coordination of Medicare and Medicaid benefits for FBDEs and shall submit such policies and procedures to TennCare for review and written approval prior to implementation. The Contractor's policies and procedures must be approved and implemented prior to January 1, 2013. The Contractor's operations shall be subject to onsite review, observation and audit by TennCare to confirm the Contractor's compliance with approved policies and procedures regarding coordination of Medicare and Medicaid benefits and the terms of this Contract.

10. The Contractor shall submit to TennCare annual HEDIS (Healthcare Effectiveness Data and Information Set), CAHPS (Consumer Assessment of Healthcare Providers and Systems) and HOS (Medicare Health Outcomes Survey) data and shall make available to TennCare upon request all information regarding the Contractor's performance for the D-SNP plan, including (but not limited to) HEDIS, CAHPS, and HOS data, Medicare Advantage Star Quality ratings, including poor performing icons, notices of non-compliance, audit findings and corrective action plans.

11. The Contractor shall participate in meetings as requested by TennCare to discuss the program and its operations, and to address performance issues and concerns. The Contractor shall be required to have appropriate staff member(s) attend certain on-site meetings held at TennCare offices or at other sites as requested and designated by TennCare.

6. Contract section A.2.c.1(b) is deleted in its entirety and replaced with the following:

(b) Encounter data for any and all claims, including Part D claims to the extent the Contractor has access to such information and including claims with no patient liability. Encounter data submissions shall be in accordance with the following:

(1) The Contractor's systems are required to conform to HIPAA-standard transaction code sets as specified in the HIPAA Implementation and TennCare Companion guides.

(2) The Contractor shall submit encounter data that meets established TennCare data quality standards. These standards are defined by TennCare to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. TennCare will revise and amend these standards as necessary to ensure continuous quality improvement. The Contractor shall make changes or corrections to any systems, processes or data

transmission formats as needed to comply with TennCare data quality standards as originally defined or subsequently amended. The Contractor shall comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim. In the event that the Contractor denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the Contractor shall submit all available claim data to TennCare without alteration or omission. Where the Contractor has entered into capitated reimbursement arrangements with providers, the Contractor must require submission of all utilization or encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims; the Contractor shall require this submission from providers as a condition of the capitation payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data. The Contractor shall be required to submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by TennCare, in order to support comprehensive financial reporting and utilization analysis. The Contractor must submit encounter data according to standards and formats as defined by TennCare, complying with HIPAA standard code sets and maintaining integrity with all reference data sources, including provider and member data. All encounter data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates shall be rejected and returned to the Contractor for immediate correction.

(3) TennCare shall reject or report individual claims or encounters failing certain edits, as deemed appropriate and necessary by TennCare, to ensure accurate processing or encounter data quality, and shall return these transactions to the Contractor for research and resolution. TennCare shall require expeditious action on the part of the Contractor to resolve errors or problems associated with said claims or the adjudication thereof, including any necessary changes or corrections to any systems, processes or data transmission formats. Generally the Contractor shall, unless otherwise directed by TennCare, address ninety percent (90%) of reported errors within thirty (30) calendar days and address ninety-nine percent (99%) of reported errors within sixty (60) calendar days. Such errors will be considered acceptably addressed when the Contractor has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute. TennCare may require resubmission of the transaction with reference to the original in order to document resolution.

(4) Within two (2) business days of the end of a payment cycle, the Contractor shall generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the Contractor has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.

(5) Any encounter data from a subcontractor shall be included in the file from the Contractor. The Contractor shall not submit separate encounter files from subcontractors.

(6) The files shall contain settled claims and claim adjustments, including, but not limited to, adjustments necessitated by payment errors processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the Contractor has a capitation arrangement.

(7) The level of detail associated with encounters from providers with whom the Contractor has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the Contractor received and settled a fee-for-service claim.

(8) The Contractor shall adhere to federal payment rules and regulations in the definition and treatment of certain data elements, e.g., units of service, that are HIPAA-standard fields in the encounter data submissions.

(9) The Contractor shall provide encounter data files electronically to TennCare in adherence to the procedure and format indicated in the HIPAA Implementation and TennCare Companion guides.

(10) The Contractor shall institute processes to ensure the validity and completeness of the data it submits to TennCare. At its discretion, TennCare shall conduct general data validity, integrity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include, but are not limited to: member ID, date of service, provider ID (including NPI number and Medicare I.D. Number), category and subcategory (if applicable) of service, diagnosis codes, procedure codes and modifiers, revenue codes, adherence to benefit limits, date of claim processing and, date of claim payment. Control totals shall also be reviewed and verified.

(11) Encounter records shall be submitted such that payment for discrete services that may have been submitted in a single claim can be ascertained in accordance with the Contractor's applicable reimbursement methodology for that service.

(12) The Contractor shall be able to receive, maintain and utilize data extracts from TennCare and its contractors, e.g., pharmacy data from TennCare or its pharmacy benefit manager (PBM).

7. The following is added as Contract section A.2.c.3.

3. The Contractor shall receive, process, update, and submit all applicable outbound and/or inbound eligibility, enrollment, and ancillary/supplemental files sent by TennCare in a TennCare prescribed HIPAA-compliant format and a frequency that shall be established and required by TennCare. In addition, the Contractor shall meet the following requirements:

(a) The Contractor shall update its eligibility/enrollment databases, including, but not limited to, MCO assignment within twenty-four (24) hours of receipt of said files.

(b) The Contractor shall transmit to TennCare, in the formats and methods specified in the HIPAA Implementation and TennCare Companion guides, or as otherwise specified by TennCare, member address changes, telephone number changes, and primary care provider (PCP).

(c) The Contractor shall be capable of uniquely identifying a distinct TennCare member across multiple populations and systems within its span of control.

(d) The Contractor shall be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by TennCare, and resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

(e) The Contractor shall be responsible for establishing connectivity to TennCare's/the state's wide area data communications network, and the relevant

information systems attached to this network, in accordance to all applicable TennCare and/or state policies, standards and guidelines.

(f) The Contractor's systems shall be able to transmit, receive and process data in HIPAA-compliant or TennCare -specific formats and methods, including, but not limited to, Secure File Transfer Protocol (SFTP) over a secure connection such as a VPN, that are in use at the start of systems readiness review activities. These formats are detailed in the HIPAA Implementation and TennCare Companion guides.

(g) In the event of a declared major failure or disaster, the Contractor's core eligibility/enrollment/encounter or other systems that interact with TennCare shall be back online within seventy-two (72) hours of the event.

(h) Regardless of the architecture of its systems, the Contractor shall develop and be continually ready to invoke a BC-DR (Business Continuity/Disaster Recovery) plan that is reviewed and prior approved in writing by TennCare.

(i) The Contractor shall cooperate in a "readiness review" conducted by TennCare to review the Contractor's IT readiness for electronic data interchange. This review may include, but is not limited to, on-site review of the Contractor's systems, a system demonstration (including systems connectivity testing), and other readiness review components as determined by TennCare.

(j) The Contractor shall also work with TennCare pertaining to any testing initiative as required by this Contract, including providing sufficient systems access to allow testing by TennCare of the Contractor's systems during readiness review.

(k) In the event that reports are required, the Contractor shall comply with all the reporting requirements established by TennCare. TennCare shall provide the Contractor with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required. TennCare may, at its discretion, change the content, format or frequency of reports.

(l) TennCare may, at its discretion, require the Contractor to submit additional reports both ad hoc and recurring. If TennCare requests any revisions to the reports already submitted, the Contractor shall make the changes and re-submit the reports, according to the time period and format required by TennCare.

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

1.The Contractor warrants to TennCare 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:

a. Compliance with the Privacy Rule, Security Rule, and Notification Rule;
b. The creation of and adherence to sufficient Privacy and Security Safeguards and Policies;
c. Timely Reporting of Violations in the Access, Use and Disclosure of PHI;
d. Timely Reporting of Privacy and/or Security Incidents; and

e. Failure to comply may result in actual damages that TennCare incurs as a result of the breach and liquidated damages as set forth in this Contract.

2. The Contractor warrants that it shall cooperate with TennCare, including cooperation and coordination with TennCare privacy officials and other compliance officers required by HIPAA and HITECH and their accompanying regulations, in the course of performance of this Contract so that both parties shall be in compliance with HIPAA and HITECH.

3. TennCare and the Contractor shall sign documents, including, but not limited to, business associate agreements, as required by HIPAA and HITECH, that are reasonably necessary to keep TennCare and the Contractor in compliance with HIPAA and HITECH.

4. As a party to this Contract, the Contractor hereby acknowledges its designation as a covered entity and/or business associate under the HIPAA regulations and agrees to comply with all applicable HIPAA and HITECH (hereafter HIPAA/HITECH) regulations.

5. In accordance with HIPAA/HITECH regulations, the Contractor shall, at a minimum:

a, Comply with requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), including, but not limited to, the transactions and code sets, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data sharing agreements required under the regulations;

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

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

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

e. Report to TennCare's Privacy Office immediately upon becoming aware of any use or disclosure of PHI in violation of this Contract by the

Contractor, its officers, directors, employees, subcontractors or agents or by a third party to which the Contractor disclosed PHI;

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

g. Make available to TennCare enrollees the right to amend their PHI in accordance with the federal HIPAA regulations. The Contractor shall also send information to enrollees educating them of their rights and necessary steps in this regard;

h. Make an enrollee's PHI accessible to TennCare immediately upon request by TennCare;

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

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

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

2. If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of an any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of this Contract, and in accordance with this Section of this Contract. The Contractor shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of this Contract. The Contractor shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of this Contract, the Contractor shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which cannot feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;

3. Implement all appropriate administrative, physical and technical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Contract and, including, but not limited to, privacy, security and confidentiality requirements in 45 CFR Parts 160 and 164;

4. Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;

5. Create and implement policies and procedures to address present and future HIPAA/HITECH regulatory requirements as needed,

including, but not limited to: use and disclosure of data; de-identification of data; minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint;

6. Provide an appropriate level of training to its staff and employees regarding HIPAA/HITECH-related policies, procedures, enrollee rights and penalties prior to the HIPAA/HITECH implementation deadlines and at appropriate intervals thereafter;

7. Track training of Contractor's staff and employees and maintain signed acknowledgements by staff and employees of the Contractor's HIPAA/HITECH policies;

8. Be allowed to use and receive information from TennCare where necessary for the management and administration of this Contract and to carry out business operations where permitted under the regulations;

9. Be permitted to use and disclose PHI for the Contractor's own legal responsibilities;

10. Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by Contractor's employees and other persons performing work for the Contractor to have only minimum necessary access to PHI and personally identifiable data within their organization;

11. Continue to protect and secure PHI AND personally identifiable information relating to enrollees who are deceased;

12. Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations;

13. Make available PHI in accordance with 45 CFR 164.524;

14. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR 164.526; and

15. Obtain a third (3rd) party certification of their HIPAA transaction compliance ninety (90) calendar days before the start date of operations.

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

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

m. NOTIFICATION OF BREACH & NOTIFICATION OF PROVISIONAL BREACH. The Contractor shall notify TennCare's Privacy Office immediately upon becoming aware of any incident, either confirmed or provisional, that represents or may represent unauthorized access, use or disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained or held by the Contractor, including any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the Contractor's system. This includes, but is not limited to, loss or suspected loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and/or disks.

(n) Social Security Administration (SSA) Required Provisions for Data Security:

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

2. The Contractor shall not duplicate in a separate file or disseminate, without prior written permission from TennCare the data governed by this Contract for any purpose other than that set forth in this Contract for the administration of the TennCare program. Should the Contractor propose a redisclosure of said data, the Contractor must specify in writing to TennCare the data the Contractor proposes to redisclose, to whom, and the reasons that justify the redisclosure. TennCare will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.

3. The Contractor agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.

4. The Contractor shall provide a current list of the employees of such Contractor with access to SSA data and provide such lists to TennCare.

5. The Contractor shall restrict access to the data obtained from TennCare to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Contract. The Contractor shall not further duplicate, disseminate, or disclose such data without obtaining TennCare's prior written approval.

6. The Contractor shall ensure that its employees:

   i. Properly safeguard PHI/PII furnished by TennCare under this Contract from loss ,theft or inadvertent disclosure;

   ii. Understand that they are responsible for safeguarding this information at all times, regardless of whether or not the Contractor's employee is at his or her regular duty station;

   iii. Ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;

   iv. Send emails containing PHI/PII only if encrypted or if to and from addresses that are secure; and

   v. Limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

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

vii. Loss or Suspected Loss of Data – If an employee of the Contractor becomes aware of suspected or actual loss of PHI/PII, he or she must immediately contact TennCare's Privacy Office **within one (1) hour** to report the actual or suspected loss. The Contractor will use the Loss Worksheet located at http://www.tn.gov/tenncare/forms/phi_piiworksheet.pdf to quickly gather and organize information about the incident. The Contractor must provide TennCare's Privacy Office with timely updates as any additional information about the loss of PHI/PII becomes available.

viii. If the Contractor experiences a loss or breach of said data, TennCare's Privacy Office, in its sole discretion, will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the Contractor shall bear any costs associated with the notice or any mitigation.

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

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

- Sections 1137, 453, and 1106(b) of the Social Security Act (the Act) (42 U.S.C. §§ 1320b-7, 653and 1306(b)) (income and eligibility verification data);

- 26 U.S.C. § 6103(l)(7) and (8) (tax return. data);

- Section 202(x)(3)(B)(iv) of the Act (42 U.S.C. § 401(x)(3)(B)(iv))(prisoner data);

- Section 205(r)(3) of the Act (42, U.S.C. § 405(r)(3)) and Intelligence Reform and Terrorism Prevention Act of 2004, Pub. L. 108-458, 7213(a)(2) (death data);

- Sections 402, 412, 421, and 435 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104-193) (8 U.S.C. §§ 1612, 1622, 1631, and 1645) (August 22, 19960 (quarters of coverage data);

- Children's Health Insurance Program Reauthorization Act of 2009, (Pub. L. 111-3) (February 4, 2009) (citizenship data); and

- Routine use exception to the Privacy Act, 5 U.S.C. § 552a(b)(3)(data necessary to administer other programs compatible with SSA programs).

- This Section further carries out Section 1106(a) of the Act (42 U.S.C. § 1306), the regulation promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. §

3541 *et seq.),* and related National Institute of Standards and Technology ("NIST") guidelines, which provide the requirements that the CONTRACTOR must follow with regard to use, treatment, and safeguarding data.

(o) For any medical records or other health and enrollment information it maintains with respect to enrollees, an MA organization must establish procedures to do the following:

1. Abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. The MA organization must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify--

a. For what purposes the information will be used within the organization; and

b. To whom and for what purposes it will disclose the information outside the organization.

2. Ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

3. Maintain the records and information in an accurate and timely manner.

4. Ensure timely access by enrollees to the records and information that pertain to them.

(p) Ensure that medical information is released only in accordance with applicable Federal or State law, or under court orders or subpoenas.

(q) Maintain the records and information in an accurate and timely manner.

(r) Ensure timely access by enrollees to the records and information that pertain to them

8. Contract section A.2.e is deleted in its entirety and replaced with the following:

e. **Provider Network Information.**

The Contractor shall submit a monthly Provider Enrollment File report that includes information on all providers of the SNP Plan's covered health benefits. This includes but is not limited to, PCPs, physician specialists, hospitals and home health agencies. The report shall include contract providers as well as all non-contract providers with whom the Contractor has a relationship. This list need not include retail pharmacies. The Contractor shall submit this report by the 5th of each month. Each monthly Provider Enrollment File shall include information on all providers of health benefits and shall provide a complete replacement for any previous Provider Enrollment Files submission. Any changes in the provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file. The provider network information shall be updated regularly as specified by TennCare. Contractor will contact TennCare's Office of Provider Networks for the proper format for the submission.

The Contractor shall develop a network of providers that specifically targets overlap of providers in its network with providers that are also enrolled with one or more TennCare MCOs in order to ensure seamless access to care for FBDE members across the Medicare and Medicaid programs.

The Contractor shall not enter into contracts with any providers for the delivery of services to FBDE members which contain clauses or payment methodologies that have the explicit intent or implicit effect of limiting the provider's participation in any TennCare demonstration for FBDEs or the TennCare program.

9. The following is added as Contract section A.2.g:

   g. The Contractor shall, upon prior review and approval by the Centers for Medicare and Medicaid Services (CMS), submit to TennCare for review and prior written approval, all marketing materials, items, layouts, plans, etc. that will be distributed directly or indirectly to FBDE members or potential FBDE members for the purposes of soliciting and/or maintaining enrollment in the Contractor's plan. The Contractor shall include in its submission, documentation of CMS approval of such materials, items, layouts, plans, etc. The Contractor shall be strictly prohibited from using any eligibility or enrollment information that has been provided by TennCare for purposes of care coordination for any marketing activities or to solicit additional members for enrollment in its D-SNP.

10. The following is added as Contract section A.2.h.

    h. The Contractor shall transmit crossover or claims for Medicare co-pays or deductibles electronically to TennCare by January 1, 2013 in a compliant format approved by TennCare.

11. Contract section A.3.a. is deleted in its entirety and replaced with the following:

    a. **TennCare's Cost Sharing Obligations.** Federal law imposes certain cost sharing responsibilities on TennCare for its Dual Eligible members. These cost sharing obligations include costs for premiums, deductibles and co-insurance or co-payment amounts. For FBDE members not enrolled in the PACE Program or an integrated dual demonstration for FBDEs, TennCare shall continue to make these payments directly to the federal government (in the case of premiums) or providers (in the case of deductibles or coinsurance) in accordance with federal law, the TennCare State Plan and TennCare Rules. No payments of these sums shall be made to the Contractor. Any of the Contractor's subcontractors or providers who attempt to file claims for co-payments or co-insurance allowed by law shall be required to become registered TennCare providers, according to the procedures developed by TennCare. These procedures may be found on the TennCare website. The Plan will notify its network providers that they shall not bill enrollee's for benefits provided, unless direct billing is permitted under State and Federal law. The Contractor shall notify its network providers and shall specify in provider agreements a requirement that providers shall not bill FBDE members for covered Medicare benefits provided, except in accordance with State and Federal law. The Contractor shall coordinate with TennCare or a FBDE member's TennCare MCO to promptly address any instance where the Contractor's provider is billing a FBDE member for covered Medicare benefits.

12. Contract section A.3.b. is deleted in its entirety and replaced with the following:

    b. **Coordination of Care**. Every TennCare FBDE member is enrolled in a TennCare MCO. TennCare shall provide the Contractor with the contact information of a FBDE member's MCO as requested by the Contractor. The member's MCO is the primary source for provision of TennCare benefits. Upon implementation of the data interface as specified in Section A.2.c.3., TennCare will provide each FBDE member's TennCare MCO enrollment information via the data interface.

13. Contract section A.3.c. is deleted in its entirety and replaced with the following:

c. **Eligibility Data.** TennCare shall make all reasonable efforts to supply Medicaid eligibility information upon the receipt of the request from the Contractor using a "realtime" access method chosen from the options described below. The Contractor shall pay for access and use of this data, according to the option chosen in Section C, Payment Terms and Conditions:

TNAnytime Online: Access to TennCare's Eligibility Information may be achieved through a user interface and socket program, and the sole charge is an annual user access fee for a premium services subscription. This method only processes a request for one (1) individual at a time.

TNAnytime Batch: Access to TennCare's Eligibility Information may be achieved through a batch interface and Secure Socket Layer or similar encryption method. The user is charged a setup fee (for transaction testing), a per transaction fee, and an annual user access fee for a premium services subscription. This method can process requests for many individuals at once. The State shall provide the response within twenty four (24) hours of the request.

The choice of method shall be binding for the term of this Contract from signing by both parties, unless TennCare agrees to allow a mid-term change. Such agreement shall not be unreasonably withheld. In the event of such a change, the Contractor shall agree to abide by all timelines, testing procedures and any other requirements mandated by TennCare to make the changeover.

Once data interface as specified in Section A.2.c.3. is tested and approved by TennCare for implementation, the Contractor shall no longer rely on TNAnytime for access to eligibility data. The data shall be submitted by TennCare and loaded by the Contractor.

14. The following is added as Contract section A.3.e.

e. TennCare shall review and approve or deny the Contractor's marketing materials within fifteen (15) calendar days of receipt.

15. Attachment D, TennCare Covered Benefits, is added to this Contract.

16. Attachment E, Liquidated Damages, is added to this Contract.

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 July 1, 2012. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

CARITEN HEALTH PLAN, INC.

Douglas E Hoaland 6/21/2012

SIGNATURE **DATE**

DOUGLAS E. HAALAND, MARKET PRESIDENT

PRINTED NAME AND TITLE OF SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE:

Mark A. Emkes/cp 6/21/12

Mark A. Emkes, Commissioner **DATE**

ATTACHMENT D

TennCare Covered Benefits

The benefits available to TennCare enrollees are listed in the TennCare Rules for TennCare Medicaid and TennCare Standard and are available on the Bureau's website. Definitions of specific services and services that are excluded from coverage are also listed in the rules. These rules should be consulted for information on particular limitations and coverage details. *Reference: See TennCare Rules 1200-13-13-.04 and 1200-13-14-.04 (Covered Services) and TennCare Rules 1200-13-13-.10 and 1200-13-14-.10 (Exclusions).*

TennCare benefits include, but are not limited to, the following:

- Community health services
- Dental services (for children under age 21)
- Durable medical equipment
- Emergency air and ground transportation services
- EPSDT services for TennCare Medicaid-eligible children under age 21; preventive, diagnostic, and treatment services for TennCare Standard-eligible children under age 21
- Home health care[1]
- Hospice care
- Inpatient and outpatient substance abuse benefits
- Inpatient hospital services
- Lab & X-ray services
- Medical supplies
- Mental health case management
- Mental health crisis services
- Non-emergency transportation services
- Occupational therapy
- Organ and tissue transplant services and donor organ/tissue procurement services
- Outpatient hospital services
- Outpatient mental health services
- Pharmacy services
- Physical therapy services
- Physician services
- Private duty nursing services[15]
- Psychiatric inpatient facility services
- Psychiatric rehabilitation services
- Reconstructive breast surgery
- Renal dialysis clinic services
- Speech therapy services

• Vision services (for children under age 21)

Additional benefits are covered for children under 21 as medically necessary.

[1] Home health benefits are limited for adults as follows: Part-time or intermittent nursing services must be no more than 1 visit/day, lasting less than 8 hours, and no more than 27 total hours of nursing care per week. Part-time or intermittent nursing services are not covered if the only skilled nursing function is administration of medication on an as needed basis. Home health aide services must be provided at no more than 2 visits/day, with care provided less than or equal to 8 hours/day. Nursing services and home health aide services combined must total less than or equal to 8 hours/day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 nursing care. See TennCare Medicaid rule 1200-13-13-.01 and TennCare Standard rule 1200-13-14-.01.

LIQUIDATED DAMAGES

Liquidated damages for Contractor's failure, or Contractor's subcontractors or providers failure, to perform the specific responsibilities and requirements described in Contract sections A.2.c.1(b) and A.2.c.3 relating to HIPAA, HITECH and the security of SSA data are set forth below. These liquidated damages may be assessed in TennCare's sole discretion, in addition to, or in lieu of, any or all actual damages permitted under State or Federal law.

1	Failure by the Contractor to ensure that all TennCare data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of TennCare enrollee PHI (See also ancillary Business Associate Agreement between the parties)		$500 per enrollee per occurrence, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those TennCare enrollees whose PHI was placed at risk by Contractor's failure to comply with the terms of this Agreement, the Contractor shall be liable for all costs associated with the provision of such monitoring and/or safeguard services
2	Failure by the Contractor to execute the appropriate agreements to effectuate transfer and exchange of TennCare enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party (See ancillary Business Associate Agreement between the parties)		$500 per enrollee per occurrence

3	Failure by the Contractor to seek express written approval from TENNCARE prior to the use or disclosure of TennCare enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States (See ancillary Business Associate Agreement between the parties)		$1,000 per enrollee per occurrence
4	Failure by the Contractor to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach (See also ancillary Business Associate Agreement between the parties)		$500 per enrollee per occurrence, not to exceed $10,000,000

CONTRACT

(state revenue contract, from which the state receives monetary compensation, with an individual, business, non-profit, or government entity of another state or country)

State Agency Tracking #	Contract #
31865-00316	DR-11-32647-00-316

Contract Party (legal entity name)	Federal Employer Identification or Social Security #
Cariten Health Plan, Inc.	☐ C- or ☒ V- 62 1579044

Contract Begin Date	Contract End Date	Service
June 30, 2011	December 31, 2013	Special Needs Plan (SNP) for Medicare/Medicaid Dual Eligible Enrollees

— OCR Use —

Agency Contact & Telephone #

Scott Pierce
615-507-6415

Speed Code	Account Code

Contract Party Selection Method

☐ RFP ☐ Competitive Negotiation * ☐ Alternative Competitive Method *

☐ Non-Competitive Negotiation * ☒ Other *

*** Contract Party Selection Process Summary**

The Contractor has entered into an agreement with the Centers for Medicare and Medicaid Services (CMS) to provide Special Needs Plan (SNP) services to Medicare/Medicaid Dual Eligible enrollees. The State of Tennessee and SNP providers are obligated under the Medicare Improvement for Patients and Providers Act of 2008 to enter into an agreement to provide Medicaid benefits to the Dual Eligible enrollees.

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
CARITEN HEALTH PLAN, INC.

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the "State" and Cariten Health Plan, Inc., hereinafter referred to as the "Procuring Party" or "Contractor" is for the operation of a Medicare Advantage Plan, as further defined in the "SCOPE OF SERVICES."

The Procuring Party is a for profit corporation.
Procuring Party Federal Employer Identification or Social Security Number: 62-1579044
Procuring Party Place of Incorporation or Organization: Tennessee

WHEREAS, the Bureau of TennCare administers the Medicaid program in the State of Tennessee under Title XIX of the Social Security Act under the terms of the Tennessee State Medical Assistance Plan and the TennCare II Section 1115 research and demonstration waiver; and

WHEREAS, the Contractor has entered into a contract ("MA Agreement") with the Centers for Medicare and Medicaid Services ("CMS") to provide a Medicare Advantage Plan, that is a Special Needs Plan ("SNP") for Dual Eligibles; and

WHEREAS, under the Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") and resulting regulations, CMS requires the SNP provider to enter into an agreement with the State to provide or arrange for Medicaid benefits to be provided to its Dual Eligible enrollees.

NOW THEREFORE, in order to assure the efficient implementation and operation of the above described program, TennCare and the Contractor agree to the follow terms.

A. SCOPE OF SERVICES:

A.1. DEFINITIONS: The following terms are defined for purposes of this Contract only:

a. Confidential Information - Any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is supplied by TennCare to the Contractor under this Contract. Any information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, relating to individuals enrolled in the TennCare program ("TennCare enrollees"), or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained through the Contractor's performance under this Contract, shall also be treated as "Confidential Information" to the extent that confidential status is afforded such information under state and federal laws or regulations. All confidential information shall not be subject to disclosure under the Tennessee Public Records Act.

b. Cost Sharing Obligations - Medicare deductibles, premiums, co-payments and coinsurance that TennCare is obligated to pay for certain Medicare beneficiaries (QMBs, SLMB-Plus's, and Other Medicare/Medicaid Dual Eligibles). For SLMB-Plus's and Other Medicare/Medicaid Dual Eligibles, TennCare is not required to pay Medicare coinsurance on those Medicare services that are not covered by TennCare unless the enrollee is a child under 21 or an SSI beneficiary. No Plan can impose cost sharing obligations on its members which would be greater than those that would be imposed on the member if they were not a member of the Plan.

c. Dual Eligible - As used in this Contract, a Medicare enrollee who is also eligible for TennCare and for whom TennCare has a responsibility for payment of Medicare Cost

Sharing Obligations under the State Plan. For purposes of this Contract, Dual Eligibles are limited to the following categories of recipients: QMB Only, QMB Plus, SLMB Plus, and Other Full Benefit Dual Eligible ("FBDE").

d. Dual Eligible Member - An enrollee who is Dual-Eligible and is enrolled in a Plan.

e. Encounter - A Medicare Part C covered service or group of covered services, as defined by the MA-SNP Agreement, delivered by a health care service provider to a Dual Eligible Member during a visit between the Dual Eligible Member and health care service provider.

f. Encounter Data - In the context of the MA Agreement, data elements from an Encounter service event for a fee-for-service claim or capitated services proxy claim.

g. Full Benefit Dual Eligible (FBDE) - An individual who is eligible both for Medicare Part A and/or Part B benefits and for TennCare benefits [services], including those who are categorically eligible and those who qualify as medically needy under the State Plan.

h. MA Agreement - The Medicare Advantage Agreement between the Contractor and CMS to provide Medicare Part C and other health plan services to the Contractor's members.

i. Marketing - Shall have the meaning established under 45 CFR § 164.501 and includes the act or process of promoting, selling, leasing or licensing any TennCare information or data for profit without the express written permission of TennCare.

j. Qualified Medicare Beneficiary (QMB) - An individual who is entitled to Medicare Part A, who has income that does not exceed one hundred percent (100%) of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid Payment of Medicare Premiums, Deductibles, Coinsurance, and Co-payments (except for Medicare Part D). Collectively, these benefits [services] are called "QMB Medicaid Benefits [Services]." Categories of QMBs covered by this Contract are as follows:

k. QMB Only – QMBs who are not otherwise eligible for full Medicaid.

l. QMB Plus – QMBs who also meet the criteria for full Medicaid coverage and are entitled to all benefits [services] under the State Plan for fully eligible Medicaid recipients.

m. Specified Low-Income Medicare Beneficiary (SLMB) PLUS - An individual entitled to Medicare Part A who has income that exceeds 100% FPL but less than 120% FPL, and whose resources do not exceed twice the SSI limit, and who also meets the criteria for full Medicaid coverage. Such individuals are entitled to payment of the Medicare Part B premium, as well as full State Medicaid benefits.

n. Special Needs Plan (SNP) or Plan - A type of Medicare Advantage plan that also incorporates services designed for a certain class of members. In the case of this Contract the special class of members are persons who are both Medicare and Medicaid Dual eligible. These plans must be approved by CMS. A SNP plan may also provide Medicare Part D drug coverage.

o. State Plan - The program administered by TennCare pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

p. Subcontract - An agreement between the MA Health Plan and a third party under which the third party agrees to accept payment for providing health care services for the MA Health Plan's members.

q. Subcontractor - A third party with which the MA Health Plan has a subcontract.

r. TennCare - The medical assistance program administered by Tennessee Department of Finance and Administration, Bureau of TennCare pursuant to Title XIX of the Social Security Act, the Tennessee State Plan, and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

s. TennCare MCO - A Managed Care Organization (MCO) under contract with the State to provide TennCare benefits.

A.2. CONTRACTOR'S RESPONSIBILITIES:

a. **Service Area.** The Plan shall specify its service area as Statewide, a specific Grand Region or regions of the state, or other specific geographic criteria (i.e., specific counties or metropolitan areas). The service area for this contract shall be the following counties:

Anderson, Blount, Bradley, Campbell, Carter,Claiborne, Cocke, Cumberland, Davidson, Fayette, Grainger, Greene, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, McMinn, Marion, Meigs, Monroe, Morgan, Polk, Putnam, Rhea, Roane, Rutherford, Scott, Sevier, Shelby, Sullivan, Tipton, Unicoi, Union, Washington, Williamson and Wilson.

b. **Benefits.**

1. TennCare uses a modified MCO system to provide TennCare benefits to TennCare enrollees. Each TennCare member is enrolled in an MCO. There are carve-outs for retail pharmacy services and dental services as applicable. It is the understanding of the Parties that any benefits provided by the Plan, even if they are also covered benefits under TennCare, are provided pursuant to the understanding between the Plan and the member. TennCare shall not be responsible for payment for these benefits, nor shall TennCare be responsible for ensuring the availability or quality of these benefits. TennCare will pay the appropriate cost sharing for these services as mandated by Federal law and TennCare rules.

2. The Contractor shall provide all of the benefits listed in its SNP to all Dual Eligible members who meet the eligibility requirements of the Plan, qualify for any such benefits, and have elected to enroll in the Plan to receive such benefits.

3. The Contractor shall provide the Summary of Benefits to its members as detailed in Attachment A.

4. The Contractor shall provide a copy of the Summary of Benefits as approved by CMS at the beginning of each Plan year. The Contractor should consult TennCare Rule 1200-13-13-04 and the TennCare website under Members: Benefits-Covered Services for a comprehensive list of covered TennCare benefits and the fit between Medicare and TennCare coverage. Further, to the extent necessary, the State will provide the Plan with information regarding Medicaid benefits in order for the Plan to meet CMS requirements for the Statement of Benefits.

5. The Contractor shall refer a Dual Eligible Member who is a QMB Plus or other FBDE to the member's TennCare MCO for the provision of TennCare benefits that are not covered by the Plan.

6. The Contractor will be responsible for providing care coordination for all services, whether Medicare or Medicaid, provided under its plan. The member's MCO is the primary source for provision of TennCare benefits not covered by the Contractor. The State shall provide each TennCare MCO with a copy of the Summary of Benefits for each Plan as approved by CMS so that MCO care coordinators will have expertise in dealing with coordination issues that might exist between the Contractor and a member's MCO. The Contractor is responsible for ensuring that the MCO SNP coordination specialist is made aware of the needs of the enrollee. The Contractor can meet its responsibilities under this section by 1) creating an in-person telephone referral or "warm transfer" to the MCO specialist, or 2) by having the Contractor's care coordinator speak directly to the MCO's SNP specialist on behalf of the enrollee if that is the enrollee's request.

7. In the event a specific benefit is covered by both the Plan and TennCare, TennCare shall be the payor of last resort.

8. The Contractor agrees to include the disclaimer set out below either annually in a written notice or on any marketing materials concerning benefits sent to members in order to reduce any potential confusion between the scope of the Plan and the scope of the members TennCare benefits.

Notice: TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits.

c. **Data.**

1. The Contractor shall submit to TennCare, in a mutually agreed upon electronic format, the following data:

   (a) Plan eligibility information, consisting of Dual Eligible Members currently enrolled in the SNP and including any third party liability information.

   (b) Encounter data for any and all claims, including Part D claims to the extent the Contractor has access to such information and including claims with no patient liability. Such encounter data will be limited to non-financial information for the purpose of State payment of crossover claims, coordination of benefits, and quality improvement.

2. This information will be submitted on a schedule agreed to by both parties and will be provided at no cost to TennCare. TennCare shall use this information to fulfill its crossover claims payment function, to coordinate care for its Dual Eligible Members and for purposes of monitoring fraud and abuse as required by federal and state law. Information submitted under this provision will be considered non-public information.

d. **Eligibility.**

1. The following classes of members or categories of eligibility for participation in the Plan:

   X QMB –Only
   X QMB- Plus
   X SLMB Plus
   X Full Benefit Dual Eligibles

2. Medicaid Eligibility data shall be made available to the Contractor by TennCare (see A. 3) only for purposes of serving individuals who have either:
   (a) Affirmed in writing, for example, by completion of a SNP enrollment application by letter, email or facsimile of the intention to join the Plan and whose TennCare eligibility category needs to be verified before the individual may be enrolled in the Plan; or

   (b) Members already enrolled in the Plan whose TennCare eligibility needs to be confirmed for: 1) renewal of a contract term, 2) verification of continuing membership on a periodic basis, or 3) before the provision of a benefit.

3. Medicaid Eligibility data shall not be supplied for the purposes of allowing the Plan to market its services to persons who are not members or who have not agreed to become members.

4. Contractor will provide its eligibility information on members of its Plan to TennCare or TennCare's designee at no charge to TennCare.

e. **Provider Network Information.**

The Contractor shall submit a monthly Provider Enrollment File report that includes information on all providers of the Plan's covered health benefits. This includes but is not limited to, PCPs, physician specialists, hospitals and home health agencies. The report shall include contract providers as well as all non-contract providers with whom the Contractor has a relationship. This list need not include retail pharmacies. The Contractor shall submit this report by the 5th of each month. Each monthly Provider Enrollment File shall include information on all providers of health benefits and shall provide a complete replacement for any previous Provider Enrollment Files submission. Any changes in the provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file. The provider network information shall be updated regularly as specified by TennCare. Contractor will contact TennCare's Office of Provider Networks for the proper format for the submission.

f. **Confidentiality, Use and Disclosure of Confidential Information.**

The Contractor shall agree to the attached Business Associate Agreement (Attachment B) and Trading Partner Agreement (Attachment C), governing the use and handling of the data it receives from TennCare under this Contract.

A.3. TENNCARE RESPONSIBILITIES:

a. **TennCare's Cost Sharing Obligations.** Federal law imposes certain cost sharing responsibilities on TennCare for its Dual Eligible members. These cost sharing obligations include costs for premiums, deductibles and co-insurance or co-payment amounts. TennCare shall continue to make these payments directly to the federal government (in the case of premiums) or providers (in the case of deductibles or coinsurance) as required by federal law, the TennCare State Plan and TennCare rules. No payments of these sums shall be made to the Contractor. Any of the Contractor's subcontractors or providers who attempt to file claims for co-payments or co-insurance allowed by law shall be required to become registered TennCare providers, according to the procedures developed by TennCare. These procedures may be found on the TennCare website. The Plan will notify its network providers that they shall not bill enrollee's for benefits provided, unless direct billing is permitted under State and federal law.

b. **Coordination of Care.** Every TennCare Dual Eligible member is enrolled in a TennCare MCO. TennCare shall provide the Contractor with the contact information of a member's MCO as requested by the Contractor. The member's MCO is the primary source for provision of TennCare benefits, referrals and coordination of care. TennCare will provide each member's MCO information in quarterly lists or an annual list supplemented by a monthly report of terminations and changes.

c. **Eligibility Data.** TennCare shall make all reasonable efforts to supply Medicaid eligibility information upon the receipt of the request from the Contractor using a "realtime" access method chosen from the options described below. The Contractor shall pay for access and use of this data, according to the option chosen in Section C, Payment Terms and Conditions

_X_ **TNAnytime Online**: Access to TennCare's Eligibility Information may be achieved through a user interface and socket program, and the sole charge is an annual user access fee for a premium services subscription. This method only processes a request for one individual at a time.

TNAnytime Batch: Access to TennCare's Eligibility Information may be achieved through a batch interface and Secure Socket Layer or similar encryption method. The user is charged a setup fee (for transaction testing), a per transaction fee, and an annual user access fee for a premium services subscription. This method can process requests for many individuals at once. The State will provide the response within 24 hours of the request.

The choice of method shall be binding for the term of this contract from signing by both parties, unless TennCare agrees to allow a mid-term change. Such agreement will not be unreasonably withheld. In the event of such a change, the Contractor shall agree to abide by all timelines, testing procedures and any other requirements mandated by TennCare to make the changeover.

d. **Provider Data.** TennCare will make reasonable commercial efforts to make available its list of TennCare providers to the Contractor upon Contractor's request prior to plan start-up. TennCare will also update the Provider listing on a regular basis.

B. CONTRACT TERM.

This Contract shall be effective for the period commencing on June 30, 2011 and ending on December 31, 2013.

C. PAYMENT TERMS AND CONDITIONS.

The Contractor shall pay the amounts specified below according to the option selected for setup fees and per transaction fees. Payment shall be made by the Contractor within thirty (30) days of receipt of an invoice from TennCare for access to eligibility data. The invoices shall be issued monthly unless the Contractor has specified a service with an annual fee. A decision as to payment methodology (i.e., check, electronic deposit, etc.) shall be made between the parties at the commencement of the Contract term. The Contractor is responsible for all invoices covering access during the term of this Contract even if they are submitted after the Contract has been terminated.

__X__ **TNAnytime Online**: Access to TennCare's Eligibility Information may be achieved through a user interface and socket program, and the sole charge is an annual seventy-five dollar ($75.00) user access fee for a premium services subscription.

____**TNAnytime Batch**: Access to TennCare's Eligibility Information may be achieved through a batch interface and socket program. The user is charged a one thousand dollar ($1,000.00) setup fee (for transaction testing), two cents ($.02) per transaction, and an annual seventy-five dollar ($75.00) user access fee for a premium services subscription. A transaction is a request to check eligibility for one individual.

D. STANDARD TERMS AND CONDITIONS.

D.1. Required Approvals. The State is not bound by this Contract until it is approved by the appropriate State officials in accordance with applicable Tennessee State laws and regulations.

D.2. Modification and Amendment. This Contract may be modified only by a written amendment executed by all parties hereto and approved by the appropriate Tennessee State officials in accordance with applicable Tennessee State laws and regulations.

D.3. Termination for Convenience. The Contract may be terminated by either party by giving written notice to the other, at least sixty (60) days before the effective date of termination. Said termination shall not be deemed a Breach of Contract by the State. Should the State exercise this provision, the State shall have no liability to the Contractor. Should either the State or the Contractor exercise this provision, the Contractor shall be required to compensate the State for satisfactory, authorized services completed as of the termination date and shall have no liability to the State except for those units of service which can be effectively used by the Contractor. 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.

Upon such termination, the Contractor shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

D.4. Termination for Cause. If either party fails to properly perform or fulfill its obligations under this Contract in a timely or proper manner or violates any terms of this Contract, the other party shall have the right to immediately terminate the Contract. The Contractor shall compensate the State for completed services.

D.5. Subcontracting. Neither the Contractor nor the State shall 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 other. If such subcontracts are approved, they shall contain, at a minimum, sections of this Contract below pertaining to "Conflicts of Interest," "Nondiscrimination," and "Records" (as identified by the section headings).

D.6. Conflicts of Interest. The Contractor warrants that no 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 other than as required by Section A. of this Contract.

D.7. Nondiscrimination. The State and the Contractor hereby agree, warrant, and assure 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 State or the Contractor on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.

D.8. Records. The Contractor shall maintain documentation for its transactions with the State under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money paid under this Contract, shall be maintained for a period of three (3) full years from the final date of this Contract and shall be subject to audit, at any reasonable time

and upon reasonable notice, by the state agency, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.9. 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.10. 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.

Claims against the State of Tennessee, or its employees, or injury damages expenses or attorney's fees are heard and determined by the Tennessee Claims Commission or the Tennessee Board of Claims in the manner prescribed by law (*Tennessee Code Annotated*, Sections 9-8-101 *et seq.*, 9-8-301 *et seq.*, and 9-8-401 *et seq.*). Damages recoverable against the State of Tennessee shall be expressly limited to claims paid by the Board of Claims or the Claims Commission pursuant to *Tennessee Code Annotated*, Section 9-8-301 *et seq.*

D.11. State Liability. The State shall have no liability except as specifically provided in this Contract.

D.12. 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.13. State and Federal Compliance. The Contractor and the State shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.

D.14. 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.15. 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.16. 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.17. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

E. SPECIAL TERMS AND CONDITIONS.

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.

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

The State:
Darin Gordon
Bureau of TennCare
310 Great Circle Road
Nashville, Tennessee 37242
615-507-6443 (Phone)
615-741-0882 (Fax)
Darin.j.gordon@tn.gov

The Procuring Party:

Douglas Haaland, Regional President
Cariten Health Plan, Inc.
1420 Centerpoint Blvd.
Knoxville, TN 37932
(865) 470-8401 (Phone)
(865) 470-7472 (Fax)
dhaaland@humana.com

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

E.3 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.4 HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this Contract.

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA.

c. The State and the Contractor will sign documents, including, but not limited to, business associate agreements, as required by HIPAA and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA. This provision shall not apply if information received by the State under this Contract is NOT "protected health information" as defined by HIPAA, or if HIPAA permits the State to receive such information without entering into a business associate agreement or signing another such document.

E.5. HITECH Compliance. HIPAA was amended and enhanced by the Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA). The Grantee shall comply with the obligations under HITECH.

a. The Grantee warrants to the State that it is familiar with the requirements of HITECH and will comply with all applicable HITECH requirements in the course of this Contract.

b. The Grantee warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HITECH in the course of performance of the Contract so that both parties will be in compliance with HITECH.

c. The State and the Grantee will sign documents, including, but not limited to, trading partner agreements, as required by HITECH that are reasonably necessary to keep the State and the Grantee in compliance with HITECH. This provision shall not apply if information received by the parties to the Contract is NOT "protected health information," as defined by HIPAA, and "electronic health record," "personal health record," "PHR-Identifiable Health Information," or "unsecured protected health information" as defined by HITECH; should HITECH permit the parties to receive such information without entering into a trading partner agreement or signing another such document.

E.6. The Contractor will carry adequate liability or other insurance as needed to cover any actual damages incurred by the State as a result of a breach by Contractor of the HIPAA or confidentiality provisions.

E.7. Payments Due Upon Termination. In addition to the terms as set out in Sections C, D.3 and D.4 , upon termination by either party, should there be outstanding payments due to the State as allowed under this Contract, the Contractor shall satisfy any and all payments within 30 (thirty) days after the date of the termination of the Contract. If the State is not satisfied that the Contractor has fulfilled its obligations under this Contract, the State shall follow any and all

recourse available to it under state or federal law for actual monetary damages or liquidated damages.

E.8. The date of termination under D.3 and D.4 may be subject to CMS requirements on Contractor's requirements to notify its beneficiaries in advance of termination. CMS requires the SNP to give 60 days advance notice to its enrollees if the SNP contract is going to be terminated.

IN WITNESS WHEREOF,

CARITEN HEALTH PLAN, INC.

Douglas E Haaland — JUNE 21, 2011

DOUGLAS HAALAND, REGIONAL PRESIDENT — **DATE**

DOUGLAS E. HAALAND

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE:

Mark A Emkes /SY — 6/22/11

MARK A. EMKES, COMMISSIONER — **DATE**

ATTACHMENT A

SUMMARY OF BENEFITS ATTACHED

Tennessee Comprehensive Benefit Chart

IMPORTANT INFORMATION			
	Benefit	**Medicaid**	**Humana Gold Plus**
1	**Premium and Other Important Information**	• Medicaid assistance with premium payment may vary based on your level of Medicaid eligibility.	Covered – plan coverage information will be inserted
2	**Doctor and Hospital Choice** (For more information, see Emergency-#15 and Urgently Needed Care-#16.)	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services. • Members should follow Original Medicare guidelines related to hospital and doctor choice.	Covered – plan coverage information will be inserted
INPATIENT CARE			
3	**Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services)	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
4	**Inpatient Mental Health Care**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
5	**Skilled Nursing Facility (SNF)**	• For duals protected by the State Medicaid	Covered – plan coverage information will

	(in a Medicare-certified skilled nursing facility)	Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	be inserted
6	**Home Health Care** (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
7	**Hospice**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
OUTPATIENT			
8	**Doctor Office Visits**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
9	**Chiropractic Services**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
10	**Podiatry Services**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-	Covered – plan coverage information will be inserted

		payments, and deductibles for Original Medicare covered services.	
11	**Outpatient Mental Health Care**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
12	**Outpatient Substance Abuse Care**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
13	**Outpatient Services/Surgery**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
14	**Ambulance Services** (medically necessary ambulance services)	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
15	**Emergency Care** (You may go to any emergency room if you reasonably believe you need emergency care.)	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted

16	**Urgently Needed Care** (This is NOT emergency care, and in most cases, is out of the service area.)	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
17	**Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/Psychological Services, and more)	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18	**Durable Medical Equipment** (includes wheelchairs, oxygen, etc.)	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
19	**Prosthetic Devices** (includes braces, artificial limbs and eyes, etc.)	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
20	**Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies** (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted

	management training, retinal exam/glaucoma test, and foot exam / therapeutic soft shoes)		
21	**Diagnostic Tests, X-rays, Lab Services, and Radiology Services**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
22	**Cardiac and Pulmonary Rehabilitation Services**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
PREVENTIVE SERVICES			
23	**Preventive Services and Education / Wellness Programs**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
OTHER SERVICES			
24	**Kidney Disease and Conditions**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
25	**Prescription Drugs**	• [$.50 - $3] copayment for Medicaid covered prescription drugs not covered by a Medicare Prescription Drug Plan.	Covered – plan coverage information will be inserted

ADDITIONAL SERVICES			
26	**Dental Services**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
27	**Hearing Services**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
28	**Vision Services**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
29	**Physical Exams**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
30	**Over-the-Counter Items**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
31	**Transportation** (routine)	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays	Covered – plan coverage information will be inserted

		coinsurance, co-payments, and deductibles for Original Medicare covered services.	
32	**Acupuncture**	• For those who meet QMB requirements, Medicaid pays coinsurance, copayments and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted
33	**POS**	• For duals protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, co-payments, and deductibles for Original Medicare covered services.	Covered – plan coverage information will be inserted

Additional Medicaid Covered Services

Duals who meet financial criteria for full Medicaid coverage, may also be eligible to receive all Medicaid services not covered by Medicare. Humana Gold Plus may also offer coverage for these services. The services covered by Medicaid could include:		
PRODUCTS AND DEVICES		
Dentures	• Not covered	See Benefit #30 for Humana Gold Plus Dental Services.
Eyeglasses	• [$0] copayment • Only covered for adults after cataract surgery.	See Benefit #32 for Humana Gold Plus Vision Services.
Prescription Drugs	• [$0.50 - $3] copayment for Medicaid covered prescription drugs not covered by a Medicare Prescription Drug Plan.	See Benefit #29 for Humana Gold Plus Hearing Services.
TRANSPORTATION		
Non-Emergency Medical Transportation Services	• [$0] copayment	See Humana Gold Plus Transportation (Routine) benefit
INPATIENT LONG TERM CARE SERVICES		
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in	• [$0] copayment	Not covered.

Institutions for Mental Diseases (IMD), age 65 and older.		
Inpatient Psychiatric Services, under age 21	• [$0] copayment	See Benefit #4 for Humana Gold Plus Inpatient Mental Health benefit.
Intermediate Care Facility Services for the Mentally Retarded	• [$0] copayment	Not covered.
Nursing Facility Services, other than in an Institution for Mental Diseases	• [$0] copayment	See Benefit #5 for Humana Gold Plus Skilled Nursing Facility benefit.
HOME AND COMMUNITY BASED WAIVER SERVICES		
Duals who meet the financial criteria for full Medicaid coverage, may also be eligible to receive Waiver services. Waiver services are limited to individuals who meet additional waiver eligibility criteria. For information on waiver services and eligibility, contact your MCO.		

The table above reflects Medicaid services available on a fee for service basis for dual eligibles who meet the eligibility requirements for full Medicaid benefits and your Humana Gold Plus (HMO) Special Needs Plan benefits.

Our sources of information for Medicaid benefits include:
The State Medicaid website and Medicaid Benefits by State

ATTACHMENT B

HIPAA BUSINESS ASSOCIATE AGREEMENT

IN COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT ("Agreement") is between **The State of Tennessee, Department of Finance and Administration, Bureau of TennCare** ("TennCare" or "Covered Entity"), 310 Great Circle Road, Nashville, TN 37243 and Cariten Health Plan, Inc. ("Business Associate"), located at 1420 Centerpoint Blvd., Knoxville, TN , including all office locations and other business locations at which Business Associate data may be used or maintained. Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Covered Entity acknowledges that it is subject to 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.

If Business Associate provides services to Covered Entity pursuant to one or more contractual relationships, said Agreements are detailed below and hereinafter referred to as "Service Agreements."

LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT	**Execution Date**
Medicare Advantage Plan	June 30, 2011

In the course of executing Service requests, Contracts, Agreements or Grant Contracts, (Service Agreements) Business Associate may come into contact with, use, or disclose Protected Health Information ("PHI") (defined in Section 1 below). Said Service Agreements are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, D and E, which require Covered Entity to have a written memorandum with each of its Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard PHI and, therefore, execute this Agreement.

1. DEFINITIONS

1.1 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR Parts 160 and 164.

1.2 "Breach of the Security of the [Business Associate's Information] System" shall mean the unauthorized acquisition, including, but not limited to, access to, use, disclosure, modification or destruction, of unencrypted computerized data that materially compromises the security, confidentiality, or integrity of personal information maintained by or on behalf of the Covered Entity under the terms of Tenn. Code Ann. § 47-18-2107 and this Agreement.

1.3 "Commercial Use" means obtaining protected health information with the intent to sell, transfer or use it for commercial, or personal gain, or malicious harm; sale to third party for consumption, resale, or processing for resale; application or conversion of data to make a profit or obtain a benefit contrary to the spirit of this Agreement, including but not limited to presentation of data or examples of data in a conference or meeting setting where the ultimate goal is to obtain or gain new business.

1.4 "Confidential Information" shall mean any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is supplied by TennCare to the Business Associate under this Agreement. Any information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, relating to individuals enrolled in the TennCare program ("TennCare enrollees"), or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained through the Trading Partner's performance under this Agreement, shall also be treated as "Confidential Information" to the extent that confidential status is afforded such information under state and federal laws or regulations. All confidential information shall not be subject to disclosure under the Tennessee Public Records Act.

1.5 "Designated Record Set" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.6 "Electronic Protected Health Information" (ePHI) shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.7 "Encryption" means the process using publicly known algorithms to convert plain text and other data into a form intended to protect the data from being able to be converted back to the original plain text by known technological means.

1.8 "Health Care Operations" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.9 "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.10 "Marketing" shall have the meaning under 45 CFR § 164.501 and the act or process of promoting, selling, leasing or licensing any TennCare information or data for profit without the express written permission of Covered Entity.

1.11 "Privacy Officer" shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1). The Privacy officer is the official designated by a Covered Entity or Business Associate to be responsible for compliance with HIPAA regulations.

1.12 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.13 "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. PHI includes information in any format, including but not limited to electronic or paper.

1.14 "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.

1.15 "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.16 "Security Event" shall mean an immediately reportable subset of security incidents which incident would include:

a) a suspected penetration of Business Associate's information system of which the Business Associate becomes aware but for which it is not able to verify within FORTY-EIGHT (48) HOURS (of the time the Business Associate became aware of the suspected incident) that enrollee PHI or other confidential TennCare data was not accessed, stolen, used, disclosed, modified, or destroyed;

b) any indication, evidence, or other security documentation that the Business Associate's network resources, including, but not limited to, software, network routers, firewalls, database and application servers, intrusion detection systems or other security appliances, may have been damaged, modified, taken over by proxy, or otherwise compromised, for which Business Associate cannot refute the indication within FORTY-EIGHT (48) HOURS of the time the Business Associate became aware of such indication;

c) a breach of the security of the Business Associate's information system(s)(see definition 1.2 above), by unauthorized acquisition, including, but not limited to, access to or use, disclosure, modification or destruction, of unencrypted computerized data and which incident materially compromises the security, confidentiality, or integrity of TennCare enrollee PHI; and/or

d) the unauthorized acquisition, including but not limited to access to or use, disclosure, modification or destruction, of unencrypted TennCare enrollee PHI or other confidential information of the Covered Entity by an employee or authorized user of Business Associate's system(s) which materially compromises the security, confidentiality, or integrity of TennCare enrollee PHI or other confidential information of the Covered Entity.

If data acquired (including but not limited to access to or use, disclosure, modification or destruction of such data) is in encrypted format but the decryption key which would allow the decoding of the data is also taken, the parties shall treat the acquisition as a breach for purposes of determining appropriate response.

1.17 "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information" at 45 CFR Parts 160 and 164, Subparts A and C.

1.18 "Unsecured PHI" shall mean protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Compliance with the Privacy Rule. Business Associate agrees to fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose PHI other than as permitted or required by this Agreement, the Service Agreements, or as Required By Law. In case of any conflict between this Agreement and the Service Agreements, this Agreement shall govern.

2.2 Privacy Safeguards and Policies. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the Service Agreement(s), this Agreement or as Required By Law. This includes the implementation of administrative, physical, and technical safeguards to reasonably and appropriately protect the Covered Entity's PHI against any reasonably anticipated threats or hazards, utilizing the technology commercially available to the Business Associate (See also Section 3.2). The Business Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, procedures, records of training and sanctions of members of its workforce.

2.3 Business Associate Contracts. Business Associate shall require any agent, including a subcontractor, to whom it provides PHI received from, maintained, created or received by Business Associate on behalf of Covered Entity, or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI or other confidential TennCare information, to agree, by written contract with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

2.4 Mitigation of Harmful Effect of Violations. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use

or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.5 Reporting of Violations in Use and Disclosure of PHI. Business Associate agrees to require its employees, agents, and subcontractors to promptly report to Business Associate any use or disclosure of PHI in violation of this Agreement and to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. The Business Associate shall report such violation to Covered Entity within FORTY-EIGHT (48) HOURS of event.

2.6 Access of Individual to PHI and other Requests to Business Associate. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity in order to meet its requirements under 45 CFR § 164.524. If Business Associate receives a request from an Individual for a copy of the individual's PHI, and the PHI is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the individual in a timely manner. If Business Associate receives a request for PHI not in its possession and in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall promptly forward the request to Covered Entity. Business Associate shall then assist Covered Entity as necessary in responding to the request in a timely manner. If a Business Associate provides copies of PHI to the individual, it may charge a reasonable fee for the copies as the regulations shall permit.

2.7 Requests to Covered Entity for Access to PHI. The Covered Entity shall forward to the Business Associate in a timely manner any Individual's request for access to or a copy of their PHI that shall require Business Associate's participation, after which the Business Associate shall provide access to or deliver such information as follows:

a) The Parties understand that if either Party receives a request for access to or copies of PHI from an Individual which the Party may complete with only its own onsite information, the time for such response shall be thirty (30) days, with notification to the Covered Entity upon completion.

b) If Covered Entity does not have the requested PHI onsite and directs Business Associate to provide access to or a copy of his/her PHI directly to the Individual, the Business associate shall have sixty (60) days from the date of the Individual's request to provide access to PHI or deliver a copy of such information to the Individual. The Business Associate shall notify the Covered Entity when it completes the response.

c) If the Covered Entity receives a request and requires information from the Business Associate in addition to the Covered Entity's onsite information to fulfill the request, the Business Associate shall have thirty (30) days from date of Covered Entity's notice to provide access or deliver such information to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day requirement of 45 CFR § 164.524.

d) If the Party designated above responding to the Individual's request is unable to complete the response to the request in the time provided, that Party shall provide the Individual with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Party may extend the response time once for no more than thirty (30) additional days.

2.8 Individuals' Request to Amend PHI. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, regarding an Individual's request to amend PHI. The Business Associate shall make the amendment promptly in the time and manner designated by Covered Entity, but shall have thirty (30) days notice from Covered Entity to complete the amendment to the Individual's PHI and to notify the Covered Entity upon completion.

2.9 Recording of Designated Disclosures of PHI. Business Associate agrees to document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

2.10 Accounting for Disclosures of PHI. The Business Associate agrees to provide to Covered Entity or to an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. The Covered Entity shall forward the Individual's request requiring the participation of the Business Associate to the Business Associate in a timely manner, after which the Business Associate shall provide such information as follows:

a) If Covered Entity directs Business Associate to provide accounting of disclosures of the Individual's PHI directly to the Individual, the Business Associate shall have sixty (60) days from the date of the Individual's request to provide access to or deliver such information to the Individual. The Covered Entity shall provide notice to the Business Associate in time to allow the Business Associate a minimum of thirty (30) days to timely complete the Individual's request.

b) If the Covered Entity elects to provide the accounting to the Individual, the Business Associate shall have thirty (30) days from date of Covered Entity's notice of request to provide information for the Accounting to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day period.

c) If either of the Parties is unable to complete the response to the request in the times provided above, that Party shall notify the Individual with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Parties may extend the response time once for no more than thirty (30) additional days.

d) The accounting of disclosures shall include at least the following information: (1) date of the disclosure; (2) name of the third party to whom the PHI was disclosed, (3) if known, the address of the third party; (4) brief description of the disclosed information; and (5) brief explanation of the purpose and basis for such disclosure.

e) The Parties shall provide one (1) accounting in any twelve (12) months to the Individual without charge. The Parties may charge a reasonable, cost-based fee, for each subsequent request for an accounting by the same Individual if he/she is provided notice and the opportunity to modify his/her request. Such charges shall not exceed any applicable State statutes or rules.

2.11 Minimum Necessary. Business Associate agrees it must use reasonable efforts to limit any use, disclosure, or request for use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.11.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, PHI shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.11.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.11.3 Business Associate agrees to adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity

2.12 Privacy Compliance Review upon Request. Business Associate agrees to make its internal practices, books and records, including policies, procedures, and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of Covered Entity available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.13 Cooperation in Privacy Compliance. Business Associate agrees to fully cooperate in good faith and to assist Covered Entity in complying with the requirements of the Privacy Rule.

2.14 HITECH Act Compliance. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) was adopted as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act and its implementing regulations impose new requirements on Business Associates with respect to privacy, security, and breach notification. These provisions of the HITECH Act and the regulations applicable to Business Associates are collectively referred to as the "HITECH BA Provisions." The HITECH BA Provisions shall apply commencing on February 17, 2010, or such other date as may be specified in the applicable regulations, whichever is later (Applicable Effective Date).

Business Associate hereby acknowledges and agrees that to the extent it is functioning as a Business Associate of Covered Entity, Business Associate will comply with the HITECH BA Provisions and with the obligations of a Business Associate as proscribed by HIPAA and the HITECH Act commencing on the Applicable Effective Date of each such provision. Business Associate and the Covered Entity further agree that the provisions of HIPAA and the HITECH Act that apply to business associates and that are required to be incorporated by reference in a business associate agreement are incorporated into this Agreement between Business Associate and Covered Entity as if set forth in this Agreement in their entirety and are effective as of the Applicable Effective Date and as amended.

3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Compliance with Security Rule. Business Associate agrees to fully comply with the requirements under the Security Rule applicable to "business associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Security Safeguards and Policies. Business Associate agrees to 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 on behalf of the covered entity as required by the Security Rule. This includes specifically, but is not limited to, the utilization of technology commercially available at the time to the Business Associate to protect the Covered Entity's PHI against any reasonably anticipated threats or hazards. The Business Associate understands that it has an affirmative duty to perform a regular review or assessment of security risks, conduct active risk management and supply best efforts to assure that only authorized persons and devices access its computing systems and information storage, and that only authorized transactions are allowed. The Business Associate will maintain appropriate documentation of its compliance with the Security Rule.

3.3 Security Provisions in Business Associate Contracts. Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI received from, maintained, or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI supplied by Covered Entity, shall execute a bilateral contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, incorporating the same restrictions and conditions in this Agreement with Business Associate regarding PHI.

3.4 Tennessee Consumer Notice of System Breach. Business Associate understands that the Covered Entity is an "information holder" (as may be Business Associate) under the terms of Tenn. Code Ann. § 47-18-2107, and that in the event of a breach of the Business Associate's security system as defined by that statute and Definition 1.2 of this agreement, the Business Associate shall indemnify and hold the Covered Entity harmless for expenses and/or damages related to the breach. Such obligation shall include, but is

not limited to, the mailed notification to any Tennessee resident whose personal information is reasonably believed to have been acquired by an unauthorized individual. In the event that the Business Associate discovers circumstances requiring notification of more than one thousand (1,000) persons at one time, the person shall also notify, without unreasonable delay, all consumer reporting agencies and credit bureaus that compile and maintain files on consumers on a nationwide basis, as defined by 15 U.S.C. § 1681a, of the timing, distribution and content of the notices. Substitute notice, as defined by Tenn. Code Ann. § 47-18-2107(e)(2) and (3), shall not be permitted except as approved in writing in advance by the Covered Entity. The parties agree that PHI includes data elements in addition to those included by "personal information" under Tenn. Code Ann. § 47-18-2107, and agree that Business Associate's responsibilities under this paragraph shall include all PHI.

3.5 Reporting of Security Incidents. The Business Associate shall track all security incidents as defined by HIPAA and shall periodically report such security incidents in summary fashion as may be requested by the Covered Entity, but not less than annually within sixty (60) days of the anniversary of this Agreement. The Covered Entity shall not consider as security incidents, for the purpose of reporting, external activities (port enumeration, etc.) typically associated with the "footprinting" of a computing environment as long as such activities have only identified but not compromised the logical network perimeter, including but not limited to externally facing firewalls and web servers. The Business Associate shall reasonably use its own vulnerability assessment of damage potential and monitoring to define levels of Security Incidents and responses for Business Associate's operations. However, the Business Associate shall expediently notify the Covered Entity's Privacy Officer of any Security Incident which would constitute a Security Event as defined by this Agreement, including any "breach of the security of the system" under Tenn Code Ann. § 47-18-2107, within FORTY-EIGHT (48) HOURS of any unauthorized acquisition including but not limited to use, disclosure, modification, or destruction of PHI by an employee or otherwise authorized user of its system of which it becomes aware. The Business Associate shall likewise notify the Covered Entity within FORTY-EIGHT (48) HOURS of event.

3.5.1 Business Associate shall identify in writing key contact persons for administration, data processing, Marketing, Information Systems and Audit Reporting within thirty (30) days of execution of this Agreement. Business Associate shall notify Covered Entity of any reduction of in-house staff persons during the term of this Agreement in writing within ten (10) business days.

3.6 Contact for Security Event Notice. Notification for the purposes of Sections 2.5, 3.4 and 3.5 shall be in writing made by certified mail or overnight parcel within FORTY-EIGHT (48) HOURS of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

Privacy Officer
Bureau of TennCare
310 Great Circle Rd.
Nashville Tennessee
Phone: (615) 507-6855
Facsimile: (615) 532-7322

3.7 Security Compliance Review upon Request. Business Associate agrees to make its internal practices, books, and records, including policies and procedures relating to the security of electronic PHI received from, created by or received by Business Associate on behalf of Covered Entity, available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

3.8 Cooperation in Security Compliance. Business Associate agrees to fully cooperate in good faith and to assist Covered Entity in complying with the requirements of the Security Rule.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Use of PHI for Operations on Behalf of Covered Entity. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services (i.e., treatment, payment or health care operations) for, or on behalf of, Covered Entity as specified in Service Agreements, provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity.

4.2 Other Uses of PHI. Except as otherwise limited in this Agreement, Business Associate may use PHI within its workforce as required for Business Associate's proper management and administration, not to include Marketing or Commercial Use, or to carry out the legal responsibilities of the Business Associate.

4.3 Third Party Disclosure Confidentiality. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or, if permitted by law, this Agreement, and the Service Agreement, provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached within FORTY-EIGHT (48) HOURS of event.

4.4 Data Aggregation Services. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation Services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B).

4.5 Other Uses Strictly Limited. Nothing in this Agreement shall permit the Business Associate to share PHI with Business Associate's affiliates or contractors except for the purposes of the Service Agreement(s) between the Covered Entity and Business Associate(s) identified in the "LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT" on page one of this Agreement.

4.6 Covered Entity Authorization for Additional Uses. Any use of PHI or other confidential TennCare information by Business Associate, its affiliate or Contractor,

other than those purposes of this Agreement, shall require express written authorization by the Covered Entity, and a Business Associate agreement or amendment as necessary. Activities which are prohibited include, but not are not limited to, Marketing, as defined by 45 CFR § 164.503 or the sharing for Commercial Use or any purpose construed by Covered Entity as Marketing or Commercial use of TennCare enrollee personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws.

4.7 Prohibition of Offshore Disclosure. Nothing in this Agreement shall permit the Business Associate to share, use or disclose PHI in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without express written authorization from the Covered Entity.

4.8 Data Use Agreement - Use and Disclosure of Limited Data Set. Business Associate may use and disclose a Limited Data Set that Business Associate creates for Research, public health activity, or Health Care Operations, provided that Business Associate complies with the obligations below. Business Associate may not make such use and disclosure of the Limited Data Set after any cancellation, termination, expiration, or other conclusion of this Agreement.

4.9 Limitation on Permitted Uses and Disclosures. Business Associate will limit the uses and disclosures it makes of the Limited Data Set to the following: Research, public health activity, or Health Care Operations, to the extent such activities are related to covered functions, including business planning and development such as conducting cost-management and planning-related analysis related to managing and operating Business Associates functions, formulary development and administration, development and improvement of methods of payment or coverage policies, customer service, including the provision of data analysis for policy holders, plan sponsors, or other customers, to the extent such activities are related to covered functions, provided that PHI is not disclosed and disclosure is not prohibited pursuant to any other provisions in this Agreement related to Marketing or Commercial use.

5. OBLIGATIONS OF COVERED ENTITY

5.1 Notice of Privacy Practices. Covered Entity shall provide Business Associate with the notice of Privacy Practices produced by Covered Entity in accordance with 45 CFR § 164.520, as well as any changes to such notice.

5.2 Notice of Changes in Individual's Access or PHI. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses.

5.3 Notice of Restriction in Individual's Access or PHI. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use of PHI.

5.4 Reciprocity for Requests Received by Business Associate. The Parties agree that this Section (Section 5) is reciprocal to the extent Business Associate is notified or receives an inquiry from any individual within Covered Entity's covered population.

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 Requests Permissible under HIPAA. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy or Security Rule.

7. TERM AND TERMINATION

7.1 Term. This Agreement shall be effective as of the date on which it has been signed by both parties and shall terminate when all PHI which has been provided, regardless of form, by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if the Parties agree that it is unfeasible to return or destroy PHI, subsection 7.3.5 below shall apply.

7.2 Termination for Cause. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Agreement in the event Business Associate fails to comply with, or violates a material provision of this Agreement and any provision of the Privacy and Security Rules.

7.2.1 Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

a) Provide notice of breach and an opportunity for Business Associate to reasonably and promptly cure the breach or end the violation, and terminate this BAA if Business Associate does not cure the breach or end the violation within the reasonable time specified by Covered Entity; or

b) Immediately terminate this BAA if Business Associate has breached a material term of this BAA and cure is not possible; or

c) If termination, cure, or end of violation is not feasible, Covered Entity shall report the violation to the Secretary.

7.3 Effect of Termination. Upon termination of this Agreement for any reason, except as provided in subsections 7.3.2 and 7.3.5 below, Business Associate shall at its own expense either return and/or destroy all PHI and other confidential information received, from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision applies to all confidential information regardless of form, including but not limited to electronic or paper format. This provision shall also apply to PHI and other confidential information in the possession of sub-contractors or agents of Business Associate.

7.3.1 The Business Associate shall consult with the Covered Entity as necessary to assure an appropriate means of return and/or destruction and shall notify the Covered Entity in writing when such destruction is complete. If information is to be returned, the Parties shall document when all information has been received by the Covered Entity.

7.3.2 This provision (Section 7.3 and its subsections) shall not prohibit the retention of a single separate, archived file of the PHI and other confidential TennCare information by the Business Associate if the method of such archiving reasonably protects the continued privacy and security of such information and the Business Associate obtains written approval at such time from the Covered Entity. Otherwise, neither the Business Associate nor its subcontractors and agents shall retain copies of TennCare confidential information, including enrollee PHI, except as provided herein in subsection 7.3.5.

7.3.3 The Parties agree to anticipate the return and/or the destruction of PHI and other TennCare confidential information, and understand that removal of the confidential information from Business Associate's information system(s) and premises will be expected in almost all circumstances. The Business Associate shall notify the Covered Entity whether it intends to return and/or destroy the confidential with such additional detail as requested. In the event Business Associate determines that returning or destroying the PHI and other confidential information received by or created for the Covered Entity at the end or other termination of the Service Agreement is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible.

7.3.4 Except for Business Associate Agreements in effect prior to April 21, 2005 when the Security Rule became effective, for the renewal or amendment of those same Agreements, or for other unavoidable circumstances, the Parties contemplate that PHI and other confidential information of the Covered Entity shall not be merged or aggregated with data from sources unrelated to that Agreement, or Business Associate's other business data, including for purposes of data backup and disaster recovery, until the parties identify the means of return or destruction of the TennCare data or other confidential information of the Covered Entity at the conclusion of the Service Agreement, or otherwise make an express alternate agreement consistent with the provisions of Section 7.3 and its subsections.

7.3.5 Upon written mutual agreement of the Parties that return or destruction of PHI is unfeasible and upon express agreement as to the means of continued protection of the data, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

8. MISCELLANEOUS

8.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and/or Security Rule means the section as in effect or as amended.

8.2 Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act,

Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended, including, but not limited to, changes required by the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

8.3 Survival. The respective rights and obligations of Business Associate under Section 7.3 of this Agreement shall survive the termination of this Agreement.

8.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

8.5 Headings. Paragraph Headings are used in this Agreement are for the convenience of the Parties and shall have no legal meaning in the interpretation of the Agreement.

8.6 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice. (For purposes of this section, effective notice to "Respective Party" is not dependent on whether the person named below remains employed by such Party.) The Parties agree to use their best efforts to immediately notify the other Party of changes in address, telephone number, fax numbers and to promptly supplement this Agreement as necessary with corrected information. **Notifications relative to Sections 2.5, 3.4 and 3.5 of this Agreement must be reported to the Privacy Officer pursuant to Section 3.6.**

COVERED ENTITY:	BUSINESS ASSOCIATE:
Darin Gordon Director State of TN Department of Finance and Adm. Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 Phone: (615) 507-6443 Fax: (615) 253-5607	Douglas Haaland, Regional President Cariten Health Plan, Inc. 1420 Centerpoint Blvd. Knoxville, TN 37932 Phone: (865) 470-8401 Fax: (865) 470-7472

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

8.7 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

8.8 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

8.9 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA and without giving effect to principles of conflicts of law. Jurisdiction shall be Davidson County, Nashville, Tennessee, for purposes of any litigation resulting from disagreements of the parties for purpose of this Agreement and the Service Agreement (s).

8.10 Compensation. There shall be no remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative requirements of Tennessee State government and Services Agreement(s) referenced herein.

IN WITNESS WHEREOF, the Parties execute this Agreement to be valid and enforceable from the last date set out below:

BUREAU OF TENNCARE

By: Darin Gordon /SN

Darin Gordon, Director

Date: 6/22/11

State of Tennessee, Dept of Finance & Adm.
310 Great Circle Road
Nashville, Tennessee 37243
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BUSINESS ASSOCIATE

By: Douglas E Haaland

Douglas Haaland, Regional President

Date: JUNE 21, 2011

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ATTACHMENT C

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 GREAT CIRCLE ROAD
NASHVILLE, TENNESSEE 37228

Trading Partner Agreement

THIS TRADING PARTNER AGREEMENT (Agreement) is between **The State of Tennessee, Department of Finance and Administration, Bureau of TennCare,** 310 Great Circle Road, Nashville, TN 37243 (TennCare) and CARITEN HEALTH PLAN, INC. located at 1420 CENTERPOINT BLVD, KNOXVILLE, TN 37932 (Trading Partner), including all office locations and other business locations at which Trading Partner data may be used or maintained. TennCare and _____ as Trading Partner may be referred to herein individually as "Party" or collectively as "Parties."

1. PURPOSE and BACKGROUND

1.1 TennCare by law, in its capacity as the Medicare/Medicaid Agency for the State of Tennessee, must operate the TennCare Medicaid Management Information System (TCMIS). The TCMIS system contains information regarding claims adjudication, eligibility verification, prior authorization and other information related to the TennCare Program.

1.2 TennCare owns the data in the TCMIS and operates the system in which the claims and eligibility data flow. Trading Partners provide the pipeline network for the transmission of electronic data; thus, are required to transport TCMIS data to and from TennCare and providers of TennCare services.

1.3 This Agreement delineates the responsibilities of TennCare and the Trading Partner in transporting TCMIS data for TennCare in its operation of the TennCare Program.

1.4 This Agreement is ancillary to any State Revenue Contract (SRC), Contractor Risk Agreement (CRA) and Business Associate Agreement (BAA) entered into between the parties where applicable. The provisions of the SRC, CRA and BAA are hereby incorporated by reference and shall be taken and considered as a part of this Agreement the same as if fully setout herein.

2. SCOPE

2.1 System Access. TennCare agrees to provide Trading Partner with electronic access to TennCare TCMIS systems and network for the purpose of exchanging transactions via Trading Partners' computer systems and network or their authorized designee's computer systems and network.

2.1.1 To the extent Trading Partner executes a contract with TennCare service providers, or their authorized designee (clearinghouse, Virtual Access Network (VAN), billing service, etc.), Trading Partner shall represent that it has on hand all necessary authorizations for submitting and receiving TennCare TCMIS data. Said contract must stipulate that providers use software tested and approved by Trading Partner as being in the proper format and compatible with the TennCare TCMIS system.

2.1.1.1 Trading Partner agrees that the TennCare TCMIS data transmitted or received by it shall be released only in support of the terms of an executed contract between Trading partner and the authorized party requesting information to the extent authorized party's request is for the purposes of reporting eligibility for Medicaid benefits specific to individuals and dates of service and a treatment relationship exists to support and justify the authorized party's request in keeping with this Agreement.

2.1.2 Prior to the submission of any transactions to the TennCare TCMIS production systems, Trading Partner agrees to submit test transactions to TennCare for the purpose of determining that the transactions comply with all requirements and specifications required by TennCare.

2.1.3 Successful transaction testing must be achieved by Trading Partner for each provider number that the Trading Partner represents before any production transaction submissions are processed for that provider. No electronic transaction received by TennCare for providers without successful transaction testing shall be processed.

2.1.4 The parties agree that TennCare shall make the sole determination that test data is acceptable and that transaction testing is successful. This capability to submit test transactions shall be maintained by Trading Partner throughout the term of this Agreement.

2.2 Transaction Types. Trading Partner agrees to submit to the TennCare TCMIS only those individual transaction types for which specific approval from TennCare has been requested and received via the Electronic Data Interchange (EDI) Request Form. Prior to the submission of any transaction types to the TennCare TCMIS production system, or as a result of making changes to an existing transaction type or system, Trading Partner agrees to submit test transactions to TennCare for both the additional and any previously approved transaction types.

2.3 Data Submission. Trading Partner shall prepare and submit or receive TCMIS data using network connectivity, protocols, and media approved by TennCare. The addition and deletion by TennCare of approved submission network connectivity, protocols, and media may occur from time to time. To the extent the deletion of a network connectivity, protocol, or media is contemplated from the approved list, TennCare shall supply the Trading Partner with ninety (90) days notice of the date of impending deletion.

2.4 Transmission Speed. For electronic transmission, such as File Transfer Protocol (FTP), that does not involve the physical exchange of storage media, the Trading Partner agrees to provide a minimum design transmission speed of 56 kilobits per second (KBS) with an effective transmission speed of at least eighty percent (80%) of the design transmission speed on a dedicated, secure channel or Virtual Private Network (VPN) from the Trading Partner data center to the TennCare facility. Trading Partner is free to choose type of channel and ultimate speed above 56 KBS. Trading Partner must coordinate any equipment selection or changes with TennCare to ensure compatibility with the TennCare facilities. Trading Partner is responsible for all costs including installation costs, equipment, and line charges.

2.5 Data Encryption. Trading Partner must encrypt all data transmitted on channels not otherwise secured and maintain full compatibility with TennCare facilities. TennCare reserves the right to determine when encrypted transmissions are necessary and what encryption technologies and implementations are considered sufficiently secure.

2.6 Compression/Decompression. Trading Partner must be capable of compressing and transmitting and receiving and decompressing transaction data files that are compressed and decompressed using the algorithms commercially known as "zip" or "gzip."

2.7 Network Connectivity Agreement. Trading Partner shall execute a Network Connectivity Agreement with the State of Tennessee.

3. DEFINITIONS

3.1 "Confidential Information" shall mean any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is supplied by TennCare to the Trading Partner under this Agreement. Any information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, relating to individuals enrolled in the TennCare program ("TennCare enrollees"), or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained through the Trading Partner's performance under this Agreement, shall also be treated as "Confidential Information" to the extent that confidential status is afforded such information under state and federal laws or regulations. All confidential information shall not be subject to disclosure under the Tennessee Public Records Act.

3.2 "Covered entity" shall mean (1) A health plan.(2) A health care clearinghouse.(3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 & 164.

3.3 "*En Masse* Inquiry" shall mean data matching of less than fifty percent (50%).

3.4 "Health care clearinghouse" shall mean a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following functions: (1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction. (2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

3.5 "Health care provider" shall mean a provider of services (as defined in section 1861(u) of the Act, > 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, > 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

3.6 "Health plan" shall mean an individual or group plan that provides, or pays the cost of, medical care information or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. A covered entity must limit any request for protected health information to that which is reasonably necessary to accomplish the purpose for which the request is made, when requesting such information from other covered entities.

3.7 "Individually identifiable health information" means any information, including demographic information collected from an individual, that (a) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (b) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and identifies the individual; or, with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

3.8 "Payment" shall mean (1) The activities undertaken by: (i) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or (ii) A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and (2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided.

3.9 "Proprietary Information" shall mean TennCare processes, procedures, software, methods and any property of, or relating to, TennCare data.

3.10 "Protected Health Information" shall mean individually identifiable health information, that is transmitted by electronic media, maintained in electronic media; or transmitted or maintained in any other form or medium.

3.11 "Standard Eligibility Transaction" shall mean the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 270/271 eligibility inquiry from a sender that is a health plan or health care provider and the designated response from TennCare.

3.12 "Treatment" shall mean the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

3.13 "Treatment Relationship" shall have the following meanings:

3.13.1 "Direct Treatment Relationship" shall mean a treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.

3.13.2 "Indirect Treatment Relationship" shall mean a relationship between an individual and a health care provider in which (1) The health care provider delivers health care to the individual based on the orders of another health care provider; and (2) The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

4. COMPLIANCE

4.1 Trading Partner agrees to comply with all State and Federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Agreement, including, but not limited to, ancillary agreements such as the SRC, CRA and BAA (Section 1).

4.1.1 Proprietary and Confidential Information [See 3.1 & 3.9]. All proprietary information, including but not limited to, provider reimbursement information provided to TennCare, shall be deemed confidential and not subject to disclosure under the Tennessee Public Records Act.

4.1.2 Duty to Protect. Confidential Information (i) shall be held by the Trading Partner in strictest confidence at all times; (ii) shall not be disclosed or divulged by the Trading Partner to any person or entity, except those employees and agents of the Trading Partner who require access to such information, and only after those employees and agents have been instructed that the information is subject to the confidentiality obligations set forth herein; and (iii) shall not be used by the Trading Partner for any purpose not set forth herein or otherwise authorized in writing by TennCare. The Parties shall diligently exercise the highest degree of care to preserve the security and integrity of, and prevent

unauthorized access to, the Confidential Information. By executing this Agreement, Trading Partner and TennCare assure that each respective organization has established written policies and procedures relating to confidentiality, including the confidentiality of protected health information and eligibility information. The Trading Partner and TennCare further assure, by executing this Agreement, that its respective organization has implemented administrative, technical and physical safeguards and mechanisms that protect against the unauthorized or inadvertent disclosure of confidential information to any person or entity outside its organization.

4.1.3 Any information obtained by TennCare Trading Partners, intermediaries or carriers in the course of carrying TennCare agreements shall not be disclosed and remain confidential; furthermore, such requests which have been made pursuant to the Freedom of Information Act (FOIA) shall be denied under authority of an appropriate FOIA exemption.

4.2 Explicit Data Sharing. TennCare contemplates data sharing within the ambit of HIPAA to include, but not be limited to, specific testing environments for the purpose of establishing a treatment relationship or to respond to Medicare Advantage plan finder file eligibility inquiries for the purpose of identifying dual eligibles enrolled in the Medicare Advantage plan.

Such transactions shall be implemented under the health care operations exception set forth in HIPAA and for payment purposes, respectively.

4.2.1 Data Storage. Trading Partner, if a Health care Clearinghouse, shall not store eligibility information received on behalf of a request by a subscriber provider except to the extent confirmation of delivery is necessary. In no event shall Trading Partner store eligibility information beyond a reasonable threshold period defined by TennCare, nor shall Trading Partner retain TennCare related data for independent third-party documentation without prior approval and written authorization from TennCare.

4.2.2 To the extent Trading Partner is classified as a Health care Clearinghouse, Trading Partner shall not inquire *en masse* for eligibility data for an entire subscriber provider roster where the inquiry is not in the context of immediate treatment, payment or health care operations.

To the extent Trading Partner is classified as a Health care Clearinghouse, Trading Partner may forward requests on behalf of and on the explicit request of health care provider subscribers who in turn can request the eligibility data only to support a direct patient treatment relationship and verification of eligibility to support treatment, payment or health care operations for a patient who represents that he/she is covered by Medicaid or whom the health care provider reasonably believes to be covered by Medicaid.

4.2.3 Prohibition of Data Mining. Trading Partner is prohibited from any and all automated extraction of predictive information from data for the purpose of finding patterns of behavior and trends or anomalies that may otherwise escape detection, the advanced statistical analysis and modeling of the data to find useful patterns and relationships, and

the use of computational techniques involving statistics, machine learning and pattern recognition to analyze the data.

4.3. Treatment Relationship. To the extent data sharing or EDI is utilized between the Parties for the purposes of provision, coordination or management of a treatment relationship, such use or disclosure shall be governed by strict compliance with return and destruction of protected health information (PHI) referenced in Section 9.3 of this Agreement.

4.3.2 Medicare Advantage Plan. TennCare may use or disclose PHI for its payment purposes, as well as for the payment purposes of another covered entity that receives the information. TennCare will accept and respond to Medicare Advantage plans' "finder files" to enable Medicare Advantage plans to claim the appropriate payment rate for their dual eligible enrollees pursuant to the limiting provisions within this Agreement.

4.3.2.1 Access/Usage Fee. TennCare reserves the right to amend this Agreement to institute fees predicated upon Trading Partner's access to and usage of TennCare enrollee data absent a bidirectional relationship for such data.

4.3.3 Suspension of Access. TennCare reserves the right to suspend Trading Partner's access in the event of Trading Partner's inappropriate use of access as determined by TennCare, including, but not limited to, in the event fifty percent (50%) of Trading Partner requests received are not matched. TennCare may evaluate such patterns for indications of inappropriate use, including inquiry outside of the context of immediate treatment, payment or healthcare operations, or where the Trading Partner has no reasonable cause to believe that information requested was for individuals eligible for TennCare.

5. CLAIMS, CHARGES AND PAYMENT

5.1 Consideration. The Trading Partner certifies that all services for which reimbursement will be claimed shall be provided in accordance with all federal and state laws pertaining to the TennCare Program.

5.1.1 The Trading Partner certifies that all charges submitted for services and items provided shall not exceed Trading Partner's and/or Provider's usual and customary charges for the same services and items provided to persons not entitled to receive benefits under the TennCare Program.

5.1.2 The Trading Partner understands that any payments made in satisfaction of claims submitted through Electronic Media shall be delivered from federal and state funds and that any false claims, statements or documents, or concealments of a material fact may be subject to prosecution under federal and state law.

5.2 Access. The Trading Partner and/or Provider shall allow TennCare access to claims data and assures that claims data shall be submitted by authorized personnel so as to preclude

erroneous payments received by the Trading Partner and/or Provider regardless of the reason for such erroneous payments.

6. HIPAA GUIDELINES FOR ELECTRONIC TRANSACTIONS

6.1 HIPAA Transactions. TennCare has adopted the HIPAA transaction standards and has created companion documentation to assist in conducting electronic transactions with TennCare. The ASC X12 and National Council for Prescription Drug Programs (NCPDP) standards required by HIPAA regulation are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of common interchange structures.

6.2 Capacity. TennCare shall acknowledge standard HIPAA X12 transactions from an authorized trading partner. No other transactions are acknowledged including proprietary formats and those from an unauthorized submitter.

6.3 HIPAA Companion Guide. All TennCare specific information can be found in the TennCare HIPAA Companion Guide, which is a de facto part of this Trading Partner Agreement. The TennCare HIPAA Companion Guide is a multi-part document that can be accessed from the TennCare website or provided by e-mail via written request.

6.3.1 270/271 Healthcare Eligibility Benefit Inquiry/Response. Transaction Standard for Eligibility for a Health Plan - This transaction is used by fee-for-service (FFS) providers to receive eligibility information about a subscriber. TennCare may also use this transaction set to verify eligibility for a third party health plan or Medicare Advantage plan. Data sharing or EDI utilized between the Parties shall be for the purposes of provision, coordination or management of a current treatment relationship or for an enrollee for whom an open balance exists which has been timely filed and is within TennCare's look-back time parameters.

6.3.2 276/277 Health Care Claim Status. Transaction Standard for Health Care Claim Status and Response – This transaction is used by the FFS provider to get the status of a claim.

6.3.3 278 Referral Certification and Authorization. Transaction Standard for Referral Certification and Authorization – This transaction is used by FFS providers to request prior authorization for clients receiving services from a FFS provider.

6.3.4 820 Payment Order/Remittance Advice. Transaction Standard for Health Plan Premium Payments – This transaction shall be sent to the Managed Care Contractors (MCCs) and shall contain the capitated payment summary for the month.

6.3.5 834 Benefit Enrollment and Maintenance. Transaction Standard for Enrollment and Disenrollment in a Health Plan – This transaction is sent to the MCCs and shall contain enrollment information for the MCC. A 271U response transaction that primarily contains service limits information is always distributed with an 834.

6.3.6 835 Remittance Advice. Transaction Standard for health Care Payment and Remittance Advice - This transaction is used by FFS providers to receive an electronic remittance advice.

6.3.7 837 Professional. Transaction Standard for Health Care Claims or Equivalent Encounter Information: Professional – This transaction is used to submit professional claims from FFS providers and encounter data information from the MCCs.

6.3.8 837 Dental. Transaction Standard for Health Care Claims or Equivalent Encounter Information: Dental - This transaction is used to submit dental encounter data from the Dental MCC.

6.3.9 837 Institutional. Transaction Standard for Health Care Claims or Equivalent Encounter Information: Institutional - This transaction is used to submit institutional claims from FFS providers and encounter data information from the MCCs.

6.3.10 NCPDP 1.1. Transaction Standard for Health Care Claims or Equivalent Encounter Information: Pharmacy - This transaction is used to submit retail pharmacy crossover claims from the Durable Medical Equipment Regional Carrier (DMERC) and encounter data information from the Pharmacy MCC.

7. ELECTRONIC DATA INTERCHANGE (EDI) DOCUMENTS

7.1 EDI Request Form. The EDI Request Form outlines all transactions used between TennCare and the Trading Partner including HIPAA transactions and proprietary formats. For most proprietary formats, the transaction name is sufficient identification information; however, a file format and/or additional clarification data for any proprietary format may be appended to the EDI Request Form, if necessary.

7.1.1 Updates to the EDI Request Form may be made at any time by mutual agreement of both parties. Each update of the EDI Request Form supersedes all prior versions; therefore, each EDI Request Form must contain all transactions between both parties.

7.2 Acknowledgment. All transactions received by TennCare shall receive a 997 acknowledgement regardless of their HIPAA status.

7.2.1 Each Trading Partner has the option to send back to TennCare 997 acknowledgement transactions on all formats, except the TennCare outbound 834 and 271U transactions, which require acknowledgements. The Trading Partner must indicate their acknowledgement intent for every transaction on the EDI Request Form.

7.2.2 Any transaction, per the Trading Partner Agreement, requiring an acknowledgement back to TennCare where an acknowledgement is not received, shall result in a transmission re-send before the next update cycle is processed.

7.3 Transaction Tables. The "Transaction Frequency" column shall contain the anticipated normal frequency of this transaction. Anticipated values are "D" for daily, "W" for weekly, "S" for semi-monthly, "M" for monthly, "Q" for quarterly, "A" for annually, "R" for on-request, "O" for other. Multiple indicators may be used for a transaction that has multiple processing cycles.

7.3.1 The "Transaction Source" column shall contain the origination source for the transaction. For transactions that come from TennCare, this column is already filled in with "TennCare". For transactions from the Trading Partner, "TP" may be used. For transactions created by a third party for the Trading Partner, enter the third party's name.

7.3.2 The "Trading partner access person" column shall contain the name(s) of all individuals listed on the Security Forms below who shall access the given transaction.

7.3.3 The blank transaction rows on the request form are for proprietary file formats. Each production file sent between TennCare and the Trading Partner shall be represented on this form. Trading Partners that have multiple sources for a given transaction should include the file format once for each source.

7.4 Unique Identifier. TennCare shall assign a unique identification number or "Submitter ID" to every trading partner. For most trading partners, the Submitter ID shall be based upon tax ID – Employer Identification Number (EIN) or Social Security Number (SSN) – since the tax ID is already a required identifier on many HIPAA transactions. The assigned Submitter ID shall be used on all HIPAA transactions. The Submitter ID shall be used as the Receiver ID for transactions that originate from TennCare.

7.4.1 The Trading Partner may provide a GS02 sender code on the EDI Request form. This code shall be used as the GS03 receiver code for transactions originating from TennCare. A default value of the Trading Partner's Submitter ID shall be used if a value is not specified.

7.4.2 See attached EDI Request form.

8. SECURITY

8.1 Security Forms. Trading Partner shall complete an acknowledgement of the TennCare Acceptable Use Policy for every individual that shall access the TennCare System. TennCare's security standards and the Center for Medicare and Medicaid Services (CMS) privacy and security regulations require the assignment of individual IDs.

8.1.1 See attached TennCare Acceptable Use Policy.

8.1.2 For all forms requiring signatures, two (2) signed copies of completed forms must be mailed to TennCare Security at the TennCare address above. All forms must be completed as accurately as possible.

8.1.3 Upon processing of security forms, TennCare will countersign and return one copy of the forms for Trading Partner's files, along with Trading Partner's pertinent sign-on information.

8.1.4 Additional Security Forms may be submitted by the Trading Partner at any time after the execution of this Agreement to request access for additional individuals. Standard TennCare processing shall apply to the additional requests.

8.2 Terminated Employees - Security. It is the responsibility of the Trading Partner to notify TennCare when a listed individual leaves the employment of the Trading Partner or has a legal name change. Failure to do so may result in the contract termination.

8.3. Access Request. Trading partner shall submit a completed TennCare Access Request form for each type of access desired for the transmission or reception of transaction data, and for each Trading Partner workforce individual controlling such transmissions or receptions.

8.3.1 The Trading Partner shall submit for TennCare's approval a list of from one (1) to three (3) Trading Partner workforce individuals authorized to submit Access Requests on behalf of the Trading Partner.

8.3.2 It is the responsibility of the Trading Partner to notify TennCare when a Trading Partner workforce individual authorized to submit Access Request forms leaves the employment of the Trading Partner or has a legal name change.

8.3.3 See attached Access Request form.

8.4 Network Connectivity Agreement. The Trading Partner shall complete and provide to TennCare a State of Tennessee Network Connectivity Agreement. It is the responsibility of the Trading Partner to notify TennCare, by providing an updated Network Connectivity Agreement, any material changes to their systems and networks that would have impact on their connectivity with the State of Tennessee's networks.

8.4.1 See attached Network Connectivity Agreement.

9. TERM AND TERMINATION

9.1 Term. This Agreement shall be effective as of the last date on which it has been executed by the Parties below and shall terminate three (3) years from its effective date.

9.1.1 TennCare reserves the right to extend this Agreement for a(n) additional period(s) of time representing increments of no more than one (1) year and a total term of no more than five (5) years, provided that TennCare notifies the Trading Partner in writing of its intention to do so at least six (6) months prior to the Agreement expiration date. An extension of the term of this Agreement shall be effected through an amendment to the Agreement.

9.1.2 This Agreement may be terminated by either party by giving at least thirty (30) days advanced written notice to the other party. Any provisions required by State or Federal

statue shall survive the expiration, cancellation, or termination of this Agreement.

9.2 Termination for Cause. This Agreement authorizes and Trading Partner acknowledges and agrees TennCare shall have the right to immediately terminate this Agreement and suspend operations, including, but not limited to, all processing operations, or any part thereof, or payments to providers, if Trading Partner fails to comply with, or violates a material provision of this Agreement.

9.2.1 Upon TennCare's knowledge of a material breach by Trading Partner, TennCare shall either:

(i) Provide notice of breach and an opportunity for Trading Partner to reasonably and promptly cure the breach or end the violation, and terminate this Agreement if Trading Partner does not cure the breach or end the violation within the reasonable time specified by TennCare; or

(ii) Immediately terminate this Agreement if Trading Partner has breached a material term of this Agreement and cure is not possible; or

(iii) If termination, cure, or end of violation is not feasible, TennCare shall report the violation to the Secretary.

9.3 Effect of Termination. Upon termination of this Agreement for any reason, Trading Partner shall, at its own expense, either return and/or destroy all confidential information (including PHI) received, from TennCare or created or received by Trading Partner on behalf of TennCare. This provision applies to all confidential information regardless of form, including but not limited to electronic or paper format. This provision shall also apply to PHI and other confidential information in the possession of sub-contractors or agents of Trading Partner.

9.3.1 The Trading Partner shall consult with TennCare as necessary to assure an appropriate means of return and/or destruction and shall notify TennCare in writing when such destruction is complete. If information is to be returned, the Parties shall document when all information has been received by TennCare.

9.3.2 9.3.1 shall not prohibit the retention of a single separate, archived file of the confidential TennCare information by the Trading Partner if the method of such archiving reasonably protects the continued privacy and security of such information and the Trading Partner obtains written approval at such time from TennCare. Otherwise, neither Trading Partner nor its subcontractors and agents shall retain copies of TennCare confidential information, including enrollee PHI, except as provided herein.

9.3.3 The Parties agree to anticipate the return and/or the destruction TennCare confidential information, and understand that removal of the confidential information from Trading Partner's information system(s) and premises will be expected in almost all circumstances. The Trading Partner shall notify TennCare whether it intends to return and/or destroy the confidential information with such additional detail as requested. In the event Trading Partner determines that returning or destroying confidential

information received by or created for TennCare at the end or other termination of this Agreement is not feasible, Trading Partner shall provide to TennCare notification of the conditions that make return or destruction unfeasible.

9.3.4 The Parties contemplate confidential information of TennCare shall not be merged or aggregated with data from sources unrelated to this Agreement, or Trading Partner's other business data, including for purposes of data backup and disaster recovery, until the parties identify the means of return or destruction of the TennCare data or other confidential information of TennCare at the conclusion of this Agreement, or otherwise make an express alternate agreement consistent with the provisions of this Section.

9.3.5 Upon written mutual agreement of the Parties that return or destruction of all TennCare confidential information is unfeasible and upon express agreement as to the means of continued protection of the data, Trading Partner shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI or other confidential information to those purposes that make the return or destruction unfeasible, for so long as Trading Partner maintains such PHI or other confidential information.

10. GENERAL PROVISIONS

10.1 Regulatory Reference. A reference in this Agreement to a State or Federal law or regulation means the State or Federal law or regulation as in effect or as amended.

10.2 Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary to comply with related State and Federal regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended.

10.3 Assignment. Trading Partner shall not sell, transfer, assign or dispose of this Agreement, whole or in part, or any right, title or interest therein, to any other party without the express written consent of TennCare. Such consent, if granted, shall not relieve Trading Partner of its obligations under the Agreement.

10.4 Billing Service(s). In the event a billing service is used, the Trading Partner hereby certifies that the billing service is authorized to submit claims on the Trading Partner's behalf using Electronic Media. The Trading Partner agrees that if the billing agreement with the billing service is terminated, the Trading Partner shall immediately report the termination in writing to TennCare. The Trading Partner must complete a new security agreement and testing cycle when making a change from one billing service to another.

10.5 Entire Agreement. This Agreement, together with all addenda attached hereto and incorporated by reference herein, and construed in conjunction with a Service Agreement or State contract, contains the entire agreement of the parties and supersedes any previous understanding, commitment or agreement, oral or written, concerning the subject matter hereof, all of which are hereby incorporated. Any change to this Agreement shall be effective only when set forth in writing and executed by the parties.

10.6 Prohibition of Offshore Disclosure. Nothing in this Agreement shall permit the Trading Partner to share, use or disclose TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without prior approval and express written authorization from TennCare.

10.7 Survival. The respective rights and obligations of Trading Partner under Section 9.3 of this Agreement shall survive the termination of this Agreement.

10.8 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Trading Partner and TennCare to comply with State and Federal laws or regulations.

10.9 Headings. Paragraph Headings are used in this Agreement are for the convenience of the Parties and shall have no legal meaning in the interpretation of the Agreement.

10.10 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice. (For purposes of this section, effective notice to "Respective Party" is not dependent on whether the person named below remains employed by such Party.) The Parties agree to use their best efforts to immediately notify the other Party of changes in address, telephone number, fax numbers and to promptly supplement this Agreement as necessary with corrected information.

BUREAU OF TENNCARE:	**TRADING PARTNER:**
Darin Gordon, Director	DOUGLAS E. HAALAND
Department of Finance and Adm.	REGION PRESIDENT
Bureau of TennCare	HUMANA, INC
310 Great Circle Road	1420 CENTERPOINT BLVD
Nashville, TN 37243	KNOXVILLE, TN 37932
(615) 507-6443	865-470-8401
Fax: (615) 253-5607	Fax: 865-470-7472

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

10.11 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

10.12 Severability. With respect to any provision of this Agreement finally determined by a -- court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

10.13 TennCare Liability. TennCare shall have no liability except as specifically provided in this Agreement.

10.14 Intellectual Property. Neither party shall acquire any rights in the other party's Proprietary and/or Confidential Information under this Agreement except the limited rights necessary to perform or carry out the intended purposes set forth in this Agreement. This Agreement grants no license by either party to the other, either directly or by implication, estoppel or otherwise. All right, title and interest emanating from ownership of the Proprietary and/or Confidential Information shall remain vested in TennCare.

10.15 Injunctive Relief. The parties acknowledge that any remedy at law for the breach or threatened breach of the provisions of this Agreement may be inadequate to fully and properly protect TennCare and, therefore, the parties agree that TennCare may be entitled to injunctive relief in addition to other available remedies; provided, however, that nothing contained herein shall be construed as prohibiting TennCare from pursuing any other remedies available in law or in equity for such breach or threatened breach.

10.16 Force Majeure. The obligations of the parties to this Agreement 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, acts of God, riots, wars, strikes, epidemics or any other similar cause.

10.17 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by federal legislation and without giving effect to principles of conflicts of law. Jurisdiction shall be Davidson County, Nashville, Tennessee, for purposes of any litigation resulting from disagreements of the parties for purpose of this Agreement.

IN WITNESS WHEREOF, the Parties execute this Agreement to be valid and enforceable from the last date set out below:

BUREAU OF TENNCARE

By: Darin J Gordon /SCP

Date: 6/22/11

Darin J. Gordon, Director
State of Tennessee, Dept of Finance & Adm.
310 Great Circle Road
Nashville, Tennessee
(615) 507-6443
Fax: (615) 253-5607

TRADING PARTNER

By: Douglas E. Haaland

Date: JUNE 21, 2011

DOUGLAS E. HAALAND, REGION PRESIDENT
HUMANA, INC
1420 CENTERPOINT BLVD
KNOXVILLE, TN 37932
865-470-8401
Fax: 865-470-7472